TAPPING TRIBAL WISDOM:

Providing Collaborative Care for Native Pregnant Women with Substance Use Disorders and Their Infants

Lessons Learned from Listening Sessions with Five Tribes in Minnesota

Fall 2018

Developed with support from the

National Center on Substance Abuse and Child Welfare

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This document was prepared for the Substance Abuse and Mental Health Services Administration and the Administration on Children, Youth and Families (ACYF), Children's Bureau by the Center for Children and Family Futures under contract #HHSS270201200002C. Points of view or opinions expressed in this report are those of the authors and do not necessarily represent the official position or policies of SAMHSA or ACYF.

OVERVIEW AND APPROACH

In 2014, NCSACW[i] launched the Substance Exposed Infants (SEI)[1] In-Depth Technical Assistance (IDTA) program to advance the capacity of states, tribes, and their community partner agencies to improve the safety, health, permanency, and well-being of infants with prenatal substance exposure and the recovery of pregnant and parenting women and their families. Minnesota's Department of Human Services (DHS) was selected to participate in the first round of SEI-IDTA along with five other states (Connecticut, Kentucky, New Jersey, Virginia, and West Virginia).

> *"About 33.3% of American Indian Medicaid pregnancies (in Minnesota) have a diagnosis of substance abuse, including alcohol (from ten months prior to two months following delivery). This compares to about 7.5% of all Medicaid pregnancies. Diagnosed opiate use in pregnancy has risen from 7.7% of American Indian births and 0.9% of all births in 2009, to 14.8% and 1.6% respectively in 2012."*[ii]

The intent of the SEI-IDTA program is to improve outcomes for infants and their families at each point of intervention based on SAMHSA's Five-Point Intervention Framework[iii] (e.g. on pre-pregnancy, prenatal, birth, infancy, and childhood). The intensive program is designed to strengthen collaboration among child welfare, substance use disorder treatment, maternal and infant health care providers, early care and education, home visiting, and other key partners.

BACKGROUND AND GOALS

Minnesota's SEI-IDTA project resulted from concerns brought forward by tribal partners in Minnesota, focusing on the crisis of American Indian babies that are prenatally exposed to substances. As depicted in Figure 1 below[iv], Minnesota has seen increased

WHAT IS NCSACW?

The National Center on Substance Abuse and Child Welfare (NCSACW) is a national resource center providing information, expert consultation, training and technical assistance to child welfare, dependency court and substance abuse treatment professionals to improve the safety, permanency, well-being and recovery outcomes for children, parents, and families.

NCSACW is jointly funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Administration on Children, Youth and Families (ACYF), Children's Bureau.

[1] *This NCSACW program is now known as IPSE (Infants with Prenatal Substance Exposure) IDTA*

rates of American Indian women admitted to treatment programs for heroin and prescription opioids, as well as increased rates of those identified as using these drugs during their pregnancies.

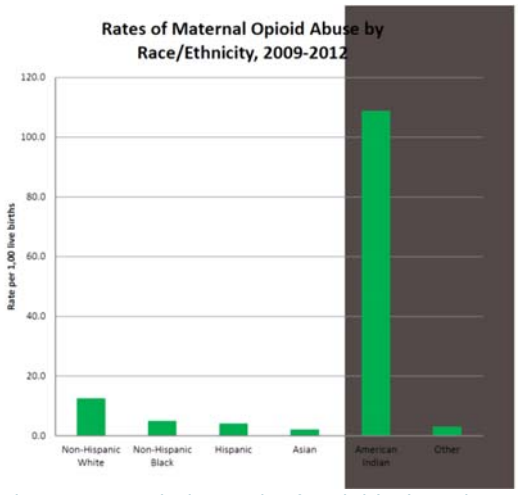

Fig 1: Maternal Diagnosis of Opioid Abuse in MN

This led to a spike in the rate of Neonatal Abstinence Syndrome (NAS) births among native women in Minnesota. Further data collection requested by tribal partners identified that many American Indian pregnant women in need of services were not accessing prenatal care and therefore not identified until the birth of their child. Over 50% of American Indian opiate-affected newborns received no or inadequate prenatal care during pregnancy, compared to 34% of all such newborns.[v]

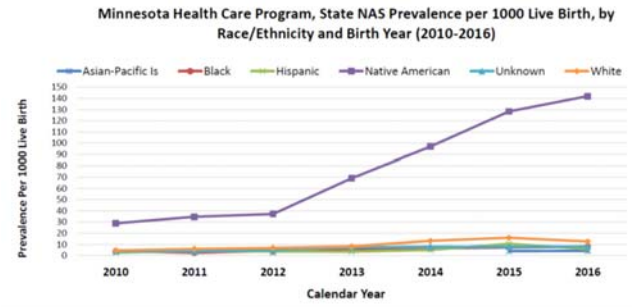

Fig 2: Prevalence of NAS in MN

Against this backdrop, Minnesota DHS engaged in SEI-IDTA to work with its tribal partners to improve coordination across tribes as well as with Minnesota's treatment, child welfare and maternal and child health agencies to employ a unified response to this crisis to yield the best results for these women and their children. The following goals guided Minnesota's initiative:

Goal 1: **Screening and Assessment** – Pregnant women, substance-exposed infants and their families will be identified in a consistent, uniform, and timely manner across all systems.

Goal 2: **Joint Accountability and Shared Outcomes** – Develop a collaborative practice approach to serving substance-exposed infants and their families that intersect each of their systems.

Goal 3: **Services for pregnant women, substance-exposed infants and their family** – Partners will agree upon evidence-based practices and programs that meet the needs of the target populations and have processes in place for monitoring use and effectiveness of these programs.

PROGRESS

Over the course of Minnesota's three and a half-year engagement in SEI-IDTA, DHS has worked with its tribal partners to improve coordination across tribes as well as with Minnesota's treatment, child welfare and maternal and child health agencies to employ a unified response to this crisis to yield the best results for these women and their children. In 2016, Minnesota's legislature authorized state funding to target pregnant Medical Assistance[vi] enrollees residing in geographical areas identified as being above-average risk for prenatal opioid exposure. This funding, part of Minnesota's Health Care Administration's Integrated Care for High Risk Pregnant Women (ICHRP) grant program, was awarded to the following tribes in 2017:

- Fond du Lac Band of Lake Superior Chippewa[vii]
- Leech Lake Band of Ojibwe[viii]
- Mille Lacs Band of Ojibwe[ix]
- Red Lake Nation[x]
- White Earth Nation[xi]

Each tribal grantee implemented a different collaborative care model for working with pregnant Native American women and their families. In late summer 2018, a listening tour was conducted with program staff from each of the five ICHRP grantees as part of the final SEI-IDTA site visit. An interview framework was developed to attain the following objectives:

To learn what works well and what doesn't in developing and sustaining a collaborative approach to caring for pregnant women with SUDs and their families

To solicit recommendations for next steps in how to achieve and sustain better birth, safety, health, and recovery outcomes

To gather feedback and gain insight into how state and federal technical assistance (TA) and resources can be most useful for Tribes

Several key themes emerged from the listening sessions with Minnesota's five tribal ICHRP grantees. These are summarized below.

DIRECT CARE: WHAT WORKS, WHAT DOESN'T

The first area of focus that the ICHRP listening sessions addressed encompassed critical components surrounding the clinical care of pregnant women with substance use disorders (SUDs) and their ability to access health and treatment services, including:

- barriers to care;
- integrating culture into service delivery;
- outreach and engagement in prenatal care and SUD treatment;
- the use of medication assisted treatment;
- caring for infants with prenatal substance exposure;
- gaps in the continuum of available supports; and
- relapse prevention.

Program managers and staff responsible for planning and implementation of the ICHRP grants shared their insights, lessons learned and recommendations regarding these elements of care. Their feedback is summarized below.

BIGGEST BARRIERS TO CARE

Fear. The primary factor that inhibits Native pregnant women from accessing prenatal care and from seeking treatment for a substance use disorder is fear—fear of having their newborn (as well as older children) taken from the home, fear of legal consequences (including incarceration), and fear stemming from the stigmatization associated with addiction, especially in small communities where everyone knows everyone else. For families that are involved in social services before the baby is born, clients are "very educated" that services are voluntary and therefore savvy about avoiding engagement in front-end services that they perceive might subject them to more scrutiny. This makes it very difficult to intervene during pregnancy due to the fear, stigma and shame that inhibits pregnant women in need of help from obtaining it.

> *"Most pregnant women hide—only those with social service involvement come in. We have high out of home placement for kids in this area…. county practice varies by hospital, but mom typically goes home while baby stays."*

Most Native pregnant women are referred to ICHRP programs by hospitals, courts, the Indian Health Board, other health providers, and Child Protective Services (CPS). In discussing access challenges, ICHRP grantees are concentrating their attention on working more closely with prenatal providers

and CPS to reduce barriers related to fear. For example, the White Earth MOMS (Maternal Outreach and Mitigation Services) program has "a huge push to repeat messaging that you won't get kids removed if you come for help. We've held firm to that model so the community knows it's true." These efforts are paying off, as evidenced by an increased number of women who are willing to sign up for voluntary cases to receive extra help and protection for their families.

Lack of Trust. In conjunction with the fear that women experience, providers and program staff are challenged with coordinating care for their patients in the context of federal policies (e.g. HIPAA and 42 CFR) regarding patient privacy and confidentiality that inhibit information sharing. Prenatal providers express concern about going against what the patient wants and feel caught between maintaining client trust and choosing to screen for a health condition (e.g. substance use disorder) that requires them, as mandated reporters, to notify CPS.

> *"Women are still scared to come in— society has taught them to hide. Getting them to trust us in the beginning was the hardest. Now that the program has taken off, its better but there is still fear that CPS will 'take my baby away.'"*

Finding a non-judgmental physician or care provider that women feel comfortable with is critical, so it is important for programs to establish an organizational climate and professional reputation that fosters trust and assures women that they will not be criticized, judged or shamed for seeking help for their addiction. As one program manager put it, "*Going to the clinic and not getting judged is critical. It is easier to say, 'I'm part of the MOMS program' rather than saying 'I'm an opiate user.'*"

Need for Education. Patients and providers need education about what is involved in treatment, as well as where to go to find help. In addition to feelings of fear and uncertainty about adopting an "abstinence lifestyle", women and their family members are not sure about which resources are available or how to access those resources. At the provider level, there is a huge gap in knowledge about resources as well, which makes it challenging to link patients to available support when it is indicated. Finally, it is important to educate and empower women who are trying to find their voice to advocate for themselves.

Transportation and Child Care. For many Native families residing on the reservation, services are spread out, so it is a jaunt to get to services and transportation is always an issue. In addition to geographic isolation, finding

clients is a challenge since pregnant women with SUDs hide at home and isolate from others. Some women have multiple children, but most programs and clinics do not have on-site space or resources to provide child care.

Infrastructure. Many reservations have no central building or complex where services are co-located, so multiple programs are scattered throughout the reservation. This can make it hard to coordinate care. In addition to space limitations, deferred building maintenance and insufficient capital funds, housing is not available to support long-term recovery. Furthermore, recruiting and retaining a qualified Native workforce is a significant challenge and creates barriers to sustaining successful programs and building capacity.

Housing. Homelessness is a particularly big issue in the metro area. As one program manager noted, "We see every day that it is hard to focus on treatment with no roof over your head." Another shared the story of a current client that completed treatment and recently got custody of her children but is homeless with nowhere to go. Most low-income housing programs don't accept clients with assault or felony records, or any evictions in the last 5 years. This makes it very difficult to find safe, sober housing for a new mother and her young child, so they are not compelled to return to the using environment which may have led to them to addiction in the first place.

Community Readiness. Tribes, like states, are working to coordinate discretionary funding for prevention, treatment and re-entry programming to ensure that none of the resources are wasted. Some tribes are in infancy stages in terms of strategic planning for health and human services and are working actively to align resources across programs while simultaneously increasing community awareness and support through health fairs, training, community expos and recovery-oriented events. ICHRP grantees point out that these events are a first step in knowing that communities are ready to address the problem of addiction with support rather than stigma and shame.

INTEGRATING CULTURE

Tribal grantees agree that culture is foundational to healing and recovery for Native Americans. As one program manager from Fond du Lac stated,

"Culture is organic. It is not something you can write down or create a policy around. It is how we interact with each other, greet each other. Culture is more than just having ceremonies available."

For most of the tribes participating in these listening sessions, culture is the core of their programs and services, and cultural considerations are written into the treatment plan. In some tribes, cultural supports are in place in some programs but are not fully integrated across all tribally-run programs. Regardless of the degree to which cultural practices and beliefs are imbedded into clinical programming, each of the five ICHRP grantees underscored how important it is for recovery and how much more is needed—"clients crave it."

> *"We do it every day in everything we do—smudging everywhere, talking circles, ceremonies, culture-based SUD treatment, weekly sweats, pow wows…we develop natural supports that way. In the afternoons, girls will sit and bead, developing strong bonds with each other. They have their own long-term recovery community." (White Earth Nation)*

Since many pregnant women can't participate in some cultural practices such as sweat lodges, there is a need to establish internal collaborative relationships across programs that integrate cultural practices where they are not commonly offered (e.g. perinatal programs) so that cultural bridges are built between programs to support more coordinated and person-centered care. The most successful groups and services are those that incorporate culture, e.g. Families of Tradition (hosted by a peer recovery coach); cultural crafting; drumming; smudging, etc. into multiple aspects of the program.

One grantee reflected that tribal culture is "coveted" and is protected somewhat like a secret or a special privilege. This can feel shaming for those with addiction who perceive that they aren't pure enough to be allowed to participate. At least one tribe is trying to weave cultural practice into programs with a bit less ceremony so that services feel more welcoming for individuals seeking treatment. If cultural practices were reimbursable, there would be more options for programs to purchase culture-centric resources (curricula, songbooks, beading materials, or coloring sheets in Ojibwe, for instance) and supplies for clients to make ribbon skirts, regalia, etc. As one program manager stated, *"We know there are successes when you build culture into programs."*

OUTREACH AND ENGAGEMENT STRATEGIES THAT WORK

The ICHRP program staff from the five tribes participating in the listening session employ multiple outreach and engagement strategies to encourage pregnant women with SUDs to engage in treatment and supportive services.

Incentives. Several grantees noted that the use of non-cash cash incentives (e.g. gift cards, diapers, baby blankets, transportation vouchers) works well with pregnant women, and one tribe (Fond du Lac) is leveraging what every department within the tribe is doing with incentives. For example, WIC Nutrition Program, Social Services, Positive Indian Parenting, Public Health and the Doula program pool incentives through a combined approach where the more clients participate in services from each of these agencies, the bigger the incentive.

"Past successes tend to be the best kind of advertising. Our treatment coordinator is not there to turn you in or bring the cops, and this has established lots of trust in the community. Women will check in even if they are hiding out. It has taken us three years to build this level of rapport with the community."

Community Outreach. Some ICHRP grantees hold regular outreach efforts at local community centers, clinics and schools, and report having established close working relationships with Tribal Social Services and medical providers within their service area. One grantee (Leech Lake Band of Ojibwe) has held successful "Bringing Back Hope" health expos in each district on the reservation that made real-time screening and assessment services available, along with speakers and an open mic that allowed people to tell their stories. These expos were so well received, with 100+ community members participating in each district, that the Tribe plans to bring them back again.

Collaboration. ICHRP grantees are working to collaborate across tribal health and human service programs in a more coordinated fashion so they serve one another more effectively. This can be challenging as there is no clear mechanism to support ongoing collaboration in terms of staffing or centralized leadership. Tribes are geographically widespread, which inhibits in-person meetings that are central to building trust.

Grantees are also working more closely with referral sources across county lines and are using culturally-based strategies to build relationships with hospitals, prenatal providers, opiate programs, home visiting programs, and doula programs to cross-pollinate what works well. To support more streamlined referral processes, they offer education and support about NAS, treatment options, and available resources for shared clients.

Peer Supports. Peer recovery supports are increasingly being utilized both on and off the reservation, especially as Minnesota's SUD System Reform has gone into effect in mid-2018. All five tribes are now incorporating peer

recovery coaches into their program models, training and certifying Native Americans with lived experience in recovery to support outreach and engagement through harm reduction activities, conducting outreach and intervention in tribal health clinics to engage pregnant women in treatment, and keeping clients engaged in community.

During the listening tour, Minnesota's SEI-IDTA leadership team learned that the State's 1115 Medicaid waiver was approved which allows for a higher level of reimbursement for certified peer recovery support specialists. Additionally, Minnesota is piloting an effort with Red Lake and White Earth that allows the tribes to define their own qualifications for peer recovery coaches. These peer supports provide a critical lifeline to Native pregnant and parenting women with few options and starkly limited resources. One program manager (Red Lake Band of Chippewa Indians) meets individually with moms in their homes, bringing prenatal vitamins from the hospital when she does and aiming to schedule a sonogram at the first meeting.

At least one tribe plans to replicate the MLB Sober Squad model (see highlighted practice below) using federal funding targeted to tribes (i.e. Tribal STR grants). At the state level, DHS is dedicating resources to working with tribal colleges to support recruitment and training of peer recovery specialists, including certifying doulas as peer recovery specialists to improve engagement of pregnant women who need SUD treatment as early as possible during pregnancy.

PROMISING STRATEGIES

- Create a universal release for agency-to-agency referrals
- Give providers culturally validated screening tools
- Geo-map regional NAS rates to support targeted outreach in collaboration with providers and hospitals
- Build trusting relationships by meeting regularly with courts, CPS and law enforcement
- Establish informal agreements with CPS to allow mothers to retain custody of their newborns if they are actively engaged in SUD treatment
- Educate health providers about available resources and how they can be accessed (e.g. try to get on the docket to have conversations with medical team)
- Build community buy-in through tribal elders

Photo Source: https://www.millelacsband.com/news/grassroots-groups-are-changing-minds-and-changing-lives

SPOTLIGHT ON SUCCESS:

SOBER SQUAD and NATIVES AGAINST HEROIN (Mille Lacs Band of Ojibwe)

Two grassroots groups—Sober Squad and Natives Against Heroin (NAH)—have emerged in Mille Lacs Band (MLB) communities in recent months. Historically, although MLB has been a very abstinence-based reservation, the stigma surrounding addiction has been relatively minimal.

This has allowed the abstinence-focused Sober Squad and the harm reduction-focused NAH to be supportive of each other despite some philosophical differences. Both groups share a genuine enthusiasm for recovery.

Peer recovery coaches are part of MLB Sober Squad and are located in each district of the MLB reservation, providing transportation assistance, staffing community events, and linking individuals with treatment and recovery supports. In some districts, treatment providers are ingrained in community and work with recovery coaches to support recovery-oriented activities on the reservation, such as a women-specific crafting support group that has been going for 10+ years.

Sober Squad chapters have launched in Grand Rapids and Fond du Lac, and are attracting non-Indians as well as tribal members. The Sober Squad has bridged a lot of barriers and effectively broken down stigma, so that non-tribal people are supporting Indian people in recovery. NAH is a Minneapolis-based recovery support network. Both groups use social media effectively to provide outreach, engagement and support to those looking for sobriety.

To learn more, go to: https://www.millelacsband.com/news/grassroots-groups-are-changing-minds-and-changing-lives

https://www.millelacsband.com/news/community-members-step-up-come-together-to-fight-addictions

https://kstp.com/news/natives-against-heroin-little-earth-community-minneapolis-help-curb-heroin-overdoses/4667402/

MEDICATION ASSISTED TREATMENT DURING PREGNANCY

Tribal knowledge, attitudes, and beliefs about the use of medication assisted treatment (MAT), including during pregnancy and post-partum periods, have shifted since the SEI-IDTA project was initiated in 2014. Initially, most tribes in Minnesota were reluctant to endorse the use of MAT because of concerns about diversion of the medication and negative health consequences for the unborn child, as well as a fundamental belief in abstinence

and the power of traditional healing methods. Over the course of the project, however, each of the five ICHRP grantees have incorporated MAT as a treatment option for pregnant and post-partum women with opioid use disorders to at least some degree. Some have embraced MAT as an evidence-based and effective strategy when it is coupled with cognitive behavioral therapy and comprehensive wraparound supports, while others have only recently begun to roll out MAT programs.

> *"I was just in the store and heard a client receive a compliment about how good she looked. She responded, 'I've been in the MOMS program for 7 months clean!!'. Being in the program is now seen as a badge of honor."*

During the listening sessions, ICHRP program staff emphasized the need for ensuring that multiple treatment pathways are available, since not all pregnant women want MAT and should not be criticized for choosing to not want medication. One tribal grantee lamented that there need to be more options supported for Native people, observing that the current discussion about MAT during pregnancy is a "one-sided conversation". He reported that wraparound services contribute to recovery more than any other intervention, and beyond that, culture is the most important element of healing. For many tribe members, there is a cultural perception held by those in SUD treatment, out of respect for tribal beliefs, that "if I'm on medication, I don't go to ceremony—because I am not clean, and I might affect someone else's experience."

Other barriers persist in terms of medication diversion, physician reluctance to prescribe MAT for pregnant women, and philosophical disconnects between tribal health systems and state health systems. One grantee explained that many pregnant women are diverted away from tribal health programs by non-tribal insurance programs, and once this occurs, the State takes over and makes recommendations to move them to methadone programs based off reservation in the Twin Cities. This creates frustration for the highly trained tribal medical providers that have been managing a woman's care just to watch non-tribal medical providers totally change the approach.

Primarily because of medication diversion concerns related to the use of methadone, most tribes prefer Suboxone to treat pregnant women, although some program staff expressed the importance of taking a non-biased approach and facilitate their client's access to what they need and prefer. The White Earth Urban MOMS sees a high number of clients referred that are on methadone and avoid tapering until after delivery so they can start on

Suboxone. Program staff noted that it took a lot of conversations with Hennepin County to reimburse Suboxone at the same rate as methadone.

One grantee noted that most pregnant women with SUDs don't access prenatal care until their third trimester, which makes it difficult to initiate MAT since many physicians aren't comfortable treating them at 37 weeks. In these cases, the strategy is to provide as much structure as possible to keep clients busy with culturally supportive activities such as quilting, beading, and naming ceremonies.

One Foster Mom's Perspective

"As a foster mom, I've seen and heard how hard moms struggle with addiction. There is a lot of pressure put on people to take home these meds that are worth money. Even within the first week of our MAT clinic's opening, there were drug dealers in the parking lot waiting for people to come out.

I've seen women get kicked off WIC for selling formula online. If moms risk not feeding their babies, how will they manage their MAT meds??"

Despite these barriers, tribal acceptance of MAT as a viable option has increased. For instance, program staff from the White Earth MOMS program, an early adopter of MAT, has worked hard to remove the stigma associated with MAT and reported that there is no longer much push-back from the community any more. To achieve this shift, they conducted a lot of community outreach with families, hosting family suppers at the local casino to explain MAT and walk through the components of the MOMS program. During these events, licensed behavioral health staff are always available to answer specific clinical questions that families might have.

TREATING WOMEN AND THEIR INFANTS AFTER PREGNANCY

ICHRP grantees indicate that many women remain on buprenorphine after delivery, which is consistent with clinical practice guidance from multiple national maternal health organizations, including ACOG (American College of Obstetrics and Gynecology), SAMHSA and IHS (Indian Health Service). Nonetheless, tribes continue to express concerns that there is insufficient oversight of MAT providers. This concern is amplified through the lens of communities and providers that perceive that "people who are struggling (with addiction) are given a medication that is similar to what they used to get high." Most MAT providers serving Native pregnant and post-partum aren't based in tribal communities, so case management and care

coordination is limited. In most cases, "they don't hold their hands on a regular basis."

Tribes are sharing their policies and procedures regarding MAT with one another, and the early adopters of MAT have encouraged those tribes that are more recently adopting a MAT-supported treatment methodology to integrate behavioral health into the approach so that clients who may not be fully in recovery receive the necessary structure, services and supports to succeed. Grantees emphasized that MAT is only one of multiple strategies that are needed to support and sustain recovery. Early access to treatment and immediate access to recovery housing is both essential and hard to come by.

With vacancy rates of 2% in some communities, safe and affordable housing is in short supply, so treatment program staff are working more closely with their tribal housing counterparts to intervene and do outreach with housing clients as they strive to engage them in treatment.

CARING FOR INFANTS PRENATALLY EXPOSED TO OPIOIDS

Minnesota's tribal ICHRP grantees have been encouraged by the improvements that they have seen over the past few years related to hospital NICU practices. Program staff used to see newborns kept at the hospital for weeks or even months but are seeing less of this now as birthing centers are promoting the importance of maternal-infant bonding practices, which both parents and social workers tend to embrace, as well as offering more training for hospital staff and parents/caregivers related to NAS infant care.

Since there are no reservation-based delivery rooms in Minnesota, the birth event means that many Native families deliver outside of their home community. While different hospitals have different practices (and outcomes), it tends to be the case that when mothers are on MAT prior to delivery, they go home with their newborns much sooner. Close collaboration with the birthing centers is recommended so that parents are prepared for what to expect and learn that NAS is a manageable, treatable condition.

While concern remains high about the alarming NAS rates that are associated with well-documented health disparities for tribes in Minnesota, ICHRP grantees have assembled skilled and seasoned teams of nurses, health educators, case managers, physicians, and ancillary care providers that have amassed a wealth of experience and knowledge about how to successfully address perinatal substance exposure using a holistic approach. These collaborative care

"Every single mom that has been engaged during delivery has taken their baby home."

teams work hard to ensure that pregnant women with opioid use disorders are educated prior to giving birth about what to expect before, during and after delivery so that the birth experience is much less intimidating than it used to be. Parents learn that infant withdrawal is possible but not automatic.

This experience with achieving successful outcomes for infants with prenatal substance-exposure and their families has boosted grantee confidence in their ability to manage this difficult and complicated scenario so that these cases are less scary than they once were, which allows them to preserve hope for both families and the care teams working with them in the process. In addition to training parents and caregivers, there remains a significant need for specific trainings targeted to tribal health and child care programs as well as to community providers to help staff calmly manage the predictable emotional and behavioral challenges that arise for families and caregivers of a newborn who is experiencing withdrawal.

Preventing Relapse

"Coming in daily and having honest conversations is the best thing—we don't sugarcoat or baby them. They know we're here to support them. Graduates say, 'they never babied us, they were there every single day.' Our relapse rate is low; out of 32 graduates, there is maybe only one that we don't know where they stand. Some are going on three years of sobriety. Continued engagement is biggest practice that keeps people from relapse…the nurse just asking, 'How is your day going?'. They can't come in and just dose—they have to check in with mental health."

Training resources for staff in outside child-serving agencies are still not widely available. The ICHRP program staff participating in the listening sessions indicated a need for more knowledge about the use of traditional medicines, such as sweet grass and essential oils, to treat some of the behavior issues they see in young children with prenatal substance exposure to support mothers who don't want to place their child on medication. Tribal early childhood care and education programs are also using developmental tools, such as the Ages and Stages Questionnaire, to look at data and trends that will help them better understand what impacts perinatal substance exposure has on child development. One tribe mentioned that they use the Four Hills of Life[xii] human development model, which offers reparative and protective strategies to support social and psychological healing from trauma.

STRATEGIES TO PREVENT RELAPSE

Minnesota's five ICHRP grantees have a wealth of knowledge and experience in terms of what works best to assist their clients with relapse

prevention (in addition to MAT). The following comments reflect a summary of their recommendations.

"Wrap around services, flexibility of meeting where they are at, and having programing at times that fit their schedule and culture. You have to have treatment ready when they are ready. This is hard to do with our workforce challenges."

"Being there for support and linking them to resources for their daily struggles. Sometimes clients will call in the evening for support. Their needs don't stop at 5:00 pm."

"Connection, calling, and continuous outreach—even when people check out. The Sober Squad is also really great at being present, welcoming, and making really genuine person-to-person connections."

"Women go off reservation for residential treatment, but use support services on reservation, e.g. Wellbriety, AA/NA (more Red Road type talking circles). The trend for people in recovery is not to come back to the community because that's where the people live that they used with, but we're finding some good success with supportive recovery housing in other communities."

"Culture. Medicine bags, language camps, canning—making sure they have something to eat, sage picking, etc."

"We introduce a lot of healing ceremonies; those are natural supports in the community that support long-term engagement."

One tribe reported that parenting education and support provided through the Family Spirit home visiting program is instrumental in preventing relapse when mothers in early recovery bring home their newborn and are not equipped with the necessary skills and resources to cope with the stress associated with becoming a new parent.

COLLABORATION AND COORDINATION

TRIBAL COLLABORATIVE STRUCTURES

Each of the five ICHRP grantees has set up their collaborative structure to maximize available resources. Several of the tribes (Fond du Lac, Red Lake, and Mille Lacs) use a model where the behavioral health entity helms the tribe's ICHRP program. In Fond du Lac, for example, the SUD treatment provider serves as the lead in making referrals to the Tribe's recovery case management services, behavioral health, medical and social services every time a client is admitted to the program. They meet monthly about ICHRP clients with other involved agencies to coordinate care and problem-solve issues as they arise. In addition to holding regular team meetings, they hold weekly case consultations with multiple disciplines.

Mille Lacs takes a similar approach, also incorporating peer recovery coaches and law enforcement. They conduct weekly MAT recovery meetings that begin with case consultation. In Fall 2018, Fond du Lac will roll out a fully integrated treatment plan, in conjunction with a single-system electronic health record (EHR) that will allow all departments to share a single plan. Conversely, in Leech Lake and White Earth, the health department takes the lead in coordinating care on behalf of ICHRP clients with other tribal agencies, including mental health, the tribal opiate program, child welfare, home visiting and social services. For the White Earth Urban MOMS (UMOMS) program, primary partners also include the Indian Health Board, Minnesota Indian Women's Resource Center (MIWRC) and the Native American Community Health Clinic (NACC). Program staff meet weekly with these partners but are in communication daily to coordinate care.

Regardless of which agency serves as the lead, tribes are utilizing their collaborative structures effectively to build cross-system partnerships that allow them to streamline tribal resources and improve coordination of services so that client barriers to recovery are minimized. As collaboration evolves, tribes are also leveraging new relationships to bring in additional partners (e.g. hospitals, law enforcement, medical providers) which helps to reduce stigma and raise awareness, as well as widens the circle of support that is available for Native women that are pregnant and struggling with addiction.

While Minnesota was engaged in SEI-IDTA, the assigned NCSACW Consultant Liaison facilitated monthly calls to support cross-tribal collaboration and ideas exchange among the ICHRP grantees. Ideally, DHS will continue to offer this opportunity to interested tribes.

COLLABORATING WITH COUNTY CHILD WELFARE OFFICES

The relationship between tribes and counties when it comes to child protection can be complicated. In addition to operating their own Indian Child Welfare (ICW) agencies, most of the tribal ICHRP grantees are on large reservations that cross over multiple counties which administer public child welfare/child protective services that impact the tribe. There are also tribes such as Red Lake where child welfare services are primarily tribally-managed, and families living off reservation can elect to move onto the reservation to

have their CPS case handled by the tribe. Both tribe-county relationships and county-specific CPS practices vary widely, and the tribes interviewed in the listening sessions are actively working to improve these connections so that families impacted by parental substance use disorders are offered more supportive options.

Some county child welfare offices have imbedded Indian Child Welfare Act units that notify the tribes of an open case with a member family, and others have policies which directly transfer these cases to the tribe. A few ICHRP grantees that have had their programs operating for some time have been successful in establishing informal agreements with county offices to keep children with their mother if she is engaged in the tribal treatment program.

"Project Child clients see the benefits of care coordination and don't have trouble signing releases. We show clients how they take the lead in their own care and case management. I wish there was a Project Child in each county!"

In Hennepin County, where White Earth Urban MOMS (UMOMS) program is located (downtown Minneapolis), the Tribe works closely with Project Child, which is a county-run child welfare program for women who are using drugs or alcohol before their 34th week of pregnancy. Project Child refers pregnant Native women to UMOMS for chemical health assessments and treatment services, as well as education, support, one-to-one counseling, referrals for help in the community, assistance with basic needs and parenting education. According to the UMOMS Program Director, Project Child staff are very solution-oriented, going "above and beyond" to avoid child removal and attending family meetings on the UMOMS campus to support coordinated care and case management.

Judicial attitudes have a significant impact on options available to pregnant Native women, and ICHRP grantees report that there is still a lot of work to be done to reduce judicial stigma around opioid use during pregnancy, especially on the reservation where bias is stronger than in the metro area. Both tribal and county child welfare staff are trying to understand MAT and are becoming more open-minded and willing to hire people on MAT as they learn how it helps to support recovery. One grantee noted that it is difficult to find the right staff person to connect with that understands multiple systems and can build the necessary bridges, so collaboration with child welfare remains a challenge.

Some county CPS workers are hesitant to engage in collaboration, especially in the early phase of program start-up when county staff may be reluctant to invest time and energy in "the tribe trying something new again". This creates

additional barriers to relationship and trust building, although grantees acknowledge that each county is different. "Some are 'do it yourself/take care of your own people', some are helpful, some are wishy washy."

This variation in attitude and approach makes it difficult for those tribes working with multiple counties that range from being very inviting to being blatantly disrespectful. In many cases, tribe-county relationships are informal and exist primarily at the practice level between direct service providers rather than at the systems level between policy makers. While this dichotomy accommodates some ground-level service coordination, it inhibits a more systemic collaborative approach that can weather staff turnover and changes in administration.

COMMUNITY-BASED RECOVERY SUPPORTS

For both reservation-based services as well as non-reservation/urban-based services, informal community-based supports are a vital part of the service continuum available to Native pregnant women and their families. Clients are "referred" to cultural events and community gatherings in the same manner that they are referred to more formal supports, and peer recovery coaches are deployed to assist with follow-up, including transporting them to events when needed. Participation in these traditions-based ceremonies and cultural activities helps to counter the isolative tendencies for pregnant women that may hide out and steer clear of more formal services.

Tribal websites are also an important resource for Native individuals and families, linking them to supportive resources and sober activities that are designed to strengthen community bonds. For example, Fond du Lac's Tagwii Recovery Center hosts weekly breakfasts for program alumni, who return week after week to take part in a growing recovery network on the reservation. In Mille Lacs, peer recovery coaches serve as the bridge to community supports. As the MLB ICHRP program director put it, "peer recovery coaches are so community-connected that it doesn't even feel like a referral. It's more like an invitation, or it happens the other way where the person in need knows how and who to ask for help."

BUILDING CAPACITY

FOCUS ON OUTCOMES

Tribal ICHRP grantees are funded to focus primarily on building their collaborative capacity to prevent or mitigate the risks to pregnant women and their children that are associated with substance use during pregnancy. In addition to tracking birth outcomes (including NAS), grantees are also seeking to prevent child removal and family disruption for the women in their care and to improve overall health, social and economic outcomes. While hard data was not available during the listening tour, grantees shared some of their success stories. In many cases, successful clients become peer recovery coaches and counselors.

Fond du Lac reported that 29 of its 32 graduates are now working full-time. In White Earth, 100% of the mothers engaged in the MOMS program have been able to bring their babies home with them from the hospital.

Grantees told of numerous moms and dads that have been able to surmount overwhelming obstacles, including losing child custody, homelessness, extreme poverty, transportation challenges, and lack of sober family and friend supports, to successfully engage in treatment and recovery support services. These parents in recovery are inspiring hope among providers and in the community that change is possible in the context of a collaborative approach that is culturally rooted, non-judgmental, and community-driven.

IMPLEMENTATION CHALLENGES

Tribal ICHRP grantees described several persistent challenges to program implementation and expanding collaboration that could be alleviated by funding and policy change at the state level. These include:

- Longitudinal data tracking. While having an EHR system helps, most tribes indicated that they need resources to strengthen and formalize their evaluation process.
- Grants management. Tribes are adept at braiding multiple discretionary grant funds together to provide a comprehensive array of health and human services. Support from DHS and its sister agencies is needed to streamline reporting requirements and align objectives

across agency initiatives where possible to minimize the significant burden on tribes.

- Peer supports. Tribes need targeted training and recruitment resources to be able to hire peer workers for more tribal programs. Current training options are limited and difficult to access for those living on reservation.
- Child care assistance. There are currently so many hoops that parents are required to jump through to access child care assistance in Minnesota that it isn't worth it for many of them.
- Training. Law enforcement officers and criminal court judges need focused training regarding MAT and tribe-specific resources to bolster their ability to divert Native pregnant women from jail to treatment.
- Coordination with MAT providers. Tribes have done a lot of work with local prescribers to get them to prescribe and coordinate care. White Earth sends moms to the birthing hospital with a letter that explains her MAT dosage in an effort to improve coordination and support continuity of care post-delivery.

Minnesota DHS and its state agency partners are encouraged to work with the tribes to explore funding and policy options to alleviate these challenges. The ICHRP program staff participating in the listening sessions offered several recommendations which are summarized below.

RECOMMENDATIONS TO STRENGTHEN CAPACITY

Recommendations and lessons learned from ICHRP grantees to build tribal capacity to provide coordinated care for pregnant Native women with SUDs, as well as to increase collaboration on their behalf are woven through this report. The recommendations below are more systemic in nature and are directed at state government.

1. Increased grant funding is needed for infrastructure/capital projects in rural Minnesota.
2. More culturally-based family-centered treatment facilities are need for women that allow them to bring children with them.
3. More supportive housing options that support recovery are needed in rural Minnesota as well as in the metro area. Housing eligibility policies need to support family reunification and allow for a safe environment for moms to be in recovery and with their children.
4. Tribes need to be able to bill Medicaid and third-party payers for cultural interventions. (This reimbursement mechanism is included in the SUD system reform package that just went into effect in Minnesota on July 1, 2018.).

SUMMARY AND FINAL THOUGHTS

The ICHRP grantee listening tour highlighted some important threads that, when woven together, create a lifeline for struggling Native families seeking recovery from the disease of addiction. Even though the practice models differ from one grantee to the next, the listening tour underscored the hallmarks of success that are shared across programs. These include:

- Ensuring that culture is at the core of policy, programming and daily interactions.
- Utilizing peers with lived experience to facilitate outreach, engagement and retention of women and families in treatment, supportive services and community activities.
- Keeping and treating families together as a unit, preventing the trauma of family separation.
- Eliminating the stigma associated with substance use disorders and the need for help.
- Breaking down silos within tribes through improved coordination and collaboration across agencies.
- Engaging the support of tribal leadership, beginning in the planning phase, and preparing for sustainability in the face of anticipated (and unanticipated) changes in leadership and governance.

These threads originate from within the tribal community and can be further strengthened by external support from non-tribal partners, including county and state agencies, community-based service organizations, and health care providers. By providing targeted funding and other resources for tribes where health disparities are the most severe, along with facilitating coordination across tribes to support inter-tribal collaboration, the state can support improved outcomes for Native families and communities.

During the listening tour, ICHRP program staff emphasized the inherent complexities of working with tribal communities in the capacity of a state agency or an external technical assistance provider. They underscored the

reality that every tribe across the country is unique with needs that are so specific that it is problematic to reach out to the state or to national centers for help. Not only is it difficult to communicate the necessary history and context to outside entities, but tribal councils need a lot of buy-in from the internal community to endorse a particular approach.

"Family members might have used together all their lives but can't get sober together. We have to teach people how to get sober in their own community. Half the battle is convincing tribal leaders to support what we're doing."

Ideally, in addition to cross-pollinating effective policy and practice that effectively addresses the needs of Native families with substance use problems, state and federal TA resources can be mobilized to support tribes in serving as their own experts—which they are. The ICHRP grantees made great strides in implementing successful strategies to address many of the challenges noted in this report over the course of Minnesota's SEI-IDTA initiative, demonstrating the powerful contribution of community and cross-system collaboration in helping families move from a place of despair to one filled with hope and healing.

ADDITIONAL RESOURCES

Marnie Werner, VP Research & Operations. "It's an addiction crisis: Across Minnesota, the "opioid crisis" is so much more than just opioids." Center for Rural Policy and Development, June 2018. https://www.ruralmn.org/its-an-addiction-crisis/

This article discusses the factors that contribute to Minnesota's "addiction crisis" and makes the case that the root problem is more complex than opioids alone. Up-to-date data about the impact of substance use disorders on children, families and communities is presented and several programs that are having a positive impact, including Sanford Medical Center's "First Steps to Healthy Babies", which includes Red Lake Nation as a collaborative partner.

Minnesota Department of Human Services. "Tribal and Urban Resources for Native Americans in Minnesota." https://mn.gov/dhs/partners-and-providers/news-initiatives-reports-workgroups/indian-child-welfare-news-reports-work-groups/

This Tribal and Urban Resource Guide DHS-7623 (PDF) was a result of the Minnesota's Substance Exposed Infants In-Depth Technical Assistance (SEI IDTA) initiative. This guide encompasses resources for eleven Tribes in Minnesota, including: Bois Forte, Fond du Lac, Grand Portage, Leech Lake,

Lower Sioux, Mille Lacs, Prairie Island, Red Lake, Shakopee, Upper Sioux and White Earth. The Guide lists their resources related to chemical dependency, chemical dependency assessments, mental health, maternal and child health, child welfare, sexual assault services, medical, housing, half-way houses, services for pregnant women and families, behavioral health, parenting groups, peer mentoring and cultural or spiritual links to services. Urban programs are also listed that offer services for pregnant women and families, cultural resources, medical services, parenting and peer mentoring.

Pember, Mary Annette. Rewire News. "Stigma Surrounds Addiction Treatment for Pregnant People in Indian Country." Oct 16, 2018.
https://rewire.news/article/2018/10/16/stigma-surrounds-addiction-treatment-for-pregnant-people-in-indian-country/

This article highlights the White Earth MOMS program approach and accomplishments and provides an in-depth analysis of the complex dynamics associated with substance use during pregnancy and the use of harm reduction strategies such as MAT on reservations.

Testimony of the National Indian Health Board to the United States Senate Committee on Indian Affairs Opioids in Indian Country: Beyond the Crisis to Healing the Community. National Indian Health Board, March 14, 2018.
https://www.indian.senate.gov/sites/default/files/3.14.18_Opioids_NIHB%20Testimony.pdf

Presents the U.S. Senate Committee on Indian Affairs hearing on the opioid crisis in Indian Country. Features testimony from representatives of the U.S. Department of Justice, the Substance Abuse and Mental Health Administration, the Indian Health Service, the Port Gamble S'Klallam Tribe, and the National Indian Health Board, which is represented by Samuel Moose, Treasurer and Bemidji Area Representative, National Indian Health Board (Bemidji, MN).

END NOTES

[i] https://ncsacw.samhsa.gov/
[ii] These data were taken from Medicaid claims linked to birth records.
[iii] Young, N. K., Gardner, S., Otero, C., Dennis, K., Chang, R., Earle, K., & Amatetti, S. Substance-Exposed Infants: State Responses to the Problem. HHS Pub. No. (SMA) 09-4369. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2009.
[iv] Schiff, Jeff, MD, MBA. Opioid Crisis — Time for a Coordinated Community Response (presentation), Jan. 7, 2017. https://www.google.com/search?q=ichrp+mn&client=firefox-b-1&ei=3HGpW8_kLYm9zwLc0Y3AAw&start=10&sa=N&biw=1173&bih=545#
[v] Thiese data were taken from Medicaid claims linked to birth records.
[vi] Minnesota's Medicaid program
[vii] http://www.fdlrez.com/

[viii] http://www.llojibwe.org/
[ix] https://www.millelacsband.com/
[x] http://www.redlakenation.org/
[xi] http://www.whiteearth.com/
[xii] Peacock, Thomas; Wisuri, Marlene. The Four Hills of Life - Ojibwe Wisdom. 2011. Minnesota Historical Society.