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COMMENTARY

Coming of age: 21 years of providing opioid substitution treatment within an Aboriginal community-controlled primary health service

BRADLEY FREEBURN[1], SUMMER LOGGINS[2,3], K. S. KYLIE LEE[2,3,4,5,6,7] & KATHERINE M. CONIGRAVE[2,3,4,8]

[1]The Drug and Alcohol Unit, Aboriginal Medical Service Redfern Cooperative, Sydney, Australia, [2]Central Clinical School, Faculty of Medicine and Health, The University of Sydney, Sydney, Australia, [3]NHMRC Centre of Research Excellence in Indigenous Health and Alcohol, Sydney, Australia, [4]The Edith Collins Centre for Translational Research in Alcohol Drugs and Toxicology, Drug Health Services, Sydney Local Health District, Sydney, Australia, [5]Health Sciences, Curtin University, National Drug Research Institute, Perth, Australia, [6]Centre for Alcohol Policy Research, La Trobe University, Melbourne, Australia, [7]Burnet Institute, Melbourne, Australia, and [8]Drug Health Services, Royal Prince Alfred Hospital, Sydney, Australia

Abstract

In Australia, Aboriginal and Torres Strait Islander community controlled health services have been established since 1971 to provide accessible, quality and culturally-appropriate primary healthcare. The first of these services, the Aboriginal Medical Service Cooperative Redfern ('the AMS'), created its own Drug and Alcohol Unit ('the Unit') in 1999. The Unit initially prescribed opioid substitution treatment (OST) and its coordinator, Bradley Freeburn, a Bundjalung man, provided counselling. Soon afterwards, the Unit started dispensing OST. It now cares for around 150 individuals, each of whom is understood in the context of family, community and culture. The Unit is on the same site as the AMS's primary care service, specialised medical and mental health clinics, and dental clinic. This allows for integrated physical and mental health care. The Unit contributes to drug and alcohol workforce development for other AMS staff, state-wide and nationally. Several Aboriginal and Torres Strait Islander community controlled health services around Australia now offer OST prescription, and a small number administer slow-release buprenorphine. We are not aware of others that dispense Suboxone. In the USA and Canada, over the last 10 years, First Nations communities have also responded to lack of treatment access, by creating standalone OST clinics. We were not able to find examples of Māori-controlled OST clinics in Aotearoa, New Zealand. The feasibility of this model of readily accessible OST, situated within a holistic, culturally-grounded primary health-care service recommends it for consideration and evaluation, for Indigenous or non-Indigenous communities. [Freeburn B, Loggins S, Lee KSK, Conigrave KM. Coming of age: 21 years of providing opioid substitution treatment within an Aboriginal community-controlled primary health service. *Drug Alcohol Rev* 2022;41:260–264]

Key words: opioid substitution treatment, Aboriginal, community-controlled health service, primary care, Indigenous.

Introduction

Indigenous peoples in colonised countries face increased risks of alcohol and other drug use disorders due to intergenerational trauma, oppression, racism and stress [1]. However, resilience is embedded in community, allowing culture and identity to be maintained. Indigenous peoples worldwide have developed responses to substance use disorders [2,3]. This includes combining evidence-based 'mainstream' treatments with culturally-informed healing approaches.

Care of substance use disorders through a primary care service can avoid the need for individuals to access a separate and unfamiliar specialised treatment service

Bradley Freeburn Certificate IV etc. in Counselling, Coordinator, Summer Loggins Research Assistant, K. S. Kylie Lee PhD, Associate Professor, Katherine M. Conigrave FAChAM, Senior Staff Specialist and Professor. Correspondence to: Professor Katherine M. Conigrave, Drug Health Services, Royal Prince Alfred Hospital, Missenden Road, Camperdown, NSW 2050, Australia. Tel: 61 2 9515 8650; E-mail: kate.conigrave@sydney.edu.au

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[2]. It can also remove barriers such as stigma; real or feared discrimination in 'mainstream' services (i.e. not Indigenous-specific); transport difficulties; and lack of awareness of service options [2,4]. Primary care staff may also know the client and their context (e.g. health, family and community).

Here we provide a case study of one Aboriginal community-controlled primary care service which offers comprehensive ambulatory drug and alcohol (D&A) treatment, including opioid substitution treatment (OST). We believe this may be one of the first Indigenous-controlled primary care services worldwide to do so.

The service and the unit

The Aboriginal Medical Service Cooperative, Redfern (the 'AMS') in New South Wales, Australia, was established in 1971 to improve access to comprehensive and culturally secure primary health care for local Aboriginal people [5]. It arose because of the experience of racism at mainstream health services. AMS Redfern was the first of more than 140 Aboriginal and Torres Strait Islander Community Controlled Health Services (ACCHS) across Australia [5,6]. These services have resulted in improved health service access and health outcomes [6,7].

In the late 1990s, a record number of people were dying from heroin overdose in Sydney and New South Wales [8,9]. The AMS's founding CEO, Naomi Mayers AO, and the Board agreed to act to prevent further community members overdosing or dying. Ms Mayers asked an AMS Aboriginal Health Worker, BF, who had experience working with individuals with D&A problems, to establish a D&A unit (personal communication, BF).

The AMS Drug and Alcohol Unit (the 'Unit') opened in 1999 [5,10] in an unmarked building, across the road from the main AMS. To avoid potential local opposition, the Unit's opening was not publicised. Instead, news of it spread by word-of-mouth. The Unit started with a coordinator (BF), a general practitioner, John Faros, who was accredited to prescribe methadone, and a nurse unit manager, Michael Englert. Some months later, several other AMS doctors commenced prescribing.

At first, the Unit provided only methadone prescribing and counselling. Because of limited security, dosing was provided offsite by one of three nearby public D&A units or by local pharmacies. In 2001, when it became available in Australia [11], the Unit started prescribing and dispensing buprenorphine tablets. This long-acting medication gave clients the option to receive a second daily (supervised) double dose, with no dose needed the next day. Buprenorphine also appealed to potential clients who disliked the stigma associated with methadone. Methadone was sometimes seen by community as 'just another [addictive] drug' [12]. Client numbers rose to around 60 within months.

Later, Suboxone (buprenorphine plus naloxone) became available in Australia, first as sublingual tablets (2005) then in 2010 as a film [13]. Its lower diversion potential meant that stable clients could have some unsupervised (takeaway) doses. As Suboxone film dissolves readily, dosing became quicker. This further reduced the Unit's dispensing burden.

In 2015, the Unit moved from across the road into the main AMS building. This facilitated further integration of management of substance use disorders with general health care.

With the onset of the COVID-19 pandemic in early 2020, the Unit fast-tracked its plans to offer slow release, injectable buprenorphine (weekly or monthly Buvidal). Over half of the AMS's clients on Suboxone transferred to slow-release buprenorphine within the year. This further freed clients from daily or near-daily visits to the Unit. The monthly formulation offered benefits for clients who were working, caring for children or family members, or who had to travel (e.g. to rural funerals). It also helped clients who were struggling to become stable, including those recently released from prison.

At the time of writing, the AMS prescribes for around 150 OST clients. Staff dispense Suboxone or Buvidal onsite to around 50 clients. The Unit's doctors also prescribe methadone, sublingual buprenorphine (e.g. for pregnant women) or Suboxone for dosing at public OST clinics or pharmacies.

Staffing and roles

The Unit has a small, cohesive team of four staff on any day. The Unit's coordinator since its foundation (BF), is a Bundjalung man who trained as an Aboriginal Health Worker at the AMS. This Coordinator also provides counselling for people with D&A problems, who often have a history of trauma. BF is assisted by an Aboriginal D&A worker (male or female). That staff member typically has relevant work experience and/or training in mental health or in D&A.

The nurse of the Unit administers Suboxone or Buvidal. Another staff member of the Unit (or of the broader AMS) witnesses the dosing, for added medication safety. Three general practitioners, who otherwise work in the primary care section of the AMS, conduct regular OST clinics in the Unit. A visiting addiction medicine specialist (KC) 1 day each week helps with the management of individuals with complex disorders. This position also aids two-way learning and liaison between the AMS and the local mainstream specialised drug

treatment service. The Unit's doctors conduct a small number of alcohol, cannabis or methamphetamine 'home detoxes' (ambulatory withdrawal management), using a local pharmacy for daily dispensing of diazepam or other medication. The doctors also offer alcohol relapse prevention medicines, nicotine replacement therapy and treatment for Hepatitis C.

The service's plans to commence a SMART ('Self-Management and Recovery Training') Recovery group [14] were deferred because of COVID-19. That mutual support group will be facilitated by the Unit's Aboriginal D&A worker, a trained SMART Recovery facilitator.

Holistic care

The person's whole health can be attended to in the primary care section of the AMS, via onsite and visiting allied health or medical specialist [5]. The AMS has a mental health counsellor, a social worker and (outside of the pandemic) an exercise physiologist and mini-gym. There are clinics for visiting dentist and medical specialists (for liver, heart, kidneys, diabetes, pregnancy, joints, mental health and chronic pain). Transport is provided for clients when needed.

Culturally-centred care

The Unit has a relaxed and friendly atmosphere—without the glass screens between clients and staff sometimes seen in mainstream services. The staff are positive and understand and care for the clients. Episodes of abuse or aggression are uncommon. One often hears a new (or returning) client coming in and saying to the Coordinator, 'Unc, I need to get on the program' ('Uncle' is a term of respect, used for Elders). Typically, the person can start OST the next day. No appointments are needed for general practitioner prescribers. The sense of humour of the Aboriginal staff makes clients feel at ease. Aboriginal staff combine their cultural and community knowledge with mainstream relapse prevention approaches. For example, as well as suggesting a client consider Buvidal, staff understand the importance of getting back 'to Country' to 'heal' after emotional trauma. This spiritual connection to country is a key part of Aboriginal wellbeing [15].

Workforce development

The Unit supports skills development of AMS staff. The Unit's Aboriginal Drug and Alcohol Workers are supported to attain vocational training qualification(s) or attend skills development courses. Six of the AMS's general practitioners are now accredited OST prescribers. Most of the AMS's nurses periodically dispense OST. This allows backup if regular Unit staff are away. Importantly, it also increases understanding of substance use disorders across the service. The Unit hosts guest speakers on D&A topics for all AMS staff. The Unit's Coordinator (BF) has also contributed to local, state, national and international workforce development in Indigenous health and D&A use [e.g. 12,16–18].

External collaborations

Since its early days, the Unit has built links with the three local public D&A clinics (each affiliated with major hospitals). This enhances access to antenatal care and inpatient withdrawal management when needed. These links, and relationships with Justice Health and a range of residential rehabilitation services, help ensure continuity of care.

Advice to government and researchers

The Unit's Coordinator (BF) has provided advice to federal and state government on D&A and Aboriginal health (e.g. through the National Indigenous Drug and Alcohol Committee and the Aboriginal Drug and Alcohol Network, New South Wales). He has made regular contributions to research [4,17,19–21].

The Australian and international context

Many ACCHS around Australia have D&A units, often providing counselling, casework and cultural support. However, anecdotally, few ACCHS provide OST. Winnungah Nimmityah Aboriginal Health Service in the Australian Capital Territory also began prescribing OST in 1999 [22], though dispensing was elsewhere until 2020 (personal communication). Nonetheless, that program achieved comparable or better retention than mainstream OST programs [22]. Nunkuwarrin Yunti Aboriginal Health Service in South Australia described working with local mainstream services to increase access to OST [23], and now has its own prescribers (personal communication). Anecdotally, at least three other ACCHS Australia-wide now prescribe OST, sometimes with help from visiting addiction medicine physicians. Though around Australia, only a small number of ACCHS provide onsite dispensing (to our knowledge, of long-acting buprenorphine only).

Challenges for Indigenous peoples in access to OST have been documented in other colonised countries [24,25]. In Canada, 22 First Nations communities in the remote Sioux Lookout region, responded by setting up their own OST clinics [26]. These seem to be discrete clinics, though staffing may overlap with the primary care service. Physicians fly in to prescribe and provide telemedicine support [26]. Their strong outcomes have been attributed to the combination of medication and a cultural healing approach [26]. In the USA, we found newspaper reports (though not scientific reports) of Tribal OST clinics [e.g. 27]. In Aotearoa/New Zealand, we were unable to find reports of OST delivered through Māori community-controlled health services, and are advised that these do not yet exist (personal correspondence).

Concluding Remarks

This Unit at the AMS Redfern has been operating for more than two decades, showing the feasibility of accessible, holistic and culturally-secure care for substance use disorders within a primary care service. This model helps ensure that substance use disorder is seen as another health condition, and that the person with the disorder is recognised as worthy of quality, compassionate care. The feasibility of such a model suggests that it is worth consideration and evaluation in Indigenous and non-Indigenous health services worldwide.

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Conflict of Interest

BF is the Coordinator of the Unit described in this report; KC is based there 1 day per week.

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