Family Care PLANS

Creating Family Care Plans

for American Indian & Alaska Native Pregnant & Parenting People Experiencing Substance Use Disorders

A Guide for Healthcare Providers

NPAIHB
Indian Leadership for Indian Health

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American Indian and Alaska Native (AI/AN) pregnant and parenting people (PPP) experiencing substance use disorders (SUDs) and their infants, partners, and families benefit from high-quality healthcare that is:

- Part of an integrated network of community-based social, cultural, and spiritual supports
- Attuned to individual and family needs
- Evidence-based
- Culturally-responsive, and
- Holistic in nature.

This Guide

This guide offers healthcare providers recommendations that have been demonstrated to improve outcomes for PPP and their infants for three potential points of intervention: prenatally, during birth, and postnatally.

This guide also contains practical advice for developing and strengthening cross-system networks of community support essential for effectively addressing the expansive ways SUDs affect the lives of AI/AN PPP, and their infants, partners, and families.

Who Developed This Guide

This guide was developed in 2022 by the Northwest Portland Area Indian Health Board (NPAIHB), alongside Indian Health Service, Tribal, and Urban Indian (I/T/U) healthcare providers, and AI/AN individuals affected by SUDs. Together, we located, synthesized, and, at times, adapted available resources to aid I/T/U healthcare providers in supporting:

- AI/AN PPP transitioning into and remaining in active recovery
- Infants mending from substance exposure, and
- Affected partners, families, and communities in growing stronger.

Points of Intervention

Prenatal - Focus on identifying and encouraging pregnant people experiencing SUDs to access treatment services and wrapping these individuals and their partners and families in supportive medical, social, cultural, spiritual, and other services. Speak with pregnant people, their partners, and families about the role of child protective services.

Birth - Focus on identifying and addressing the needs of infants affected by prenatal substance exposure and withdrawal symptoms, including the immediate need for bonding and attachment. Develop support strategies that keep families together and minimize court and child welfare agency involvement where possible.

Postnatal - Focus on tending to the needs of the person who gave birth, as well as the needs of their infant, partner, and family affected by SUDs. Support a stable early care environment through a community-based, culturally-responsive approach. Offer home visitation programs, peer recovery supports, childcare, and parenting groups and classes, alongside integrated SUD care.

Prenatal Practices – Common Challenges and Key Considerations

Fear Stops Many AI/AN Pregnant People from Accessing Support Services

AI/AN pregnant people experiencing SUDs often face significant barriers to accessing care before birth. This results in a high numbers of AI/AN pregnant people with SUDs receiving little or no prenatal care.

Factors that inhibit AI/AN pregnant people from accessing prenatal care, include fears surrounding:

- Having their newborn (or other children) removed from the home
- Facing legal consequences, including incarceration, and
- Stigmatization and marginalization by service providers and others.

These fears cause many AI/AN pregnant people experiencing SUDs to self-isolate and avoid seeking care from social services and medical providers. Many of these individuals present to the emergency department (ED) late in pregnancy or in labor. This can make it difficult for healthcare providers to initiate certain potentially beneficial treatments, such as medications and facilitating connections to recovery groups and harm reduction services.

To address this, clinicians can:

- Work closely with service providers, including child protective services (CPS), peer recovery specialists, and others to spread the message that "your children may not be automatically removed from your care if you seek help." It is also important to share the message that "effective treatments are available for pregnant people experiencing SUDs wherever they happen to be at in their recovery journey."
- Establish formal agreements with CPS and written clinic policies to support parents in retaining custody of their newborns if they are actively engaged in SUD treatment.
- Encourage pregnant people and their partners and family members to access medical, social, cultural, spiritual, and other services by offering incentives (e.g., gift cards, diapers, and baby blankets). Not only does offering incentives support pregnant people and their partners and family members in obtaining needed supplies, it can also support them in developing positive care-seeking behaviors.

Notifying vs Reporting to Child Protective Services

Learn your responsibility for notifying vs reporting to CPS under the Child Abuse Prevention and Treatment Act (CAPTA). While notifying CPS is required by CAPTA when a provider identifies a substance-exposed infant, many states do not distinguish between *notifying* child welfare and *reporting* child abuse or neglect. This is an important distinction, because a notification does not contain information that identifies the individual who gave birth, whereas a report does.

If state law does not specifically define your use of notifying vs reporting to CPS, consider *notifying* child welfare services (and not reporting) if the individual experiencing an SUD is stable and engaged in treatment with a licensed physician. To learn more about your state's policies regarding notifying vs reporting, visit childwelfare.gov/state-resources. Here you can view your state's reporting policies. If this search does not yield adequate results, contact your state's child welfare agency.

Prenatal

- Collaborate with peer recovery specialists to support outreach and engagement with pregnant people experiencing SUDs. Peer recovery specialists can meet pregnant people in their homes, or wherever they are comfortable, and provide prenatal vitamins, harm reduction services (including routine vaccinations), and encourage pregnant people to schedule essential medical and social service visits. To learn more about the role of peer recovery specialists, view this resource.
- Learn about the history of systematic removals of AI/AN children from their parents. To effectively advocate for your patients, it is important to understand the historical context surrounding your patients' fears regarding child removals. Here is a useful article on the topic.
- Gather community resources so that you and your colleagues can connect individuals experiencing SUDs to medications, recovery groups, and harm reduction services.
- Focus efforts on treating all active SUDs, even if pregnant people have ongoing substance use.
- Provide priority access to services for pregnant people experiencing SUDs.
- When appropriate and safe to do so, involve the patient's partner and other supportive family members in all aspects of prenatal care.
- Deliver trauma-responsive services that incorporate the sanctuary model of care: an approach that provides a template for changing social service delivery systems, so that they are better equipped to respond to the complex needs of trauma survivors. This resource includes further details.
- Educate pregnant people and their partners and families on the fact that SUDs are chronic medical conditions that affect the mind, body, and spirit.
- Address healthcare worker and system stigma surrounding SUDs via regular staff training intended to reduce discriminatory practices in clinical settings. View these resources to support training efforts at your clinic.
- Create a consistent approach to caring for pregnant people that have a positive urine-drug test. Remember that, for many individuals experiencing SUDs, abruptly stopping all substance use is not a realistic expectation.

- Develop proactive approaches for addressing provider burnout that acknowledge providers' personal experiences and histories related to SUDs. Include connection with others doing this work, as well as cultural connectedness and other self-care strategies as means for mitigating burnout.
- Ensure healthcare and other providers use evidence-based assessment tools to identify appropriate levels of care and services for affected individuals.
- Train medical, social service, and other staff to communicate in non-stigmatizing, non-judgmental ways with pregnant people experiencing SUDs and their partners and families. This is essential for establishing a climate that fosters trust and assures individuals impacted by SUDs that they will not be criticized, judged, or shamed for seeking services.

Patient Education is Key

Patient education should be non-judgmental, culturally-responsive, and describe SUDs as chronic medical conditions that can be effectively addressed. Emphasize that recovery is possible. Stress the importance of connection to family, peers, culture, and community. Pregnant people should receive education regarding the medical effects of continued use of substances for both themselves and their infant. Finally, linkages to care to appropriate medical, social, cultural, spiritual, and other services should be discussed to ensure a holistic approach to care.

Based on: *Recommendations to the Indian Health Service on Neonatal Opioid Withdrawal Syndrome by the American Academy of Pediatrics*

Disconnected Services Create Cracks in the Care Delivery System

Disconnected services create cracks in the community care delivery system. Recovery works best when supported by comprehensive and tightly integrated support services. Research and practice demonstrate that individuals experiencing SUDs benefit from connection to a strong base of integrated community supports – such as those that provide food, clothing, transportation to and from medical and other service appointments, job and life skills development, and childcare. Although this is true, most SUD treatment programs accessible to AI/AN PPP lack an adequate level of comprehensiveness and integration. This results in medical, social, cultural, spiritual, and other support services being physically separated, difficulties coordinating care, and infrequent communication between cross-departmental or inter-agency care providers.

To address this, clinicians can:

- **Provide an integrated treatment model: where a range of outpatient medical, social, and other services are provided under one roof (or collaboratively) for PPP experiencing SUDs and their infants, partners, and families**

  Using an integrated model of care, where PPP experiencing SUDs are provided substance use counseling, along with mental and behavioral health services, primary medical care, social worker case management, and other needed services under one roof (or collaboratively), offers a 'one stop shop' for recovery. To serve the needs of infants impacted by SUDs, this model should also include the integration of pediatric and family medicine, as well as developmental care services. To serve the needs of partners and families impacted by SUDs, this model should include a family-centered approach. Research demonstrates that treatment, recovery, and family well-being outcomes improve when the complex needs of each family member are met through clinical treatment and related support services. Learn more about implementing a family-centered approach here.

Red Lake Recovery Care Program – Ensuring Pregnant and Parenting People Experiencing SUD Get Comprehensive Care

In 2017, Red Lake IHS Hospital staff saw long lag times between when pregnant patients experiencing SUDs were initially referred to treatment to when they were finally able to access care. According to Dr. Kari Josefson, a family nurse practitioner, "patients would come into primary care highly motivated, but as days or months went by, their motivation waned. We knew we needed to fill that critical gap."

With funding obtained to do just that, Nikki Larsen, a registered nurse experienced in counseling patients on medication-assisted treatment, was hired. As a Care Coordinator working within the newly formed Recovery Care Program, Nikki began offering patients rapid assessment and connection to a comprehensive body of services, including behavioral health, social work, primary care, spiritual services, and Tribal programs that teach parenting skills, work to keep families together, and offer childcare, food, baby products, transportation, and housing. Nikki also prioritized connecting with providers and external partners. "I just started calling people and going to Tribal events, introducing myself and what we do, and asking other service providers what they offered. Little by little we grew our network, built trust, and spread the word about the program," said Nikki.

Around the same time, Teresa Grund, a seasoned Clinical Pharmacist working in Red Lake's behavioral health department, joined the Recovery Care Program

as a provider extender. Dr. Josefson, and other providers she encouraged, also received DATA waiver training to be able to effectively prescribe buprenorphine. This was fortunate, because as Nikki's outreach efforts paid off, the teams' patient population grew exponentially.

When COVID-19 emerged, the Recovery Care team recognized the spike in overdose and saw an opportunity to serve patients at a critical time when they were motivated to seek treatment. They reached out to the ED, where most people with overdose first landed, and encouraged ED staff to contact the Recovery Care team, now equipped to start patients on medications, if appropriate, and connect patients with an established network of medical and social service providers. "Our goal," said Teresa "is to encourage hospital staff to engage patients in treatment the moment they are ready, wherever that is – the ED, primary care, wherever. We try to meet patients where they are at, without judgment, and listen to their stories, so we can respond to what they need."

The Red Lake team's approach to care is paying off. In the last 6 months, their program has seen an increase in patient satisfaction- largely based off of word-of-mouth referrals from patients and providers from across the reservation. "When you are able to share with patients that 'we can help you here and now,' you see the weight being lifted off their shoulders. It's an amazing feeling," said Kari.

Comprehensive Integrated Models of Care Fill Cracks in the System

Using a comprehensive integrated model of care:

- Makes it less likely that PPP experiencing SUDs will be lost to follow-up
- Provides the opportunity for medical, social, cultural, spiritual, and other service providers to collaborate across disciplines
- Helps providers quickly recognize PPP and their partners and family members who are struggling and provide time-sensitive support
- Makes it more likely that PPP experiencing SUDs will successfully participate in treatment and recovery, and
- Increases the chance that families can be cared for and remain together.

didgʷálic Wellness Center

The didgʷálic (deed-gwah-leech) Wellness Center – owned and operated by the Swinomish Indian Tribal Community – is a multi-specialty outpatient treatment facility that according to John Stephens, the Center's CEO, "provides everything under one roof that a person experiencing opioid use disorder (OUD) might need."

Before this tight level of integration, said Stephens, "patients often encountered providers unfamiliar with treating their condition, as well as stigmatizing language and behaviors. They also struggled with securing transportation and childcare. These difficulties stopped many patients from actively engaging in medical and social services essential to their recovery."

In response, the Center developed a model of care that eliminates the need to refer patients out of house. They do this through offering personalized, intensive substance use disorder counseling by certified professionals, full-service medication-assisted treatment, primary medical care, hepatitis C screening and treatment, behavioral and mental health services, psychiatric diagnosis and medication management, acupuncture, naloxone training, social worker case management, group counseling and classes, and dental care all under one roof.

The Center also addresses patients' barriers to care through providing the following services:

- Free onsite childcare during visits for children 6 weeks to 12 years of age
- Free transport to/from appointments, classes, and groups via 15 passenger vans
- Transitional housing for women, men, and families
- Assistance with insurance enrollment

Today, people across Swinomish are noticing positive changes in their family members and friends who once experienced OUD. Patients at the Center are keeping appointments and meeting the goals of their treatment plans, and over a 12-month period from 2018 to 2019, the Center's client retention rate was over 75%, and opioid overdose deaths among Swinomish Tribal members dropped by 50%.

Innovative Ideas

Develop Increased Transportation Options

SUDs often affect peoples' ability to obtain consistent transportation to and from medical, social, cultural, spiritual, and other service appointments. To improve access to care, offer PPP experiencing SUDs and their infants, partners, and families free transportation during the times they attend appointments, classes, and group therapy.

Develop Onsite Childcare Opportunities

Although some PPP experiencing SUDs have multiple children, many I/T/U clinics do not offer onsite childcare. Without good options for safe childcare, some SUD-affected PPP cannot access services. To remedy this, offer free short-term childcare for PPP experiencing SUDs during the times they attend appointments, classes, and group therapy. Childcare services should be in close proximity to healthcare services to facilitate easy access. If you are a federal entity, consider collaborating with Tribal partners to explore the option of childcare services for PPP accessing clinical services.

Advocate for Transitional or Recovery Housing

Many individuals experiencing SUDs face homelessness or housing instability due to their substance use. Often low-income housing programs do not accept clients with felony records or recent evictions. This can make it particularly challenging for PPP experiencing SUDs to find stable, safe housing. Without safe and stable housing, it is challenging to fully participate in all aspects of recovery, including safely storing medications. To remedy this, it is vital to offer individuals experiencing SUDs and their partners and families transitional or recovery housing. It is also vital to advocate to Tribal leadership or other local policy makers to remove limitations on housing that are based on convictions or outstanding warrants for nonviolent crimes related to substance misuse.

Establish a Tribal Healing to Wellness Court

Creating pathways by way of the court system into treatment for PPP experiencing SUDs can be accomplished using a Tribal Healing to Wellness Court model. Commonly, for communities implementing this model, participation in treatment is mandated as a part of an individual's sentence. Patient's progress is monitored and supported by their probation officer, as well as by clinic staff. Offering treatment as an alternative option can prevent many PPP experiencing SUDs from being placed in facilities where they may not receive adequate treatment. To learn more about the Tribal Healing to Wellness Court model, visit this website.

Establish Inpatient Facilities for PPP That Allow Children

Permit children of PPP experiencing SUDs to be housed with PPP in inpatient facilities. This has been demonstrated to improve outcomes for both PPP experiencing SUDs and their children.

Increase Access to OB and Mental Health Telemedicine Services

Consider expanding OB and mental health telemedicine service to PPP to increase access to care. Research suggests that telehealth can be as effective in delivering substance use treatment for pregnant people as in-person care. Read this article in JAMA for additional information.

Create Supportive Employment and Education Structures

Many people recovering from SUDs want to work and can work successfully. Education and work are basic human needs, a way out of poverty, and a motivation for achieving or maintaining recovery. In fact, work for individuals experiencing behavioral health conditions has been shown to help increase self-esteem, improve financial security, and reduce mental health symptoms and substance use. Learn more from this report by SAMSHA.

Prepare Pregnant People Experiencing SUDs and Their Families for Birth, SUD Recovery, and Caring for an SUD-impacted Infant

Healthcare providers must ensure that pregnant people experiencing SUDs and their partners and families are educated prior to giving birth about what to expect before, during, and after delivery.

To address this, clinicians can:

- Develop a *Family Care Plan* to address the health and SUD treatment needs of the PPP, infant, partner, and family. Ideally, each plan should include a delivery plan and pain management plan for during and after birth. It should also include, as needed, treatment plans for neonatal opioid withdrawal syndrome (NOWS), also known as neonatal abstinence syndrome (NAS), and details about the coordination of postpartum appointments. Often people experiencing SUDs, will concurrently use other substances in addition to opioids. Clinicians should also prepare PPP to deal with disturbances of behavioral regulation in their infant using techniques like Eat, Sleep, Console – a model of care used to treat babies experiencing substance withdrawal symptoms. Learn about developing an effective *Family Care Plan* here.
- Plan for delivery at a location that provides both nonpharmacological and pharmacological therapies. Unless contraindicated, nonpharmacological therapies should include rooming with infants, swaddling, skin-to-skin contact, a quiet and dimly lit environment, encouragement and support for chestfeeding, family support opportunities, and behavioral and mental health services. Unless contraindicated, pharmacological therapies may include morphine, methadone, and other evidence-based therapies for addressing SUDs.
- Ensure that all appropriate staff are trained on the aforementioned approaches, as well as how to use respectful language and demonstrate anti-stigma behaviors that honor PPP experiencing SUDs and their infants, partners, and families.
- Prepare pregnant people and their partners and family members for what to expect and how to support infants with prenatal exposure to drugs, alcohol, or tobacco in utero. Here is useful information to share from the American Academy of Pediatrics.

Service Provider Collaboration, Community Connection, and Access to Cultural Supports Helps with Recovery

No single entity in a Tribal or urban Indian community has the resources to fully address all of the needs of pregnant people and their families affected by SUDs. Collaboration across departments and agencies, such as child welfare, courts, cultural affairs, housing, transportation, healthcare, and workforce/vocational support, is needed to coordinate services and provide comprehensive care that improves the overall health and well-being of SUD-affected PPP and their infants, partners, and families.

To strengthen and better integrate networks of supports, clinicians can:

- **Implement universal screening and assessment for SUDs**

  Universal screening of pregnant people for SUDs at each trimester is an important first step in identifying individuals who may benefit from care. It is vital that providers normalize these screenings by informing patients that all pregnant people are screened for substance use disorders. Minimally, screens should be included for opioids, tobacco, alcohol, stimulants, and benzodiazepines.

  Validated screening tools include: 4Ps Screening Tool, TAPS, and CRAFFT, using a SBIRT. SBIRT stands for *Screening, Brief Intervention, and Referral to Treatment*. The SBIRT method involves using screening questions to

assess whether your patient has an SUD, and, if so, the severity of their substance misuse. After screening, the next step is the brief intervention. This involves briefly speaking with your patient to raise their awareness about their substance use, as well as creating a space for providing feedback and guidance to your patient. Referring your patient to treatment or other additional services is the last step of the SBIRT approach. If you would like to learn more about SBIRT, visit: www.ihs.gov/asap/providers/sbirt.

To strengthen screening and assessment of pregnant people, clinicians can work with other professionals who may come into contact with pregnant people experiencing SUDs. Together clinicians and allies can develop consistent, uniform, and timely approaches to identify pregnant people, substance-exposed infants, and their partners and families across all systems.

- **Implement universal screening and assessment for co-morbid mental health disorders**

In addition to universal screening for SUDs at each trimester, it is important to screen pregnant people for co-morbid mental health disorders, including depression and anxiety. The American College of Obstetricians and Gynecologists (ACOG) recommends that providers screen patients at least once during the perinatal period for depression and anxiety symptoms using a standardized, validated tool. Pregnant people experiencing current depression or anxiety, a history of perinatal mood disorders, risk factors for perinatal mood disorders, or suicidal thoughts warrant particularly close monitoring, evaluation, and assessment. Learn more here. Additionally, due to increased rates of adverse childhood experiences (ACEs) experienced by AI/AN peoples, all pregnant patients should be screened for PTSD and a history of trauma.

Follow the protocol of your facility in terms of timing and screening methods. If your facility does not have a protocol in place, there are many useful validated screening tools. For screening and assessment tools for SUDs and mental health disorders, view these tables, which include information about research that suggests modifications and reports testing discrepancies among racial and ethnic populations. Also, consider reading this resource by SAMSHA designed to help providers improve their cultural competence and provide culturally responsive, trauma-informed services to AI/AN patients.

- **Screen for other conditions and social determinants that might increase risks of maternal morbidity or mortality, including risks of intimate partner violence, trafficking, poverty, food insecurity, tobacco use, homelessness, and trauma**

  To provide whole-person care, providers must screen for other conditions that might increase the risk for maternal mortality and morbidity. Provider care plans should include supportive and appropriate interventions to holistically address patient needs.

  This tool can be used to screen patients for social determinants of health and identify community-based resources to help them.

  Note: delayed prenatal screening can result in poor outcomes for pregnant people and their infants if not addressed early on. Providers should implement "catch-up" perinatal testing, vaccination, and treatment per ACOG guidelines, especially when patients lack access to other basic prenatal care services, including routine STI care.

- **Develop inter-departmental and inter-agency relationships and agreements that are bound by a joint vision, mission, protocols, and shared outcomes**

  - Develop a collaborative practice approach to serving PPP experiencing SUDs, substance-exposed infants, and their families that intersect each system.
  - Establish close working relationships with medical, social, cultural, spiritual, and other providers within your area who could play a role in supporting SUD-affected PPP, infants, partners, and families.
  - Create a universal release of information for agency-to-agency referrals.
  - Build trusting relationships by meeting regularly with courts, CPS, law enforcement, and cultural and spiritual supports.
  - Train all staff on calmly managing the predictable emotional, behavioral, and spiritual challenges that arise for families and caregivers of a newborn who is experiencing withdrawal.
  - Train all staff across departments/agencies on providing care using language and behaviors that are anti-stigma, patient-centered, and honor the sacredness of pregnancy, birth, and the transition to parenthood.

- **Offer evidence-based, community-tested treatments**

  - Work with clinical and non-clinical partners to develop evidence-based, culturally-responsive practices and programs that meet the needs of PPP experiencing SUDs and have processes in place for monitoring the effectiveness of the practices and programs.
  - When treating patients, the environment should be quiet, dimly lit and calm. Ensure patients have direct access to entry/exit points to limit feelings of being trapped.

- Provide education to all collaborative team members on the efficacy of medications for opioid use disorder (MOUD) for treating pregnant and parenting people experiencing OUD, as well as effective medication and other treatment options for alcohol use disorder, methamphetamine use disorder, benzodiazepine use disorder, tobacco use disorder, and other SUDs that commonly affect your patient population.
- Ensure that treatments are trauma-responsive, and all staff are trained on the provision of trauma-responsive care. Consider this resource and these trainings for additional information.
- Ensure treatments are culturally-responsive, and all staff are trained on the provision of culturally-responsive care. Considerations may include culturally appropriate ways of asking questions, approaching and moving around patients, making eye contact, and touching patients' bodies and personal items. To gather information about appropriate protocols for engaging with PPP and their infants, partners, and families, consult community Elders, spiritual leaders, and other knowledge bearers.

Culture, Spirituality, and Connection Are Healing

Refer PPP and their partners and families to cultural events, community gatherings, and spiritual supports in the same manner you would refer them to medical or social service supports. Participation in ceremonies, cultural activities, and traditional spiritual supports helps some AI/AN people experiencing SUDs and their families counter the tendency to isolate and avoid support services. They are also healing.

- **Recognize the sacredness of pregnancy and birth, as they are special times in an individual's life and an opportunity for positive change**
  - Incorporate community-specific traditional Indigenous knowledge and teachings into your programming and patient-education materials that recognize the sacredness of pregnancy, birth, and the life transition into parenthood.

- Consult Elders, spiritual leaders, and other community knowledge bearers about how to incorporate tradition and ceremony into birth preparations and how to help individuals and families draw on cultural strengths and community-based supports.
- Recognize that each Tribe carries unique Indigenous teachings and knowledge; acknowledge that families and individuals interpret these teachings differently.

- **Offer group prenatal care designed to improve patient education and enhance opportunities for social support while maintaining individualized prenatal screening and assessment**
  - Bringing together patients experiencing similar needs for health care can increase the time available for education and improves efficiency.
  - Evidence suggests pregnant people in prenatal care groups have better prenatal knowledge, feel more ready for labor and delivery, are more satisfied with care, and initiate chestfeeding more often. Learn more about group prenatal care and group prenatal centering.

Medications for Opioid Use Disorder During Pregnancy

Methadone and buprenorphine, in conjunction with behavioral therapy and medical services, are first-line options recommended for pregnant people experiencing OUD. Although combination products containing buprenorphine and naloxone have not historically been recommended due to limited evidence, the body of evidence is growing in support of this option and commonly used in health care settings. Findings from a 2021 systemic review, meta-analysis, and subgroup analysis reinforce previous support indicating buprenorphine-naloxone during pregnancy has similar pregnancy and neonatal outcomes compared to other forms of treatment such as buprenorphine alone or methadone. Learn more here. ACOG recommends that if an individual is stable on naltrexone prior to pregnancy, the decision regarding whether to continue naltrexone treatment during pregnancy should involve a careful discussion between the provider and the patient, weighing the limited safety data on naltrexone with the potential risk of relapse with discontinuation of treatment. Learn more here.

Birth Practices - Common Challenges and Key Considerations

- To support individuals giving birth and their infants, partners, and families, healthcare providers should administer universal screening and assessment for SUDs to all pregnant people at delivery and develop clear, non-biased guidelines on the use of toxicology testing for pregnant people and their infants.
- If developed, implement the *Family Care Plan*. If not, create a *Family Care Plan* using a collaborative approach with the pregnant person, their medical team, their infant's medical team, early childhood care/development providers, and other providers, departments, and agencies as needed. The *Family Care Plan* should address the health and SUD treatment needs of the person who is giving birth and their infant, partner, and family. It should include a pain management plan, potential treatment plans for infants exposed to substances, including alcohol, in utero, and details about the coordination of postpartum care, including home visitation, where possible, such as that delivered through the Family Spirit program.
- Assess and treat infants with prenatal exposure with evidence-based, culturally-responsive approaches using both nonpharmacological therapies, unless contraindicated, and pharmacological therapies, as needed. Nonpharmacological therapies include: rooming with infants, swaddling, skin-to-skin contact, keeping a quiet and dimly lit environment, and encouraging and supporting chestfeeding. Pharmacological therapies include: morphine, methadone, suboxone, and other medications to treat SUDs.

Nonpharmacological Therapies

Unless contraindicated, it is recommended to room individuals who gave birth with their infants and encourage swaddling, skin-to-skin contact, and chestfeeding in a quiet and dimly lit environment. All of these promote better outcomes for both parents experiencing SUDs and their infants. This intervention should be supported by appropriate hospital staff education and care practices.

- Create clear guidelines for child welfare responses to infants experiencing prenatal substance exposure, and educate healthcare providers, SUD care providers, child welfare, and other partners about these guidelines, and implementation roles and responsibilities.
- Develop support strategies that keep families together, promote positive healthcare outcomes, and, when possible, minimize court and child welfare agency involvement. Punitive responses based on a parent's substance use alone may lead to negative short- and long-term health outcomes for parents and infants. Avoid penalizing individuals who are in active recovery. Avoid discriminatory practices toward infants, such as focusing on their irritability or fussiness over behavioral capacities and growing regulation abilities.
- Train providers on treating uncomplicated NOWS in-house and make every effort to avoid transporting infants unnecessarily to distant neonatal intensive care units. Transporting infants to outside hospitals results in more disjointed care and negatively affects parent-infant bonding. It also increases stress and psychosocial disruption among individuals who gave birth, their infants, and their families.
- Ensure hospital discharge plans address parental substance use, medication dosage changes, mental and behavioral health, primary medical care, social work and case management, safety of the home environment, safe sleeping practices, parenting skills, home visitation, preferred modes of parental communication, and enrollment status in pediatric and childcare; coordinate parental substance use disorder treatment entry or reentry, including considerations about insurance funding sources for sufficient lengths of stay before departure from the hospital.

- Enhance hospital discharge protocols to ensure connection to a pediatrician before discharge and proper consent is obtained for parental care providers to share information with pediatric care providers about identified prenatal substance exposure.
- Offer parents, partners, and family members information on what to expect after delivery and how to best support the infant.
- Offer obstetric telemedicine services to individuals experiencing SUDs and their families.
- When necessary and with consent, ensure that child welfare, SUD care providers, and the courts receive copies of discharge plans, and use the information to implement and support the *Family Care Plan*.

Postnatal Practice - Common Challenges and Key Considerations

Continue to Support Parents, Partners, Infants, and Families Through Connecting Them to Community-based Medical, Social, Spiritual, and Cultural Supports

Collaboration across departments and agencies is needed postnatally to improve the overall health and well-being of SUD-affected parents, infants, and families.

To strengthen connections, clinicians should consider:

- Following up with parents, partners, infants, and families to ensure that they have appropriate access to integrated medical, social, cultural, spiritual, and other support services. This helps parents on their path to recovery, prevents relapse, and ensures that the infant is able to bond, has a stable early care environment, and is meeting development milestones. It also ensures that family members affected by SUDs have access to appropriate services to address their complex needs.

Comprehensive Recovery Services

To walk the road to recovery, parents, partners, infants, and families require sufficient discharge coordination and linkages to care.

Recovery support often includes:

- Stable housing
- Transportation to/from clinic and court appointments
- Social work services
- Case management
- Medical and behavioral health services
- Connection to cultural and spiritual supports
- Food assistance
- Dental health services
- Employment services
- Parenting support
- Self-care, communication, stress management, and other life skills

Connection and Continuous Outreach are Invaluable

Home visitation programs, such as Family Spirit, are important for preventing relapse when parents experiencing SUDs are in early recovery, especially when they may not be fully equipped with the parenting skills and resources to cope with the stress associated with being a new parent. Additionally, home visitation programs can offer early childhood screening to ensure infants are meeting early developmental goals and that parents, and their infants, partners, and families are connected to the supports they may need.

- Peer recovery specialist supports can play a vital role in connecting parents and their partners and families with community-based supports, such as parenting and caregiver groups and classes.
- Continue to collaborate with parents, partners, families, and across departments and agencies to use strategies that keep families together and minimize court and child welfare agency involvement when possible. Keeping and treating families together as a unit prevents the trauma of family separation and improves treatment outcomes.

Continue to Encourage and Support Parents Experiencing SUDs in Accessing Evidence-based, Culturally-responsive Treatments

- Support parents in starting or remaining on evidence-based medications
- Provide education to parents experiencing SUDs about the efficacy of medication and other treatments for SUDs, including recovery groups and harm reduction services
- Ensure that treatments are trauma-responsive
- Refer parents and infants to cultural events, community gatherings, and spiritual supports in the same manner you would refer them to medical or social service supports
- Refer infants to early childhood developmental services
- Encourage parents to participate in ceremonies, cultural activities, and traditional spiritual supports with their infants and families

Medications for Opioid Use Disorder After Pregnancy

Methadone and buprenorphine, in conjunction with behavioral therapy and medical services, are first-line options recommended for individuals experiencing OUD postnatally. Note, the amount of buprenorphine and methadone in chest milk is expected to be too low to pose a problem for the nursing infant; however, a nursing infant should be watched for sleepiness and proper weight gain. Abruptly stopping chestfeeding while taking buprenorphine or methadone is not recommended, because doing so may result in withdrawal symptoms in the infant. Encourage pumping and storage of chest milk for nutritional support of the baby during recovery. Chestfeeding is not supported for parents who take street or illicit drugs, because the purity and contents of these may vary from what the parent expects. Also, drugs altered by additional substances can pass into chestmilk.

Implement Universal Screening and Assessment for Co-morbid Behavioral Health Disorders

It is important to screen parents prenatally and postnatally for co-morbid behavioral health disorders, including depression and anxiety. ACOG and the AAFP recommends that providers complete a full assessment of mood and emotional well-being, including screening for postpartum depression and anxiety

with a validated instrument, during the comprehensive postpartum visit for each patient. Parents who gave birth with current depression or anxiety, a history of perinatal mood disorders, risk factors for perinatal mood disorders, or suicidal thoughts warrant particularly close monitoring, evaluation, and assessment. Learn more here.

Ensure that Treatment and Recovery Services are Inclusive

Many Two Spirit and lesbian, gay, bisexual, transgender, queer, and intersex (LGBTQI+) people have difficulty finding treatment and recovery services where they feel included and accepted. Healthcare providers can create an affirming environment for Two Spirit and LGBTQI+ patients by:

- Asking clients, partners, and family members how they prefer to be identified
- Using correct pronouns to identify patients, partners, and family members
- Adopting policies and practices that affirm clients' identities
- Partnering with Two Spirit and LGBTQI+ organizations to support prevention, treatment, and recovery efforts
- Acknowledging diverse AI/AN concepts of gender and sexual orientation
- Using gender neutral terms like "chestfeeding" (instead of breastfeeding) or "pregnant person" (instead of mom), and
- Advocating for Two Spirit and LGBTQI+ people.

Agencies should support clients by conducting phone or in-person screening of community treatment providers in collaboration with insurance care coordinators to determine if treatment and recovery services are inclusive of LGBTQI+ and gender diverse families.

Two Spirit and LGBTQI+ PPP who feel safe and respected in clinical settings are more likely to access care, communicate openly about their health needs, and build lasting relationships with their healthcare providers. View the resources list at the end of this document to learn more.

Meet Parents Experiencing SUDs Where They Are at Using a Harm Reduction Approach

- Work with parents experiencing SUDs and their families, partners, and infants without judgement to understand their needs, their relationship to substance use, and their hopes for maintaining their own health.
- Acknowledge that stopping drug use "cold turkey" is not possible for most people experiencing SUDs. Therefore, requiring abstinence in order to receive services is harmful to the health and recovery of parents experiencing SUDs.
- Listen to parents experiencing SUDs and their partners and families and make sure that their thoughts, experiences, and recommendations are incorporated into services.
- Develop programming that fits the needs of and accommodates the schedules of parents, infants, and families.
- For parents experiencing OUD, offer naloxone and naloxone training. Learn more here.
- Advise parents who are chestfeeding to consider the timing of their alcohol, nicotine, and non-prescribed drug use to minimize passage of drugs into chestmilk their infant might ingest. Or recommend pumping and dumping chestmilk with potential drug content for 24 to 48 hours. Learn more about chestfeeding harm reduction techniques here.

Prescribing Naloxone for Parents Experiencing OUD Can Be Lifesaving

Naloxone is a powerful medication that can quickly reverse an opioid overdose. Make naloxone kits and training available to parents experiencing OUD, their partners, and families. Making naloxone widely available, training parents and their family members and partners, as well as staff and community members how and when to use naloxone has been demonstrated to prevent deaths by overdose. Offer patients this useful handout. Additional patient and provider resources on OUD can be found here.

Encourage Pregnant People and Parents to Use Lockboxes

Lockboxes are a useful harm reduction tool. Clinicians should ask parents to use lockboxes to provide safe storage of drugs. Clinicians and other support staff should make lockboxes easily accessible and train parents on using them. Lockboxes keep your medications and other drugs in the right hands. Order lockboxes and learn more here.

Include Parents Experiencing SUDs and their Families and Partners in the Development and Implementation of Services

A harm reduction approach includes listening to parents experiencing SUDs and their families and partners and developing services based on their expressed needs. Make sure to:

- Include parents experiencing SUDs on bodies, like community advisory boards,
- that inform the development and implementation of community-based services
- Regularly collect data on the current health needs of PPP experiencing SUDs
- Use this data to determine critical gaps and unmet needs in current service offerings across departments, agencies, and within the clinic
- Take action to improve SUD services using an evidence-based approach, and
- Create opportunities for people in recovery to become a formal part of services and supports through paid positions.

Healing Parents, Partners, Families, and Infants Through Community

Because AI/AN PPP experiencing SUDs are at times shamed for participating in community cultural practices, recovery support for some should include reintroduction or introduction to cultural healing practices and other ceremonies, like traditional dance, art practices, sweat lodge, and drumming. For some AI/AN PPP experiencing SUDs and their partners, families, and infants, cultural supports are integral to sustained recovery. For many AI/AN people experiencing SUD, cultural supports might include statements from community leadership about SUD as a chronic disease that can be improved through participation in community supports and treatment services. This can reduce isolation and shame directed at the individual and their partner, children, and loved ones.

Share Stories of Those Who Have Successfully Engaged in Treatment and Recovery Support Services

Parents in recovery and healthy infants have the potential to inspire hope among healthcare providers and other community members that change is possible. With consent, share stories that demonstrate the benefits of a holistic approach that is nonjudgmental and rooted in connecting parents, infants, and families to community-based medical, social, spiritual, cultural, and other supports.

To access a full list of resources included in this guide, please use the digital version of the guide: https://www.indiancountryecho.org/family-care-plans-toolkit

Sources & Additional Resources

1. Tapping Tribal Wisdom: Providing Collaborative Care for Native Pregnant Women With Substance Use Disorders and Their Infants
   https://ncsacw.samhsa.gov/files/tapping_tribal_wisdom_508.pdf

2. Tribal Opioid Response National Strategic Agenda: Healing Our Nations Together
   NPAIHB_TOR_Agenda_Booklet_FINAL.pdf

3. didgwalic Wellness Center Report (2019). Growing Your Tribal Community's Capacity to Address Opioid Use Disorder Guidance for Tribal Leaders, Policymakers, and Program Staff Based on Lessons Learned from the Swinomish Indian Tribal Community. To view report, contact the didgwalic Wellness Center:
   https://www.didgwalic.com/no-form-contact.htm.

4. Infants with Prenatal Substance Exposure and their Families: Five Points of Family Intervention
   https://ncsacw.samhsa.gov/files/five-points-family-intervention-infants-with-prenatal-substance-exposure-and-their-families.pdf

5. Plans of Safe Care Checklist
   Plan-of-Safe-Care.pdf (ct.gov)

6. Plans of Safe Care Learning Modules
   https://ncsacw.samhsa.gov/topics/plans-of-safe-care-learning-modules.aspx

7. Recommendations to IHS on AI/AN Pregnant Woman and Women of Childbearing Age with Opioid Use Disorder
   https://www.ihs.gov/sites/opioids/themes/responsive2017/display_objects/documents/acogguidelines2018.pdf

8. What is a Plan of Safe Care (video)
   https://www.cffutures.org/qic-main-page/qic-serving-native-families/

9. Recommendations to the Indian Health Service on Neonatal Opioid Withdrawal Syndrome (American Academy of Pediatrics)
   https://www.ihs.gov/sites/opioids/themes/responsive2017/display_objects/documents/aapnowsrecommendationstoihs.pdf

10. Guidance from the Centers for Disease Control and Prevention on the Treatment for Opioid Use Disorder Before, During, and After Pregnancy
    https://www.cdc.gov/pregnancy/opioids/treatment.html

11. Family Spirit
    https://cih.jhu.edu/programs/family-spirit-home-visiting-program/

12. American College of Obstetrics and Gynecology – Opioid Use Disorder and Pregnancy. Accessed: August 19, 2021
    https://www.acog.org/womens-health/faqs/opioid-use-disorder-and-pregnancy

13. American College of Obstetrics and Gynecology – Screening for Perinatal Depression. Accessed: August 19, 2021 https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2018/11/screening-for-perinatal-depression

14. Child Welfare Information Gateway – State Child Welfare Agency Websites https://www.childwelfare.gov/organizations/?CWIGFunctionsaction=rols:main.dspList&rolType=Custom&RS_ID=16

15. Peers Supporting Recovery from Substance Use Disorders: https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tacs/peers-supporting-recovery-substance-use-disorders-2017.pdf

16. National Center on Substance Abuse and Child Welfare – Family-Centered Approach: https://ncsacw.acf.hhs.gov/topics/family-centered-approach/

17. Tribal Healing to Wellness Courts www.wellnesscourts.org

18. Guille C, Simpson AN, Douglas E, et al. Treatment of Opioid Use Disorder in Pregnant Women via Telemedicine: A Nonrandomized Controlled Trial. *JAMA Netw Open.* 2020;3(1):e1920177. doi:10.1001/jamanetworkopen.2019.20177

19. Substance Use Disorders Recovery with a Focus on Employment and Education – Evidence-Based Resource Guide Series: https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/pep21-pl-guide-6.pdf

20. National Center on Substance Abuse and Child Welfare – CAPTA Plans of Safe Care: https://ncsacw.acf.hhs.gov/topics/capta-plans-of-safe-care/

21. Healthy Children.org – Neonatal Opioid Withdrawal Syndrome (NOWS): What Families Need to Know: https://healthychildren.org/English/ages-stages/prenatal/Pages/Neonatal-Opioid-Withdrawal-Syndrome.aspx

22. ACOG – Screening and Diagnosis of Mental Health Conditions During Pregnancy and Postpartum: https://www.acog.org/clinical/clinical-guidance/clinical-practice-guideline/articles/2023/06/screening-and-diagnosis-of-mental-health-conditions-during-pregnancy-and-postpartum

23. AAFP – Address Your Patients' Social Determinants of Health: https://www.aafp.org/family-physician/patient-care/the-everyone-project/toolkit/assessment.html

24. The American College of Obstetricians and Gynecologists Guidelines: https://www.acog.org/

25. IHS Tele-Education Training Resources: https://www.ihs.gov/teleeducation/traininghosting/

26. ACOG Group Prenatal Care: https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2018/03/group-prenatal-care

27. Centering Healthcare Institute – Centering Pregnancy: https://www.centeringhealthcare.org/what-we-do/centering-pregnancy

28. UNC School of Medicine – Buprenorphine-Naloxone as a Medication to treat Opioid Use Disorder Among Pregnant Women: https://www.med.unc.edu/obgyn/horizons/infographic-buprenorphine-naloxone-as-a-medication-to-treat-opioid-use-disorder-among-pregnant-women/

29. CDC Treatment Before, During, and After Pregnancy: https://www.cdc.gov/pregnancy/opioids/treatment.html

Harm Reduction Resources

30. IHS Naloxone Resources: https://www.ihs.gov/opioids/naloxone/naloxone/

31. National Harm Reduction Coalition – Pregnancy and Substance Use: A Harm Reduction Toolkit: https://harmreduction.org/issues/pregnancy-and-substance-use-a-harm-reduction-toolkit/

32. Using Nasal Spray to Reverse an Opioid Overdose: https://www.npaihb.org/wp-content/uploads/2020/07/Using_Nasal_Spray_to_Reverse_Opioid_Overdose_Factsheet.pdf

33. Opioid Use Disorder: https://www.npaihb.org/opioid/

34. Medication Locking Technology – Lockboxes – RxGuardian: https://rxguardian.com/

Validated Screening Tools

35. 4 Ps Screening Tool: How to Document in the IHS RPMS EHR: https://www.ihs.gov/sites/opioids/themes/responsive2017/display_objects/documents/4Pscreeningtoolhowto.pdf

36. TAPS
https://nida.nih.gov/taps2/

37. CRAFFT
https://crafft.org/

38. SBIRT
https://www.samhsa.gov/sbirt

Trauma-Informed Care Guidance for Providers

39. Renick, C. (2018, September 10). The Nation's First Family Separation Policy. The Imprint. https://imprintnews.org/child-welfare-2/nations-first-family-separation-policy-indian-child-welfare-act/32431

40. A Treatment Improvement Protocol – Trauma-Informed Care in Behavioral Health Services: https://store.samhsa.gov/sites/default/files/d7/priv/sma14-4816.pdf

41. Reducing Discriminatory Practices in Clinical Settings – Resource Guide: https://www.samhsa.gov/sites/default/files/programs_campaigns/02._webcast_3_resources.pdf

Ensuring Culturally Competent Care

42. National Library of Medicine – Improving Cultural Competence – Screening and Assessment Instruments: https://www.ncbi.nlm.nih.gov/books/NBK248419/

43. Behavioral Health Services for American Indians and Alaskan Natives – For Behavioral Health Service Providers, Administrators, and Supervisors: https://store.samhsa.gov/sites/default/files/d7/priv/tip_61_aian_full_document_020419_0.pdf

44. Administration for Children & Family Services – Resources Specific to American Indian/Alaskan Native (AI/AN) Communities: https://www.acf.hhs.gov/trauma-toolkit/american-indian-alaskan-native-communities

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45. Link, Heather Met al. “Buprenorphine-naloxone use in pregnancy: a subgroup analysis of medication to treat opioid use disorder.” American journal of obstetrics & gynecology MFM, vol. 3,5100369. 5 Apr. 2021, doi:10.1016/j.ajogmf.2021.100369

Medications for Opioid Use Disorder After Pregnancy

46. American College of Obstetrics and Gynecology https://www.acog.org/womens-health/faqs/opioid-use-disorder-and-pregnancy

47. Mother to Baby Fact Sheet on Buprenorphine https://mothertobaby.org/fact-sheets/buprenorphine/pdf

48. Dorey A, et al. 2019. Possible buprenorphine toxicity in a breastfeeding neonate. Clin Toxicol. 57:889-890.

49. Ito, S. 2018. Opioids in breast milk: Pharmacokinetic principles and clinical implications. J Clin Pharmacol 58 Suppl 10:S151-S163.

50. Jansson LM, et al. 2016. Maternal buprenorphine maintenance and lactation. J Hum Lact. 32:675-81.

51. Reece-Stremtan S, Marinelli KA 2015. ABM Clinical Protocol #21: Guidelines for Breastfeeding and Substance Use or Substance Use Disorder, Revised 2015. Breastfeed Med 10(3):135-141.

Ensuring Treatment and Recovery Services are Inclusive of Two Spirit and LGBTQ Community Members

Provider Education:

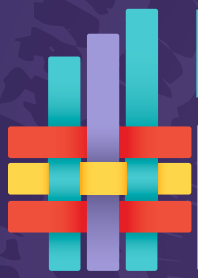
52. Fenway Health - National LGBT Education Center: https://fenwayhealth.org/the-fenway-institute/education/the-national-lgbt-health-education-center/
53. Northwest Portland Area Indian Health Board - Two Spirit and LGBTQ Resources: www.npaihb.org/2SLGBTQ
54. Educational Text Campaign: Text PROVIDER to 97779.

Collecting Sexual Orientation and Gender Identity Information:

55. Toolkit for collecting data on sexual orientation and gender identity in clinical settings: http://doaskdotell.org/
56. Comprehensive, LGBTQ-Inclusive, Implicit-Bias-Aware, Standardized-Patient-Based Sexual History Taking Curriculum: https://www.mededportal.org/publication/10634/

Two Spirit Health Resources:

57. SAMHSA Two Spirit Webinars: https://www.samhsa.gov/tribal-ttac/webinars/two-spirit
58. Indian Health Service Two Spirit LGBT Resources: https://www.ihs.gov/lgbt/health/twospirit/
59. (W)righting Our Relations- Working with and For Two-Spirit Individuals: https://www.ymsmlgbt.org/webinars/
60. Walking in Good Way - Cultural Considerations when Working with Two-Spirit Individuals: https://www.ymsmlgbt.org/nativeamricanresources/
61. Paths Remembered Project of the Northwest Portland Area Indian Health Board https://www.pathsremembered.org/



Family Care PLANS

indiancountryecho.org/family-care-plans-toolkit

NPAIHB

Indian Leadership for Indian Health