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Megan: ..."Ask the Expert" webinar, "Criminalization of Substance Use Among Pregnant Women in Tribal Communities." I'm Megan Hiltner with the Healthy Start EPIC Center. We have approximately 60 minutes set aside for the event today. The webinar is being recorded, and the recording along with the transcript and the slides will be posted to the EPIC Center's website following the webinar.

We have a nationally well-known expert speaker here with us today to share. But before we get to Dr. Puneet Sahota's introduction and her presentation, I have a couple more housekeeping announcements for you. We want your participation. So, at any point, if you have any questions or comments, please chat them into the chat box at the bottom left corner of your screen. We will only be taking questions through the chat box. And we will get to those questions following Dr. Sahota's presentation. Also, we want your feedback on the event. So, please take a moment following the webinar to complete the survey that will pop up on your screen right after the webinar.

Here's a look at our agenda for today's webinar. You'll first hear some welcoming remarks from Dawn Levinson. She's the Behavioral Health Advisor to the Division of Healthy Start and Perinatal Services. And then, she will introduce Dr. Sahota, then you'll hear from Dr. Sahota, and then, we'll get to some questions and answers.

But before we get to that, we wanna do a quick knowledge check of where you're at on this topic. So, if you'll please, take a moment and respond to this question on your screen by clicking on one of the radio buttons. The question is, the main barrier faced by American Indian/Alaskan Native pregnant women from seeking care for substance use is historical trauma, poverty, lack of access to health care, or all of the above? If you'll take a moment and click in and respond to this knowledge check, please. We're gonna then revisit this question at the end of Dr. Sahota's presentation.

So, I see a lot of folks are chiming in with some responses. All right. Here we are. It looks like everyone thinks that it is all of the above. All right. So, thank you all for taking a moment to weigh in on that. Like I said, that we will revisit that question at the end of the webinar to see if there's been any shifts and what you think.

So, now I'm gonna turn it over to Miss Dawn Levinson with the Division of Healthy Start and Perinatal Services for some welcoming remarks. Dawn?

Dawn: Good afternoon, everyone. Can you hear me okay?

Megan: Yes, we hear you fine, Dawn. Thanks.

Dawn: Terrific. So, good afternoon, everyone. This is Dawn Levinson. I'm the Behavioral Health Lead in the Division of Healthy Start and Perinatal Services, and Coordinator of all things behavioral health in HRSA's Maternal and Child Health Bureau, and I'm very pleased to be the Division Representative on today's webinar. I wanna welcome our speaker who I'll turn it over to in a moment, and welcome to our Healthy Start grantees across the country.

As it relates to behavioral health, Healthy Start's role, of course, is to present mental and/or substance use disorders through health education as well as you screen, intervene, refer, and support women and their families who may have a behavioral health problem. You also address toxic stress in the family and support trauma informed care.

We hope today's presentation will add some knowledge and tools to your toolbox as you support women and their families who may have a problem with substance use or misuse, or a substance use disorder.

Today's webinar will focus on issues related to pregnant women in tribal communities and common reasons that they don't self-report substance use due to fear of child removal or fear of legal action. And this is a really very critical issue. And we heard from grantees across the country that this is definitely something that we wanted to talk about and address.

So, without further ado, I'd like to warmly welcome our speaker today, Dr. Puneet Sahota who is the Research Director at the National Indian Child Welfare Association. I think she'll tell us just a brief bit about herself. And Dr. Sahota, thank you so much.

Dr. Sahota: Thank you for having me. It's a pleasure to be with you all today. So, my name is Puneet Sahota. And as you heard, I work at the National Indian Child Welfare Association. I'm a psychiatrist practicing in Philadelphia halftime, and halftime, I am working with NICWA helping with our research program.

I would like to say today that I'm really representing our program team. So, this presentation was prepared collaboratively as efforts from all of

us on the program team at NICWA and I'm honored to be representing the team today. So, I will just say that, you know, my remarks are not uniquely my expertise, but the collective thinking of myself and my colleagues at NICWA.

So, I thought I would begin by introducing you to our organization. So, NICWA is the National Indian Child Welfare Association. We are a national non-profit based in Portland, Oregon. And the mission of NICWA is that we are dedicated to the well-being of American Indian and Alaskan Native children and families. We seek to support the safety, health, and spiritual strengths of American Indian and Alaskan Native children.

NICWA was founded in 1983, first, in response to training needs for American Indian/Alaskan Native child welfare workers. NICWA is a membership-based organization and our membership is diverse, including both individuals and organizations as well as tribal governance, urban and reservation-based social service programs and staff who work with American Indian and Alaskan Native children and families. And it's really in service to our members that we do all of our work.

There are some key areas of our work and I thought this might help provide context for the perspective we'll provide on the topic today. The key areas of NICWA's work include public policy and advocacy on behalf of American Indian and Alaskan Native children and families, community development where our staff help to support native communities in terms of their own child welfare and children's mental health programming. We seek to help communities develop their own capacity to do those things.

NICWA provides training and technical assistance in the areas of Indian child welfare, children's mental health, and other areas as well. We respond to inquiries from families, tribal staff, and others who need support or assistance in the areas of child welfare and children's mental health. And on the research side, my department, the research department, conducts studies and gathers data in service to these other areas of NICWA work. We provide support to our staff that work on the ground in communities as well as our staff who provide technical assistance and training.

And so, the presentation content we'll talk about today is in line with that, where we're trying to gather data and knowledge, and bring it to you in

service to these other broader missions that NICWA has. We also have an annual conference which is coming up here in a couple weeks. And every year, this conference is focused on preventing child abuse and neglect in Indian country.

And so, that's a brief introduction to NICWA and our orientation to this work. The core issue areas that NICWA focuses on include child abuse and neglect, the Indian Child Welfare Act, foster care and adoption, children's mental health, youth engagement, juvenile justice, and context for children's well-being. And that's where today's topic sits in.

So, in terms of moving into today's webinar theme, which is substance use in pregnancy, I wanted to first begin by giving a broader background. As I think many of you know, on the call today, substance use is a factor in the majority of child welfare cases in native communities. And so, this really is a critical issue both in terms of substance use in pregnancy and after parents have had a child as well.

Women using substances during their pregnancy may come into contact with multiple different systems including healthcare systems, child welfare, and justice systems. And these can include complicated jurisdiction issues because there are both tribal jurisdiction areas as well as state jurisdiction areas that these women may come in contact with.

So, to really understand substance use in Indian country in general and in pregnant women in particular, the colleagues I have at NICWA with greater cultural expertise than me pointed out they felt, you know, I should start with historical trauma. And so, that's really the most critical context, I think, that you'll hear about today.

So, historical and intergenerational trauma is a leading factor underlying substance use in American Indian and Alaskan Native communities. And I'll go into more detail about historical trauma on the next slide. But essentially, what we're trying to say here is that the multiple forms of trauma that native people have faced, that indigenous people have faced as a group don't just stop when the trauma itself has ended.

And so, all the ways in which native people as a group has been harmed by the federal government, by policy, has resulted in intergenerational transmission of trauma, where these traumas reverberate down through generations. And the way that happens is complicated. Some of it has to do with the way that families are disrupted and that traditional ways of raising children were disrupted. Some of it may, in fact, be through

changes to the genome in terms of epigenetics and ways that regulation of genes can be affected by severe trauma, and then what that means for future generations.

And so, the way historical trauma is passed down is complex. And without a doubt, pregnant women are at a nexus of that both in terms of genetic transmission and then becoming parents, and having, you know, influence on early development of their children. And so, historical trauma is really a key factor up for this discussion.

In the studies that we've reviewed in preparation for this webinar and other work that we've been doing at NICWA recently in substance use, we found a number of qualitative studies where researchers had asked native people in communities about what they think are the leading cause of substance use, in particular, opioids. And in a number of these papers, respondents have said they sort self-medication either to fill an emotional void or to essentially numb pain from trauma or other adverse experiences is a key reason that people in their community are using substances. And this has also been true in some of the direct experience that NICWA's staff has had working in communities or through clinical experience as well. And so, with that in mind, you know, we would suggest that substance use in pregnancy is often co-occurring with deep pain or loss of a variety of types.

So, in terms of historic trauma specific to this topic, my colleagues, again, at NICWA with cultural expertise listed these different historic traumas that they thought were most relevant. So, one is that when federal policies were put in place to outlaw religious practices or traditional healing, a number of communities found that their historic or traditional ways of supporting pregnant women became disrupted also.

And so, women might have relied on traditional healers, on spiritual systems, extended family and clan systems in terms of traditions that were put in place through community wisdom and cultural wisdom to help keep a woman healthy while she was pregnant. And many of those healing systems were disrupted and even outlawed by federal policy.

Boarding schools and the forcible removal of native children into boarding schools is another key historic trauma. In boarding schools, many children were abused. And as a result, their own ability to parent when they became parents was challenged. And so, the boarding school experience has continued to affect generations of people even those who were not in the boarding schools directly.

Another key context that my colleagues brought up was forced sterilization. And so, Indian Health Service sterilized many native women without their knowledge or consent. And so, at this point, there remains a certain mistrust around reproductive health within native communities, and that context is especially relevant for pregnant women and what kind of care they may or may not seek.

Removal of native children; forced removal of native children into foster care and removing them from their communities was a historic policy of the federal government as part of a broader effort to forcibly assimilate native communities and to destroy cultures. And so, that forced removal history also becomes a critical context for pregnant women when they're making their own decisions about whether or not to come in contact with healthcare providers.

There's also historic trauma that native communities have experienced around the misuse of data and research. And I bring that up because sometimes individual native people may avoid seeking healthcare or even responding to screenings, whether they're health screenings or other types of screenings, because of their worries or concerns about confidentiality and how data collected about them may be used. And that's as a result of a difficult history where researchers sometimes did take data, misuse it, or use it in ways that was harmful to native communities.

And so, broadly, within these different...and there are many other types of historic trauma, these are just the highlights in terms of which ones the native staff at NICWA thought were particularly salient to today's topic. But through all these different types of historic trauma, there becomes a disruption in terms of transmission of culture across generations and also disruption of traditional family structures so that when one generation is removed from the community through boarding schools or removal of children, even when they return, there's been a deep pain that's happened and a deep loss to the community. And so, healing from that is an ongoing journey now for many natives, individuals, and communities. And as they heal, there are impacts that continue of these traumas for young women who become pregnant.

So, with those in mind, just wanted to review what some of the barriers to care might be. So, there are mistrusts of the healthcare system and social service systems that result from some of the things we just talked about on the last slide like the forced removal of native children. And so,

with those barriers, native women may choose not to even seek prenatal care because of their fears that their children may be removed, current children or future children if they're pregnant. They also may be afraid to let a healthcare provider know that they are using substances because of the fear of either criminalization or of losing their children.

And one point that NICWA staff made when we were preparing this is that in some clinics, there is drug testing done without consent. So, every time that a pregnant woman comes in for a prenatal visit and her urine is checked, you know, if drug testing is happening without her knowledge, to some people that harkens back and feels similar to historic policies of forced sterilization. And so, for some women, you know, although these practices are very different, you know, that history continues to be a shadow and continues to, you know, color how people understand current practices. And so, for me, that was a really wise and helpful point to receive from others at NICWA without wisdom.

So, in terms of barriers to care and reasons that women may not seek care, there are some of the historic traumas we talked about and the mistrust in different systems that follow. But there's also a system level barriers to care. So, the reasons that women may use substances include self-medication, which we went over. But it was also pointed out to me that in some rural areas, it's easier to access substances than it is to access healthcare. And so, rather than penalizing women or blaming them as individuals, which is what criminalization does, we need to look at the broader system's context here and understand what structural factors people in these communities may be facing.

So, criminalization, essentially, transfers the responsibility to the individual saying that an individual woman is using a substance and the way to deal with that is through arrest or punishment. But in fact, there are all these broader factors that are behind substance use including historic trauma, intergenerational trauma, some of the poor social support that women may experience due to the disruptions in community and culture that we talked about that have happened historically, as well as poverty.

So, we tried to find information about how pregnant women in Indian country experience criminalization if they're using substances, and we found that there was really very little research about this in Indian country. And so, the information that is out there is anecdotal. There are a few news media reports but we did not find any specific case examples of tribal communities that criminalized this or any published

cases of, you know, native women being criminalized within their tribal communities.

So, we did try to find at least what perspectives women might express and we found one small qualitative study done in the general U.S. population. And there was one Native American woman within that sample of 30, but some of the themes in that study we thought were helpful. Even though they may not be specific to native communities, we thought that they resonated with our NICWA staff's experiences in communities. And so, this paper by Stone showed that women will avoid prenatal care, but they also isolate themselves socially if they're using substances during pregnancy to avoid being detected.

And usually, the leading fear these women expressed was being afraid their children would be removed. And isolating them socially means that they would not really spend time with friends or family while they were pregnant because they were afraid that, you know, members of their family or people close to them might notice they were using substances and report them to either child welfare or justice systems.

And so, in avoiding prenatal care, not getting checked on while they were pregnant, not having their baby monitored through regular care, and isolating themselves socially, in fact, these women end up in an even more vulnerable position and end up being, you know, even more cut off from different sources that could support them and help them to stop using substances both for them and their children. So, the fear of criminalization in this study, essentially, was causing women to get even less care and was harmful to them.

So, we also looked for research on criminalization and what the effects were to see if there was research we could cite on either benefits or harms to it. And the multiple experts' consensus panel papers or policy statements we found were pretty unanimous in saying that criminalization in research has been ineffective and harmful both to the mother and the baby because of what we just discussed in terms of women avoiding prenatal care. And so, the American Psychiatric Association, OB-GYN Association, and some nurses associations all advocate against criminalization, although in 23 states, women have been prosecuted for using substances while pregnant.

And so, this is an ongoing debate and challenge that women face. But in terms of healthcare experts, they are pretty unanimous in saying that this is not a helpful strategy either for a mother or a baby. And I

mentioned already that we did not locate any published accounts of criminalization in tribal communities specifically.

And so, with that in mind, we thought we would present from NICWA's collective experience and perspective on what we would recommend as best practices of how to support women when they're pregnant and using substances in native communities. And one of the key things my colleagues with cultural expertise brought up is that treatment should be culturally based. And so, what that means is that communities often have healing traditions and cultural wisdom that has been transmitted across generations. And so, taking a strengths-based approach that really relies on culture as a source of healing can be very powerful broadly in terms of treating and preventing substance use, but specifically for pregnant women in particular.

Taking a community-based approach that goes outside the clinic is also a best practice. Women who are reluctant to come into healthcare settings because of some of the barriers we discussed might be better reached through home visiting programs, other kinds of outreach, you know, health fairs, ways that they can be reached within the community. And so, taking the community-based approach that reduces stigma and that really brings healthcare out of the clinic and into the community is another best practice.

In terms of which substances are being used in pregnancy, there's been a rise in all populations across the U.S. of opioid use disorder. As I'm sure all of you know, in pregnancy, medication is just a treatment is the standard of care because if a woman were to stop using suddenly, she would go through opioid withdrawal, but the opioid withdrawal results to the baby are even more severe and can even be fatal. And so, medication is just a treatment with medications like methadone or suboxone is recommended in pregnancy.

That can be challenging for healthcare providers to convince women of because on the one hand, healthcare providers are saying, "Don't use substances while pregnant," but then on the other hand, they're saying, "Here's a substance that we would prescribe, that we recommend you take." And one barrier to using medication-assisted treatment for opioids in general in Indian country is that people will say that they feel like they're trading one addiction for another, something like, "Okay. You know, I was using, you know, an opioid that wasn't prescribed, but now, I'm taking one that's prescribed. So, what's the difference?"

And so, it's helpful, which I'll go over a couple examples here in a moment of programs in American Indian and Alaskan youth communities, but it's helpful to emphasize from the get-go that for a pregnant woman, the goal is to slowly, gradually come off the medication. And so, it's not that, you know, medication would be prescribed forever, but that immediate forced withdrawal from opiates is more dangerous to the baby than a gradual, supported way of coming off those medications. So, I just wanted to go over that briefly given the prevalence of opioid issues right now.

So, also, I just wanted to say that another best practice is integrated care between prenatal care, substance use care, mental health, and case management. And integrated care means co-location when possible so that women have one place to go to access these different kinds of services because even coming in for one type of healthcare can be very difficult in terms of trust, transportation, resources, access, all of those things.

And so, integrated care means co-location. Meaning, these different kinds of services are in the same facility or clinic, but also means collaboration between these different types of providers so that they are working together to provide a network of support for a pregnant woman, her baby, and her family.

Collaboration between child welfare and healthcare systems is another best practice so that when a community designs a preventive program or even a treatment program for pregnant women using substances, it's important to have buy-in from leadership in these different systems so that it doesn't become that any woman, for example, treated with opioid replacement therapy automatically has her children removed, or other, you know, difficult scenarios like that. So, having buy-in from child welfare and healthcare systems that are both in tribal jurisdiction can be really a critical first step.

So, in our scan for this presentation, we did find from examples of innovative programs in Indian country and just wanted to speak about that. And so, one program that we found was the Maternal Outreach and Mitigation Services or MOMS program at White Earth Nation. And this program really exemplifies some of the best practices that I was just discussing.

For pregnant women using substances, they offer intensive outpatient care, case management to help with things like supported housing,

economic support, nutrition support. They also offer mental health services, parenting groups, and cultural groups as well as referrals to medication-assisted treatment for opioid use and prenatal care. And so, all of these services are located in the same place, so there's all of this on-site including early childhood education, nutrition classes, and even support services for infants and children. Women participating in this program are even eligible to apply for supportive housing that's on-site where these services are provided.

And speaking of that collaboration that I brought up a moment ago between healthcare and Indian child welfare, this is just a quote from the MOMS program materials. It says, "Moms fully involved in this program will not have their child removed at birth for being on Subutex. Indian child welfare fully supports the program as a way to stay out of child protection." And so, this is clear to women upfront that if they do seek treatment for substance use, they will be supported and they will not be at risk if they've been detected, so to speak, as using substances. They will not be at risk of losing their children if they engage fully in treatment. And so, this is the kind of approach that, you know, we would recommend rather than, you know, criminalization.

Another program we found as a best practice example is Wrapped in Hope. And this is a collaboration in Montana that involves healthcare systems and public health systems serving those native and non-native communities. But because of this collaboration, there is better access for native women in that area to substance use care. And similar to the MOMS program, in Wrapped in Hope, prenatal care, psychotherapy, and substance use counseling are all co-located. And one of the staff who works in this program was interviewed for a newspaper article. And she said that what was so helpful about the co-location of services was that providers could even introduce a woman to each other in the same visit.

And so, by doing that, you know, if a nurse practitioner, for example, is seeing a woman for her pregnancy care, she can just walk with that woman down the hallway and say, "Let me introduce you to my colleague, this other provider, who's a counselor. She's really great. I think you'll have a good experience with her. You know, why don't you take a few moments to talk with her about, you know, substance use or about your mental health?"

That kind of approach which is personal, personable, can help to maintain trust and build rapport in the face of historic trauma and some

of the barriers and mistrust that these women may have toward healthcare providers. That co-location is really helpful not in terms of just being in the same office for convenience, but in terms of healthcare providers working as a team across different specialty areas in order to really give women comfort and access in their care.

The other point that was made about the Wrapped in Hope program is that with this co-location, there's a reduced stigma. So, pregnant women using substances are indistinguishable from other pregnant women seeking care because in these...you know, the clinical settings, anyone can come in to be seen and there's nothing setting apart a woman who might be using substances. There's no sign that says, "Chemical dependency program this way," for example. So, that really helps as well with people feeling comfortable coming in and more willing to come in for treatment.

And so, we were really impressed with these best practices and we hope that sharing these might be helpful to you as well. And so, these are just some of the references that we wanted to share. The first one, the article by Stone is the qualitative study I mentioned of pregnant women and some of their perspectives on substance use, and the reasons they might choose not to come in for care. And then, we have links here to much more detailed materials on the MOMS program and the Wrapped in Hope program that we mentioned.

And so, I wanted to leave a lot of time for questions and I hope we'll have a chance to answer some of them. This is my contact information. I would be happy to receive any emails or questions after today if there's anything I can do to connect you with resources. And I will say that some question you may have might be better answered by my colleagues who are natives at NICWA and who have that much more deeper cultural experience. And so, I would be happy to connect you with them as well if that would be helpful.

And so, I think those are the main points that I had wanted to raise. Maybe I can pause and hand it back over to you all if there's any questions you'd like us to address.

Megan: Right. Well, thank you so much, Dr. Sahota, for the remarks. And there are some questions here that I'd like to post to you. And how about this, if there are some questions that you'd rather take back to your team, just let me know and we'll track those questions, and we'll send them back to you, and then we can help relay those at Q and A.

So, the first question goes back to some early remarks you made. The question is, do you have evidence specific to First Nations or Native Americans on epigenetics?

Dr. Sahota: So, before I respond to that, I might be putting one of our respondents on the spot here. But I saw one of the participants is Dr. Francine Gachupin, and Dr. Gachupin is an expert on genetics much more so than I am. And so, I'm wondering if she might want to respond and if that's a possibility. If not, I will try to answer the question. But I wanted to defer to Dr. Gachupin if she's willing or able to answer that.

Megan: And Dr. Gachupin, I know you're in listen-only mode, but if you don't mind typing in or chatting in a response, I can then relay that message back to the audience. So, you can do that by the chat box in the left corner of your screen.

Dr. Sahota: So, what I will say in the...Francine is asking if we can repeat the question. So, Francine, the question is, is there evidence for epigenetic influences regarding historic trauma that's specific to native communities or indigenous populations? Are there any specific studies on that? So, that's what the question is.

And so, what I'll say in the meantime is that most of the information that I've seen on epigenetics is about mechanism of how various kinds of stress, trauma or other kinds of stress can impact the genetic expression within a parent and then how that might be passed on. So, specific to historic trauma, I will defer to Dr. Gachipin to give a response if she has any studies that she might cite in the chat box, but most of what I've seen is more broadly.

And so, Dr. Gachupin says there are preliminary studies that show there is a strong epigenetic component to stress, which is correlated to experiences of historical trauma, so yes.

Megan: Great. So, thanks for that question and thank you. And as I was also just looking, just internet searching as you all were talking, I do see some citations and things like that. So, as we pull together, maybe the follow-up email for this webinar, I can include some of those citations in that, so great.

Dr. Sahota: Great.

Megan: All right. Well, so, the next question here is, are you aware of any treatment support for pregnant women addicted to opioids who have a history of trauma to reduce the risk of disassociation in delivery which impacts on oxytocin and bonding with baby?

Dr. Sahota: Yeah. That's a really good question. So, dissociation is a common symptom that many people with trauma experience. So, I guess, for those who might not be aware of what that means, dissociation is where someone may feel like they're not quite in their body or they may feel like they're not quite experiencing everything in the moment, and that's a stress response that people have in times of great fear or trauma. And so, sometimes an individual who's experienced significant trauma can have that symptom when they're under stress again. And, of course, delivery of a baby is a time of stress for some people, for sure.

And so, to promote bonding, I would say...I mean, I can answer from my clinical experience, but I would welcome others to enter their expertise in the chat box if they have responses to that. And I'll pause in case you wanna read that out, Megan.

Megan: Sure.

Dr. Sahota: But from my clinical experience, one key way to help prevent dissociation is therapy, talk therapy. And there are many different kinds of talk therapy, but there are specific techniques that women can learn for keeping themselves grounded. And although this is not my area of expertise, I will say my colleagues at NICWA could point to cultural practices in native communities that have been traditionally used to help people stay grounded also. And so, I would say that preparation for delivery during pregnancy with a therapist or a cultural healer can be a helpful way to prevent dissociation.

Other things that, you know, across cultures that have been shown to promote early bonding are skin-to-skin contact, so putting baby to mother's chest as soon as they can. You know, giving a chance for that skin-to-skin bonding to happen, that helps to release oxytocin and helps with early bonding as well. And there are, you know, traditional practices within native communities of how babies were treated after birth and some of that involve some of those same principles. So, I hope that's helpful.

Megan: Thank you. There were no other additional resources or

suggestions in the chat box. But if you have them, folks, please chat them in and I'll report them back to the group.

So, there are a couple more questions here that I'll pose to you, Dr. Sahota. So, is there any data from the programs and best practices that you cited? And is it possible to share the policy statements that you spoke of?

Dr. Sahota: I have not yet seen any published data. Some of these programs are fairly new. And I guess I would recommend contacting them directly if you have questions about whether they have data showing efficacy. But one of the challenges in looking at this topic is there really has been very little research done about programs in Indian country for prenatal substance use. And NICWA was recently asked to be a consultant in the development of one of those studies because there is so little research. And so, we're certainly trying to monitor that field as it goes on, but there's a surprising, you know, lack of studies on this in Indian country.

Megan: All right. So then, we'll get to a couple more questions here. And folks, feel free to chat in any more questions. So, have you seen a connection between the Indian Child Welfare Act programs, ICWA, and home visiting programs? And if so, what has NICWA found?

Dr. Sahota: I appreciate the question also. And one of my colleagues from NICWA is in the participant list. So, Adam, I don't know if you would wanna respond in the chat box to that at all, but you might have more information to provide than I do.

So, in terms of home visiting, there is one program, Family Spirit, that's been studied in native communities, and that was a home visiting program. And I can send the citation out for that after this to you, Megan, but that program was aimed at supporting teen mothers. And, you know, there's a high rate of teen pregnancy in many communities including some native communities. But in that program, home visiting sessions were done by other native members of the same community who were trained as peer support and they went to visit these young women throughout their pregnancies and delivered a number of lessons, so to speak, home visiting lessons in a curriculum, and those lessons involved parenting, child care nutrition, self-care, and culture.

And what they found...and so this is a randomized clinical trial where they compared that home visiting program plus standard care to a group

that received what they called optimal standard care. So getting, you know, prenatal care in clinics, being transported to access those, and so on. And they did find that women and their babies who participated had less externalizing behaviors, so to speak, so less behaviors or indicators of emotional challenge.

There was not a difference in the rates of substance use, but this was also like a short-term follow-up study. And so, you know, there were some hopeful signs there in terms of indicators that would help keep families together. As far as the Indian Child Welfare Act and home visiting programs, any links, I can try to find out more from my colleagues at NICWA about that, but I am not...I don't have any like specific things to say directly to that.

Megan: We can loop back together on that and put that in the follow-up email as well.

Dr. Sahota: Great.

Megan: And so, a couple more questions here. One is that the government is supposed to support native communities to develop cultural treatment centers. Is there funding attached? And did the two examples that you described receive any government funding?

Dr. Sahota: I'm not sure if the two examples received government funding from the federal side or not. I could look into that and get back to you. And in terms of the government supporting cultural treatment centers, I guess I would need a better understanding of the question if you mean cultural treatment centers specifically for substance use or for pregnancy, and then I could look into better resources for you on that.

Megan: So, if you don't mind chatting in, the folks at...or that...who asked that question, if you wanna add a little bit more to your question, we can follow up on that, but... So, here's another question. Do you know anything about the bridging program in Maine that works with the Passamaquoddy tribe? I hope I did not mispronounce that.

Dr. Sahota: I don't specifically, but I can look into that and get back to you on that as well.

Megan: And to your point about family spirit, I do know that a couple of the Healthy Start grantees that are in supporting tribal communities are using Family Spirit. So, when we send out the follow-up email, I will link

to those folks that are using that program as part of their Healthy Start initiative.

Dr. Sahota: And my colleague, Adam Becenti, from NICWA also responded when I called out and asked him to enter into the chat box. And so, Adam says, "Home visits have proven to be an effective strategy to connect with native families and to maintain family structure. We are happy to share additional resources regarding the topic. Feel free to reach out to us." And Adam gave his email as well in the chat box, and so he's able to be a resource for those who have questions as well.

Megan: Great. And so, Dr. Sahota, the person that did ask that last question that we wanted some follow-up says that, "We met with ICW and they said that they needed to review UCHIP [SP] about what guidelines were present for in-utero. Would you know what this entails? Their concern was that they can be done to first time pregnant women who are misusing substances with no other children."

Dr. Sahota: I'm sorry, I'm not sure what the acronyms mean, so I'm just trying to decipher the question.

Megan: Yeah. Okay. ICW, I think, Indian Child Welfare, and they said that UCHIP...yeah, I'm not as familiar with UCHIP either. We could do some quick searching. And it seems like we do have a knowledgeable group here on the line. So, if all of you have additional info on this question, feel free to chime into the chat box. We've got a good community discussion going.

And so, how about this, we will take your...we're tracking those questions and comments, and we will pull these back together. And I'll work with you, Dr. Sahota, to get...see if we can find out more information on this.

Dr. Sahota: Great.

Megan: And so, folks, thank you all. I wanna thank you all for participating on the webinar today. I'm gonna highlight a few key takeaways here that Dr. Sahota shared in her presentation.

First, the historical trauma is a major contributor to substance use, that pregnant women face multiple barriers to accessing substance use and care, and that the best practice cited throughout her remarks was

culturally-based, integrated treatment between prenatal care and behavioral health are included in those best practices.

So, here's that question that we had right at the beginning. Let's revisit it and see if anybody's perspective has shifted. So, if you'll take a moment to respond. The main barrier faced by American Indian/Alaskan Native pregnant women from seeking care for substance use is historical trauma, poverty, lack of access to healthcare, or all of the above?

And folks are weighing in here. We're gonna skip to the results here. A couple of people have shifted and are now citing historical trauma and lack of access to healthcare. And the majority of folks think it's all of the above. Dr. Sahota, do you wanna say any more on that?

Dr. Sahota: I think that all of these are important factors and it depends on the woman and the context, for sure.

Megan: So, I just wanna give a couple of wrap up and reminders up for upcoming webinars that we have on the schedule as well as...I mean, I have my colleague, Hannaba Blue [SP] talk about some other resources that are available to you.

First, we have another webinar similar to this topic, but in a bit more general sense. It's focused on criminalization, but in a...more for in a broader sense, and the presenters on that are the National Advocates for Pregnant Women. That's April 26th, from 3 p.m. to 4 p.m. Eastern Time. We'll be sending information out on that soon with registration information. Of course, it's free.

And then, there's going to be a webinar in May. The date is still to be determined, but focusing on building your referral network. So, look after that webinar as well.

This webinar, the slides, the recording, all will be posted on the EPIC Center's website in about a week or so. So, look forward to that. And as well as if you've registered for the event, you'll get a follow-up email with some other highlights, some citations, and things like that. So, Hannaba, I'm gonna turn it over to you to highlight some of the resources through the ACE Step Initiative. Hannaba?

Hannaba: Yes. Hi, everyone. Yes. [inaudible 00:55:46]. My name is Hannaba Blue and I am [inaudible 00:55:49] Navajo, from New Mexico. I wanna thank you all again for joining our webinar. I am part of the

Healthy Start EPIC Center and with the ACE Step Team as Megan mentioned. We focus on addressing alcohol and substance-exposed pregnancies with the Healthy Start grantees. I wanna mention a little bit about some resources that we have for Healthy Start grantees through the ACE Step Initiative. We have a particular focus through this initiative on our grantees that are working with Native American and tribal communities. So, in addition to these webinars, we also have technical assistance available pertaining to behavioral health, including substance use in mental health.

Another exciting area we have that we are working on are some video segments pertaining to behavioral health-related topics including social determinants of substance use in tribal communities. So, please keep an eye up for updates on these videos. These videos will be coupled with discussion guides that organizations and communities can use with their population. We'll also be putting together a resource guide around behavioral health for tribal communities.

So, those are just a few other things that we have available. Keep an eye out for these opportunities or you can feel free to contact myself or our...another colleague who works in the ACE Step Initiative, Janet Benneth [SP]. And then, for the Healthy Start grantees, your technical assistance coordinator can also give you more information about this. And I can put my email address in the chat box.

Megan: Super. Thank you, Hannaba, so much. So, just in closing, an enormous thank you so much to you, Dr. Sahota, and the team that came together to pull together this information for this webinar. It was of great interest among the grantees that have been working on this in this work. And so, thank you for bringing such great information and remarks.

And thank you to all of you for joining today's webinar. I really appreciate all of the back and forth dialogue that so many experts also chimed on the webinar as well. So, thanks to everyone for your participation and for joining the webinar, and for NICWA and Dr. Sahota for your participation.

This concludes our webinar for today. Thanks again.