

Addiction in the family

Two Indigenous families overcoming barriers to opioid agonist therapy

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Every day, Indigenous people in Canada leave their communities to access health care services¹—the norm for all people living outside of large urban centres, owing to hospital closures and a centralizing of services all across Canada. For Indigenous peoples—especially those who live on reserves—the Government of Canada purposefully shifted health care services outside of their communities as a means of advancing a colonial assimilatory project.²⁻⁵ Today, Health Canada's evacuation policy continues to be applied to all pregnant people who live on reserves and it requires that they be medically evacuated to urban centres between 36 and 38 weeks' gestation to await labour and delivery.

The following is an account of 2 families from different northern reserve communities who were flown to Kingston Health Sciences Centre (KHSC) in Ontario because of pregnancy complications. The rooming-in program for infants born to opioid-dependent mothers at KHSC has been described elsewhere, and rooming-in and skin-to-skin contact between baby and parent is supported as a standard of care for opioid-dependent babies.⁶⁻⁸ The cases presented here demonstrate the use of buprenorphine opioid agonist therapy (OAT) for pregnant women with opioid use disorder (OUD), which is now recognized as a safe and effective first-line treatment.⁹ The practical benefits of buprenorphine OAT specifically for pregnant Indigenous women who live in remote areas have been described extensively elsewhere.¹⁰⁻¹³

Editor's key points

- ▶ Indigenous women often have to leave their remote communities to give birth. In the 2 cases reported, pregnant First Nations women with opioid use disorder presented to a southern tertiary care centre for obstetric care. Opioid agonist therapy (OAT) was initiated, and both patients indicated that their partners also wanted to receive OAT.
- ▶ When the partners presented for OAT initiation, results of urine drug testing were positive for buprenorphine. When questioned, both men admitted that a dose of OAT had been diverted by their pregnant partners.
- ▶ People from First Nations communities transported to urban centres for obstetric care may be vulnerable to multiple stressors. When experiencing a stigmatized disease such as addiction, these stressors are likely to be magnified. In such circumstances patients may divert their OAT medications to help a partner who is also experiencing opioid use disorder.
- ▶ Health care providers must consider the broader context and the family unit when providing health care services. When caring for Indigenous patients, non-Indigenous practitioners must consider all the barriers to safe, respectful, anti-oppressive care.

Points de repère du rédacteur

- ▶ Les femmes autochtones doivent souvent quitter leur collectivité éloignée pour donner naissance. Dans les 2 cas du présent rapport, les femmes des Premières Nations enceintes qui avaient un trouble de consommation d'opioïdes se sont rendues dans un centre de soins tertiaires du Sud pour y recevoir des soins en obstétrique. Un traitement par agonistes opioïdes (TAO) a été amorcé, et les 2 patientes ont indiqué que leurs partenaires souhaitaient aussi recevoir un TAO.
- ▶ Lorsque les partenaires se sont présentés pour commencer leur TAO, les résultats du dépistage de drogues dans l'urine se sont révélés positifs quant à la présence de buprénorphine. Lorsqu'ils ont été questionnés, les 2 hommes ont admis que leurs partenaires enceintes avaient partagé avec eux une dose du TAO.
- ▶ Les membres des collectivités des Premières Nations déplacés vers des centres urbains pour des soins en obstétrique peuvent être vulnérables à de multiples facteurs de stress. Lorsqu'ils souffrent d'une maladie stigmatisée comme la dépendance, ces facteurs de stress seront probablement amplifiés. Dans de telles circonstances, il se peut que les patientes partagent les médicaments du TAO pour aider un partenaire qui vit aussi avec un trouble de consommation d'opioïdes.
- ▶ Les professionnels de la santé doivent tenir compte du contexte plus large et de l'unité familiale lorsqu'ils dispensent des services de soins de santé. Quand ils traitent des patients autochtones, les professionnels non autochtones doivent considérer tous les obstacles à des soins sécuritaires, respectueux et dépourvus d'oppression.

Case 1

A.B. is a 38-year-old mother of 5 from a reserve community of 2800 people with no road access.* She presents to the nursing station at approximately 30 weeks' gestation (uncertain dates) with threatened preterm labour. She is transferred by plane to the regional secondary care hospital (a 1-hour flight south), where she is given steroids and intravenous antibiotics. She is then transferred to KHSC, a further 2-hour flight south. Her partner, C.D., accompanies her on the flight for moral support, although he is not considered a patient. On arrival A.B. discloses that she had been crushing and snorting approximately 2.5 oxycodone-acetaminophen tablets daily until 2 days previously and is feeling some withdrawal symptoms (dysphoria, muscle aches, restlessness, nausea). Results of a urine sample are negative for methamphetamine, cocaine, tetrahydrocannabinol, opiates, benzodiazepines, and amphetamine, and are positive for oxycodone. An addiction medicine physician with perinatal expertise is consulted (A.N.).

A.B. expresses a desire to stop using oxycodone-acetaminophen, and OAT with buprenorphine is initiated. She receives 2 doses of 2 mg buprenorphine/0.5 mg naloxone 4 hours apart. She then requests her partner, C.D., also receive OAT as he, too, is experiencing withdrawal. Since C.D. is being housed at the Indigenous patient services residence and is subject to limited visiting hours because of the COVID-19 pandemic, A.B. is asked to direct C.D. to visit A.N.'s community addiction medicine practice the following afternoon.

The following morning (day 2) A.B. reports an improvement in withdrawal symptoms after a single further dose of 4 mg buprenorphine/1 mg naloxone.

C.D. presents to the physician's office on day 2. He is 50 years old and has been in a monogamous relationship with A.B. since 2012. He is registered as a private fee-for-service patient under the Ontario Health Insurance Plan. He reports occasionally snorting methamphetamine and crushed oxycodone-acetaminophen tablets. He reports having had a "drinking problem" but has not had any alcohol in the past 4 months. Results of a urine sample are positive only for buprenorphine. When questioned, he admits that A.B. gave him one of her 2-mg buprenorphine/0.5-mg naloxone tablets that morning and that he subsequently felt an improvement in his withdrawal symptoms. He is started on a dose of 2 mg buprenorphine/0.5 mg naloxone dispensed twice daily.

On day 4, A.B. is discharged, and she and C.D. stay together at the local residence provided by KHSC's Indigenous patient services.

On day 7, A.B. is readmitted for induction of labour after developing chorioamnionitis, and she vaginally delivers a male infant, E.F., weighing 2800 g, measuring 47 cm in length, with a head circumference of 32 cm. The infant appears clinically to be 35 weeks old and has Apgar scores of 8 at 1 minute and 9 at 5 minutes. Baby E.F. successfully rooms-in with A.B., where he is monitored under the hospital's Eat-Sleep-Console protocol for opioid-dependent infants, and he is exclusively breastfed. A.B.'s OAT dose at this point is 4 mg buprenorphine/1 mg naloxone twice daily. The dose is gradually increased to 8 mg buprenorphine/2 mg naloxone twice daily. Results of urine drug testing are consistently positive for buprenorphine and naloxone.

A.B. and E.F. are discharged from hospital on day 12 without E.F. having required pharmacologic treatment for neonatal abstinence syndrome. Native Child and Family Services in their home community are contacted and, although the family is known to them, they express no concerns with A.B. and C.D. maintaining custody of their baby for the return home. The family flies home 2 weeks after their arrival in Kingston, with an appointment to meet remotely with an OAT provider in their community the following week.

Case 2

G.H. is a 30-year-old mother of 3 who is at 37 weeks and 6 days' gestation. She lives in a First Nation community of 2500 people with a secondary care hospital. She reports smoking fentanyl every 1 to 2 days for chronic leg pain following the birth of her third child. This is her second child with her current partner, J.K. Native Child and Family Services are involved with the family, and G.H.'s 3 children remain in their home community with their maternal grandparents.

On day 1, G.H. is transferred to KHSC after presenting to her local hospital with symptoms of spontaneous rupture of membranes. The reason given for transfer is to manage her OUD. She is accompanied by her partner, J.K., who is not a patient. G.H. delivers a female child, L.M., vaginally 4 hours after arrival in Kingston. Apgar scores are 9 at 1 minute and 9 at 5 minutes; weight is 3200 g, length is 48.5 cm, and head circumference is 32.5 cm. Baby L.M. and her mother room-in together under the Eat-Sleep-Console protocol.

On day 2, G.H. is interviewed by A.N. and she reports that her most recent use of fentanyl had been on the previous day, before presenting at her local hospital. She also reports smoking 5 to 10 cigarettes per day as well as occasional marijuana. She snorts speed on occasion. She denies having had any alcohol for 3 years. Results of urine drug testing are positive for tetrahydrocannabinol and negative for opiates, benzodiazepines, and methamphetamine.

*All adult patients granted verbal and written consent for the writing of this case report. Demographic details were changed to obscure their identities.

Her Clinical Opioid Withdrawal Score is 8 (mild withdrawal). The hospital's toxicology screen uses immunoassays that do not test for fentanyl. The sample is sent to an external laboratory; 5 days later the results are reported as being positive for fentanyl.

Buprenorphine-naloxone is initiated, and by the next morning G.H. is receiving 4 mg buprenorphine/1 mg naloxone sublingually. She reports that J.K. is also in withdrawal from a similar OUD pattern and requests OAT for him, as well. Because J.K. is not present at the time, G.H. is asked to relay an appointment to him for the following day at A.N.'s community office.

G.H. breastfeeds L.M. exclusively. Her buprenorphine-naloxone dose stabilizes at 8 mg buprenorphine/2 mg naloxone once daily. Her daughter's weight increases from a nadir of 2980 g to 3022 g on day 5.

J.K. attends A.N.'s community office on day 4, where he is registered as a private fee-for-service patient. He is a 37-year-old man reporting daily fentanyl use (smoked patches) for 2 years. He also smokes methamphetamine and cigarettes. He denies any current use of alcohol. He is in mild withdrawal, with a Clinical Opioid Withdrawal Score of 6, and he provides a urine sample, the results of which are positive only for buprenorphine. When asked, he acknowledges that G.H. had given him one of her tablets that morning. He is started on a prescription for 8 mg buprenorphine/2 mg naloxone once daily, directly observed.

Upon completion of 5 days of rooming-in, and without L.M. having required pharmacotherapy for neonatal abstinence syndrome, the family flies home on day 10.

Discussion


A search of MEDLINE and Embase using the terms *Indians, North American; Indigenous Canadians; Indigenous Peoples; First Nations; Aboriginal; pregnancy; pregnancy complications; pregnant women; analgesics, opioid; opiates; opioid-related disorders; opiate addiction; opiate agonist* yielded 2 articles describing the incidence of opioid use among Indigenous communities in the Sioux Lookout Zone in northwestern Ontario^{14,15}; 3 describing the phenomenon of OUD among pregnant women there¹⁶⁻¹⁸; and another 6 describing the treatment of perinatal OUD at the Meno Ya Win Health Centre in Sioux Lookout.^{10-13,19,20} Three papers specifically mentioned that a proportion of pregnant women started on OAT had partners who initiated OAT at the same time.^{14,17,19} No articles documented a woman diverting her buprenorphine to her partner.

A search of MEDLINE and Embase was conducted for similar cases involving the treatment of OUD in pregnant women generally in rural and remote communities and without reference to ethnicity or Indigeneity, using the terms *pregnancy; pregnancy complications; pregnant woman; opiate; opiate agonist; opiate addiction; opioid; analgesics, opioid; opioid-related disorders; opioid epidemic;*

hospitals, rural; rural area; rural health; rural health care; rural health services; rural population. This search yielded several articles documenting different patterns of OUD and its severity in rural versus urban communities,²¹⁻³¹ but none mentioned the diversion of buprenorphine doses from a pregnant patient to her partner.

The cases presented here demonstrate that OUD affects entire families and that, for a pregnant woman to recover, treatment should be offered that takes into account her social and family context. We wish to emphasize that people from First Nations communities transported to urban centres for obstetric care are exposed to multiple stressors. When experiencing a stigmatized disease such as addiction, these stressors are likely to be magnified. For our patients, coming to a city populated mainly by White settlers made the pregnant women and their partners reliant on each other when navigating a new city, in a second language, with new care providers, and in a new health care centre. These cases demonstrate that patients in such circumstances may divert their OAT medications to help a partner who is also experiencing OUD, something that care providers should consider when offering OAT to women in similar circumstances.

Conclusion

Opioid use in pregnancy appears to be a growing problem in remote First Nations communities, and the importance of a culturally appropriate, community-based, family-centred means of treating perinatal OUD has been described by Jumah and colleagues.^{11,20} Anticipating that women will continue to be evacuated from their home communities because of perinatal OUD, the authors hope to encourage awareness of women's partners and the importance of treating OUD simultaneously in both. By treating both the woman and her partner as patients, and by facilitating rooming-in for the entire family after delivery, these cases demonstrate favourable outcomes for 2 families affected by addiction who received treatment far from their home communities and in the context of multiple intersecting vulnerabilities. 

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Competing interests

Dr Adam Newman is a descendant of European settlers. He has received speakers' honoraria from Indivior and Knight Therapeutics. **Dr Karen Lawford** has no conflicts to disclose; she is an Anishinaabe midwife and has not received speakers' fees from any pharmaceutical company.

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