Clinical Breakout: Tailored Approaches for Special Populations

People of Color, LGBTQ+ and Pregnant Women,

Eboni C. Winford, Ph.D.
Cherokee Health Systems

Amanda Antenucci, LCSW, MAC
Outside –In
Portland, OR

Deborah Borne, MSW, MD
San Francisco Department of Public Health
Goals

1. Identify two cultural biases that may affect treatment of underserved, stigmatized, and marginalized patients

2. Describe two culturally sensitive approaches that are applicable to each population discussed;

3. Describe two strategies to identify and address culturally insensitive practices within your own organization.
Let’s get on the same page

• Diversity
  • A core value, NOT a destination
  • Characterized by inclusiveness, integration, mutual respect, and multiple perspectives
Let’s get on the same page

- Inclusion
  - KEY factor for diversity to exist and thrive
  - Creating an environment that fosters belonging, respect, and value for all persons
Cultural Competence

• Awareness of one’s own assumptions, biases, cultural background, and values
• Exploring (with kindness) own world view and that of our diverse patients
• Developing interventions that are personalized and sensitive to our patients’ needs and values
How Do We Build Cultural Competence?

• Consider CRASH approach
  • CULTURE
  • RESPECT
  • ASSESS/AFFIRM
  • SENSITIVITY/SELF-AWARENESS
  • HUMILITY

“To be culturally humble means that I am willing to learn,”
- Joe Gallagher
Culture

• Unique worldview
  • Shared values, perceptions, connections, historical roots, traditions/customs, language
• Interactions between pt’s worldview and their experience of healthcare
Respect

• Understanding that demonstrations of respect are more important than gestures of affection
  • Building rapport with a foundation of mutual respect and understanding

• Finding ways to learn how to demonstrate respect in various cultural contexts
Assess/Affirm

• Assess
  • Recognize within-group differences
  • If relevant, asking about identity, beliefs, understanding of health conditions (remember invisible minorities)
  • Assess their language preferences, acculturation-level, and health literacy

• Affirm
  • Validate that each person as the expert on his/her own world experience
  • Understanding cultural differences as assets to treatment and engagement in healthcare
Sensitivity/Self-Awareness

• Sensitivity
  • Awareness of specific issues within each culture that may negatively impact the relationship between patient and professional
  • Remember: the responsibility to learn is on you; patient should not feel compelled to teach you

• Self-awareness
  • Awareness of one’s own worldview, cultural norms, societal beliefs, values and “hot-button” issues that may impact delivery of services
Humility

• “Cultural competence” as a lifetime commitment to learning
• Understanding contextual factors surrounding our own perspectives and biases
• Being quick to apologize and accept responsibility for cultural missteps
• Embracing opportunity to learn and expand your worldview
Unearned Privilege

- Privilege: When a group of people are entitled to get special things just based on the group they belong to, even thought they have done nothing to deserve it

- Ex. Being left-handed in a right-handed world
  - Left-handed people adapt to function in a world designed opposite to them
  - Right-handed people often do not realize that they have this privilege. **However, anyone who does not have this unearned privilege is very aware of it.**
Barriers to Treatment

**Structural**
Later referrals to tx, higher rates of involuntary commitment, fewer specialty services in specific communities

**Provider**
More frequent misdiagnosis, bias, lack of cultural competency, fewer providers of similar backgrounds

**Individual/cultural**
Delayed problem recognitions (meds), delayed entry into tx, fear of stigma/discrimination, historical mistrust of providers

**Historical**
Past studies (Tuskegee syphilis study), “running away” from slavery as a disease, politics in the media
Cultural Mistrust

• “Healthy paranoia”
  • Based on recent and generational history, current laws, and past interactions with healthcare providers
  • Homelessness in healthcare
• Perceiving majority-group providers as less culturally competent/sensitive than those who have similar backgrounds
  • What does LGBTQIA stand for?
  • Difference between political asylee and refugee?
  • Process of deportation? Typical length of immigration proceeding?
• Cultural belief of “keeping family business at home”
  • Low health-literacy given limited access to healthcare in the past
Consider Protective Factors

- Positive identity development has been shown to buffer effects of oppression
- Strong bonds of family/kinship are source of strength and support (may include friends and neighbors)
- Religious institutions and spiritual beliefs are sources of strength
- Conceptualizing their values as functions of behavior
Engage Minority Patients in Care

• Structural characteristics of the provider
  • Culturally-welcoming environment
  • Ethnic compatibility of staff
  • Flexible hours
  • Child-care arrangements

• Interpersonal characteristics of the provider
  • Engaging in collaborative & active problem-solving (reduce mistrust)
  • Taking time to build trust and rapport
  • Use multiple treatment modalities (personalize treatment)
  • Addressing cultural differences as appropriate (avoid bringing it up all the time)
  • Avoid assumption that racial similarities will enhance therapeutic relationship or outcome
We Will All Make Mistakes

• Offer respectful guidance and correction when you observe something that is not culturally sensitive
• Accept correction from peers/colleagues nondefensively
• Advocate for the patient
• Attend continuing education series
• Ask—never assume
• Model respectful behavior

Hello, my pronouns are they · them
Hello, my pronouns are she · her
Hello, my pronouns are he · him

Hello, my pronouns are
Ask me... about my pronouns
Culturally Sensitive Care Takes Practice

• Be aware of your biases—we all have them
• Don’t make assumptions
• Remember the golden rule—even if “others” are not like you
• Keep calm, and remember our values and mission
Tailored Approaches to Special Populations: Working with Transition Age LGBTQ+ Youth

Amanda Antenucci, LCSW, MAC
Behavioral Health Director
Portland’s Homeless Youth Continuum

53% are people of color

47% are LGBTQ

10% transgender and/or gender nonconforming

93% have psychiatric and/or substance use related disability
A 2014 study of 601 homeless youth reported that up to 60% met criteria for a substance use disorder.

Polysubstance use is common among homeless youth.

Homeless youth with substance use issues are more likely to have co-occurring mental health disorders.
Transgender Care
Why is it important to be affirming?

According to a 2015 U.S. Transgender Survey of 28,000 transgender individuals (18 and older):

- 19% reported being uninsured
- 50% reported having to educate their providers on transgender related care
- 33% of those who saw a health care provider had at least one negative experience related to being transgender, such as being verbally harassed or refused treatment because of their gender identity.
- 23% of respondents reported that they did not seek the health care they needed due to fear of being mistreated as a transgender person. This percentage is higher among transgender people of color.
- 33% did not go to a health care provider when needed because they could not afford it.
Barriers to Care for Youth Experiencing Homelessness

- Lack of knowledge of services
- Stigma of seeking help
- Past and current negative experience with providers
- Poor coordination of services
- Lack of transportation
- Care being unaffordable
- Fear of being reported to police or CPS and ending up in justice or foster systems
- Not being age of consent for care
- Perception that there are not available services
Needs of LGBTQ Youth Experiencing Homelessness

PRIORITY OF NEEDS Cited by LGBQ Youth

- Housing
- Acceptance/Emotional Support
- Employment
- Health Care
- Other
- Education

PRIORITY OF NEEDS Cited by Transgender Youth

- Housing
- Transition Related Support
- Employment
- Health Care
- Other
- Education
Screen for LGBTQ Competency at hire

All agency spaces are queer informed.

Clinic and Youth Department have trans and LGB specific services

Prioritize competent services for LGBTQ youth

Agency has a history of taking radical stances on political issues

Staff call each other out- in a supportive way

Serving queer youth is part of our mission

Staff gets to know people

When I see someone who is queer, I feel safe.

They ask my pronoun preference and remember it

You know, we use drugs. It’s a safe place to be real about what’s going on

Staff are down to earth
Pronouns

Pronouns are a linguistic tool used to refer to someone in the third person.

- Pronouns are not “preferred”, pronouns are mandatory.
- Ask someone “what are your pronouns?” or “what pronouns do you use?”
- Introduce yourself with your own, this creates equity for transgender/gender variant people.
Pronouns

- **She/Her:** “*She* is a writer and wrote that book *herself*. Those ideas are *hers*. I like both *her* and *her* ideas.”

- **He/Him:** “*He* is a writer and wrote that book *himself*. Those ideas are *his*. I like both *him* and *his* ideas.”

- **They/Them:** “*They* are a writer and wrote that book *themself*. Those ideas are *theirs*. I like both *them* and *their* ideas.”

- **Ze/Hir:** “*Ze* is a writer and wrote that book *hirsself*. Those ideas are *hirs*. I like both *hir* and *hir* ideas.”

*When in doubt, use their name and/or they/them pronouns. Don’t make assumptions.*
What to **DO** if you mispronoun someone

Don’t panic. Accidents happen.....

- Apologize.
- Correct. And correct others.
- Move on.
- Practice.

**Examples:**

“I was talking to her, sorry him, and blah blah blah....”

“She was, I mean, they were blah blah blah....”

“He wasn’t *stops self* she wasn’t blah blah blah.....”

*Practice makes practiced. Put the person’s image in your mind’s eye, so to speak, and practice the syntax of dialogue, in your head, with consenting friends, on your own time.*
What NOT to do if you mispronoun someone

• Don’t dwell.
• Don’t move on without correcting.
• Don’t get upset when you’re corrected.
• Don’t make excuses.

Examples:

“I was talking to her, sorry them. Oh my god, I’m so sorry, I’ve really been trying but it’s just so hard ya know? I’ve always used she/her or he/him my whole life so it’s just difficult to learn blah blah etc.....”

“He was, sorry not he, they. I don’t know why I always do that. I’m really trying, I’m so sorry, will you forgive me? I’ll try harder next time”

Dwelling on the mistake and seeking forgiveness from the person that was initially harmed can be worse and have a more prolonged emotional effect. By doing so, it puts the person on the receiving end of the mispronoun situation in a place where they are now responsible to soothe/forgive/ease tension when the initial transgression was against them.
Take Aways

• Assertive Outreach
• Use Peer Support Specialists
• Wrap around, coordinated care to include mental health care
• Hire staff with similar racial, cultural, and identity backgrounds
• Pay attention to pronouns and ask!
• Make your support of LGBTQ populations visible
• Flexible scheduling, as much as possible
Amanda Antenucci, LCSW, MAC
Behavioral Health Director
amandaa@outsidein.org

www.outsidein.org
Care of Pregnant Cis-Gender Women who use Opiates
Learning Objectives

• Understand why treating pregnant patients before, during and after delivery is important

• Learn how provider bias and system barriers can undermine effectiveness of care

• Identify elements of a successful care model used to treat pregnant women experiencing homelessness and using substances
HCH cares for woman of reproductive age.

Nationally, girls/women of reproductive age (age 15-44):

• 23% of all HCH patients
• 26% of all Health Center patients
HCH cares for women who have a history of pregnancy
Survey cis-women living on the street and encampments

**Have you ever been pregnant? (n=55)**

- 91% Yes
- 9% No

**Have you ever given birth? (n=50)**

- 70% Yes
- 30% No

By Age Group:

<table>
<thead>
<tr>
<th>Age Group</th>
<th>&lt;25</th>
<th>25-39</th>
<th>40-55</th>
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</thead>
<tbody>
<tr>
<td>Yes</td>
<td>2</td>
<td>37</td>
<td>8</td>
</tr>
<tr>
<td>No</td>
<td>5</td>
<td>1</td>
<td>3</td>
</tr>
</tbody>
</table>
Many women living on the street have had their children removed or relinquished:
Survey cis-women living on the street and encampments n=35
If you could start any birth control today, what one would you choose?

40%: none

30%: Birth Control Pills

20%: Condom

10%: IUD

Society for Family Planning Innovations Grant: Planning for vs. preventing pregnancy among women experiencing homelessness: Newmann S, Seidman D, Shapiro B, Borne D,
Pregnancy Intentions

Would you like to be pregnant in the next year?

👍 40% staying at encampments
👍 86% at methadone clinics

How would you feel if you found out you were pregnant today?

😊 50% happy
😢 14% unsure

Society for Family Planning Innovations
Grant: Planning for vs. preventing pregnancy among women experiencing homelessness: Newmann S, Seidman D, Shapiro B, Borne D,
Nearly 9 out of 10 pregnancies among women with OUD are unplanned.
The system often fails to engage women postpartum

- Cohort of pregnant women living with HIV
  - At delivery 90% of woman were virally suppressed
  - Viral suppression falls postpartum:
    - 67% viral suppression at 6 months
    - 44% at 12 months
- Cohort of men and women living with HIV, chronic co-morbidities and homelessness
  - Women who had their children removed or relinquished had the lowest rates of viral suppression and becoming housed
Why should HCH providers support women during pregnancy?

- HCH cares for women of reproductive age: most are pregnant, have been pregnant or want to be pregnant.
- Many women do not stay in care after giving birth.
- Women who have had their children removed or relinquished have experienced increased trauma and stigma.
- Pregnancy is an unique opportunity to make a change in the trauma/stigma cycle.
- We must take care of women at all stages of their lifecycle.
• From 2000 through 2012, the incidence of maternal opiate use during pregnancy increased from 1.19 to 5.77 per 1,000 hospital live births each year.

• Every 25 minutes an infant is born with chronic opioid withdraw also known as neonatal abstinence syndrome.

• Source – National Institute on Drug Abuse, 2017
Some Information Adapted from ACOG District II Presentation Opioid Use Disorder Bundle, 2018

ARE OPIOID PAIN MEDICATIONS SAFE FOR WOMEN WHO ARE PREGNANT OR PLANNING TO BECOME PREGNANT?

Possible risks to your pregnancy include\(^1\):^2:

- **Neonatal Opioid Withdrawal Syndrome (NOWS):** withdrawal symptoms (irritability, seizures, vomiting, diarrhea, fever, and poor feeding) in newborns\(^3\)
- **Neural tube defects:** serious problems in the development (or formation) of the fetus’ brain or spine
- **Congenital heart defects:** problems affecting how the fetus’ heart develops or how it works
- **Gastroschisis:** birth defect of developing baby’s abdomen (belly) or where the intestines stick outside of the body through a hole beside the belly button
- **Stillbirth:** the loss of a pregnancy after 20 or more weeks
- **Preterm delivery:** a birth before 37 weeks

LEARN MORE | [www.cdc.gov/drugoverdose/prescribing/guideline.html](http://www.cdc.gov/drugoverdose/prescribing/guideline.html)
Women who use opiates also frequently experience:

- Cigarette smoking (77–95%)
- Alcohol
- Stimulants
- Comorbid psychiatric illness
- Inadequate prenatal care
- Poor nutrition
- Chronic medical problems,
- Domestic violence
Why use Medication Assisted Treatments for Pregnant Women?

- Avoid withdrawal and fetal stress
- Maintain abstinence from heroin or other opioids (unknown quantity and dose)
  - Overdose prevention
- Mothers can be impacted by toxemia, communal infections, Hepatitis C, HIV, hypertension, miscarriage and even death
- Used during pregnancy to provide overall safety for the pregnant woman and the fetus

Some information adapted from ACOG District II Presentation Opioid Use Disorder Bundle, 2018
Policy impacts health and access

- **23 states** (and DC) substance use during pregnancy is child abuse under civil child-welfare statutes,
  - **3** consider it grounds for civil commitment.
- **25 states** (and DC) require health care professionals to **report** suspected prenatal drug use,
  - **8 states** require them to test for prenatal drug exposure if they suspect drug use.
- **19 states** have specifically targeted to pregnant women,
- **17 states** (and DC) provide pregnant women with priority access to state-funded drug treatment programs.
- **10 states** prohibit publicly funded drug treatment programs from **discriminating** against pregnant women.
Check out your state

• SUD Considered Child Abuse
• WHEN DRUG USE DIAGNOSED OR SUSPECTED, STATE REQUIRES
  • Grounds for Civil Commitment
  • Reporting
  • Mandatory test
• Drug treatment
  • Priority access
  • Targeted program
  • Non discrimination

Pregnant women who are experiencing homelessness or are housing insecurity and use substances...

• Less likely to seek PNC because of provider bias and a lack of wrap around services

• Often feel that providers and care team operate with an “equality perspective” rather than an “equity perspective”

AND

• Are strong beyond measure

• Lean on religion and social support

• Want quality care

• Are the experts in what they need
Reduce the Stigma

• Emphasize that stigma, bias and discrimination negatively impact pregnant women with OUD and their ability to receive high quality care.

• Change perceptions of opioid use disorder through the use of a common language and emphasize that SUDs are chronic medical conditions that can be treated.

• Use appropriate language, approach, inquiry and support.

• DO not ask about anything you cant do something about.
Approaches to Care

SYSTEM WRANGLERS
How does your birthing hospital handle patients with SUD – what is their philosophy?

You need to know!
Education for You and Your Team

• Ensure that you and your team are all on the same page regarding harm reduction interventions/programs for patients

• Work collaboratively to ensure appropriate levels of treatment maintained throughout the delivery

• Plan for Post Partum

• Identify community resources with which to partner (e.g., agencies that treat SUD, domestic violence shelters, WIC, home visiting agencies etc.)

Some Information Adapted from ACOG District II Presentation Opioid Use Disorder Bundle, 2018
Levels of Support for Pregnant Women Experiencing Homelessness and Using Substances

- **Homeless**
  - HCH & OB
  - Clinic Based Social Work & Care Coordination

- **Navigation**
  - Nurse-Family Partnership
  - Public Health Nurse- (PHN)
    - ‘CHW’

- **Case Management & BH care**
  - Homeless Outreach Team
  - ‘OB Based intensive service- Team Lily’

- **Mobile Medical**
  - ‘Street Medicine’

Healthy Moms & Babies Stay in Care!
Clinical Guidance for Treating Pregnant and Parenting Women With Opioid Use Disorder and Their Infants

Key Take-Aways:

- Women’s health across the lifecycle needs to be part of all HCH Medicated Assisted Treatment Programs
- HCH providers must be trained on reproductive autonomy and bias about pregnancy, substance use & homelessness
- Our programs must embody HCH values and mission and have policies to include pregnant women in care and center their experience
- Partner with public health nursing, housing providers, local labor and delivery and others to serve pregnant women
- You don’t have to be a pregnancy expert—you can partner with one. You are the HCH expert!
THANK YOU!

Deborah Borne
Deborah.Borne@sfdph.org
415-225-1074
Let's Talk......

• Wow! I can't believe I.....

• When I go back to work I am going to.....

• I will discuss this with my colleagues.....

• I will ask a consumer.....
• National Health Care for the Homeless Council: https://www.nhchc.org/

• SAMHSA: Homeless Programs Resources

• Matthew Bennet: https://connectingparadigms.org/

• American Journal of Public Health: https://ajph.aphapublications.org/toc/ajph/108/S7

• Unexpected https://www.nfb.ca/film/unexpected/

  • This short film from the Filmmaker-in-Residence project is a provocative and transformative dialogue between homeless mothers and healthcare professionals who deliver babies.
Research and Resources

• PREGNANT WOMEN AND SUBSTANCE USE Overview of Research & Policy in the United States 2017 [https://publichealth.gwu.edu/sites/default/files/downloads/JIWH/Pregnant_Women_and_Substance_Use_updated.pdf]


Research and Resources

• https://store.samhsa.gov/series/pregnancy-and-opioid-use-disorder


• Treating Women Who Are Pregnant and Parenting for Opioid Use Disorder and the Concurrent Care of Their Infants and Children, Literature Review to Support National Guidance
  • Klaman, Stacey L. MPH; Isaacs, Krystyna PhD; Leopold, Anne MSc; Perpich, Joseph MD, JD; Hayashi, Susan PhD; Vender, Jeff MLIS; Campopiano, Melinda MD; Jones, Hendrée E. PhD
• https://journals.lww.com/journaladdictionmedicine/Fulltext/2017/06000/Treating_Women_Who_Are_Pregnant_and_Parenting_for.4.aspx
### Methadone or Buprenorphine?

<table>
<thead>
<tr>
<th>Considerations</th>
<th>Buprenorphine</th>
<th>Methadone</th>
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</table>
| **Patient Selection**   | • new to treatment because it is easier to transfer from buprenorphine to methadone  
                          | • who do not like or want methadone, or who have requested this medication.  
                          | • Could not tolerate daily pick up                                                  | • do not like or want buprenorphine treatment or who have requested this medication. |
| **Treatment Retention** | Some studies show treatment dropout is higher than that for methadone.       | Some studies show treatment retention is higher than that for buprenorphine                      |
| **Starting Dose**       | 2–4 mg                                                                        | 20–30 mg                                                                                       |
| **Target Dose**         | Daily, 16 mg or product equivalent to 16 mg, is the most common dosage.      | Daily, 80–120 mg. Many women need split dosing by third trimester                             |
| **Risk of NAS**         | • NAS may be milder  
                          | • proximately 50% of exposed neonates are treated for NAS                                      | Approximately 50% of exposed neonates are treated for NAS.                                    |
| **Time to NAS Onset and Duration of NAS** | • Monitor neonates for a minimum of 4–7 days after delivery  
                          | • Most studies show shorter NAS duration compared with methadone.                            | Monitor neonates for a minimum of 4–7 days after delivery                                       |
| **Breastfeeding Considerations** | Generally safe if the mother is stable and no other substance | Generally safe if the mother is stable.                                                     |
Buprenorphine

- Bup is a high-affinity partial agonist opioid that is SAFE in pregnancy and highly effective for treating opioid use disorder.
- If patient is stable on methadone or prefers methadone, recommend continuation of methadone as first-line treatment.
- Fetal Monitoring is not required to start Bup in a normal pregnancy regardless of gestational age.
- Admission for observation is NOT required at Bup starts.
- Bup/Nx or Bup mono-product is OK in Pregnancy.
- Split dosing and an increase in total Bup dose is often necessary esp in later trimesters
NEONATAL ABSTINENCE SYNDROME

Neonatal Abstinence Syndrome (NAS) occurs when a child born to a substance-using mother develops a passive dependency to the substance, and expresses symptoms once the supply of the drug is cut off after birth (Finnegan, 2016).

NAS is usually apparent within the first 24-72 hours after birth. These symptoms are temporary and generally last a few weeks.

NAS symptoms fall into four clinical categories: central nervous system signs (including irritability, crying, tremors, and seizures), gastrointestinal signs (including vomiting and diarrhea), respiratory signs (including abnormal or rapid breathing), and autonomic nervous system signs (including sneezing, tearing, yawning, and sweating) (Finnegan, 2016).

Several factors affect whether an infant will experience NAS, including separation from the mother and genetics. NAS can occur in the infants of women who are currently undergoing medication-assisted treatment and are no longer using drugs illicitly. Prescription opioid dependency medication, such as methadone, also can cause the infant to experience NAS (Finnegan, 2016).
Words Matter

Use
- Alcohol, drug use disorder
  - Addiction
  - Person with/who...
- Opioid Agonist treatment
- Medication Assisted Treatment
- (Agonist) treatment
- Positive/negative (test)
- Unhealthy
- At-risk, risky, hazardous
- Heavy use, episode
- (Return to) use
- Low risk

Avoid
- Abuse, abuser, user, addict, alcoholic
- Substitution, replacement
- Clean, dirty
- Misuse*
- Heavy use
- Relapse
- Binge*
- Dependence*
- Problem
- Inappropriate

*Instances where use may be clinically appropriate (eg, dependence for a patient dependent upon prescribed opioids but not addicted)

Source: Boston University School of Public Health
## Words Matter

<table>
<thead>
<tr>
<th><strong>DON'T USE</strong></th>
<th><strong>DO USE ✓</strong></th>
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<tbody>
<tr>
<td>Dehumanizing, demeaning, demoralizing language, such as:</td>
<td>People-first language that confers dignity and respect, such as:</td>
</tr>
<tr>
<td>Addict/fiend</td>
<td>It's important to distinguish between problematic use and personal use—not all people who use a drug are inherently addicted.</td>
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<tr>
<td></td>
<td><em>When speaking generally, say:</em> person who uses drugs.</td>
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<td></td>
<td><em>When talking about a specific issue, say:</em> person who has a problematic relationship with drugs.</td>
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<tr>
<td>Get clean, Clean drug test</td>
<td>Stay away from this term, which implies that a person was previously “dirty.”</td>
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<td></td>
<td><em>Instead say:</em> a person who formerly used drugs. When possible, ask the person directly how they refer to themselves and their journey.</td>
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<td><em>If referring to a test, say:</em> test was negative, test was not positive for a substance.</td>
</tr>
<tr>
<td>Junkie, Crackhead, Zombie, Tweaker</td>
<td>Do not use dehumanizing terms for people who use various substances—that contributes to the othering, stigmatizing, and discrimination of people who have needs.</td>
</tr>
<tr>
<td></td>
<td><em>Instead say:</em> person who uses injection drugs/crack cocaine/synthetic cannabinoids, if in fact it's necessary to specify.</td>
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<tr>
<td>Expression</td>
<td>Definition</td>
</tr>
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<tr>
<td>&quot;Those&quot; people</td>
<td>Don’t use othering language that draws false distinctions among people.</td>
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<td><em>Instead:</em> use inclusive language and describe the group or individual</td>
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</tr>
<tr>
<td></td>
<td>using people-first language.</td>
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<tr>
<td>Crazy vs. &quot;normal&quot; (acting/behavior)</td>
<td>Avoid using terms that refer to mental illness—unless that's truly</td>
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<td></td>
<td>what's being discussed.  Also stay away from speech that defines</td>
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<td></td>
<td>mainstream actions or behavior as normal—which implies those who don't</td>
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<td></td>
<td>fall in line with that are wrong.</td>
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<td></td>
<td><em>Instead:</em> celebrate difference and diversity of experiences and approaches.</td>
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<tr>
<td>Crack baby</td>
<td>This label is not scientifically supported and leads to damaging stereotyping.</td>
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<tr>
<td></td>
<td>A major long-term study has shown that there is no statistically significant</td>
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<td>difference in health or life outcomes for babies exposed to crack in utero.</td>
</tr>
<tr>
<td></td>
<td>Poverty—not drugs—was found to pose a much higher danger to children's</td>
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<tr>
<td></td>
<td>outcomes.</td>
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<tr>
<td></td>
<td><em>Instead say:</em> pre-natal exposure to a controlled substance.</td>
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<tr>
<td>“Poisoning themselves”</td>
<td>Stigmatizing use only makes it harder for people to ask for help when they</td>
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<td></td>
<td>need it. Due to prohibition many people are hesitant to seek help for fear</td>
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<tr>
<td></td>
<td>of criminalization and stigmatizing—we should avoid speaking in ways that</td>
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<td></td>
<td>reinforce stigma.</td>
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<tr>
<td>“New” crack</td>
<td>This analogy reinforces fear-mongering. Our response to crack was</td>
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<tr>
<td></td>
<td>criminalization, but we're in a different era now—prioritizing public</td>
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<td></td>
<td>health and harm reduction—and harkening back to the crack era plays on</td>
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<td></td>
<td>hysteria and harmful stereotypes.</td>
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<tr>
<td>Synthetic marijuana</td>
<td>An inaccurate term that perpetuates the myth that novel substances such as</td>
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<td></td>
<td>K2 and Spice are like marijuana when synthetic cannabinoids actually</td>
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<tr>
<td></td>
<td>have quite different, and more powerful, effects than marijuana.</td>
</tr>
<tr>
<td>Offender/inmate</td>
<td><em>Instead say:</em> formerly incarcerated person.</td>
</tr>
<tr>
<td>Drawing distinctions (type of drug, violent/nonviolent crime)</td>
<td>It’s best to stay away from creating unnecessary distinctions, such as</td>
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<td></td>
<td>whether someone sniffs a drug or injects, or between how a crime is</td>
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<tr>
<td></td>
<td>classified, since those differences are often arbitrary and lead to</td>
</tr>
<tr>
<td></td>
<td>othering.</td>
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<tr>
<td>“Crack down” / cut off the supply</td>
<td>Prohibition and criminalization as a strategy has failed in the past and</td>
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<td></td>
<td>won’t work now. There are more drugs, and they’re more accessible, than</td>
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<td></td>
<td>ever before. Trying to stop the market only pushes it underground and</td>
</tr>
<tr>
<td></td>
<td>makes it less safe. Also, “cutting off supply” often victimsizes</td>
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<tr>
<td></td>
<td>substance-level sellers without solving the problem.</td>
</tr>
</tbody>
</table>
Body Language Matters, too

Use
- Genuine compassion - this COULD happen to anyone
- Thoughtful interpretation of the patient’s situation - direct eye contact, taking the extra minute to be sure she knows you CARE
- Sit at her level and talk with her not at her
- Pause often for patient to continue sharing

Avoid
- Standing over the patient while talking
- Looking away while she is talking - comes across as either inpatient or dismissive
- Crossing your arms in front of patient - implies I am better than you
- Interrupting her talking - you come across as telling not inquiring

Source: Boston University School of Public Health
Recognize that pregnancy is a great window of opportunity to empower women to care for their baby and, as a result of her care of the baby, benefits herself.

Establish your practice’s approach and be consistent!

What is opioid use disorder and who is affected (universal terminology and definitions for common language) - covered!

Offer strategies to engage the patient and how to overcome barriers in her life to successful outcomes (Navigators can help!)

What medications are appropriate during pregnancy?
  
  • Medication Assisted Treatment (MAT): Methadone vs. Buprenorphine (ie, Subutex/Suboxone) regimens - and accept patients who are NOT willing to take the treatment
Reduce the Stigma of using MAT

Change perceptions of opioid use disorder through the use of a common language and emphasize that SUDs are chronic medical conditions that can be treated.

- Strive to use language that helps reduce stigma, accurately reflects science, promotes evidence-based treatment, and demonstrates respect for patients. For example, replace “drug abuser” with “person with a substance use disorder” or “in recovery” rather than being “clean.” (see slide 21 for more examples)

- Develop tools to educate multidisciplinary teams of providers on the use of non-judgmental and harm-reduction focused language and learn how to acknowledge and change implicit biases of providers. Engage all staff in training, including clinical, administrative, and all other office personnel.