



Commentary on the impact of the COVID-19 pandemic on opioid use disorder treatment among Indigenous communities in the United States and Canada



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ABSTRACT

This commentary focuses on how some Indigenous communities in the United States (U.S.) and Canada are addressing the opioid epidemic within the context of the COVID-19 pandemic, from the perspective of the co-authors as researchers, clinicians, and pharmacists working within or among Indigenous communities in three eastern Canadian provinces and two western U.S. states. The pandemic has likely exacerbated opioid use problems among Indigenous communities, especially for individuals with acute distress or comorbid mental illness, or who are in need of withdrawal management or residential services. In response to the pandemic, we discuss first how greater prescription flexibility has facilitated and even increased access to medications for opioid use disorder. Second, we describe how Indigenous-serving clinics have expanded telemedicine services, albeit not without some challenges. Third, we note challenges with restricted participation in traditional Indigenous healing practices that can be helpful for addiction recovery. Fourth, we mention providers' worries about the pandemic's impact on their patients' mental health and safety. We argue that certain treatment transformations may be helpful even after the pandemic is over, through enhancing access to community-grounded treatment, decreasing stigma, and promoting patient self-efficacy.

This commentary focuses on how some Indigenous communities in the United States (U.S.) and Canada are addressing the opioid epidemic

within the context of the COVID-19 pandemic. The situation is of urgent concern: a pandemic on top of an epidemic (Alexander, Stoller,

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Haffajee, & Saloner, 2020; Becker & Fiellin, 2020; Priest, 2020) for a population that is disproportionately vulnerable to both. This disproportionate vulnerability is in the context of ongoing ills stemming from settler-colonialism and systemic racism, which have had an incalculable toll on Indigenous Peoples and have greatly exacerbated substance use problems among this population (Brave Heart, Chase, Elkins, & Altschul, 2011; Currie, Wild, Schopflocher, & Laing, 2015; cf. Collins, Boyd, Cooper, & McNeil, 2019). American Indian and Alaska Native (AI/AN) peoples have the second highest rate of opioid overdose deaths among U.S. ethnoracial groups (Centers for Disease Control and Prevention, 2016; Venner et al., 2018), while First Nations peoples in certain Canadian provinces have up to three times the rate of opioid overdose deaths compared with non-Indigenous people (Belzak & Halverson, 2018). Likewise, the pandemic poses a disproportionate threat to Indigenous reservations/reserves, due to disparities in known risk factors for poorer COVID-19-related outcomes such as chronic health conditions, inadequate healthcare service/infrastructure, and limited resources (e.g., running water, housing; Hedgpeth, Fears, & Scruggs, 2020; Maher, 2020). These disparities add to heightened vulnerabilities for opioid users (Priest, 2020).

Based on available data thus far, the pandemic has clearly taken an enormous toll on Indigenous Peoples collectively, especially on certain U.S. reservations (see, e.g., Silverman, Toropin, Sidner, & Perrot, 2020). In the U.S., as of October 15, 2020, an estimated 90.0 of every 100,000 AI/AN individuals have died from the virus, which is likely an undercount due to disaggregated data from some jurisdictions (APM Research Lab, 2020). When adjusting for age, the AI/AN mortality rate is 3.1 times higher than the rate for White Americans (APM Research Lab, 2020). In Canada, the toll on Indigenous Peoples is difficult to estimate. Whereas federal counts of on-reserve Indigenous infection rates and deaths are currently markedly lower than the general population (Indigenous Services Canada, 2020), these likely are dramatic undercounts because they do not include many jurisdictions and ignore those living off-reserve (who constitute the majority of Indigenous individuals; Skye, 2020). In any event, in both countries the pandemic has seriously affected Indigenous communities even with low infection rates, due to their shutting down nonessential activities and restricting travel to and from their communities (Lakhani, 2020; Macyshon & Bogart, 2020). Furthermore, emerging data suggest that the pandemic has increased opioid overdose rates among Indigenous individuals. In British Columbia, from January to May 2020 (vs. January–May 2019) Indigenous overdose rates increased 93%, including an increase from 10% to 16% of total overdoses in the province (Bellrichard, 2020).

We focus here primarily on medications for opioid use disorder (MOUD), given that provision of opioid agonists (e.g., buprenorphine and methadone) is generally critical to prevent return to use and overdose as well as to promote recovery (Fullerton et al., 2014; Thomas et al., 2014). Although MOUD research with Indigenous Peoples has been sparse, preliminary studies demonstrate that Indigenous-serving clinics have successfully implemented MOUD and that MOUD has improved a variety of outcomes among Indigenous patients (e.g., Kanate et al., 2015; Mamakwa et al., 2017; see Venner et al., 2018). However, Indigenous Peoples have inadequate access to MOUD. For example, in a survey of 192 substance use disorder (SUD) treatment centers serving AI/AN peoples, only 28% reported implementing MOUD (Rieckmann, Moore, Croy, Aarons, & Novins, 2017). Many Indigenous communities face unique barriers to MOUD implementation, such as being geographically remote, having difficulty retaining clinicians, and having limited healthcare access (DeFlavio, Rolin, Nordstrom, & Kazal Jr., 2015; Dorman, Biedermann, Linklater, & Jaffer, 2018; Venner et al., 2018). Indigenous-serving clinics are more likely to implement MOUD when staff are adequately trained and when MOUD provision is consistent with the clinic's treatment philosophy (Rieckmann et al., 2017). One challenge in this regard is integrating MOUD within relevant services that are culturally safe, meaning that providers critically contextualize social and historical power differentials and determinants of

health (Curtis et al., 2019).

How the pandemic has impacted Indigenous communities' opioid use treatment and recovery is rapidly emerging and needs to be empirically studied. As researchers, clinicians, and pharmacists working within or among Indigenous SUD clinics in three eastern Canadian provinces and two western U.S. states, we cautiously report and discuss some preliminary trends. These include (a) increased flexibility for prescribing MOUD, (b) telemedicine expansion, (c) restricted participation in traditional Indigenous healing practices, and (d) providers' worries about the pandemic's impact on patients. We do not pretend to comment on all Indigenous communities—which undoubtedly vary in their struggles and successes—and we acknowledge a perspectival limitation in that we have not directly solicited the views of treatment-seekers for this report.

First, relaxing certain policies—such as allowing larger take-home prescription carries and giving greater flexibility to pharmacists in delivering prescriptions—have aided MOUD access and continuity. In the U.S., for example, providers conducting telemedicine visits are now allowed to initiate patients on buprenorphine (Priest, 2020). In Canada, clinicians can now use telemedicine to provide addiction medicine treatment services, and there is an increased number of unsupervised carries that can be prescribed for buprenorphine and methadone (Bruneau et al., 2020). For patients who were already stable on MOUD, we are unaware of treatment disruptions or problems with larger prescription carries. For rural and remote communities, initial anxieties about disruptions in medication supply-chains seem to have stabilized. In fact, there may be increased access for some patients who prior to the pandemic had to travel outside their region to obtain their medication. However, these adjustments have raised concerns related to safe transport, storage, and dispensing in some communities, along with worries about increased diversion and misuse. For those who are not yet in treatment, clinicians are concerned about the logistical difficulties in accessing MOUD due to the quarantining of communities and travel restrictions.

Second, Indigenous-serving SUD clinics have ramped up or expanded outpatient telemedicine services. Service providers have done remarkably well in this transition given the circumstances, and this expansion has increased access for some who were previously unable to obtain in-person services. However, obstacles to the use of telemedicine exist, such as limited Internet access, privacy concerns (especially for those living in crowded housing), and greater difficulty for emotional connection among patients (e.g., within a psychotherapy group). These concerns are exacerbated for those who had not already developed rapport with their clinical team or support group. Many patients have experienced ruptures to important routines associated with in-person treatment and mutual support groups.

Third, the pandemic has restricted participation in traditional Indigenous healing practices, which facilitates cultural connectedness and can be helpful in promoting addiction recovery (see Rowan et al., 2014). Communities have especially struggled with not being able to provide traditional burial ceremonies during a time of increased death. Although individuals have creatively engaged in certain practices while physically distancing or remotely participating (e.g., smudging and prayer), there are significant constraints. In some regions, participants in drum groups have moved to video-conference to remain connected to this important practice.

Finally, providers are worried about the pandemic's impact on their patients, in terms of exacerbating anxiety, isolation, and economic difficulties, as well as increasing maladaptive coping and other negative outcomes such as return to use, overdose, increased substance use, suicide, child abuse/neglect, and domestic violence. These concerns are especially worrisome in light of greatly reduced withdrawal management, outpatient, and residential treatment services.

Despite these challenges, we note certain positive developments. In particular, increased prescription flexibility may promote access to treatment, decrease stigma, and promote patient self-efficacy. Research

has criticized SUD treatment systems as reflecting and sometimes perpetuating stigma about addiction as well as perpetuating societal and racial inequities (Goedel et al., 2020; Hansen et al., 2013; Hansen & Roberts, 2012). Policies for prescribing MOUD have been especially restrictive in the U.S. (vs. Canada); for example, U.S. providers must apply for a federal waiver to prescribe buprenorphine to a limited number of patients (Priest et al., 2019). These restrictions to treatment pose even greater barriers for many Indigenous patients' access to MOUD (e.g., many patients in both countries must travel long distances for access to medication; see Kleinman, 2020; Priest et al., 2019). With loosened restrictions, many patients have had greater access to and flexibility with MOUD, and without significant problems for stable patients of which we are aware.

In addition, prior to the pandemic in both the U.S. and Canada, rural and remote Indigenous communities generally had insufficient access to medical and psychosocial services, and telemedicine was not adequately recognized and supported as a method to deliver addiction services. In the current pandemic climate, it is promising to see that addiction treatment continues outside the normal confines of "the clinic"—including expanded telemedicine options, telephone calls, text messaging check-ins, physically distanced home visits, and creative community solutions.

If these service changes are helpful during a pandemic, why not continue them during more stable times? We are optimistic that some of these changes and initiatives may remain in place after the pandemic, although research should provide guidance to programs, providers, and patients (several of the authors are undertaking this research imminently in partnership with Indigenous communities). Indeed, the pandemic may be an opportunity to acknowledge that many people who use drugs can play a larger role in directing their own care and treatment. Moreover, we are hopeful that the pandemic may ultimately enable greater flexibility and support for Indigenous communities in calling forward solutions (beyond a "medical model" that tends to overly pathologize) to provide greater access to community-grounded and culturally safe services.

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