Medication-Assisted Treatment: A Promising Resource for Addressing Opiate Use in Tribal Communities

Catching Up With COSSAP, June 2021

Substance use disorders affect millions of Americans, as evidenced by the dramatic increase in overdose deaths over the past 20 years. Compared with other racial/ethnic groups in the United States, American Indians and Alaska Natives (AI/AN) have experienced the largest increases in drug- and opioid-involved overdose mortality rates—and some research suggests that those rates are underreported.

But it is important—and encouraging—to keep in mind that addiction is treatable. And the most frequently used evidence-based practice available to treat opioid use disorders and alcohol use disorders is medication-assisted treatment (MAT), the subject of this article. In an effort to explore the value of MATs in treating such disorders, this article will first define opioid use disorders and then offer statistics related to opiate use by race. It then delves into MATs and covers some common myths and misconceptions surrounding them. The article concludes with a brief review of a number of current MAT programs in tribal communities around the country.

Addiction and Opioid Use Disorder

Addiction is a chronic, treatable, neurobiological disease characterized by impairment of the reward system resulting in compulsive drug seeking and drug use, despite their negative consequences.[1] "Chronic" means that addiction is ongoing and that it is common for a person to relapse. Therefore, treatment needs to be viewed as a continuing care model rather than as a specific incident resulting from an acute episode. Addiction affects an individual's biology (the way the body works) and neurology (the way the brain works) and hence is a neurobiological disorder. Although use is initially voluntary, repeated use results in changes to the brain, and the reward system in particular, that make it harder to control subsequent use.[2]

One of the neurochemicals most impacted by addiction is dopamine.[3] Dopamine is a neurochemical necessary for motivation, pleasure, learning, and memory. It is essential for our survival. Use of substances increases dopamine to such high levels that the body adapts by reducing the production of dopamine, turning off receptor sites that recognize dopamine, and in some instances killing receptor sites for dopamine. As a result, the body begins to rely on external sources of dopamine to function.

Addiction to opiates, or opioid use disorder (OUD), is a chronic brain disease related to the use of opiates. Opiates include prescription drugs such as oxycodone, hydrocodone, codeine, fentanyl, and morphine, as well as illicit drugs such as heroin. All opiates produce pleasure and relieve pain. Like an addiction to any substance, opiate addiction impacts the brain's reward system in general and dopamine in particular. OUD affects more than 2.6 million Americans.[4] About 2 million Americans are addicted to prescription drugs and a little over half a million are addicted to illicit drugs such as heroin. Heroin addiction frequently starts with the misuse of prescription medication; indeed, about four in five heroin users started by misusing prescription painkillers and then moved on to heroin use. A considerable number of drug overdoses and deaths are related to OUDs: drug overdose is the leading

cause of accidental death in the United States, and over half of those drug overdoses can be contributed to opiates alone. Although prescription opiates had previously been the leading cause of overdose deaths, more recently, heroin and synthetic opiates such as fentanyl account for the most overdose deaths.[5]

For people facing an OUD, relapse rates are high. With the use of counseling or behavioral therapies alone in the treatment of opiate addiction, relapse rates after a year of treatment sometimes are as high as 90 percent.[6] Yet these relapse rates *are cut in half* when medication is added to treatment. Combining medication and treatment is therefore the most effective way of treating opiate addiction. This is especially true for people with limited social support and stability, trauma and who have experienced adverse childhood experiences. Unfortunately, not all who need treatment receive it, and current research estimates that nearly 80 percent of those with an OUD do not receive treatment.[7]

Medication-Assisted Treatment

Medication-assisted treatment (MAT) is defined as the use of a combination of medication and counseling or behavioral therapies in the treatment of addiction. These medications serve to support the production of dopamine, normalize brain chemistry, reduce craving and withdrawal, and support the restoration of normal physiology to a body that has been impacted by addiction. Further, they do not have the same negative or euphoric effect that the substance of abuse has. MATs are most frequently used in the treatment of OUD and alcohol use disorder.[8]

Combining medication with behavior therapies is the most effective method of treating OUDs.[9] The different types of medications used to treat OUDs vary in their target population and effectiveness, so a thorough assessment and a medical plan are needed before a regimen is started. Medications used include naltrexone (Vivitrol/Revia), which blocks opiate receptors, thereby limiting the reward circuity activated when drinking or craving, and is available as a monthly injectable and can be prescribed by anyone licensed to prescribe medications; methadone (Methadose/Diskets/Dolophine), which acts as an opiate agonist and can only be dispensed by certified and approved opioid treatment programs; and buprenorphine (Butrans/Buprenex), which relieves the symptoms of opiate withdrawal. When buprenorphine is combined with naloxone (Suboxone), it relieves symptoms of opiate withdrawal and also reduces the likelihood of abuse of the medication. Suboxone can be prescribed only by physicians who have completed special training to prescribe buprenorphine.[10]

MAT is usually considered for clients with a moderate or severe alcohol use disorder or for those struggling with cravings and relapse. Medications that are most commonly prescribed and approved for treating alcohol use disorders include disulfiram (Antabuse), which causes a significant physical reaction when alcohol is consumed; naltrexone (Vivitrol/Revia); and acamprosate (Campral), which supports the rebalancing of neurotransmitters GABA and glutamate.[11]

Data Specific to American Indians/Alaskan Natives

American Indians/Alaskan Natives (AI/AN) have higher rates of substance use disorders than any other race. Three times as many AI/ANs are diagnosed with substance use disorders compared with white Americans.[12] Twice as many require treatment for addiction compared with any other racial and ethnic group, but fewer receive treatment. Tribal communities also have the highest rates of alcohol-related deaths as well as a higher opioid mortality rate than any other racial and ethnic group. Deaths of AI/ANs vary significantly by state, with the highest rates of overdose deaths in Minnesota and Washington State.

Unfortunately, implementation of MATs is significantly lower in tribal communities than in the general population. A survey of treatment providers serving AI/AN clients found that only 28 percent offer MATs.[13] This could be due to numerous barriers, including structural barriers such as issues related to funding, transportation, and access to services; community barriers such as stigma and misperceptions around MATs; organizational barriers such as inability to recruit qualified providers particularly in remote areas; and individual barriers such as fear or mistrust of MATs and a mismatch between MATs and a more holistic healing tradition common in AI/AN communities.[14,15]

Myths and Misconceptions

MATs are just substituting one drug for another.

Medications used in MATs differ from addictive substances (alcohol or opiates) in terms of intensity and effect. The

dosage provided is not intense enough for an individual to get the same high he or she would get from a substance of choice. Further, the effect is not euphoria but instead a reduction in withdrawal symptoms and cravings. Some medications reduce the euphoric effect of the substance of choice if they are consumed during a course of MAT. Finally, addiction is defined as compulsive use of a drug despite negative consequences and not as physiological dependence (needing daily medication to stay healthy, similar to individuals with heart disease, diabetes, hypothyroidism, etc.).[16]

MATs are expensive.

MATs are both cost-effective and cost-beneficial, resulting in improved outcomes and reduced overall costs to society in terms of emergency room visits, overdose deaths, and criminal involvement. In one study focused on indigenous peoples, MATs reduced the likelihood of overdose by 50 percent compared with a nonmedicated control group and had an overall social cost of less than half compared with those not on MATs.[17,18]

MATs are not effective.

In several research studies, MATs appear to be more effective in the treatment of OUDs than counseling alone. MATs also significantly reduce the need for inpatient detoxification services and provide a more comprehensive and individualized program, comprising medication and behavioral therapy, to address the needs of the whole person. When compared with a placebo and with no medication, MATs reduce illicit opioid use, increase the likelihood of individuals staying in treatment, and reduce the risk of overdose. MATs also lower the risk of contracting HIV and hepatitis C.[19,20,21]

MATs are a lifelong sentence.

MATs are used to serve as part of a treatment plan to target the needs of the individual. They can therefore be used as a short-term methodology to medically manage withdrawal or as part of a long-term strategy to support and maintain treatment.[22]

MATs are not safe.

When taken as prescribed, MATs are both safe and effective. They increase the success of outpatient treatment and reduce the likelihood of relapse and overdose.[23]

People would just sell their medications to fund their habits.

Diversion of medications used in MATs is uncommon. When it does happen, the person buying the medication is usually using it to manage withdrawal, not for its euphoric effect.[24]

MAT Programs in Tribal Communities

Given the significant rates of opioid abuse in tribal communities, federal, state, local, and tribal jurisdictions have all recognized the need to identify gaps in tribal services and develop appropriate intervention strategies. While MAT can be an effective standalone intervention, specific concerns have been identified related to the effectiveness of using strictly Western criminal justice, mental health, and medical approaches for the AI/AN population. As a result, efforts are ongoing to address opioid and other substance abuse through the blending of these approaches with culturally specific prevention, treatment, and recovery services such as healing-to-wellness courts, indigenous healing services, talking circles, cultural connection and rituals, and efforts to address historical and inter-generational trauma.

The development of comprehensive, blended tribal treatment and recovery programs has been initiated through a variety of government agencies and funding mechanisms. As part of Comprehensive Opioid, Stimulant and Substance Abuse Program (COSSAP) funding awarded to tribal grantees by the Bureau of Justice Assistance (BJA), tribes are able to develop and implement MAT programs and increase tribal community

members' access to MATs. Last year, the Substance Abuse and Mental Health Services Administration also awarded grants to more than 125 programs serving tribal communities. These grants were a part of the Tribal Opioid Response funding and ranged between $100,000 and several million dollars. The objectives of the projects ranged from reducing unmet treatment needs and opioid overdose-related deaths for American Indians to increasing prevention and education efforts and access to chemical dependency treatment.

A number of states, including Alaska, California, Montana, and Nevada, have utilized federal funding to implement culturally specific interventions in conjunction with MAT for all tribes within their borders. In addition, these services have been supported at the intertribal organizational level, such as by the Northwest Portland Area Indian Health Board and the Intertribal Council of Michigan. Finally, a number of individual tribes have worked to implement treatment approaches, including MAT, with support from tribal leadership by combining tribal and/or federal funding, including the Jamestown S'Klallam Tribe, the Swinomish Indian Tribal Community, and the Quinault Indian Community in Washington; the Modoc Nation and the Cherokee Nation in Oklahoma; the Wabanaki Tribes in Maine; and the Lower Sioux Indian Community in Minnesota, among others.

Native American tribes have experienced a number of challenges in implementing comprehensive, tribal-specific treatment programs, including MAT, such as difficulties in locating a suitable facility site in the face of local nontribal community resistance; racial discrimination and stereotyping; lack of tribal community support or cultural awareness; and resource limitations. For example, the Jamestown S'Klallam Tribe has been seeking community support for its recently purchased tribal treatment facility site against significant opposition from the local jurisdiction. And as part of its effort to implement a tribal MAT project, the state of California chose to conduct a needs assessment to determine how to increase community support to address substance abuse in tribal communities, specifically identifying the need for culturally centered care in AI/AN treatment facilities.

As an example of a specific tribal MAT program development, the Makah Tribe in Washington State is working to implement new programming through FY2018 and FY2020 COSSAP grants. The Makah Tribe provides services to tribal members dealing with substance abuse issues through the Makah Tribal Healing to Wellness Court. Tribal members are eligible for this program based on a deferred sentence, term of probation, or a voluntary referral. Wraparound case management services include a chemical dependency evaluation and both inpatient and outpatient treatment, access to MAT, self-help groups, and recovery coaches, development of protective factors such as employment and education, and participation in cultural events. In addition, the Neah Bay Public Safety Department includes an Adult Corrections Center that provides services to this population.

The FY2018 COSSAP grant project, which is still in progress, has been focused on developing a multidisciplinary response team that comprises all tribal agencies and programs that address tribal substance abuse issues, as well as law enforcement-assisted diversion (LEAD). The COSSAP program coordinator and case manager assist in the Sisuk House Project (Oxford Style recovery homes) and have been requested to help the Makah Wellness Center MAT program to better serve the Makah people and the Neah Bay Community.

The FY2020 COSSAP project includes continuation of the LEAD program development, implementation, evaluation, and program analysis. In addition, it will expand MAT services to the Neah Bay Public Safety Adult Corrections Center through the development of program guidelines, review, implementation, and evaluation.

Another example of a successful tribal MAT program, the Southern Ute Tribal Health Center, provides MAT to tribal members who primarily have alcohol abuse disorders, in particular repeat offenders, based on referrals from the tribal wellness court, which features oversight by a judge and tribal probation services. The local family treatment court also intervenes with this population in conjunction with social services to prevent criminal justice system involvement. To enable access to MAT, a referral for assessment is made and a comprehensive evaluation is completed. Additional services can include psychological assessment and inpatient and outpatient treatment services. The Southern Ute Tribe currently has plans to use BJA Coordinated Tribal Assistance Solicitation (CTAS) grant funds for additional construction and remodeling of the clinic to expand capacity for a sober living facility.

A final example of the incorporation of MAT into a comprehensive approach to substance abuse is evident at the Didgwalic Wellness Center, which is owned and

operated by the Swinomish Indian Tribal Community and provides counseling, medication, primary care, and social services to Native Americans with substance abuse disorders. The treatment model was developed with input from the tribal leadership of the Swinomish, clients and their families, and the community at large. For participants, the comprehensive individualized treatment plan can include MAT. The program has won a number of innovation awards by combining treatment with evidence-based medicine, as well as tribal community knowledge and culturally competent care. The program provides services for both natives and nonnatives. The Wellness Center website features a number of videos describing the program, which can be found at https://www.didgwalic.com/links.htm.

Conclusion

The opioid epidemic continues to affect a staggering number of people in this country, with a significant impact being felt in AI/AN communities. The need to take action is clear, and the research on MATs as an effective approach is established. However, much is needed to implement MATs in tribal communities at scale, and it starts with bridging the gap between traditional tribal wisdom and what is known about MATs so that the latter can be delivered in a way that is congruent with traditional healing and wellness practices. Barriers to implementation, be they systemic, organizational, community, or individual, need to be addressed. Integrating MATs into what already works in tribal communities might help further support the treatment of OUDs and reduce their negative consequences.

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