Community-based buprenorphine treatment for opioid use disorders: A guide for Indigenous communities

This guide discusses opioid addiction and its treatment, and describes how community buprenorphine programs work.

Background: Opioid use disorders and treatment

Why are so many people in Indigenous communities addicted to opioids?

Intergenerational trauma, like other forms of trauma, is often a contributing factor in substance use. People who have endured psychological trauma during childhood often experience long-lasting symptoms of post-traumatic stress disorder: nightmares, depression, anxiety, trouble forming relationships, and low self-esteem. When people first start using opioids, these feelings vanish for a few hours, replaced by feelings of confidence, enthusiasm, and energy. Unfortunately, the nervous system quickly adapts to these positive feelings, so the person must take a higher dose to achieve the same effect (this is called *tolerance*). Within a couple of weeks of daily opioid use, people begin to experience frightening withdrawal symptoms, and must now take the opioid every day just to ward off these symptoms. A person who ends up in this cycle has an *opioid use disorder*: their opioid use has taken over their life.

In small communities, substance use and subsequent addiction can quickly spread from one or two people to their circle of friends, and sometimes even to the whole community. In some Indigenous communities in Canada, almost every family has at least one member with an addiction.

Why is it so difficult for people to stop using opioids?

People who take opioids daily experience withdrawal symptoms when they go without the medication: muscle aches, nausea, insomnia, anxiety, depression, and strong cravings. Withdrawal can cause terrible distress – some patients attempt suicide if they cannot obtain opioids to relieve their symptoms. The constant fear of withdrawal is often what keeps people from quitting, even when they know that their opioid use is ruining their life.

What are methadone and buprenorphine?

Methadone and buprenorphine are opioids used as medications to treat addiction. Methadone is taken in orange juice, while buprenorphine is dissolved under the tongue. Unlike other opioids, which reach the brain very quickly and cause an immediate, short-lasting high, methadone and buprenorphine only reach their full effect after two or three hours, and these effects last for 24 hours. As a result, methadone and buprenorphine medications relieve cravings and symptoms of withdrawal for the entire day without causing the same high that other opioids do.

At the beginning of treatment, methadone and buprenorphine are dispensed daily, under the observation of a staff member. This makes it hard for patients to use the medication in a way other than as prescribed, or to share the medication with others. Take-home doses are given when necessary for medical trips, work, or family obligations. Patients on methadone or buprenorphine are required to leave regular urine samples, which are tested for methadone or buprenorphine, illicit opioids, and other drugs.

What's the difference between methadone and buprenorphine?

Methadone is a very powerful opioid, while buprenorphine is only a *partial* opioid. This makes methadone more effective than buprenorphine at relieving withdrawal symptoms and cravings, but it also has more side effects than buprenorphine, such as sedation. Because it is such a strong opioid, people can overdose if they take even a slightly higher dose of methadone than they are prescribed. For this reason, doctors must have special training to prescribe methadone. Buprenorphine is safer than methadone; it can cause drowsiness and euphoria if it is misused, but fatal overdoses are very rare. Because of its safety, family doctors don't need any extra training in order to prescribe it, but observed daily doses are still best until the patient is stable and doing well.

Isn't giving people buprenorphine or methadone just switching one addicting drug for another?

When injected, heroin, morphine, hydromorphone, and fentanyl reach the brain within seconds, causing an intense high. These substances leave the brain after a few hours, triggering severe withdrawal symptoms. Most people with opioid use disorders are unable to work, go to school, or look after their family, because they spend the whole day getting and taking the drug in a desperate effort to feel normal and avoid withdrawal.

In contrast, people do not experience euphoria, sedation, or withdrawal after taking methadone or buprenorphine, because the medications take hours to reach their full effect, and the effects last throughout the day until the next day's dose. Patients on these medications can return to work, school, or their family without any impairment in their thinking or functioning.

Aren't methadone and buprenorphine just band-aids? Shouldn't treatment be based on counselling that addresses the root causes of addiction – trauma, poverty, and despair?

Psychological counselling is essential for long-term recovery. It is most effective, however, when used in combination with methadone or buprenorphine treatment, which enable people to participate in counselling and treatment activities without being tormented by cravings and withdrawal symptoms.

How well do buprenorphine and methadone treatments work?

Extensive research has shown that methadone and buprenorphine treatment programs dramatically reduce opioid use, overdose deaths, and crime, compared to treatments that only provide counselling.

The symptoms of opioid withdrawal can be so intense and frightening that if they are not treated medically, most patients relapse quickly, even if they receive excellent counselling and support.

Why do people have to go to special clinics to get methadone?

As mentioned above, doctors need to have special training in order to prescribe methadone. There are only about 300 doctors in Ontario who have this special training, and almost all of them work in cities in the south. Many of these doctors work in specialized methadone clinics, which are more efficient than general clinics for the specific kinds of services that methadone doctors give, like supervised urine drug screening and observed daily dispensing. Most patients receive methadone in these clinics, which are usually separate from primary care and mental health services. Many methadone clinics offer buprenorphine treatment as well; however, because doctors do not need special training to prescribe buprenorphine, it can be prescribed in any setting, not just in urban methadone clinics: in general family medicine clinics, hospitals, prisons, emergency departments, and by solo practitioners in small rural communities.

Methadone clinics keep patients on methadone for years, and sometimes for life. Doesn't it make more sense for patients to only be on methadone or buprenorphine for a week or two while they recover from their withdrawal symptoms?

Most people relapse if they are tapered off methadone or buprenorphine too quickly. This is because withdrawal symptoms – insomnia, anxiety, cravings – can last for months after the last dose of opioids. Also, addicted patients have learned that drugs give instant and complete relief when they feel stressed, lonely, bored, angry, or upset; it can take many months of counselling and hard work to learn new ways of coping with these feelings, to make new friends who aren't drug users, and to take on new responsibilities with family, work or school that keep people active and busy away from drug use.

Many people are able to taper off methadone or buprenorphine when they haven't used drugs for at least six months and they're leading productive, busy lives surrounded by supportive family and friends.

Some people in my community are attending a methadone clinic in a nearby town. How do I know if this clinic is providing good care?

Band leaders, addiction counsellors, and family members of addicted patients should ask the following questions about their local methadone clinic.

Does the clinic provide primary care? A good program should provide patients with primary care – immunizations, screening for cancer and heart disease, and management of chronic diseases such as asthma and diabetes.

Does the clinic provide counselling? As mentioned above, counselling is an essential part of addiction treatment. Patients are not likely to fully recover if they don't receive counselling and support for the underlying mental disorder that caused the addiction, such as post-traumatic stress disorder, anxiety, or depression.

Does the clinic help or hinder patients' return to an active and full life? The goal of addiction treatment is to help patients live a full and active life. Some methadone clinics require patients to attend the clinic once or twice per week to leave a urine drug screen and get a prescription. These visits can interfere with patients' work and family lives, because they often involve 4-8 hours of travelling and waiting at the clinic.

The easiest way to answer these questions is to talk to patients in your community about their experiences at the clinic. How often do they have to attend the clinic, and how long does each visit take? How much time does the physician spend with them? Do they get counselling? Does anyone at the clinic talk to them about their emotions, concerns or daily lives? Can they get help for medical problems at the clinic? Overall, do they feel that the physicians and other clinical staff care about them? Are they satisfied with the care they have received?

What should I do if my community doesn't have access to a clinic that provides good addiction care?

If there are members of your community who would benefit from methadone or buprenorphine treatment but there is no access to convenient, high-quality care, you and other members of your community should consider setting up your own buprenorphine treatment program. Sioux Lookout communities have set up a number of buprenorphine programs over the past several years, and these programs can be used as a model for your community.

Sioux Lookout programs: Description

Between 2000 and 2005, Sioux Lookout community leaders pleaded with provincial and federal health authorities for assistance in battling the opioid crisis. In 2007, tired of waiting, the band council in Round Lake, with the assistance of the local family doctor, set up the first Indigenous community buprenorphine program in Ontario. Currently there are 22 buprenorphine programs in Sioux Lookout, treating approximately 1300 patients. While every program is different, they share the following common elements:

The program team: Each program team consists of a mental health and addiction worker, a family doctor, a medication dispenser, and an administrator from the band counsel. The team meets regularly, sometimes in consultation with an addiction doctor, to make clinical and administrative decisions about the program.

Assessment: Each patient is individually assessed by a doctor (either a local family doctor or a visiting doctor with expertise in addictions), in order to determine whether the patient has an opioid use disorder and/or other mental and physical conditions. The assessment consists of a long interview with the patient, a physical exam, and blood work.

Buprenorphine prescribing: After the assessment, if the doctor determines that the patient has an opioid use disorder, they prescribe a daily dose of buprenorphine, adjusting the dose until the patient's cravings and withdrawal symptoms have resolved.

Dispensing buprenorphine: In communities that have a local NIHB nursing station, buprenorphine is dispensed daily under the nurse's observation for the first 30 days. After that period, buprenorphine is dispensed by a trained community member. If daily dispensing is not feasible after 30 days, some communities forgo daily dispensing and give patients buprenorphine tablets to take home.

Urine drug testing: Urine samples are regularly tested for buprenorphine, opioids, and other drugs using small disposable sticks that are dipped into the urine. Nurses and physicians can conduct these tests, as can trained community members.

Counselling: The clinic doctor provides counselling during the assessment and during each clinic visit. Mental health and addiction workers provide counselling and case management. Some communities have counselling programs, which patients attend daily for the first few weeks of treatment. Many patients also benefit from traditional healers, support from the church, or land-based activities such as gardening. Informal support is also provided by elders, family members, the band council, friends, and peers who are also in treatment. In some communities, a public ceremony is held for patients on their first day of buprenorphine treatment; the patients are greeted and congratulated by community leaders and family members for beginning their journey toward recovery.

Tapering and discontinuing treatment: Patients are discharged from the program if they violate program rules (for example, if they are caught selling their buprenorphine tablets). The buprenorphine dose is tapered when the patient and the treatment team feel that the patient is ready.

Funding: The medications are covered by the provincial and federal drug plans. The nurses who dispense the medications are funded by NIHB. The mental health and addiction workers are also paid by NIHB, or in some cases the band. If feasible, the band also funds the community member responsible for dispensing the medications. Outside addiction doctors that visit the community have their travel expenses covered by the College of Physicians and Surgeons of Ontario, and they are paid a daily rate by the Sioux Lookout Regional Health Authority. The costs to the bands are offset by savings in travel costs for patients who would have had to travel by bus to attend a methadone clinic in a nearby city.

How well do the Sioux Lookout programs work?

Two papers were recently published in the Canadian Family Physician journal on the buprenorphine programs in Sioux Lookout (see enclosed). The first paper looked at the impact of buprenorphine treatment on one community. It reported that one year after the introduction of buprenorphine treatment, "police criminal charges had fallen by 61.1%, child protection cases had fallen by 58.3%, school attendance had increased by 33.3%, and seasonal influenza immunizations had dramatically gone up by 350.0%. Attendance at community events is now robust, and sales at the local general store have gone up almost 20%." One community member said that the program "has brought life back to our community, [which] is being restored to the way it used to be before everyone got stuck in addiction."

The second paper looked at individual patient results in six communities. It reported that 78% of the patients were still in treatment after one year. This compares favourably with a provincial average of only 50%. In two separate analyses, 88% and 90% of urine drug screens were negative for illicit drugs.

The success of the Sioux Lookout programs is probably due to several factors. The whole community participates in and supports the program, patients have a good relationship with the treatment team, and the programs are deeply focused on helping patients return to their community activities and responsibilities. Perhaps most importantly, patients get treatment in their home community, without having to travel to attend an outside clinic.

If our community set up a community buprenorphine program, what should be done about patients who are already on methadone in an outside methadone clinic?

Methadone doctors should help patients switch from methadone to buprenorphine if they request it and it is in their best interests. The doctor prescribing methadone and the community doctor prescribing buprenorphine have to work together to organize the switch. Switching from methadone to buprenorphine is not easy, but it can be done successfully in most cases.

How can our community set up a new buprenorphine program?

Communities that wish to establish their own treatment program should consult with people who work in the Sioux Lookout programs. Sioux Lookout doctors and nurse practitioners can assist with recruiting, training and mentoring the family doctors in your community, and Sioux Lookout program staff can help train your community's mental health and addiction workers and dispensers. Administrators can assist with funding and planning.