Addressing Gaps in Prenatal Care for American Indian and Alaska Native Patients with Opioid Use Disorder

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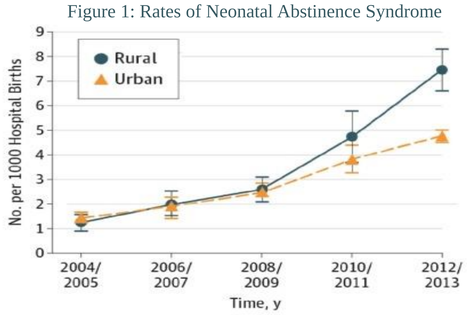
ABSTRACT

Among women, the highest prevalence of opioid use occurs between the ages of 20 and 29 years. This is also the age group with the highest fertility rate.[1] Opioid use disorder (OUD) disproportionately impacts rural and American Indian communities and has quadrupled among pregnant individuals nationwide in the past two decades. American Indian and Alaska Native (AIAN) women who use substances often face triple discrimination and marginalization and have a higher mistrust of the healthcare system than among other groups of people who use substances.[2] Fear of stigmatization can prevent mothers with OUD from seeking treatment during pregnancy and may hinder women from seeking prenatal care.[3] While considering these factors, a culturally aware, community-based approach needs to be made in addressing prenatal care for AIAN women experiencing OUD. Innovative programs and appropriate support can mitigate criminal justice and foster care involvement, which perpetuate intergenerational trauma in a demographic that already faces barriers rooted in racism and colonialism.[3]

WHY IS ADDRESSING OUD IN PRENATAL CARE IN TRIBAL PUBLIC HEALTH IMPORTANT?

Evidence exists that AIAN individuals experience a degree of mistrust in the healthcare system. A study of the general population has shown that stigma and fear of healthcare or social service systems prevented women from seeking services that they needed, such as prenatal care and counseling, and accessing services that could have benefited their health and pregnancy. Fear of child removal was shown to hinder women's ability to seek support and assistance. Further, this resulted in women concealing their substance use, including OUD, and resulted in isolating behaviors, even if they wanted support. Reluctance to seek services was amplified where women had intergenerational involvement with the child welfare system and among women with histories of traumatic experiences.[3] Intergenerational and historical trauma is prevalent in AIAN communities. Many AIAN individuals live in rural areas (Figure 1) where specialized healthcare is unobtainable due to distance or transportation issues. Evidence based practices, such as the specific outreach to AIAN populations using approaches that combine medication assisted treatment (MAT) for OUD and counseling or behavioral therapy, clearly illustrate that this is a Tribal public health problem.

Figure 1: Rates of Neonatal Abstinence Syndrome

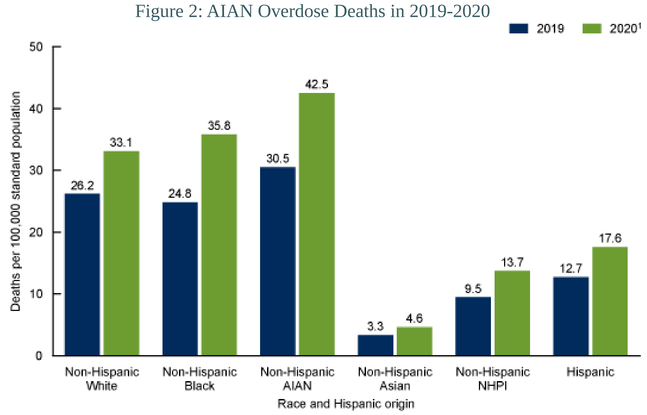


Rates of NAS are growing faster in rural areas

IMPACT OF OUD ON AIAN COMMUNITIES

The opioid epidemic plagues the entire nation. Figure 3 illustrates the rising prevalence of OUD in pregnancy. Access to funding for prevention and treatment, however, is not obtainable to many of the Tribal communities that are in serious need. The AIAN population experience opioid related fatalities at three times the rate of Blacks or Hispanic Whites.[4] A recent Centers for Disease Control publication demonstrated that in just one year, overdose death rates increased **39%** for AIAN people.[5] In 2019 and 2020, drug overdose death rates were highest for AIAN people compared to other racial and ethnic groups (Figure 2).[6]

Figure 2: AIAN Overdose Deaths in 2019-2020



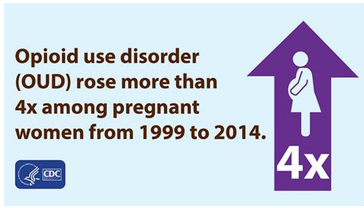
The impact on AIAN babies born from OUD pregnancies varies. Neonatal opioid withdrawal syndrome (NOWS) can manifest with different symptoms depending on a number of factors such as the mother's metabolism, what opioid(s) she used, and how long the fetus was exposed in utero. Symptoms of NOWS begin after birth and can include:

- High-pitched crying and irritability
- Tremors and uncontrolled movements
- Difficulty sleeping and fragmented sleep
- Loose stool and diarrhea
- Vomiting
- Sweating and fever
- Frequent yawning and sneezing[7]

Treatment for severe NOWS includes medicating and weaning the newborn with an opiate (morphine).

Effects on the newborn can present as reduced head circumference and smaller brain volume (that persists into childhood). Long-term effects range from developmental delay to a predisposition for psychiatric disorders.[8]

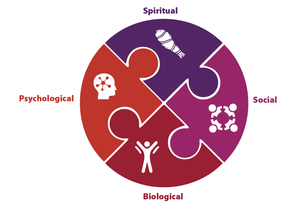
Figure 3: Rising OUD in Pregnancy



CONCLUSIONS

OUD, including use during pregnancy, has disproportionately affected AIAN. Tribal communities need to incorporate cultural and spiritual adaptations in not only prevention campaigns and methods, but intervention programs as well (Figure 4). Traditional Western practices may not resonate with AIAN prenatal patients, and a level of mistrust may not incline them to disclose sensitive information such as OUD during pregnancy to an outside provider. For rural patients, access to MAT or prenatal substance use services in the same facility is rare; addressing this issue would provide better outcomes for AIAN prenatal patients and their babies. Offering telehealth visits for rural patients could prove beneficial as well.

Figure 4: National Institute of Health, A Holistic Approach



A pilot program first implemented in Oklahoma in 2018 shows promising results. The Safely Advocating for Families Engaged in Recovery (SAFER) program involves multiple state and local agencies and addresses the continuum of care for persons with Substance Use Disorder (SUD) who are pregnant. SAFER aims to reduce adverse childhood experiences and ongoing contact with child welfare and legal systems.

One of the goals of the program is to expand early intervention and home visiting in rural areas –an approach that has shown to be of value in AIAN communities.

A vital component of SAFER is providing Family Care Plans (FCPs) to their patients. These FCPs are living documents that coordinate services between prenatal care and substance use treatment and track progress between both.[9]

FCPs have been implemented at two different facilities, a therapeutic intervention center in Tulsa and a specialty prenatal clinic in Oklahoma City, OK. Over a course of three years, 81 FCPs were created in Tulsa, OK. Of these, 100% of newborns went home with their parents. In Oklahoma City, 85% of newborns went home with their parents.[10]

Programs such as SAFER destigmatize pregnant patients seeking treatment for OUD. Health equity can be achieved through wide visibility and social acceptance of these programs. Tribal facilities could benefit from implementing similar practices with a culturally competent, holistic approach.

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