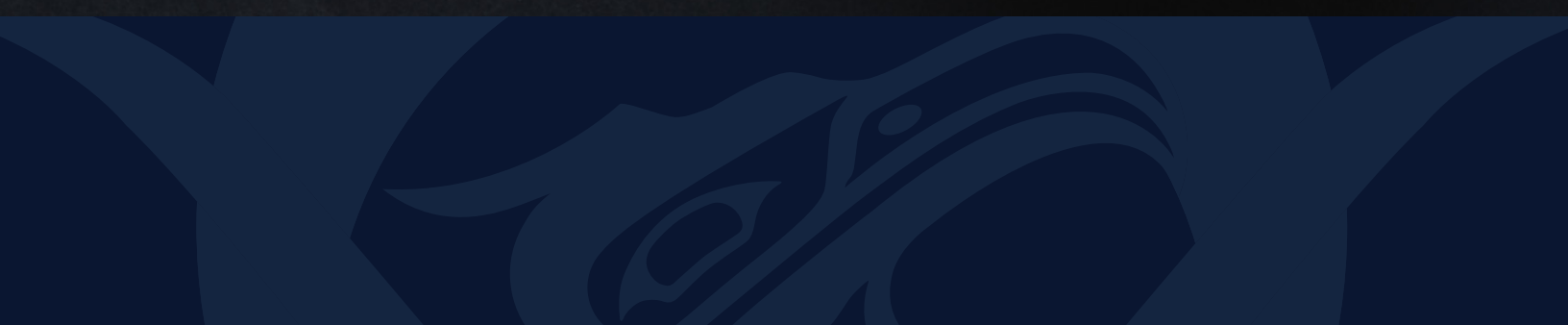




First Nations Health Authority  
Health through wellness

# Supporting Opioid Use Disorder and Opioid Agonist Therapy in First Nations Communities





First Nations Health Authority  
Health through wellness

The First Nations Health Authority (FNHA) is the health and wellness partner to over 200 diverse First Nations communities and citizens across British Columbia (BC). In 2013, the FNHA began a new era in BC First Nations health governance and health care delivery by taking responsibility for the programs and services formerly delivered by Health Canada. Since then the FNHA has been working to address service gaps through new partnerships, closer collaboration, health systems innovation, reform and redesign of health programs and services for individuals, families, communities and Nations.

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First Nations Health Authority  
501 – 100 Park Royal South  
Coast Salish Territory  
West Vancouver, BC V7T 1A2

Phone: 604-693-6500  
Toll-free: 1-866-913-0033  
info@fnha.ca | [www.fnha.ca](http://www.fnha.ca)

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# Introduction

This resource is intended to support nurses who work in First Nations communities providing trauma-informed and culturally safe care to clients who are prescribed Opioid Agonist Therapy (OAT).

This resource will provide information about how to implement an OAT program and advocate for clients prescribed OAT, including advocating for harm reduction services that are in alignment with the [First Nation Health Authority \(FNHA\) Harm Reduction Policy](#) (1). In addition to OAT, this resource includes information about opioid use disorder (OUD), First Nations harm reduction, treatment options, nursing care, addressing stigma, framing OUD around culture and community, and links to additional resources.

Culture and community are important factors in the health and wellness of First Nations people. Colonialism, discrimination, residential schools, the 60's scoop and systemic racism have led to increased experiences of trauma for First Nations people and communities, impacting their mental, physical, emotional, and spiritual health. When working with First Nations individuals who use substances, it is important to take a strengths-based, culturally safe, and trauma-informed approach. Although the clinical and pharmaceutical component of nursing care plays an integral part of health care, ensuring we use a two-eyed seeing approach when delivering nursing services is a critical step towards reconciliation and decolonization. More information about the FNHA's approach to two-eyed seeing can be found in the FNHA's [Policy on Mental Health and Wellness](#) (2).

Each community, family and individual will have their own definition of health and wellness and their own expression of culture and tradition. Therefore, getting to know the community, family and individual will improve the quality of care you provide clients. What works for one client may not work for another, even within the same community or family, so it is crucial to take the time to get to know each person on an individual level.

While the FNHA's Four Directions team, FNHA regional teams, and regional health authorities will be able to provide education and support, each community will have its own resources, strengths and supports. These can include Elders, Traditional Knowledge Keepers (TKK), people with lived and living experience (PWLLE), community health representatives (CHR), leadership, and staff involved in cultural programs such as land-based healing.





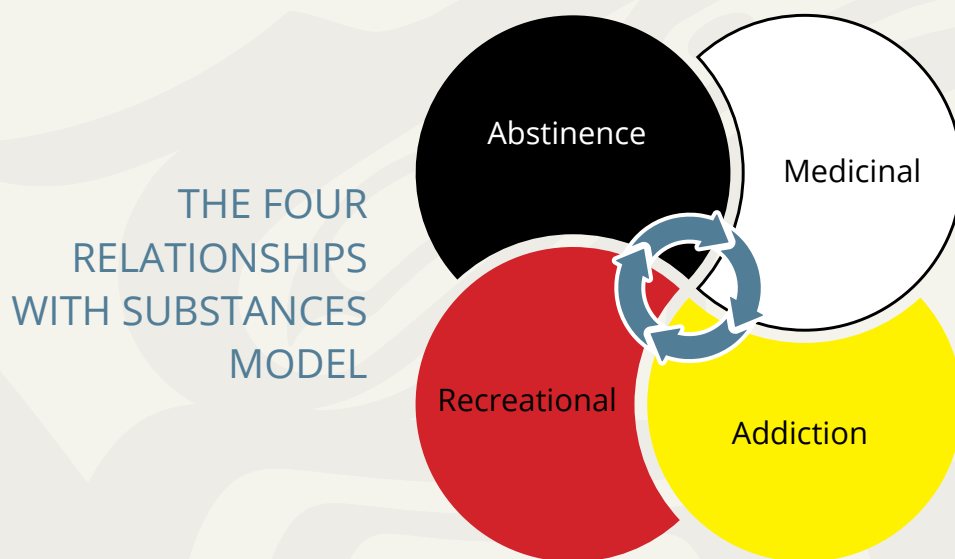
## Opioid Use

In April 2016, British Columbia (BC) declared a state of public health emergency in response to the increase in deaths related to toxic drug poisonings. In March 2020, BC declared a second public health emergency due to COVID-19. From 2019 to 2020, there was a 119 per cent increase in the number of toxic drug deaths in BC (3).

From 2020 to 2021, there was a 25.6 per cent increase in toxic drug deaths (4). More recently, there has been a further increase in toxic drug deaths, with a 7.7% increase from January to June 2022 compared to the same period in 2021 (5). First Nations people, particularly First Nations women, are disproportionately represented in toxic drug deaths. Rural and remote First Nations communities face even greater challenges due to increased barriers to accessing trauma-informed and culturally safe health care.

Opioid use disorder is a chronic, relapsing condition that involves the misuse of prescribed opioid medications, use of diverted opioid medications, or the use of opioids from the toxic drug supply. A person with OUD will experience cravings or an overpowering need to use opioids, changes in tolerance (the need to use more opioids to achieve the desired effect), and symptoms of withdrawal when they stop using opioids. Although OUD is associated with significantly increased rates of morbidity and mortality, clients who receive appropriate treatments and supports have the potential to sustain a long-term remission, which often results in cycles of relapse and remission.

Resources have been developed by the [British Columbia Centre on Substance Use](#) (BCCSU) and the University of British Columbia Continuing Professional Development Program (UBC CPD) to provide education and clinical support to nurses working with clients with OUD. Two central courses include the [Addictions Care and Treatment Online Course](#) (ACTOC) and the [Provincial Opioid Addiction Treatment Support Program for Registered Nurses and Registered Psychiatric Nurses](#) (POATSP). This resource is designed to provide guidance from a culturally safe, trauma-informed and First Nations lens. Although the clinical aspects of opioid agonist therapy will be briefly discussed in this resource, we recommend the POATSP course for Nursing for the clinical and pharmaceutical perspective of OAT care.



It's important to consider that not all clients who use opioids have OUD and that many people use opioids for different reasons. The graphic above highlights the fact that we are all connected to substance use in some way.

Some people take an abstinence approach and choose not to use substances. This might be due to a family history of substance use, fear or responsibilities that they hold. Some people use substances for medicinal purposes, such as coping with chronic pain, self-medicating for mental health issues or for cultural purposes. People also choose to use substances recreationally, which may include occasional use for personal enjoyment or experimentation. However, a small portion of community members may live with a substance use disorder in which their relationship with substances is no longer a choice and they rely on these medicines.

While not all substance use is harmful, in the current context of a toxic and unregulated drug supply, toxic drug poisonings are a risk for anyone who has a relationship with unregulated opioids regardless of the reason or frequency of use. People who live with a substance use disorder and rely on the toxic drug supply have the greatest risk of harm (including death).

First Nations people face increased stigma when accessing care for opioid use. The [Nursing Considerations – Non Prescribers](#) section of this resource provides important considerations for creating a safe space when assessing and caring for clients who use opioids. Visit this BCCSU Resource, [Common Acronyms and Glossary List](#) (6), for common definitions and acronyms used in opioid and substance use care.







## Harm Reduction

Harm reduction is an approach that helps people stay safer while using opioids. By using a harm reduction lens, we meet individuals, families and communities where they are and work alongside them as they travel along their individual health and wellness journeys, without shame or judgement.

Harm reduction is based on love, kindness, culture, traditions, relationships and self-determination. As health care providers, it is important to recognize that abstinence from opioids is not necessarily the client's end goal. Each person is on their own healing journey and how health and wellness is defined will differ from person to person. Our role is to offer them a safe space to access services and supports and the main way we can do that is through a First Nations harm reduction approach.

First Nations Harm Reduction is a process of integrating cultural knowledge and traditions into the strategies and services associated with the work of harm reduction. First Nations knowledge systems are strongly connected to spirituality, holism, and the natural environment. A First Nations approach strengthens conventional harm reduction by weaving in culture, teachings, community and connections to the land and each other. We can take a strengths-based, person-centred, Nation-led approach.

## Harm reduction encompasses several different practices, including:

- > Safe supply
- > Naloxone training
- > Drug checking supplies and services
- > Access to supplies such as pipes and needles
- > Access to medications such as OAT and naloxone kits
- > Supportive housing
- > Outreach supports
- > Accessible clinic services
- > Working with people with lived and living experience
- > Witnessed consumption and overdose prevention
- > Wrap-around supports, including culture and ceremony
- > Safer sexual practices
- > Blood-borne disease prevention (e.g. HCV/HIV)

## HARM REDUCTION RESOURCES

For further information, see the [FNHA's Overdose Prevention and Harm Reduction](#) web section. It includes resources, data, stories, videos and the [FNHA's Harm Reduction Policy](#) (1).

For more information on witnessed consumption and overdose prevention, see the [FNHA's Raven's Eye Sage Site Service Delivery Framework](#) (7), which is a guide for establishing and running an on-demand overdose prevention site for First Nations communities.

To connect with FNHA's Sexually Transmitted and Blood-Borne Infections (STBBI) team, please see the [FNHA STBBI](#) page or email them at [stbbi@fnha.ca](mailto:stbbi@fnha.ca)

The FNHA Four Directions and FNHA regional teams offer [Not Just Naloxone \(NJN\) workshops](#), which provide a deeper understanding of historical and cultural contexts and covers topics such as racism and prohibition in Canada, decolonizing substance use, trauma- and resiliency-informed practice, addressing stigma, naloxone training and First Nations harm reduction principles. Please contact [njn@fnha.ca](mailto:njn@fnha.ca) for further information on upcoming workshops.

In addition, the Four Directions team provides service through the Harm Reduction Hub. The 'Hub' provides community workers and health care providers with easy access to harm reduction services and supplies including bulk supply of nasal naloxone. The 'Hub' also helps build connections with FNHA regional teams and other harm reduction supports to help expand harm reduction options in First Nation communities. Contact the Harm Reduction Hub by emailing [harmreduction@fnha.ca](mailto:harmreduction@fnha.ca). For additional information on the Hub or bulk supply for nasal naloxone, please see the [FNHA's Harm Reduction Hub Information Sheet](#).



## Opioid Agonist Therapy

OAT is a safe and effective treatment option for people living with opioid use disorder. It involves the use of medications to provide a safe and steady level of opioids to reduce withdrawal symptoms and cravings. The evidence demonstrates that OAT does save lives and reduce harms related to OUD.

OAT helps individuals rebuild their health. People know where and when they will receive their daily dose and what their dose will be. As a result, they do not need to focus on the hustle to obtain unregulated substances, which may put themselves or others at risk.

Because OAT medications are highly regulated and not all prescribers prescribe them, First Nations people in rural or remote communities often face barriers to accessing OAT. The Four Directions team can provide support by connecting with prescribers and pharmacies to facilitate community access and build capacity within community.

Nurses and health care staff working in First Nations communities are encouraged to take a client-centered, culturally safe and trauma-informed approach to providing care when working with First Nations clients prescribed OAT. This can include wrap-around supports, such as access to culture, language, traditional territory and ceremony. It can also include strengthening bonds between family, friends and community.

## MEDICATIONS

OAT is considered the gold standard for the treatment of OUD as it provides structured access to long-acting opioids. Common medications used in the treatment of OUD include buprenorphine/naloxone, methadone, Kadian and Sublocade. Choosing the right medication can involve a variety of client-specific factors including initial presentation, comorbidities, drug-drug interactions, treatment preference and response, as well as available options. The following table outlines key clinical details for nurses working with clients who are prescribed OAT. More information is available in the [POATSP course for Nurses](#).

### Buprenorphine/Naloxone (Suboxone)

4:1 ratio in 2 and 8 mg tablets (buprenorphine 2 mg/naloxone 0.5 mg and buprenorphine 8mg/naloxone 2 mg)

Sublingual (sl) administration taking up to 10 minutes to dissolve

Naloxone prevents diversion and injection use; absorbed if injected/snorted

As a partial opioid agonist, has a “ceiling effect” to improve safety profile

Alleviates withdrawals and stops cravings but does not provide euphoria at the right dose

Registered Nurses (RNs) and Registered Psychiatric Nurses (RPNs) who have undergone specialized training can prescribe for clients

### Methadone (Methadose, Metadol-D)

Oldest form of OAT and most common, used since 1959 in Vancouver

Reduces opioid cravings and mitigates the euphoric effects of non-medical uses of opioids such as heroin

Can take weeks to reach desired effect because dose must be increased slowly

Requires daily witnessed ingestion until ongoing clinical and social stability is demonstrated

Has many potential drug-drug interactions and can cause QTc prolongation

RNs and RPNs who have undergone specialized training can prescribe for clients for continuations, titrations and restarts with strict clinical criteria outlined in [POATSP course for Nurses](#) but are unable to initiate treatment at this time

### Slow-Release Oral Morphine (Kadian)

Delivered in capsule that contains beads which release morphine over 24 hours

Usually provided to client as “open and sprinkle” with instructions to swallow beads without crushing or chewing

Often used if clients have heart problems (QT-prolongation, arrhythmia, endocarditis, or past cardiac surgery) that would make methadone less safe

RNs and RPNs who have undergone specialized training can prescribe for clients for continuations, titrations, and restarts with strict clinical criteria outlined in [POATSP course for Nurses](#) but are unable to initiate treatment at this time

### Extended-Release Buprenorphine (Sublocade)

Indicated for adult patients who have been inducted and stabilized on sublingual buprenorphine/naloxone for a minimum of seven days

Administered as a monthly subcutaneous injection in the abdominal region and must not be injected intravenously or intramuscularly

Used as part of a treatment plan that includes counselling and psychosocial supports

Associated with significantly higher treatment retention than placebo in individuals with moderate to severe opioid use disorder

Sublocade is to be either picked up by a nurse or prescriber on behalf of the patient, or delivered to the clinic, keeping in mind proper storage and delivery of the prescription

While it must be prescribed by an RN or a medical doctor (MD), administration of Sublocade can only be performed by an MD, a nurse practitioner (NP), or a nurse (RN, RPN, or licensed practical nurse (LPN)). Nurses must have a client-specific order to administer Sublocade

## URINE DRUG TESTS

Urine drug tests (UDTs) can be a useful tool in the clinical management of OUD but they can also be associated with stigma and trauma. They should be used with a non-punitive and patient-centred approach in conjunction with other sources of information and only when results would clearly impact clinical management. Clinical indications for UDTs can include supporting decision-making for take-home doses, confirming that medication is being taken, screening for non-prescribed opioids, and evaluating treatment response and outcomes.

Due to the stigma towards opioid use and OAT, as well as the discrimination many First Nations people face when accessing health care, it is important for clients to understand the clinical indications and benefits of a urine drug test rather than perceiving it as a punitive assessment. A UDT is not required to make a clinical diagnosis of OUD.

UDTs can be scheduled or random. Random UDTs, which usually require clients to provide a sample at a clinic or lab within 48 hours, can be especially burdensome for clients in rural or remote communities. Nurses can help clients understand the rationale for random UDTs, navigate barriers to providing a sample within the requested time, and advocate for clients who require more flexibility with UDTs.

UDTs are usually supervised but not witnessed. A supervised UDT allows a client to produce a sample in a designated collection area without being witnessed. Clients should never be asked to have a witnessed UDT, as this can be traumatizing and a violation of privacy. For further information, the BCCSU has created a [Urine Drug Testing Breakout Resource](#) (8).

## SPECIAL POPULATIONS

### Youth

RNs and RPNs who have completed the training can prescribe for patients between 16 and 18 years of age only after consulting with an advanced provider and must refer to another provider for patients aged 15 years and younger. Youth prescribed OAT benefit from wrap-around cultural supports and assessment and support for co-occurring disorders. Nurses can provide harm reduction education, naloxone training and naloxone kits. Further education can be provided on sexually transmitted and blood borne infections (STBBI), birth control, safer sex, and pregnancy. Special care must be given to confidentiality due to the small nature of many health centres in rural and remote First Nations communities. The BCCSU has developed an additional supplement for health care providers: [Treatment of Opioid Use Disorder for Youth](#) (9).

## Pregnancy

There are adverse obstetrical outcomes for pregnant clients with OUD. This can include preterm labour, premature rupture of membranes, and adverse neonatal outcomes, such as low fetal birth weight. Due to the stigma towards pregnant people who use opioids, this can act as a deterrent to seek care for OUD. First Nations individuals who are pregnant may fear losing custody of their child or children due to discrimination and racism evident in both the health care and foster care systems.

It is essential that nurses and health care staff approach pregnant individuals seeking support for OUD with kindness, compassion and without judgement. It is also important to assure the client that there is no legal obligation to report substance use during the course of pregnancy. By taking a trauma-informed and harm reduction approach, a client-centred, strengths-based care plan can be developed and supported throughout the perinatal period. The BCSSU has developed an additional supplement for health care providers, [Treatment of Opioid Use Disorder during Pregnancy](#) (10). The Centre of Excellence for Women's Health also has a helpful resource, [Mothering and Opioids](#) (11).

## 2SLGBTQIA+

The First Nations 2SLGBTQIA+ community face additional stigma when seeking support for OUD. These individuals can often experience bullying, violence and rejection from family and friends – which all create further barriers to accessing health care. The [Addictions Care and Treatment Online Course](#) (ACTOC) has a section on substance use care for 2SLGBTQIA+ individuals, which gives additional considerations when providing clinical care through a culturally safe and trauma-informed lens.

## Older Adults

First Nations individuals over the age of 55 hold a special place in their community. As a result, some older First Nations people may be hesitant to seek support for OUD. In this regard, it is important to ensure that the health centre ensures privacy and confidentiality. Another consideration for older individuals prescribed OAT is renal and kidney function and drug-drug interactions.



# Client Considerations

## WRAP-AROUND SOCIAL AND CULTURAL SUPPORTS

Clients prescribed OAT may have challenges accessing basic needs, such as housing, groceries, personal hygiene supplies and a cell phone. They may also need supports to meet their cultural and spiritual needs.

### Housing

The health care team can work with the health director to advocate for housing, such as with the housing department in the community or in creating a culturally safe and trauma-informed safe house for clients needing short-term housing.

### Groceries and Hygiene Supplies

The health care team can work with the social development office in the community, which can often assist with groceries. Another option would be to have gift cards available to clients who need urgent food assistance. The health care team can also keep a basic stock of hygiene items, such as toothpaste, toothbrushes, soap, socks, clothing and deodorant.

### Cell Phones

If there is room in the OAT programming budget, the health care team may be able to provide clients with a cell phone or top-ups for minutes. Communities can also apply for money for cell phones for clients through the OAT Community Access Grant. Please contact the Four Directions team at [4directions@fnha.ca](mailto:4directions@fnha.ca) for more information.



## Child Care

Clients may need assistance finding childcare so they can go to their medical appointments, especially if their appointments are in another town or city. The nurse can work with the health care director or nursing manager to find appropriate and affordable (possibly free) child care for the client.

## Mental and Emotional Wellness

The client may be interested in counselling or working with a community addictions worker, substance use worker or family support worker. The client may also be interested in working with a PWLLE. PWLLE may be local community champions who have also been through similar experiences and healing journeys. They can offer genuine support and walk alongside a person on their healing journey. The cost of counselling may be covered through FNHA Health Benefits for clients who have First Nations status. Eligible services are outlined in the [FNHA Mental Health Benefits](#) program.

## Spiritual and Cultural Support

Clients prescribed OAT may benefit from spiritual and cultural wrap-around supports. The community may have Elders, Traditional Knowledge Keepers, Healers, or programs such as land-based healing. When developing a care plan with the client, be sure to offer these options and protect confidentiality. Information on wellness supports can be found in the [section below](#).

## BELIEFS ABOUT OPIOID USE DISORDER

Each community, family member and individual will have an opinion on the topic of opioid use. Sometimes these opinions may lead to negative beliefs about people who use opioids. It is crucial to work together to provide education on opioid use to those who may have a stigma towards the topic.

As a result of Canada's history of racialized prohibition, many people believe that abstinence is the only way to "overcome" opioid use. However, each individual has a different definition of what health and wellness means to them, and this may not include abstinence from opioids.

It is important to consider the language we use when talking about opioids. We want to use strengths-based, people-first language. For example, we can say "people who use opioids" rather than "addict"; "positive" or "negative" test results instead of "clean" or "dirty". We also want to avoid language such as "abuser", "junkie" or "non-compliant". The FNHA has created a poster ["Talking about Substance Use"](#) with more information.

## CLINIC CONSIDERATIONS

How the clinic is set up will help clients feel more comfortable and safe to come in for appointments. The clinic should be welcoming, warm, friendly, safe and more home-like than facility-like. Many First Nations people find institutional settings to be intimidating and unsafe due to the history of residential schools and previous traumatic experiences accessing the health care system. Often clinics are sterile and have hard, uncomfortable chairs. It is possible to create a space that is safe and welcoming, as well as easy to clean (to comply with infection prevention and control policies).

Some ways to improve the cultural safety of the clinic can include:

- > Comfortable sofas, a TV with movies for children, toys, local First Nations art work or drawings and painting by local children
- > A space where people can replenish, with snacks, coffee or tea, and a private bathroom to wash up
- > Basic amenities like small hygiene kits
- > A white noise machine outside clinic doors, which can provide privacy, especially in communities where everyone knows each other
- > Child care while the client is in the appointment
- > Accessible clinic hours, such as walk-ins, assistance with making appointments, and non-traditional office hour options

## TRANSPORTATION

Transportation, especially in rural and remote First Nations communities, can often be a barrier for clients accessing OAT care, whether this includes getting to the clinic, their prescriber or the pharmacy. If clients are having challenges with consistent transportation, the nurse can work with the health director or nursing manager and health care team to consider options on how to provide transportation to clients. Without safe transportation arranged in advance, some clients may put themselves at risk by either hitchhiking with strangers or catching rides with people who may not be supportive of their treatment plan.

Depending on the clinic's policies and arrangements with the local pharmacy, some transportation options could include:

- > A member of the health care team driving the client or picking up their medication
- > The pharmacy drops off OAT medication to the clinic or to the client
- > An unregulated health care provider provides transportation i.e., a community health representative, community addictions worker or PWLLE.

Another approach is working with the Patient Travel Department in the office to discuss whether there is any compensation for family members or friends who are able to drive clients to appointments. Further details can also be found on the [FNHA's Medical Transportation Benefit](#) webpage.

## MISSED APPOINTMENTS/MEDICATIONS

Each OAT medication has different protocols for when a client misses a dose or doses. Review the [POATSP for Nurses](#) for further details on the criteria and protocols as well as contacting the prescriber to update them on the situation. The client may need a visit with their prescriber to restart or adjust the dose. It is important to help the client understand that this is related to their safety, as missed doses can decrease their tolerance to the prescribed medication.

However, an important consideration is working with the client to determine why the appointment or doses were missed. The nurse can work with the client to meet their needs, brainstorm to overcome barriers, and advocate for the client if they are in need of housing, child support, transportation, or if the current treatment is not meeting their needs. If medication is dispensed from the health centre and supplied by a community pharmacy, then the nurse will need to communicate missed doses to the pharmacy to ensure client safety.

## NALOXONE TRAINING AND KITS

Clients and those within their circle of support should have naloxone training and naloxone kits on hand. The client should also be offered a naloxone kit at each appointment. The British Columbia Centre for Disease Control (BCCDC) operates the [Toward the Heart](#) program, which includes the [Take Home Naloxone](#) and harm reduction program, education, resources and a site finder to locate existing naloxone and harm reduction sites nearby. If the nurse has not taken the Not Just Naloxone: Train the Trainer program, please contact [njn@fnha.ca](mailto:njn@fnha.ca). If the nurse requires support with harm reduction supplies or needs to register as a naloxone site, please contact the FNHA's Harm Reduction Hub at [harmreduction@fnha.ca](mailto:harmreduction@fnha.ca). The FNHA also has a helpful one-page resource on [nasal naloxone](#).

## PRIVACY AND CONFIDENTIALITY

The British Columbia College of Nurses and Midwives (BCCNM) has a [Privacy and Confidentiality Practice Standard](#) as well as [Boundaries in the Nurse-Client Relationship Practice Standard](#) to assist in navigating the complexities of working in First Nations communities.

Privacy and confidentiality are important factors in helping clients who are prescribed OAT to access health care in the community. Due to the often tight-knit nature of the community in which the nurse is working, maintaining privacy and confidentiality for the client can be challenging. Clients may be hesitant to seek care if they do not feel safe about the privacy options when accessing care. Clients may also feel concerned if there is someone on the health care team that they know or are related to.

Some ways to improve privacy include giving the client the direct office line in case they do not want to discuss with the receptionist or Medical Office Assistant (MOA) the reason for their visit. Some clients may want a separate entrance to come in to their appointment while others may wish to use the front door as any other client would. It would be beneficial to the client to have a conversation about confidentiality and the steps the health centre has taken to ensure confidentiality. This can include discussing the [BCCNM Practice Standards](#), as well as practical considerations such as locked cabinets or password protected electronic charting.





# Roles and Responsibilities

Clients prescribed OAT benefit from wrap-around supports, such as interdisciplinary teams, nurses, support workers and support from family and community. When developing a care plan with a client, taking a client-centered, collaborative and integrative approach will help clients meet their wellness goals. An important consideration is the dual role that some people within the circle of care may have i.e., someone may be a peer worker and a brother. People within this dual role may need extra support when working with clients.

The FNHA has a standard operating procedure for controlled substances at health centres and primary care centres that outlines regulatory considerations for people who work in various roles that involve controlled substances. The procedure document can be used to guide practice and provides information such as roles and responsibilities of those involved with controlled substance-related tasks, controlled substance storage, inventory management, transportation and regulatory documentation requirements. Please contact the Four Directions Team for more information at [4directions@fnha.ca](mailto:4directions@fnha.ca).

Below is a brief overview of the roles and responsibilities of each part of the circle of care.

## LOCAL PHARMACY

The local pharmacist plays an integral role in the client's care. As a result, building a trusting and open relationship with the pharmacy and pharmacist will be part of the role of the nurse, who can also advocate for unregulated care providers (UCPs) to be part of the medication transportation process. The role of pharmacists in supporting multidisciplinary care with OAT is evolving. Please contact [4directions@fnha.ca](mailto:4directions@fnha.ca) for support with relationship-building and process development with local pharmacists.

## PRESCRIBER

In 2020, due to the dual public health emergencies of COVID-19 and the toxic drug supply crisis, RNs and RPNs in BC were given the authority to prescribe certain forms of OAT to increase client access to prescribers and to culturally safe care. OAT medications that

are currently within an RN or RPN scope of practice include methadone, buprenorphine/naloxone (Suboxone), and slow-release oral morphine (Kadian). The BC Pharmacy Association has further information on the [history of OAT in BC](#) (12).

Prescribers can be physicians, nurse practitioners (NPs) or RNs and RPNs who have completed the BCCSU educational pathway to becoming a prescriber. Nurses who have completed the training need to be registered and acknowledged by BCCNM as a nurse prescriber. Prescribers assess, diagnose, prescribe, monitor and perform follow-ups, communicate and collaborate with other health care providers, document, and more. They are able to access PharmaNet, order laboratory and point-of-care tests, and coordinate care and referrals. RN and RPNs require a completed prescribing escalation pathway (the nurse will have a copy). When working with clients prescribed OAT, non-prescribing nurses will develop a strategy with the prescriber about when to contact them in case of concerns.

Nurses who are interested in becoming nurse prescribers, can contact the Four Directions Team at [4directions@fnha.ca](mailto:4directions@fnha.ca) for more information.

Often in rural and remote communities, it can be challenging for clients to access OAT and a prescriber. The FNHA provides options which may be able to assist clients, such as the [First Nations Virtual Substance Use and Psychiatry Service](#).

## HEALTH DIRECTORS AND NURSE MANAGERS

Health directors and nurse managers must be familiar with the roles and responsibilities of each employee involved in the client's care, including the distinct roles of prescribing and non-prescribing RNs, RPNs and LPNs. They will have an active part in developing the community health centre's policies and standards as well as implementing and evaluating their effectiveness. They will also have an active role in team building from a culturally safe and trauma-informed lens. FNHA remote nursing stations, health care centres, primary care centres and FNHA-employed nurses will have policies and procedures to guide the OAT program. However, First Nations Health Service Organizations (FNHSO) and community health centres operated by the Nation, will need to develop their own policies and procedures for OAT programming. For support with this process, contact the FNHA Four Directions Team at [4directions@fnha.ca](mailto:4directions@fnha.ca).

## UNREGULATED CARE PROVIDERS

Several roles within the circle of care may be UCPs. These may include community health representatives, family support workers, community addictions workers, outreach workers, social workers, land-based healing team members, traditional wellness specialists, regional health authority Indigenous liaisons and PWLLE. It is important to remember that the nurse must gain consent from the client prior to including additional people in the circle of care. For more information, contact the Four Directions Team at [4directions@fnha.ca](mailto:4directions@fnha.ca).



## Nursing Considerations (Non-Prescribers)

Completion of the [POATSP](#) for RNs and RPNs is required for FNHA nurses working with clients prescribed OAT and may be required for nurses hired by the community. Although a nurse may not necessarily be dispensing or prescribing OAT, the Four Directions Team can provide support to nurses working with clients prescribed OAT for the first time. The Four Directions Team is developing resources that will assist with RN prescribing and OAT program development.

### ORDER TO DISPENSE

As per BCCNM's [Medication Practice Standard](#), RNs, RPNs and LPNs require an order from an authorized prescriber to dispense client-specific medications. Further information on acting on client-specific orders is available on the BCCNM website for [RNs](#), [LPNs](#) and [RPNs](#). Further information is available below under [LPN Considerations](#). Note that a consultation, referral or professional recommendation is not considered an order.

## PHARMANET

PharmaNet is a secure computer network that links community pharmacies and hospital pharmacies throughout the province. Access to client information within the PharmaNet system is limited to nurses who have a legitimate business need and their access is restricted to the information that is necessary to either:

- > Deliver care within their scope of practice to the individual whose PharmaNet record they access;
- > Directly support a pharmacist or prescriber to deliver care within their scope of practice to the individual whose PharmaNet record they access (e.g., by preparing the client's chart before a visit)

The FNHA has a [Clinical Practice Guideline for PharmaNet Access](#) available on the Gathering Space, which provides more information. For nurses in community requiring access to PharmaNet at their health centre, more information can be found at the [Government of British Columbia's Community Health Practice Access to Pharmanet](#) webpage.

## CARE PLANNING AND COLLABORATION

Care plans must be client-driven. It is important to begin by understanding the client's personal goals for OAT, clinical and cultural care, and respecting what health, healing and wellness means to them. A client's goals can change over time so it is essential to revisit the care plan frequently. As OUD is considered a chronic and relapsing condition, it is important to help clients understand that relapse may occur and that it does not mean failure; this should be embedded within the care plan. Additionally, ensure a harm reduction approach to care planning.

Questions to consider when developing a care plan with a client:

- > Questions rooted in dignity, such as: "What do I need to know about you and your culture to give you the best possible care?" (13)
- > What are your health and wellness goals?
- > What is most important to you at this time?
- > Who is in your support network?
- > Who would you like to involve in your care?
- > Are there cultural and spiritual practices that you would like to include in your care?
- > Are there any other areas of concern that you have right now? Prompts could include housing, financial, relationships, family.

It is important to understand that a person's journey towards wellness involves more than just access to OAT medications and requires a collaborative approach.



## ASSESSMENT TOOLS

Several assessment tools are available in the [POATSP course for Nurses](#). Section 4.3 outlines the DSM-5 criteria for Opioid Use Disorder. Section 5 of the course covers specialized assessments, including opioid related assessments such as the Clinical Opioid Withdrawal Scale (COWS) and Subjective Opioid Withdrawal Scale (SOWS).

COWS is an 11-item scale which measures signs and symptoms of opioid withdrawal and is often used to determine an individual's readiness to start buprenorphine/naloxone. SOWS is a self-administered tool used by a client to determine their degree of opioid withdrawal for potential inductions of buprenorphine/naloxone outside of a medical setting, such as in their own home.

## DOCUMENTATION/MEDICATION ADMINISTRATION RECORD

Documentation and the Medication Administration Record (MAR) are separate from the documentation requirements related to controlled substances. Documentation standards must follow the [BCCNM Documentation Practice Standards](#) as well as the health centre's organizational policies on documentation.

## LICENSED PRACTICAL NURSE (LPN) CONSIDERATIONS

LPNs can only dispense doses based on a client-specific order from a physician or NP, not an RN or RPN. There needs to be a clear escalation pathway for the LPN to follow when situations arise that might fall outside of their scope i.e., when a client is no longer stable or predictable or has missed doses.

### As per the [BCCNM Scope of Practice for LPNs](#):

- > LPNs working in settings where substance misuse or a mental health disorder is the primary diagnosis require an orientation that is consistent with LPN entry-level competencies
- > LPNs work in a team nursing approach to provide care for clients whose primary diagnosis is substance misuse or a mental health disorder after successfully completing additional education
- > LPNs care for [clients with stable or predictable states of health](#) (pg. 32)

### A team nursing approach is defined by the BCCNM as:

- > *When the nursing care needs of a client include activities that are outside LPN scope of practice or the individual competencies of the LPN, the LPN seeks out the registered nurse or registered psychiatric nurse to jointly review the client's care needs and determine how the care needs will be met between them. (pg. 42)*

### Additional education is outlined by the BCCNM as:

- > *Structured education (e.g. a workshop, course or program of study) designed so that LPNs can attain the competencies required to carry out a specific activity as part of LPN practice. Additional education builds on the entry level competencies of the LPN, identifies the competencies expected of the LPNs, includes both theory and application to practice and includes an objective, external evaluation of LPNs competencies. (pg. 39)*

Additional education may include courses such as the [ACTOC](#) or the [POATSP for Nurses](#) course. The Four Directions team also has nursing practice consultants for substance use, who can be reached through [4directions@fnha.ca](mailto:4directions@fnha.ca) for clinical questions and guidance. Note that the team nursing approach does not mean that RNs, LPNs, NPs or physicians are on site, but that LPNs have a pathway for who they can call and when to ensure they are fully supported in their practice.





# Care Resources

## **FNHA Regional Mental Health and Wellness Teams**

Each region has addiction specialists, harm reduction educators and nursing practice consultants who provide support and resources to First Nations communities. To reach out to the team in your region, please contact [4directions@fnha.ca](mailto:4directions@fnha.ca) and the team will forward your request to the appropriate person.

## **First Nations Virtual Substance Use and Psychiatry Service**

The First Nations Virtual Substance Use and Psychiatry Service (FNVSUPS) provides individuals with access to specialists in addiction medicine and psychiatry, as well as mental health and wellness care coordinators. This is a referral-based service and is available at no cost to all First Nations people and their family members living in BC, including family members who are not First Nations, Metis or Inuit. Visit the FNVSUPS [webpage](#) for more information.

## **First Nations Virtual Doctor of the Day**

The First Nations Virtual Doctor of the Day (FNVDOD) program enables First Nations people in BC with limited or no access to their own doctors to make virtual appointments. The intent of the program is to enable more First Nations people and their family members to access primary health care closer to home. This is a unique service for First Nations people in BC and their family members, even if those family members are not First Nations, Metis or Inuit. The program includes doctors of First Nations, Metis or Inuit ancestry; all doctors are trained to follow the principles and practices of cultural safety and humility. Visit the FNVDOD [webpage](#) for more information.

## FNHA Mental Health Benefits

Counselling is a tool for individuals experiencing a difficult situation to resolve their emotional distress and enjoy greater wellness. For more information, visit the FNHA Mental Health Benefits [webpage](#). A list of approved providers is located [here](#).

## 24/7 Addiction Medicine Clinician Support Line

The 24/7 Addiction Medicine Clinician Support Line provides telephone consultation to physicians, nurse practitioners, nurses, midwives and pharmacists who are involved in addiction and substance use care and treatment in BC. The support line connects health care providers to an addiction medicine specialist. Consultations can include support in screening, assessment, treatment and management of substance use and substance use disorders. For more information, visit the BCCSU 24/7 Addiction Medicine Clinical Support Line [webpage](#).

## Wellness and Cultural Supports

- > Tsow Tun Le Lum: Provides cultural support and outreach services. Call toll-free 1-888-403-3123 or visit [www.tsowtunlelum.org](http://www.tsowtunlelum.org)
- > KUU-US Crisis Line Society: A 24-hour provincial crisis line for First Nations, Metis and Inuit people. Call toll-free 1-800-588-8717. Adults and Elders call 250-723-4050; children and youth call 250-723-2040 or visit [www.kuu-uscrisisline.com](http://www.kuu-uscrisisline.com)
- > Indian Residential School Survivors Society (IRSSS): Call toll-free 1-800-721-0066 or visit [www.irsss.ca](http://www.irsss.ca)
- > First Nations and Inuit Hope for Wellness Help Line: Call toll-free 1-855-242-3310 or chat online at [www.hopeforwellness.ca](http://www.hopeforwellness.ca)
- > The Métis Crisis Line: Call toll-free 1-833-MétisBC or 1-833-638-4722; 24 hours a day

## Patient Quality Care and Safety

The FNHA has a [Quality Care and Safety Office](#) and can be reached by phone at 1-844-935-1044 (toll free) or by email at [quality@fnha.ca](mailto:quality@fnha.ca). This team can help clients navigate concerns they have when accessing health care.

# Appendix A: Additional Resources

## NOT JUST NALOXONE WORKSHOPS

NJN is a workshop hosted by the FNHA's Four Directions Team and is delivered in partnership with FNHA regional teams and community harm reduction champions. This workshop was developed in response to the toxic drug crisis in BC, which continues to disproportionately impact First Nations people. While naloxone is an effective life-saving medicine to reverse an overdose, it is not our only response.

### **The NJN workshops teach participants to facilitate community-based discussions about:**

- > Racism and prohibition in Canada
- > Decolonizing substance use
- > First Nations harm reduction practices
- > Trauma- and resiliency-informed practice
- > Anti-stigma work
- > Naloxone training (nasal/injection)

For further information, contact [njn@fnha.ca](mailto:njn@fnha.ca)

## TREATMENT CENTRES

In BC, there are several residential treatment centres, as well as an outpatient centre. All status and non-status First Nations clients, and Inuit and Metis clients, are eligible for treatment at these centres. The FNHA covers the cost for status First Nations clients. These treatment centres provide services to men, women, youth and families. Programming can vary depending on the centre, so it is important to choose one that will meet individual needs and goals. The FNHA has further information on the treatment centres [webpage](#), as well as a [map](#) of First Nations treatment centres in BC.

Sometimes there are reasons why one of the FNHA-funded treatment centres is not a good fit for a particular community member. Reasons may include length of wait time, concurrent mental health diagnoses, inability to complete the required period of abstinence prior to admission, current involvement with the criminal justice system or being a registered sex offender. If this is the case, other options for treatment can be pursued, including provincially-funded centres and centres funded through the Ministry of Social Development and Poverty Reduction. An FNHA subsidy (\$45/day for a total of 90 days) is available to eligible clients. For more information, visit the non-FNHA Funded Treatment Centre Application Process [FAQs](#) resource. Applications are located [here](#).

For support with navigating the treatment pathway, connect with a regional addictions specialist or contact the Four Directions Team at [4directions@fnha.ca](mailto:4directions@fnha.ca) and connect with your regional addictions specialist.

## LAND-BASED HEALING

There is a deeply entrenched belief within Western society that in-patient treatment is the only option for people with a substance use disorder. This belief overlooks the powerful healing that can take place when land-based treatment and healing options are available within First Nations communities. Land-based treatment and healing involves a return or reconnection to the land, with supports that facilitate the ability to relearn, revitalize and reclaim traditional wellness practices (14). There are many benefits to providing land-based healing options to people who are prescribed OAT. If this is something that the community would like to explore, you can connect with your FNHA regional Mental Health and Wellness Team to learn about funding options.

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