Opioid use in pregnancy and parenting: An Indigenous-based, collaborative framework for Northwestern Ontario

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ABSTRACT

Opioid use affects up to 30% of pregnancies in Northwestern Ontario. Health care providers in Northwestern Ontario have varying comfort levels providing care to substance-involved pregnant women. Furthermore, health care practitioners, social service agencies and community groups in Northwestern Ontario often work in isolation with little multidisciplinary communication and collaboration. This article describes two workshops that brought together health and social service providers, community organizations, as well as academic institutions and professional organizations involved in the care of substance-involved pregnant and parenting women. The initial workshop presented best practices and local experience in the management of opioid dependence in pregnancy while the second workshop asked participants to apply a local Indigenous worldview to the implementation of clinical, research and program priorities that were identified in the first workshop. Consensus statements developed by workshop participants identified improved transitions in care, facilitated access to buprenorphine treatment, stable funding models for addiction programs and a focus on Indigenous-led programming. Participants identified a critical need for a national strategy to address the effects of opioid use in pregnancy from a culturally safe, trauma-informed perspective that takes into account the health and well-being of the woman, her infant, her family and her community.

KEY WORDS: Opiate dependence; pregnancy; Indigenous health services; rural population

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Communities in Northwestern Ontario began experiencing an epidemic of opioid misuse over 10 years ago. The Truth and Reconciliation Commission acknowledged that substance use is a symptom of the ongoing suffering experienced by Canada's Indigenous peoples through colonial institutions and policies such as the residential school system.[1] In 2009, the Nishnawbe Aski Nation Chiefs-in-Assembly declared a state of emergency for prescription drug abuse in all of its 49 communities[2] as rates of opioid use were estimated to reach 50%–80% of the population.[3] Given the prevalence of opioid use in rural and remote First Nations communities, it is not surprising that a significant proportion of reproductive-aged women become pregnant while using opioids.

Northwestern Ontario has over 2500 deliveries each year with 40% of the deliveries occurring in the region and 60% in Thunder Bay.[4] The prevalence of opioid use in pregnancy varies throughout the region. At Lake of the Woods Hospital in Kenora, a centre with 240 births in 2013,[4] opioid exposure is present in 3% of pregnancies.[5] At Sioux Lookout Meno Ya Win Health Centre, which had approximately 450 births in 2014,[4] the prevalence of opioid use in pregnancy has risen from 8% in 2009 to 18% in 2011, and to 28% in 2014.[6–9] A similar pattern was seen at the Thunder Bay Regional Health Sciences Centre, which has approximately 1500 births annually.[4,10]

Recent data on the pattern of use has shown that just under half of opioid-using pregnant women are now daily users of opioids and the most common opioid remains long-acting oxycodone.[8] The route of administration has also shifted from oral and intranasal use (snorting) early in the epidemic to injection drug use in up to one third of opioid-using pregnant women by 2013.[8] The individual and public health implications associated with a shift towards injection drug use are considerable.

Health care providers in Northwestern Ontario have varying comfort levels providing addiction care to substance-involved pregnant women based on their level of clinical experience, their understanding of the social determinants of health with respect to Indigenous women, and the amount of institutional support that is

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available to them. Furthermore, health care practitioners, social service agencies and community groups in Northwestern Ontario often work in isolation, with little multidisciplinary communication and collaboration. This paper describes two workshops held in Northwestern Ontario with the objectives to: 1) increase education in the area of opioid use in pregnancy; 2) facilitate intersectoral and interorganizational collaboration; and 3) develop shared clinical and research priorities to address opioid use in pregnancy in Northwestern Ontario.

The initial workshop, held on June 5, 2014, presented best practices and local experience in the management of women with opioid dependence in pregnancy and postpartum (Table 1). The workshop was grounded in a woman-centered philosophy. Although the role of fathers is very important, it was outside of the scope of this series of workshops. Sioux Lookout, Ontario, a rural community outside of Thunder Bay, was purposely chosen as the location of the first workshop in order to facilitate access for participants attending from remote communities (Figure 1) and also to validate the work being done outside of urban centres. The workshop was moderated by a clinician researcher whose work bridges obstetrics, addiction and First Nations health.

Table 1. Local experience with opioid use in pregnancy

What are local experiences with the management of opioid dependence in pregnancy in Northwestern Ontario?
- Methadone treatment is considered the gold standard for management of opioid dependence in pregnancy[11,12]
- Logistical limitations prohibit the use of methadone in rural and remote locations, namely provider licensing requirements and the availability of a pharmacy to dispense the medication
- Risks and stigma associated with methadone further limit its use
- Slow-release morphine is a local alternative to methadone used as opioid agonist treatment or in a tapering dose to achieve medical detoxification[6]

How have community-based Suboxone™ programs changed practice?
- Community-based, low dose buprenorphine + naloxone treatment became more widely available on rural and remote First Nations in Northwestern Ontario since 2012
- Although no harm has been shown in case reports of buprenorphine + naloxone in pregnancy, robust evidence is not yet available to support its use[13–16]
- Guidelines recommend that women who are stable on buprenorphine + naloxone should be counseled to switch to the buprenorphine mono-product that has been shown to be a safe and effective treatment for opioid dependence in pregnancy[17]
- Buprenorphine is only available through a Health Canada special access program
- In Northwestern Ontario, many women elect to remain on buprenorphine + naloxone and, in our region, the maternal and neonatal outcomes of this group are similar to women with no opioid exposure in pregnancy[9]

How is neonatal abstinence syndrome managed in the region?
- Supportive care while the infant is rooming in with the mother is the mainstay of treatment
- Morphine therapy is added when the infant consistently surpasses a threshold Finnegan score, a standardized rating scale of opioid withdrawal in neonates[18]
- The goal of morphine therapy is to achieve weight gain, to allow the neonate to integrate into his or her environment and to support breastfeeding
- Phenobarbital is used as a second-line agent when it is difficult to wean the neonate off of morphine
- Emphasis was placed on follow-up care of these infants in the community, which is inconsistent at best and often does not occur in our region

Are there First Nations best practices in managing opioid use in pregnancy?
- Sioux Lookout Meno Ya Win Health Centre and the Sioux Lookout First Nations Health Authority came together to form Anishnaabe Biimadiziwin, a jointly funded research unit
- Research into opioid dependence in pregnancy began in 2008 in response to community-identified needs
- A culturally safe protocol for the management of opioid dependence in pregnancy with slow-release morphine (Kadian™) was developed
- The Aboriginal Maternity Care Resource Book[19] was also developed and it was made freely available to workshop participants

The second workshop, held on December 10, 2014, sought to build on the outcomes of the first meeting and asked participants to apply a local Indigenous worldview to the implementation of clinical, research and program priorities that were identified in the first workshop (Table 2). A closed session was incorporated into the second workshop to allow First Nations' community-based service delivery programs to meet with experts in Indigenous service delivery and program management in order to better support ongoing and proposed programming. This workshop was facilitated by a leading Indigenous clinician scientist. Workshop notes were transcribed by a research assistant, summarized and presented back to the participants during interactive portions of the agenda.

Participant representation came from eight First Nations organizations, two universities, one community college, two regional public health units, six district hospitals, four community groups, the Northwest Local Health Integration Network (LHIN), Health Canada, and the College of Physicians and Surgeons of Ontario. A separate engagement strategy has been developed to understand the perspectives of patients/clients, which is outside of the scope of this report. There were a total of 55 participants at the first workshop and 45 participants at the second workshop.

The Anishnaabe and the Métis are the main Indigenous peoples in Northwestern Ontario. A local Indigenous-based approach was used to conduct the workshops. Such a worldview, sometimes called holistic in Western philosophy, identifies well-being as a balance of mind, body, spirit and emotions. Both full-day workshops were opened and closed by local First Nations elders and the workshop organizers acknowledged the traditional lands on which the workshops were held. Shifting the paradigm from a Western perspective to an Indigenous perspective created a safer space for Indigenous participants to engage in the process. Through consensus-based decision-making and the incorporation of sharing circles into the design of the workshops, we were able to facilitate intersectoral discussion and develop actionable, shared priorities.

CONSENSUS STATEMENTS

Clinical practice guidelines that are relevant to rural and remote settings

Existing clinical practice guidelines for the management of opioid dependence and addiction in pregnancy, as well as neonatal abstinence syndrome (NAS), do not take into account the realities of practice in rural and remote settings. Methadone and buprenorphine are both recommended as standards of care for opioid dependence in pregnancy; however, they are not routinely available in rural and remote communities. Further, existing guidelines address one substance at a time, when many women use more than one illicit substance in addition to tobacco and/or alcohol.[9]

Figure 1. Map of Northern Ontario

Improved transitions in care

Throughout pregnancy, women from rural and remote areas travel between their home community and a maternity centre for antenatal care, when they are evacuated for birth between 37 and 38 weeks gestational age, and often postpartum while their infant receives treatment for NAS. In the worst case, these transitions place women and infants at risk for adverse outcomes. A further layer of complexity is experienced by First Nations women who, in addition to traveling to receive care, also have to navigate both federal and provincial health care systems. Communication during these transitions was identified as an area that requires increased attention.

Facilitated access to buprenorphine

Increased access to buprenorphine in pregnancy is necessary in rural and remote settings where methadone is not an option. This should include delivery of buprenorphine to the prescribing physician within two weeks of submission of the Health Canada special access application for the medication. In addition, hospital pharmacies should be allowed to maintain an inventory of buprenorphine such that patients do not lose access to the medication when they need to travel outside of the dispensing community for specialty care. Currently, women either have to transport buprenorphine, a controlled substance with high street value, which puts her at considerable risk, or decline to transport buprenorphine and put herself and her pregnancy at risk from opioid withdrawal and relapse to illicit opioid use.

Increased focus on postpartum care for mother, baby and family

The postpartum period is often the most vulnerable time for a substance-involved woman and her children.[28] She is at highest risk for relapse in the postpartum period as the concerns of drug effects on the fetus are no longer present and the focus shifts from the mother to the infant. Some women are discouraged from breastfeeding despite the evidence of benefits for newborns, including those being monitored and treated for NAS.[29] There is a need to continue working with mothers and families after the

Table 2. Community-based initiatives addressing opioid use in pregnancy

Rural and remote community-based initiatives	
Advocacy	Open letters to the federal and provincial ministers of health as well as the members of parliament and the members of provincial parliament for constituencies in Northwestern Ontario • Increasing access to buprenorphine for the management of opioid dependence in pregnancy • Long-term, community-based funding for programs for opioid-dependent pregnant, postpartum and parenting women • Increased focus on Indigenous communities
Locally generated evidence to guide practice in rural and remote settings	• Retrospective cohort study showing that women in community-based buprenorphine + naloxone treatment programs, who choose to remain on this medication, have no difference in maternal or neonatal outcomes compared to women with no opioid exposure in pregnancy[9,20] • Retrospective cohort study demonstrating decreased separation of mother and infant, and decreased hospital length stay for in utero exposure to buprenorphine compared to methadone[21] • Systematic review about the management of opioid use in rural pregnant women[22]
Environmental scan of health and social services in Thunder Bay[23] and in Northwestern Ontario[24]	• The Thunder Bay Drug Strategy and Thunder Bay Regional Health Research Institute collaborated to define the health and social service landscape surrounding opioid-using pregnant women • Commitment of three organizations to provide coordinated addiction, mental health and maternity services under one roof at the main antenatal care hub in Thunder Bay
First Nation community-initiated programming	
Maternal Addiction Continuum of Care Project[25]	• Shibogama First Nations Health Authority, the Thunder Bay Regional Health Sciences Centre and the Northern Ontario School of Medicine have come together to develop a seamless clinical and social service pathway for substance-involved pregnant women from Shibogama First Nations • The project is based on an Indigenous consensus-building framework utilizing a family-centered approach while acknowledging that grandparents play a large role in childcare in Shibogama First Nations communities when parents need support
Aboriginal Midwifery[26]	• Dilico Anishinabek Family Care, with the support of local maternity care providers, has re-introduced Aboriginal Midwifery in Northwestern Ontario • The program aims to provide culturally appropriate antenatal and postpartum care for marginalized and substance-involved pregnant, Indigenous women
Maternal Infant Support Worker Program[27]	• A collaboration of the Sioux Lookout Meno Ya Win Health Centre, the Sioux Lookout Area Aboriginal Management Board and Confederation College • College level certificate program to train women from remote First Nations communities to provide support during pregnancy and until the infant reaches the age of three • This program is actively seeking funding

baby is born by providing counseling, parenting and life skills with the goal of keeping families intact and reducing trauma to the mother and child that result from separation.

Long-term, stable funding for addiction and mental health programs

Funding models that support research and programming for women with opioid use during pregnancy on a longitudinal basis (i.e., a 5–10 year cycle rather than year to year funding) would allow for the development, implementation and evaluation of interventions. In addition, current funding models encourage communities to compete against each other for funding rather than encouraging communities to work together. The participants stated that only through cooperation will we be able to develop capacity within our region and build on the existing programming and research.

Incorporation of an Indigenous worldview – Building on strengths and increasing local capacity within First Nations communities

Indigenous views of wellness are holistic and consider the interconnections between people, communities, generations, and the land. First Nations communities recognize the impact of the opioid epidemic and the disruptive effects on families and communities. As service providers, we need to better understand the root causes of substance use among Indigenous peoples, including the intergenerational impact of trauma suffered as the result of colonization. This is critical if we hope to foster meaningful partnerships that build on the experience, knowledge and wisdom of First Nations' peoples. Participants acknowledged that a local Indigenous worldview should be incorporated into all programming and research in opioid use in pregnancy, from the initiation of the project, through to evaluation and knowledge exchange.

CONCLUSIONS

Northwestern Ontario has near-epidemic rates of opioid use and this has significant social and health consequences, particularly when a woman becomes pregnant. This paper describes two workshops that drew together participants interested in issues facing opioid-using pregnant and parenting women from the perspectives of research, health care, social service provision and supportive care. The application of local Indigenous ways of knowing was central to the conversation, as was developing an understanding of the social determinants of health and the legacy of colonization on Indigenous peoples.

The issues faced by Indigenous and non-Indigenous communities in Northwestern Ontario are symptomatic of larger problems facing rural and remote communities across Canada. The initial successes achieved in our region speak to the need for a national strategy to address opioid use in pregnancy that encompasses education, improved access to appropriate medications, and support for community-based treatment programs, particularly those in Indigenous communities.

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RÉSUMÉ

La consommation d'opioïdes affecte jusqu'à 30 % des grossesses dans le Nord-Ouest de l'Ontario. Le personnel soignant du Nord-Ouest ontarien est plus ou moins à l'aise d'offrir des soins aux femmes enceintes qui consomment des substances. De plus, les professionnels de la santé, les services sociaux et les groupes communautaires du Nord-Ouest de l'Ontario travaillent souvent isolément et ont peu de communications et de liens de collaboration multidisciplinaires. Notre article décrit deux ateliers qui ont rassemblé des dispensateurs de services sociaux et de santé, des organismes communautaires, des établissements d'enseignement et des associations professionnelles intervenant dans les soins aux femmes enceintes et aux mères qui consomment des substances. Le premier atelier a présenté des pratiques exemplaires et l'expérience locale de prise en charge de la dépendance aux opioïdes durant la grossesse; dans le second, les participants ont appliqué une vision du monde autochtone locale à la mise en œuvre des priorités (cliniques, de recherche et de programme) définies durant le premier atelier. Les déclarations de consensus élaborées par les participants ont mentionné l'amélioration des transitions dans les soins, la facilitation de l'accès au traitement à la buprénorphine, des modèles de financement stables pour les programmes de lutte contre les toxicomanies et un accent sur les programmes dirigés par les Autochtones. Les participants ont défini le besoin urgent d'une stratégie nationale pour aborder les effets de la consommation d'opioïdes pendant la grossesse selon une perspective culturellement sûre et sensible aux traumatismes, qui tienne compte de la santé et du bien-être de la femme, de son nourrisson, de sa famille et de sa communauté.

MOTS CLÉS : dépendance aux opiacés; grossesse; services de santé autochtone; population rurale