The Way Forward: Stewardship for Prescription Narcotics in Ontario

Report to the Minister of Health and Long-Term Care from the Expert Working Group on Narcotic Addiction

October 2012

Table of Contents

We lived in ERs. My son Pete had excruciating stomach pain. He was in such physical distress when he got to the hospital that he'd get prescribed more opioids. All of a sudden he'd be good for two weeks and then he was sick again. What Pete and I didn't know was that he was repeatedly going through the physical pain of withdrawal and getting increasingly sicker from going on and off of opioids. Not one doctor considered that he might be in withdrawal. Instead he got more opioids for the pain. The gastric flare-ups started out as a legitimate problem, but Pete also suffered from depression and anxiety attacks from a young age. He ended up taking huge amounts of opioids that were legally prescribed and then when he was trapped in the addiction, he began double doctoring and getting the drug on the street.

OxyContin became a way for him to self-medicate and relieve his mental and emotional pain. Being a mother who lives in recovery from addictions to many other types of drugs, I thought I would be aware of everything he could get into. But I completely missed the boat on opioid prescription drugs because I had no knowledge of its addictiveness and physical withdrawal. He was continually taking the drugs just to stay normal and when he tried to come off them, we'd end up back in the ER.

His mental health and addiction issues weren't recognized as being concurrent and linked to his physical problems. When he was recognized as having an addiction, all the doctors could see was the addiction and they couldn't get him out of the room fast enough. His mental health needs were never really addressed, but doctors were willing to prescribe him opioids too easily and in too many doses.

They didn't listen to me as his mother. This kid had depression, this kid had panic attacks and you give him a drug that he said made him feel like superman. I think if his mental health needs had been met at an earlier stage, he wouldn't have self-medicated.

I feel like the system completely disempowered me from being an effective resource to help guide my son's care. He suffered from a complex and elongated destructive illness of addiction to narcotic pain medication wrapped around mental health issues. I was his main support, but was never incorporated into his care plan. Even when I was speaking and trying to advocate for him, I never felt that anyone was listening.

Pete died two days before Christmas on December 23, 2001 from an accidental overdose – a mixture of OxyContin and psychiatric meds. He was 25 years old. Even in his death I had to deal with the stigma of people with the attitude that he brought it on himself. Addiction is an illness... Not a choice.

Betty-Lou Kristy became a committed and outspoken advocate for mental health and addiction issues following the death of her son.

1. Toward a new model of stewardship

This section presents an overview of prescription narcotic use and misuse in Ontario and the role of the Expert Working Group on Narcotic Addiction in developing a new model of treatment and oversight.

Ontario has the highest rate of prescription narcotic use in Canada. In fact, the province's rate is two to four times higher than in any other province. Prescription narcotics are increasingly recognized as one of the primary forms of illicit drug use – even over heroin and other street drugs.

This is in no small part due to issues within Ontario's health care system. Prescription narcotics are often over-prescribed – even in some cases where there is little or no evidence to show that they are helpful. Drugs like OxyContin have also been readily available for a low cost on the street. This increases the likelihood of both use and misuse.

The harm associated with these trends affects all Ontarians and has had a major impact on those in the North, in particular on First Nations communities.

For example, in Ontario:

- Between 1991 and 2009, prescriptions for oxycodone-containing products rose by 900 per cent.
- Since 2004, the number of oxycodone-related deaths has nearly doubled.
- From 2004-2008, admissions to publicly funded treatment and addiction services doubled for narcotics abuse.

Research further suggests that up to 70 per cent of first-time users access opioids from friends or relatives. Whether experimenting with opioids from a parent's medicine cabinet or accepting leftover medication from a friend to manage pain, the consequences are enormous. Treatment for prescription opioids is the fastest growing problem seen in addiction services in Ontario. Some First Nations communities estimate that 70 % - 80 % or more of their members are addicted. But addressing access to opioids by reducing the supply alone will not get at the fundamental reasons behind misuse and addiction; systemic problems have been building for some time and we need to tackle the roots of these issues.

A need for action

The recent move to delist OxyContin has provided a catalyst for change. In August 2011, the manufacturer of OxyContin, Purdue Pharma, informed the Ontario Ministry of Health and Long-Term Care that it would no longer distribute the drug in Canada. The company would replace it with OxyNEO, another long-acting oxycodone drug. This drug is formulated to be more tamper-resistant – a change that is expected to help reduce drug misuse.

On February 17, 2012, the ministry announced it would fund OxyNEO for eligible Ontario Public Drug Program recipients through the Exceptional Access Program and the Facilitated Access to Palliative Care Drugs mechanism. As of April 2, 2012, people who were previously approved for use of OxyContin will now receive OxyNEO for a one-year transition period. If OxyNEO is required beyond the one-year period, physicians can make a request through the Exceptional Access Program. Please see Appendix B for other provincial responses to the delisting of OxyContin.

The response from communities and service providers in Ontario has been swift. They stressed the possible negative repercussions of a sudden reduction in OxyContin availability. Of particular concern are the unintended impacts on communities where there are significant numbers of people misusing opioids. This includes a number of First Nations communities.

It was in this context that Ontario saw an opportunity to review its broader strategies to address the use and misuse of prescription narcotics. The Minister of Health and Long-Term Care convened an Expert Working Group on Narcotic Addiction in March 2012. The Working Group's mandate was to provide advice on three core challenges:

1. The short-, medium- and long-term unintended health, social and economic impacts of narcotic addiction and withdrawal, with immediate attention to the new policy for OxyContin.
2. How to reduce the negative consequences of the new policy.
3. How to strengthen the existing addiction treatment system in Ontario.

Please see Appendix A for a list of Expert Working Group Members.

Ontario has much strength to build upon to arrive at solutions. A range of services are already in place, from needle exchanges and other harm reduction interventions to improve safety for substance users, to medical and non-medical addiction treatment. Intervening early before problems arise is important. Intervening in a holistic fashion is critical both for those who are being prescribed opioids for pain and for those who are misusing opioids.

A framework for change

The solution to ensuring the appropriate use of opioids and responding to opioid misuse lies in developing a stewardship approach. This includes:

- promoting the evidence-informed use of prescription narcotics;
- providing effective alternatives to manage pain;
- supporting people who are misusing with harm reduction programs and treatment services.

It requires a paradigm shift so that each player in the system, including clients, professionals, community, and government, recognizes their impact on other parts of the system and is held accountable.

There is hope in moving forward. Ontario's Comprehensive Mental Health and Addiction Strategy (*Open Minds, Healthy Minds),* the Narcotics Strategy, The Excellent Care for All Strategy and the work of the Trilateral First Nations Health Senior Officials Committee have all contributed to a framework for addressing the challenges. Communities, people with lived experience, and health, social and justice systems are ready to contribute. Ontario has access to many dedicated professionals who will provide their best knowledge and experience to ensure that opioids are prescribed safely, that those who run into problems have access to the services they need, and that help is provided in a compassionate and non-judgemental way.

The Expert Working Group recognizes that drug use, misuse and addiction are complex issues which require multiple levels of intervention. Ontario's response will need to address a spectrum of needs from mild to serious addiction. Yet interventions must not have the unintended consequence of reducing access for those with appropriately prescribed opioids.

This report presents the results of the Expert Working Group's deliberations and information gathering. It pulls together key findings and advice to inform the ministry's short-, medium- and long-term plans and provide a new model of stewardship for prescription narcotics. The advice for the Minister reflects the following strategies:

- health promotion,
- education and other supports to build provider capacity,
- community development,
- access to high quality services and treatment,
- harm reduction.

In addition, the Expert Working Group's advice aims to ensure a strong foundation of system supports, such as research, as Ontario moves forward. These supports include evidence on best practices and monitoring of changes in the province's health system.

At the age of 21, I had a $300-a-day habit. I was taking 400 plus milligrams a day of OxyContin. It took a full-time job and a marijuana grow-op just to pay for my drugs. I'd been using since I was 16, but for months I had been injecting OxyContin *daily*. This did not even get me high, but did keep me from going into excruciatingly painful withdrawal. Eventually, I lost all my sources of income and came to the realization that death was the only answer. I came very close to jumping off my 12-storey balcony. A part of me must have wanted to live because I remembered an Addiction Research Foundation (now the Centre for Mental Health and Addiction – CAMH) pamphlet on opioids and treatment options that I had picked up at some point and had held on to. I called the 1-800 number. The person I spoke to explained some options to me, including how methadone could help. She linked me to a 3-way conference call with a local methadone clinic and I got an appointment the next day. Knowing that I had almost immediate access to a medically prescribed opiate for treatment is what stopped me from taking my life. Looking back, it was a crucial moment when I phoned CAMH. I had never asked for help before, but that day I made contact out of desperation. Knowing that I had an option that I believed could work for me gave me hope. Had I just been given a phone number, the outcome would have been very different.

When I told my mom about my addiction, she drove me to my first appointment and took the time to educate herself about treatment options. For people who don't have that level of ongoing support, their decision to enter into methadone treatment can be difficult. I had a supportive family who could listen and accept what I needed to help me recover. I often see situations where I think: "If only this person had a family to turn to, who could understand and support them." When you are physically and mentally sick, you often lack the wherewithal to even ask for help, let alone navigate the addictions system alone.

Once I started treatment, my life started changing for the better. I was able to stop my use of illicit opioids, and focus on my future.

When someone is trying to access treatment, the initial contact is really important. I counsel people now and when I tell them I'm on methadone and that I was addicted to OxyContin, they're relieved. They realize that they're not alone in their struggle and they are not going to be judged by me.

Sean Winger, 32, trained to be an addiction counsellor at McMaster University and supports others recovering from OxyContin addiction. He provides consultation and training to professionals working in the field of addictions. He continues his methadone treatment and is a strong advocate for harm reduction approaches to the treatment for addiction.

2. Guiding principles

The Expert Working Group identified seven guiding principles which must underpin all interventions and initiatives recommended in this report.

Respect

Individuals are treated with respect regardless of their experiences of drug use or addiction. People and communities with lived experience are actively involved in their own treatment as well as in the wider response to opioid use and misuse.

Equity and access

Ontario strives towards an equitable system that:

- Aims to reduce or mitigate the harmful impacts of drug misuse on individuals and communities;
- Provides both medical and non-medical interventions to treat addiction;
- Is accessible to anyone who needs it;
- Aspires to be free from stigma and discrimination.

Diversity

Individuals will be offered services that respect their culture and meet their needs at all ages and stages of life. Services and treatment are available to all Ontarians regardless of location of residence, cultural background, social or economic status, sexual orientation, age or gender.

Excellence and innovation

Ontario is committed to ensuring that services are based on excellence, innovation and the best evidence available. This includes a commitment to promoting the development of evidence as well as sharing knowledge across the health care system.

Strength-based

People who use or misuse opioids have many personal strengths to draw on. Their drug use does not define them. Communities affected by opioid misuse also have strengths that can support community responses to opioid misuse. Building on these strengths is critical to ensuring a broad-based approach to opioid use and misuse in Ontario.

A holistic view

Ontario is committed to addressing all the determinants of health and well-being in its response to opioid use and misuse. These include a wide range of factors beyond personal health and coping skills, such as:

- income,
- education and literacy,
- family and other support networks,
- employment/working conditions,
- physical environments.

Integration, partnership and collaboration

Ensuring a well-rounded response to opioid use and misuse requires the partnership and collaboration of many, including people with lived experience, families, communities, the health, social and justice systems as well as pharmaceutical companies.

I lost my father when I was 19 years old. I started trying Percocet with my friends. After a while I moved on to OxyContin. I started taking more and more – 20 milligrams, 40 milligrams, 80 milligrams.

I was selling my kids' stuff to get money to buy drugs. I'd buy the stuff I needed for the house and enough to feed my kids and then I'd go buy Oxys with the rest of my money. I often took back the stuff I had bought for my kids or for my house to buy more drugs.

After I had my last son I decided to stop. I went on methadone in 2007. I was alright in the beginning. But I still had cravings. I was still using. I went on and off methadone three times and then I heard about the Suboxone program. There wasn't any room, but I kept begging to be a part of it. I was crying that I didn't want to use anymore. I started on the Suboxone program in May 2011. When I was on methadone, I still had cravings. But taking Suboxone keeps me stable. I don't think about using. I don't have those thoughts anymore.

Now I have more communication with my family. I have a better understanding of my kids and I'm trying to meet their needs. Before I was basically ignoring them. Everyone in the Suboxone program is looking healthier. I have a counsellor who I can talk to. I went from using prescription drugs to methadone and now Suboxone and soon I'll be using nothing.

I'm making arrangements to go into a family treatment program where I can take my kids with me for three or four weeks. It's in a traditional setting. I feel like I have my life back.

Gillian Muckaday, 29, is the mother of three children 12, 5 and 4. She lives in Long Lake #58 First Nation where she has been participating in a holistic community-based opioid detox program, supported by the use of the drug Suboxone, counselling and traditional approaches to healing.

3. The current situation

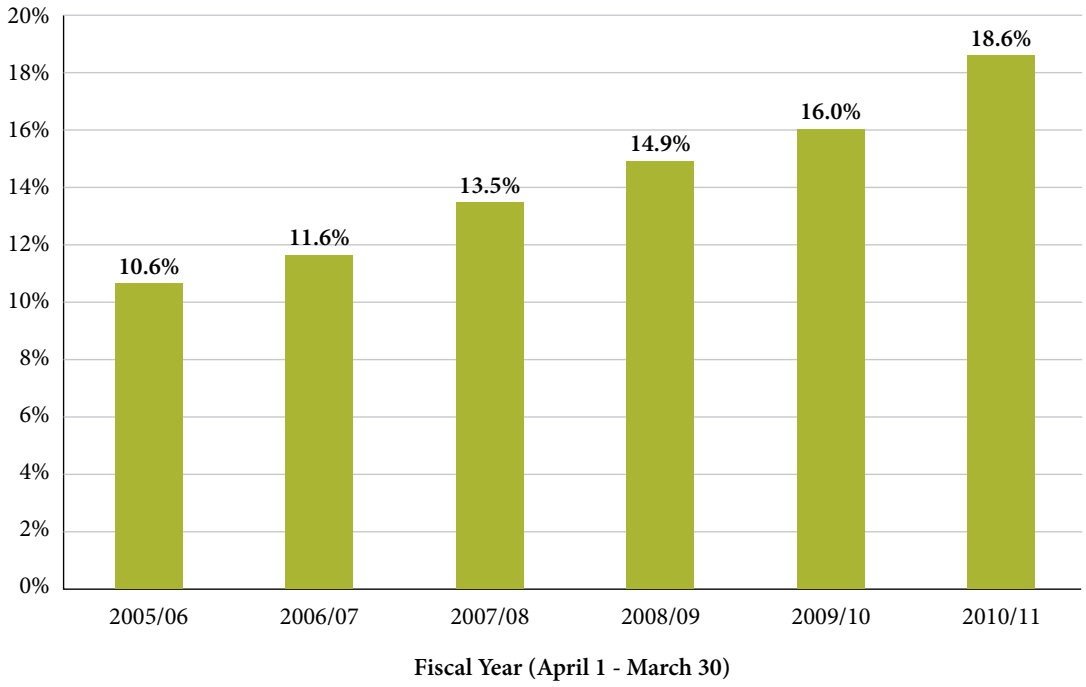
This section examines the extent and costs of prescription narcotics misuse in Ontario, the treatment services available and the policy, legal and regulatory frameworks in place at both the federal and provincial level.

Prescriptions of long-acting oxycodone medications, including OxyContin, have increased steadily over the past decade. So have opioid-related deaths. A review of data that looked at opioid prescriptions in Ontario and opioid-related deaths found that:

- between 1991 and 2007, prescriptions of oxycodone increased by 850 per cent.[1]
- after oxycodone was added to the Ontario drug formulary in 2000, associated deaths increased five times. Overall opioid-related deaths increased by more than 40 per cent.

Treatment for prescription opioids is the fastest growing presenting problem in addiction services in Ontario. In 2005/06, prescription opioids were identified by 10.6 per cent of individuals seeking addiction treatment. By the year 2010/11, the numbers had increased to 18.6 per cent.

Opioids as presenting problem in addiction treatment in Ontario



By comparison, admissions to addiction treatment for most other substances, including alcohol and tobacco, have remained relatively stable. Or, as in the case of cocaine and crack, they have declined.[2]

[1] Dhalla, A. et al. "Prescribing of opioid analgesics and related mortality before and after the introduction of long-acting oxycodone." *CMAJ*, December 8, 2009:181(12).

[2] Centre for Addiction and Mental Health (CAMH) Drug and Alcohol Treatment Information System, data collected up to February 29, 2012.

Provincial administrative data on hospital services in recent years also shows striking changes related to opioid use. This chart shows how the rate of emergency department visits for mental and behavioural disorders due to use of opioids rose between 2008/09 and 2010/11:[3]

Region	2008/2009 emergency visits	2010/2011 emergency visits
All of Ontario	2.6 for every 10,000 people	3.7 for every 10,000 people
Northern Ontario only	9.2 for every 10,000 people	22.9 for every 10,000 people
First Nations	12.1 for every 10,000 people	55 for every 10,000 people

From 2005/06 to 2010/11, there was an almost 250 per cent increase in the number of emergency room visits related to narcotics withdrawal, overdose, intoxication, psychosis, harmful use and other related diagnoses.

Since March 2012, as OxyContin began to be removed from the market in Ontario, most people on the Ontario Drug Benefit Plan have switched to the new formulation, OxyNEO.

As supplies of OxyContin dwindle, however, street prices for the drug are rising, particularly outside Toronto. Front-line programs, such as needle exchanges, informally report that users are:

- Experimenting more with breaking down OxyNEO;
- Switching to alternative narcotics (e.g., morphine, heroin and fentanyl) and other drugs (e.g., amphetamine and cocaine).

To date, increases in community mental health and addiction services' utilization have been relatively small as OxyContin is still available in most communities across Ontario. This said, programs do informally report that demand for addiction treatment seems to be on the rise. For example:

- More referrals are being made by providers to methadone programs;
- More individuals are now requesting advice on withdrawal management;
- Caseloads for community counselling and addiction services are beginning to grow.

Larger increases in service needs are expected as the supply continues to drop over the coming months.

Post-February 2012, admissions to emergency departments and hospital inpatient services have remained largely stable. Since March 2012, five deaths have been confirmed by the office of the Chief Coroner as specifically related to OxyContin.

[3] Ministry of Health and Long-Term Care. *Emergency Room Visits for Mental and Behavioural Disorders Due to Use of Psychoactive Substances, 2008/09 to 2011/12 (Q1 and Q2).*

Who is most affected by substance misuse?

In 1948, the World Health Organization (WHO) broadly defined health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."[4] The fundamental conditions that contribute to this well-being are called the social determinants of health[5] – the conditions in which people are born, grow, live, work and age.[6]

It is widely acknowledged that the social determinants of health play a strong role in an individual's likelihood of misusing drugs. A combination of any of them may play a role in increasing risk for drug misuse. At the same time, some social determinants are particularly correlated with a higher risk for drug misuse and abuse. According to Health Canada, these include:

- poverty,
- homelessness,
- lack of education,
- family dysfunction,
- parental substance misuse,
- mental health problems,
- history of childhood abuse.[7]

In Ontario, certain cultural communities are also more at risk. Aboriginal, First Nations, Inuit and Métis[8] populations are particularly affected by social and health determinants that correlate with higher vulnerability towards substance abuse and misuse in their communities – including prescription narcotics.[9] In their Prescription Drug Abuse Strategy – *Take a Stand*, the Chiefs of Ontario state that any strategy to combat prescription drug abuse must "incorporate the social determinants of health and underlying factors contributing to substance abuse."[10]

At the same time, the population of people who misuse or become addicted to opioids today has become much more diverse. In recent years, liberal prescribing practices and the high availability of OxyContin have meant that prescription opioids have become the substance of choice for a broader range of people who may have begun using opioids for pain. These users may have greater access to resources such as income, housing and social supports.[11]

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[4] World Health Organization, 1948.

[5] Commission on Social Determinants of Health, 2008.

[6] The Public Health Agency of Canada lists 12 social determinants of health: Income and Social Status; Social Support Networks; Education and Literacy; Employment/Working Conditions; Social Environments; Physical Environments; Personal Health Practices and Coping Skills; Healthy Child Development; Biology and Genetic Endowment; Health Services; Gender; and Culture. Public Health Agency of Canada, http://www.phac-aspc.gc.ca/ph-sp/determinants/index-eng.php#determinants

[7] Health Canada, *Reducing the Harm Associated with Injection Drug Use in Canada.*

[8] Ontario's Aboriginal people are comprised of three population groups, each with a different history and with distinct recognition in the Canadian Constitution. These groups are First Nations, Métis and Inuit peoples. 'Aboriginal' is an umbrella term that captures these three groups. Where the term "First Nation" is used in this document, it specifically refers to people living on or off reserve who are members of a First Nation.

[9] Chiefs of Ontario, *Prescription Drug Abuse Strategy*, 2011, p. 42.

[10] Ibid.

[11] Monga, Neerav, Rehm, Jurgen, Fischer, Benedikt, Brissette, Suzanne, Bruneau, Julie, El-Guebaly, Noel, Lina, Tyndall, Mark, Wild, Cameron, Leri, Francesco, Fallu, Jean-Sebastien, Bahi, Sara, "Using latent class analysis (LCA) to analyze patterns of drug use in a population of illegal opioid users." *Drug and Alcohol Dependence*, Volume 88, Issue 1, 17 April 2007, Pages 1-8.

The costs of untreated opioid dependence

A study by the Centre of Addiction and Mental Health in 1999 found that the health and social costs associated with opioid use in Ontario are disproportionately high. The analysis projected the costs of untreated opioid use, including a broader understanding of the economic burden of opioid dependence in terms of health care, law enforcement and social harms. For each person addicted to opioids followed in the study, researchers estimated that the average health and social costs were about $44,000 per person per year.[12] However, this figure may be low.

The study did not take into account the following costs:

- Social assistance, housing and other social support programs for opioid users and their families;
- Treatment for those who are opioid dependent and infected with HIV and/or hepatitis C;
- Health services to treat addiction-related injuries with older adults.

Another study currently in press calculated prevalence rates for opioid addiction in the province by age group.[13] The greatest prevalence is between the ages of 15 and 29, at more than one per cent of the population in this age group. Prevalance rates across all age groups is an average of 0.425 per cent. This number suggests that of Ontario's total population, more than 50,000 people, have an opioid addiction.[14] Even if only a small number of those remain untreated, at an approximate cost of $44,000 per person per year, the projected cost to Ontario would be hundreds of millions of dollars.[15]

The benefits of voluntary treatment programs

In contrast, the cost of treating a person for opioid dependence in a comprehensive methadone treatment program (i.e., a program that provides counselling and support services as well as medical care) is about $6,000 per year.[16] If we compare this figure to the estimated health and social cost of $44,000, this means that it is seven times more costly to leave opioid addiction untreated.

In addition to the economic benefits, voluntary treatment for opioid dependence can make a significant difference for both individuals and society. For example, when people who are opioid dependent receive treatment with methadone, they often report:

- less illicit drug use;
- better general health;
- better access to health care;
- greater psychological well-being;
- greater ability to acquire and maintain housing, vocational training or employment;
- less reliance on public assistance;
- better family relations;
- improved ability to parent and care for children;
- better social functioning.

Currently, 350 physicians prescribe methadone to over 37,000 people in Ontario.[17]

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[12] Wall et al. 1999.

[13] Public Health Ontario and Institute for Evaluative Sciences (in press). *Opening Eyes, Opening Minds. The burden of mental health and addictions in Ontario*. Toronto: Public Health Ontario.

[14] The Ontario population as of July 1, 2011 was 13,372,996. Extracted from the Ministry of Finance website: http://www.fin.gov.on.ca/en/economy/ecupdates/factsheet.html

[15] An estimate of 13,000 people untreated would mean $572 million in health and social costs per year to Ontario. Treating this same number of people with methadone would cost approximately $78 million.

[16] Verbal report from the Centre for Addiction and Mental Health and Breakaway Parkdale Satellite Clinic, 2003.

[17] Wade Hillier, College of Physicians and Surgeons, Personal Correspondence, May 3, 2012.

Clearly, Ontario can achieve financial benefits by investing in comprehensive or integrated treatments for opioid dependence such as methadone and Suboxone. For a relatively modest investment, Ontario estimates it could reduce the costs associated with opioid dependence by approximately 86 per cent. This is consistent with U.S. projections, which estimate that every $1 spent on methadone offers a cost-benefit from U.S. $4 to $13.[18]

Ontario's substance use and addiction services system

The ministry funds about 150 organizations to provide community addiction services through Local Health Integration Networks (LHINs). These services are primarily non-medical and include:

- withdrawal management,
- community counselling,
- residential treatment and support,
- housing supports.

The ministry also funds initiatives at the provincial level that support these services. These include professional and public education, as well as information, referral and monitoring systems.

People may access pharmacological treatments for opioid addiction such as Suboxone and methadone from doctors who have specialized training to administer them. Doctors usually work independently or in group practices and bill directly to the Ontario Health Insurance Plan for their services. Unless working from a community health centre or family health team, doctors are not usually affiliated with community-based mental health or addiction services.

The ministry currently provides support to several harm reduction programs in Ontario. These include the Ontario Harm Reduction Distribution Program, Needle Exchange Programs (run through the public health units), Injection Drug User Outreach Programs (associated with HIV/AIDS organizations across the province) and the Ottawa Safer Inhalation Program. All of these programs are evidence-based. They have been established to decrease sharing of drug-using equipment and improve the health of substance users in Ontario.

Both provincial and federal correctional facilities provide medically necessary health services to inmates. As well, most sites offer methadone maintenance therapy for those who initiated treatment prior to entering the correctional institution. Sentenced inmates may also access addiction treatment supports including psychologists and social workers.

Additional supports in place across the province include:

- The Aboriginal Healing and Wellness Strategy;
- Nurse practitioners in Aboriginal Health Access Centres who focus on mental health and addiction;
- New programs that support children's mental health through the Comprehensive Mental Health and Addictions Strategy. The strategy has a focus on child and youth mental health in the first three years.

[18] Stoller and Bigelow, 1999, 25, citing CALDATA study.

Ontario's evolving policy and regulatory frameworks

The recent discontinuation of OxyContin has put a spotlight on the extent of addiction to prescription narcotics in Ontario today. But the province has already been taking steps to address this complex challenge for some time. The following is a list of actions the ministry has taken to create the necessary legal and policy frameworks:

August 27, 2010

The Ministry of Health and Long-Term Care launched the Narcotic Strategy. The work of the Expert Working Group builds on the key elements of the Narcotics Strategy, including:

- New legislation to support the development of a narcotics monitoring system.
- Partnering with the health care sector to educate service providers on appropriate prescribing and dispensing.
- Public education to prevent excessive use of prescription narcotics, including opioids.
- Treatment for people who misuse them.

November 1, 2011

The Narcotics Safety and Awareness Act 2010 came into effect. The act:

- Enables the ministry to collect, use, and disclose information – including personal information and personal health information – that relates to the prescribing and dispensing of prescription narcotics and other monitored drugs in Ontario.
- Creates offences and establishes penalties for non-compliance with the act.
- Supports the development of a provincial monitoring system to track activities related to prescription narcotics and other controlled substances in Ontario.

April 16, 2012

The ministry launched the Narcotics Monitoring System. This System will track patterns of drug prescribing and use and help to identify trends. The Narcotics Monitoring System became fully operational on May 14, 2012.
In addition, Ontario is governed by two other long-standing pieces of legislation:

- The Drug and Pharmacies Regulation Act (DPRA). Governs the accreditation, ownership and operation of pharmacies. The DPRA and its regulations provide a legal framework under which the Ontario College of Pharmacists holds owners and operators of pharmacies accountable for safe and secure operation of their businesses.
- The Regulated Health Professions Act, 1991. Under the act, there are 21 health regulatory colleges governing 23 health professions in Ontario. These colleges have the authority to make regulations on a variety of subject matters, some of which include prescribing and dispensing of drugs, subject to the prior review of the Minister of Health and Long-Term Care and the approval of the Lieutenant Governor in Council.

By understanding how prescription narcotics are being prescribed and dispensed in Ontario, and to whom, the ministry can help make the prescribing, dispensing and use of monitored drugs safer and more secure.

The federal regulatory context for prescription narcotic use

In Canada, the regulatory context for prescription narcotics is made up of both federal and provincial legislation. Federally, the following two acts prevail:

- The Food and Drugs Act governs the sale and distribution of drugs in Canada. This legislation focuses on protecting the public from unsafe drugs and addresses false, misleading or deceptive labeling of drugs.
- The Controlled Drugs and Substances Act and related regulations (Narcotic Control Regulations, Part G of the Food and Drugs Regulations, and the Benzodiazepines and Other Targeted Substances Regulations) governs the production, distribution, importing, exporting, sale and use of narcotics, controlled and targeted drugs for medical and scientific purposes in Canada. These classes of drugs have their own legislation because they are at risk of diversion. The legislation defines who is authorized to possess these drugs/substances and governs the specific activities of pharmacists, other practitioners and hospitals related to their use.

Note: methadone is classified as a narcotic under the federal Controlled Drugs and Substances Act. To prescribe methadone in Ontario, doctors require an exemption through Health Canada on the recommendation of the College of Physicians and Surgeons of Ontario, as well as special training and completion of an internship with an experienced methadone physician. The College of Physicians and Surgeons of Ontario assesses doctors who have attained an exemption through a quality assurance program. Although training is recommended for other types of addiction treatment, such as Suboxone, it is not required. Prescribing is not monitored in the same way because there is less potential for its diversion.

Federal/provincial jurisdictional responsibilities in First Nations health and addiction services

The delivery of health care services to First Nations people living in Ontario is complex both legally and historically. While Ontario recognizes the primary role of the federal government on-reserve, the province has a constitutional responsibility for providing health care to all citizens in Ontario.

This chart sums up the types of services available to Aboriginal and First Nations people in Ontario:

Jurisdiction	Services provided
Provincial (on-reserve and off)	• Full range of Ontario health services (including mental health and addiction services) • Provincially-funded, Aboriginal-specific health programs and services such as Aboriginal Health Access Centres
Federal (on-reserve)	• Primary and emergency care in remote or isolated First Nations, primarily delivered through nursing stations or community health centres • Health promotion and public health services • Mental health and addiction services through the National Native Alcohol and Drug Abuse Program (including nine addiction treatment centres in Ontario) • Crisis intervention counselling through the Non-Insured Health Benefits Program

I had an accident when I was 18 and I suffered whiplash and back injuries. Then 10 years ago I had a secondary accident. I've been in pain for the last 20 years, but for most of those years my doctor gave me anti-inflammatory medication and muscle relaxants and that's how I coped. I still don't know why he started me on Percocet for four months and then switched me to OxyContin for about two years. Then one day he said to me, "Well you don't need them anymore." In March 2006, he stopped me cold turkey. I had no idea what I was in for. I had no clue about withdrawal symptoms. He never mentioned them. I just felt like it was the worst flu I ever had. I was vomiting and had diarrhea. I work in construction. One day I sat in my truck and just cried because I didn't have the energy to drive to an appointment.

Physicians need better information on prescribing certain drugs and to better help patients with proper tapering off if the patient no longer needs the medication. I still harbour a lot of resentment towards my GP. He has his life and mine was turned upside down after a five-minute appointment. The emotional and financial cost to my family and myself continues to this day.

I had a good life. We had a cottage and a house and three cars and then it all fell apart. I went through six months of hell. I started getting OxyContin pills from a guy I worked with. He started going to a methadone clinic and told me about it. I went for the first three months without even telling my wife. She eventually helped me through the process.

I keep my head down when I'm going into the clinic. I'd wear a balaclava if I could. It's the stigma. It's the way people look at you. I feel like I'm being treated like a common criminal. I feel it's like jail. I have to do urine samples. You have to go in so frequently and the clinic opens at 8:30 a.m. It's difficult for people who work. Why can't they open at 7 a.m.? Instead your work wonders why you have to leave and at the beginning it's every day. I think I should be able to go to my GP and get a month's supply of methadone. I don't understand how my doctor was able to prescribe me a powerful drug like OxyContin, but I can't get methadone from my GP.

I was first on methadone for about a year and a half, and then I decided I would see if I could do without it. I was fed up with going to the clinic. I was off for about four months and I tried to deal with my pain. I didn't want to go back to the methadone clinic, but I had no choice.

The College of Physicians and Surgeons of Ontario must have both doctors and lay people involved in the decision-making process. The PAG (Patient Advisory Group) I am a part of is a start, however, there is far too much time between guideline changes to the methadone clinics. There should be a way to enact changes to the rules on an ongoing basis instead of every five years.

I still wonder about whether I should have ever been prescribed OxyContin. Tests should be done – a psychological test to see where you're at mentally. There should be an interviewing process at the beginning so that a person like me – I think I have an addictive personality – should never have been given this drug.

Patrick's name has been changed to protect his identity. He lives in southern Ontario and is busy working again. He says methadone saved his life, but he regrets having been prescribed OxyContin without ever having been told the risk and consequences of taking the drug long term.

4. Preparing for change: Strategic directions

The Expert Working Group has identified eight strategic directions that form the foundation for their advice to the Minister of Health and Long-Term Care, while fostering a stewardship approach that will promote appropriate opioid use and address misuse and addiction.

A focus on harm reduction

Harm reduction is an evidence-based, pragmatic approach to addressing drug use. It does not require people to stop using drugs. Instead, the goal is to reduce or mitigate the harmful impacts of drug use and misuse. Harm reduction programs do this by engaging substance users with information and tools to help them stay safe and healthy. For example, programs may provide clean needles or pamphlets on how to prevent overdose. Individuals will receive help regardless of where they are in their journey to reduce and/or finally overcome the health, economic and social harms associated with misuse of prescription narcotics.

While abstinence and helping people who want to stop using drugs are appropriate long-term goals for some, harm reduction strategies put the emphasis on the most immediate, achievable and positive changes, whether or not they can be shown to reduce drug consumption.[19] This approach affirms the fact that opioids have an appropriate place in pain management and the intention should not be to eliminate prescribing entirely. Rather, the goal is to encourage care for the person in a way that minimizes risks – including the risk of developing an opioid dependence or addiction, or unintentionally doing harm to others.

A holistic approach to treatment planning and ongoing care

A holistic approach to health care and treatment planning does not focus only on the individual's medical or physical needs. It recognizes that a person's long-term spiritual, mental and emotional needs are also critical to his or her health and well-being. Issues of mental health, addiction and pain are often seen as inextricably intertwined.[20] This understanding is integrated right into program planning and delivery.

For example, services to address substance dependence and addiction are provided in settings with access to a wide range of expertise. Supports may include counselling, medical staff, peer support, alternative and complementary therapies, traditional healers and even referrals to housing, employment and legal services.

Community development and engagement are also important aspects of all addiction treatment, including Aboriginal and First Nations-centred approaches to care. Many First Nations and Aboriginal communities use the medicine wheel to identify the areas in need of attention in the physical, intellectual, emotional and spiritual realms.

[19] Adapted from the Hepatitis C Task Force, 2009.

[20] Amari, E. et al. "Nonmedical Prescription Opioid Use and Mental Health and Pain Comorbidities: A Narrative Review." *The Canadian Journal of Psychiatry*, Vol. 56, No. 8, August 2011.

A wide range of choices in services

Plans for addressing problematic substance use and treatment are not one-size-fits-all. People seeking services must be at the centre of decision-making about their own needs and care. The province's aspiration should be a system of health and social services that provides a comprehensive range of choices, including:

- harm reduction,
- withdrawal management,
- opioid and non-opioid pharmacotherapies,
- counselling,
- case management,
- culturally appropriate services such as working with elders or traditional healers.

These services should foster client rights with informed decision-making processes. At the same time, service providers must respect client decisions by recognizing that a singular approach for all people is not appropriate.

A trauma-informed approach to care

A trauma-informed approach acknowledges that harmful experiences such as violence, war, abuse or neglect can have a profound impact on an individual and, in some cases, an entire community. Adverse childhood experiences, family or personal history of substance use, preadolescent sexual abuse and psychological disease are all identified risk factors for opioid misuse. Many families touched by addiction are affected by trauma. They unintentionally pass the repercussions of harmful experiences from one generation to the next. A trauma-informed perspective acknowledges behaviours such as problematic substance use as possible responses or coping mechanisms related to past or current traumatic experiences. It then integrates this knowledge into planning care and delivering services.

Many Aboriginal communities have experienced the effects of unresolved trauma that is passed from one generation to the next.[21] This trauma is often a consequence of the residential school system, which was imposed on First Nations, Inuit and Métis people in Canada for more than a century. An intergenerational trauma lens must be applied to any approach to care that affects Aboriginal communities. Addressing intergenerational trauma has become a part of the addiction treatment plan in some Aboriginal-specific addiction services such as Health Canada's Suboxone pilot program at Long Lake #58 First Nation.[22]

An approach to care that respects grief and loss

Substance use and addiction services must acknowledge that grieving is normal when loss occurs. It is a part of healing. There is a tendency in Canadian culture to medicate people who are grieving, yet other types of supports are often necessary to support those dealing with grief and loss in healthy ways.

Grief and loss should also be regarded as risk factors for, and often an aspect of, mental health and addiction issues. People who are making changes to their patterns of substance use may also be dealing with grief and loss as a result of changes in their lifestyle, such as loss of friendships and community. These considerations should be integrated into planning for any programs and services related to substance misuse.

[21] Aboriginal Healing Foundation, 1999:A5. http://www.ahf.ca/downloads/historic-trauma.pdf
[22] Judy Desmoulin, Health Coordinator, Long Lake #58 First Nation. Personal Correspondence, 2012.

A commitment to evidence-based interventions, monitoring and evaluation

Interventions to address pain management and opioid misuse, dependence and addiction must be evidence-based, accessible, timely, effective and safe. Evidence may include:

- academic research,
- clinical trials,
- grey literature,
- program evaluations,
- community knowledge,
- practice wisdom.

This approach requires resources for ongoing research to inform new evidence-based practice. It also demands a clear commitment to ongoing monitoring and evaluation of both the desired and unintended impacts of actions and interventions, allowing flexibility to alter their design in response to new evidence.

A focus on optimal use of opioids

Opioids should be recognized as a valuable tool to manage pain. They can be used appropriately and judiciously to manage some, but not all, types of pain. Suitability must be considered on a case by case basis, based on:

- practice guidelines for health professionals,
- the individual's medical history,
- the availability and appropriateness of alternative options for managing pain, including non-narcotic treatments and therapies.

A reduction of inappropriate demand for narcotic analgesics

Inappropriate demand for narcotics is reduced as:

- Service providers address the many aspects of health and the root causes of opioid misuse and addiction at a system-wide level;
- People are educated on the risks of opioid misuse and become aware of the possible alternatives for pain management.

There are 166 adults in Long Lake #58 First Nation and 85 per cent of them are struggling with opioid addiction. Since the early 1990s, OxyContin prescription drug abuse has spread havoc in our community. People weren't able to hold down jobs because they needed their fix to keep focused on the tasks at hand. A lot of children were being taken away from families because their parents were neglecting them. Within the organization to which we belong, Dilico Child and Family Services, we have the highest number of children in care. We have most of our babies being born addicted and they are being placed in neonatal care units anywhere from 14 to 40 days. The crime rate in the community went up. Theft and vandalism spread. People were breaking in and stealing anything of any value for resale or trade for drugs. People were prostituting themselves, both men and women, to get money to buy the drug, when they couldn't get it prescribed or when they no longer could afford it within their means.

Eight years ago a methadone clinic opened in town. Everyone thought it was going to be a saviour. But it wasn't. It was the prescribing of another medication and we as a community had no input into the care of our people who enrolled in this program. The methadone program wasn't getting to the root of the problem to help those who were struggling with this powerful addiction. People needed help to overcome what they needed to overcome. Last April, we started a program using the drug Suboxone. The drug is a small part of the recovery program. It is like a stepping-stone. Everyone in the program has an exit plan to phase out taking Suboxone. We want to make sure that people get the support they needed to deal with their personal issues. We support them with goal setting. We offer counselling to deal with post-traumatic stress disorders and intergenerational effects. We provide addiction counselling. There is a strong spiritual piece to the program. By the third month on the program people started to take better care of themselves and their health issues. The shortage of health services soon became apparent when people wanted the medical care that was necessary for them. My vision was that we needed to quit chasing after symptoms, such as opioid addiction, and get to the root of what was ailing the individual and ailing the community.

Judy Desmoulin, Health and Social Director of the Long Lake #58 band council, spearheaded a holistic OxyContin detox program in the First Nations Community in April 2011. Twenty people are currently in the program taking Suboxone. There is a waiting list of 60 people because of financial limitations to cover the cost of the drug treatment and counselling support.

5. The way forward: Key issues and advice

This section describes the key issues surfaced by the Expert Working Group and provides specific advice for short-, medium- and long-term actions.

General issues and concerns

The need for accurate information on opioids, overdose, withdrawal and treatment

Several groups – including doctors, harm reduction program workers and drug users – have informally reported two main concerns:

- Confusion about the change from OxyContin to OxyNEO;
- The need for accurate information and education about the signs and symptoms of opioid overdose and withdrawal, appropriate prescribing and continued client management. This applies to doctors and other health care providers, including pharmacists, dentists and emergency department staff, as well as first responders and front-line workers such as ambulance workers, police, shelter workers and staff in correctional facilities.

Accurate information is also vital for all people who use prescription medications, whether for medical or illicit purposes. They need to understand both the benefits and risks of opioids to reduce the possibility of developing dependence, overdosing or experiencing other harms related to their opioid use.

Advice:

A1. Develop, disseminate and consolidate into a single web-based resource, educational materials for diverse audiences to increase knowledge of the signs and symptoms of opioid withdrawal and overdose. Work with the health professional colleges, the LHINs, public health units and pain management clinics to develop these materials. Target audiences should include:

- emergency rooms,
- physicians,
- addiction agencies,
- mental health providers,
- first responders,
- public health,
- correctional facilities,
- emergency services,
- schools and school boards,
- First Nations and Aboriginal communities and service providers,
- peer workers,
- people who use drugs,
- patients and the general public.

A2. Partner with the LHINs, health care providers (including pain management clinics) and people with lived experience to raise local awareness through community discussions and forums about both the benefits and risks of prescription opioids.

A3. Actively promote accurate information and consistent messaging in earned media of the provincial and federal governments, health care providers, their associations and colleges.

The need for real-time information and monitoring systems

There is a need for accurate, real-time monitoring information on how changes to the formulary, opioids and other narcotics in Ontario will affect the community and health care system. This information should be collected from diverse front-line sources to supplement existing administrative data on health service use and opioid-related deaths that are reported to the coroner's office. Robust information will:

- Enable timely responses to community needs, and
- Help to ensure evidence-based policy and program decision-making.

There is also a need for more data and monitoring to gain a clear picture of the impacts of changes to the formulary.

Advice:

A4. Undertake real-time monitoring on the impact of opioids across the province in all provincially funded hospitals, emergency departments, needle exchange sites, harm reduction programs and urgent care clinics. Share this information as broadly as possible to allow the field to respond to issues and needs as they arise.

A5. Work with the Ontario Provincial Police, local police forces, including on-reserve police and the justice system, to increase monitoring of the impact of opioids on community safety.

The need for information on services and referral services

People need ready access to information on the services available to them for opioid misuse or addiction. Although Ontario has a telephone and web-based referral system, ConnexOntario, it is not currently well known to the mainstream public. ConnexOntario could also be enhanced to better service people with lived experience and family members by providing information on peer-based support groups.

Advice:

A6. Partner with ConnexOntario to develop a public education and social marketing campaign on how to access information on and referrals to addiction treatment services.

A7. Work with public health units and ConnexOntario to provide web-based access to information on harm reduction programs and services available in communities across Ontario.

A8. Work with public health units and ConnexOntario to ensure that access is available to immediate telephone/Internet peer support with trained, knowledgeable people who have direct experience with addictions.

Health and service provider knowledge, education and practices

It is important that physicians, pharmacists, nurses and other health professionals operate within their scope of practice when it comes to both prescribing opioids and treating addictions. While there are many positive uses for opioids in treating pain, health care providers:

- May not always be familiar with evidence-based guidelines for prescribing.
- May not understand the risks of patients developing opioid dependence, especially when used for long-term pain treatment.[23]
- May administer opioids inappropriately for some types of pain. For example, they may prescribe too much medication at one time. There may not be enough oversight of the patient while they are taking the medication.

In dentistry, opioids are often the standard medication provided for recovery from dental surgery. But dentists will not often have knowledge of a patient's history of opioid use or addiction.

In addition, addiction treatment therapies such as methadone and Suboxone require special skills and training. These treatments, if prescribed improperly, carry significant risks – including death due to medication overdose.

Yet the need for practice knowledge and training must be balanced with the risk of over-regulating and inadvertently discouraging health care providers from working with people with addictions and pain – especially since this can be a high-needs client population. In contrast, in areas where resources are stretched, it is imperative that community-based service providers such as counsellors or elders must not be asked to provide services, such as dispensing medication, that are beyond their expertise or qualifications.

The *Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain*[24] was completed in 2010. It contains 24 evidence-based recommendations for health care providers to assist them in using opioids safely and effectively for chronic non-cancer pain. Many of these recommendations have not yet been fully integrated into practice among health care providers in Ontario – including Recommendation #10 on the watchful dose of opioids.

This guideline states that while many clients receive doses of over 200 mg/day Morphine Equivalent Dose (MED), most will respond to less than that amount. The guideline goes further to recommend that doses of higher than 200mg/day MED should be monitored very closely due to the risk of misuse and the potential adverse negative physical and psychosocial effects.[25]

Advice:

A9. Encourage the appropriate regulatory colleges, health care providers and partners to promote the best practices and recommendations as laid out in the *Canadian Guideline for Safe and Effective Use of Opioids for Non-Cancer Pain* – including Recommendation #10 on the watchful dose.

[23] The College of Physicians and Surgeons of Ontario, *Avoiding Abuse, Achieving a Balance: Tackling the Opioid Public Health Crisis*. 2010.
[24] http://nationalpaincentre.mcmaster.ca/opioid/
[25] Washington State is a leader in the area of opioid dosing. It was the first state to introduce guidelines that emphasize the importance of dosing in April 2007. The Guideline emphasized a dosing "yellow flag" at 120 mg/day Morphine Equivalent Dose for incident or new patients with chronic pain. If such a patient's dose escalates to 120 mg/day MED, and pain and function have not substantially improved, then physicians are encouraged to ask for help (e.g., consultation with a pain specialist), hold the dose, or taper. Due to the success of the pilot program in reducing opioid related usage and deaths, Washington recently introduced legislation to enforce the watchful dose of 120mg/day MED.

A10. Work with the health professional colleges to share best practices, provide mentoring and share problem-solving strategies to ensure that health care providers are treating addictions and pain within their scope of practice.

A11. Work with the Ontario Hospital Association to ensure that addiction is considered as a possible underlying health condition when people access health care in hospital settings.

Holistic and interdisciplinary approaches to care

Treatment for opioid addiction is a long-term rather than a short-term commitment. Supports should not end for someone with a serious addiction because they have stabilized. Addiction is a chronic illness and without community supports there is a high risk of relapse.

Evidence on addiction to opioids such as heroin shows that withdrawal management and therapies such as Suboxone and methadone should be provided along with ancillary services, including counselling and community supports.[26] Yet best practices for these models of care require further research and exploration specifically in the context of prescription opioids.

Providing access to ancillary services, including counselling, is considered best practice for methadone maintenance treatment and is associated with decreased drug use among people with addictions to opiates.[27] The Methadone Maintenance Treatment Practice Standards and Guidelines produced by the College of Physicians and Surgeons of Ontario state that the ideal is to provide both:

- doctors and pharmacists who are versed in treating narcotic addiction;
- ancillary services in a collaborative, interdisciplinary setting which includes access to nurses, social workers, case managers, psychologists, counsellors and peer support workers.[28]

Access to these other services improves the likelihood of retaining someone in treatment. This, in turn, improves the likelihood of successful mental health, health and social outcomes.

Community development and engagement are important aspects of all addiction treatment. They are critical to determine the types of supports that are needed in each local context. When services are intended for marginalized communities, including Aboriginal people and people with addictions, it is vital to involve those communities in the decision-making. Practice knowledge demonstrates that treatment outcomes are better when a person has access to supports that:

- engage them in their community;
- help to address all the factors that affect their health.

Community supports are crucial as they help address the emotional issues surrounding addiction as well as the medical needs. These supports can help prevent a relapse when a person decides to stop using substances.

Advice:

A12. Develop an evidence-based model specific to treatment of prescription narcotic addiction. This applies both to pharmaceutical treatment (e.g., methadone and Suboxone) and non-pharmaceutical interventions (e.g., counselling, physiotherapy, chiropractic and ancillary services).

[26] College of Physicians and Surgeons of Ontario, *Methadone Maintenance Treatment Practice Standards and Guidelines.* 2011.
[27] McLellan et al, 1993; Kraft et al, 1997; Kletter, 2003; and Rawson et al, 2002.
[28] College of Physicians and Surgeons of Ontario, *Methadone Maintenance Treatment Practice Standards and Guidelines.* 2011.

A13. Continue to work with the ministries of Community and Social Services, Education, Children and Youth Services, Municipal Affairs and Housing and Finance as well as the federal government to address all the factors that affect people's health and are often at the root of vulnerability to addiction.

A14. Encourage communication, partnership and integration between community-based addiction services and doctors to improve treatment and system co-ordination.

A15. Ensure addiction training is provided to mental health counsellors, including peer counsellors, to better integrate service delivery between mental health and addictions.

A16. Support and encourage research and evaluation to create an evidence base that addresses:

- the system impacts of prescription opioids;
- alternatives to opioids in pain management;
- support for peer-based interventions;
- interventions for families with addictions.

A17. Integrate culturally appropriate practices to address opioid misuse and addiction in diverse populations and communities.

Access to addiction services and treatment

Evidence demonstrates that access to a range of addiction treatment services provides significant benefits for both individuals and the society as a whole. Services include:

- medical and non-medical withdrawal management;
- community and residential treatment;
- opioid pharmacotherapies, such as methadone and Suboxone.[29]

As the supply of OxyContin dwindles, it is anticipated that there will soon be an increase in demand for addiction treatment, counselling and withdrawal management services. Concerns about access to treatment are twofold:

- Large numbers of people may go into involuntary withdrawal without supports due to a lack of capacity in the existing service system and inaccessibility of services in some remote communities.
- Barriers such as municipal bylaws are preventing the establishment of treatment resources such as pharmacies that dispense methadone and community Methadone Maintenance Treatment clinics.

Advice:

A18. Continue to work with Health Canada, the LHINs and municipalities to co-ordinate federal, provincial and local initiatives to address narcotic addiction.

A19. Work with municipalities to eliminate barriers that prevent access to addiction services. Examples include municipal bylaws that prevent the establishment of methadone clinics or the dispensing of methadone by pharmacies.

A20. Ensure that all across the province and in First Nations communities, people have access to a full range of services. These services include detox, treatment (including youth residential addiction treatment) and harm reduction programs.

[29] Wood, E. et al. "Improving Community Health and Safety in Canada Through Evidence-Based Policies on Illegal Drugs." *Open Medicine* 2012;6(1) e35.

A21. Increase access to comprehensive methadone and Suboxone treatment services, consistent with practice knowledge and guidelines.

A22. Continue to work with Health Canada to evaluate mobile treatment teams in First Nations communities. Assess whether this program model can be adapted for use in rural and suburban communities that lack access to treatment services.

A23. Increase access to counselling and case management to increase access to community-based services and reduce wait lists for residential addiction treatment.

A24. Integrate addiction treatment services into family health teams and other primary care practices.

Risks of unintended consequences

Possible repercussions of the reduced availability of OxyContin include substitution with and increased use of other, often riskier drugs. Misuse of OxyNEO can be dangerous due to the formulation which causes the powdered drug to turn into a gel when mixed with water. This creates a risk of choking if ingested improperly or clotting if injected. Other substitutes include prescription and non-prescription narcotics such as:

- heroin,
- emerging drugs such as "Krokodil" (an extremely harmful modified form of codeine),
- prescription drugs such as hydrocodone products, fentanyl and morphine.

Risks associated with use of these drugs include the possibility of overdose as quantities are harder to gauge, especially when extracting opioids from medication such as fentanyl patches. Risks associated with injection drug use include the spread of blood-borne infections such as HIV and hepatitis C, as well as secondary complications such as injection site infections.

Advice:

A25. Increase and sustain the availability of Naloxone overdose prevention kits and harm reduction information and materials via public health units across the province.

A26. Work with public health units to ensure that Ontario residents and professionals are educated on what harm reduction is, how it is used and where to access harm reduction programs in the community.

A27. Provide policy and resource support for peer-based interventions. These provide an entry point to harm reduction tools and interventions for highly marginalized populations of drug users that are not able to get support through traditional types of services.

A28. Require that each LHIN have in place a local strategy on opioid misuse. The strategies should include information sharing across diverse service providers and reflect partnership with local public health units.

Addressing stigma and discrimination

Stigma is a key concern as it affects everything from drug use to accessing services, including addiction treatment. People who have experienced addiction often encounter stigma and discrimination associated with their drug use in many places – in health care, in the community, within the family and at the workplace.

Stigma and discrimination may prevent people from accessing or maintaining necessities such as housing, relationships, employment and health care.[30] It may even prevent people from admitting that they have a substance misuse problem, especially if they began taking opioids for pain management reasons. Many individuals state that the stigma associated with their health issue is more difficult to bear than the illness itself.

Advice:

A29. Partner with people who have experienced addiction and their family members to address stigma and discrimination through the use of public service announcements.

Population-based issues and concerns

Northern, rural and remote communities

There is evidence that northern, rural and remote communities experience prescription drug misuse at higher rates than their urban counterparts.[31,32] To add to the problem, these communities often do not have access to as wide a range of health care services or providers. In the case of remote First Nations communities in northern Ontario, health stations are usually solely staffed by nurses. These nurses may not have adequate resources or expertise to deal with the demand for addiction or pain treatment. There is a need for further planning and community development in northern communities.

Advice:

A30. Work with federal and municipal governments to strengthen the co-ordination of federal, provincial and local addiction treatment and harm reduction activities in the context of community crises (for example, community evacuations).

A31. Increase access to clinical consultations in remote, northern and rural communities through use of telemedicine and the Ontario Telemedicine Network. Partner with Health Canada to increase access to addiction services on First Nations reserves via telemedicine.

A32. Work with Health Canada to increase access to health care providers in northern and remote communities. This includes improved access to doctors, addiction workers, counsellors, trauma workers and administrative supports.

A33. Work with the College of Nurses of Ontario and Health Canada to extend the scope of practice for nurses, particularly those working in remote and isolated communities.

[30] Committee for Accessible AIDS Treatment, 2008; Canadian HIV/AIDS Legal Network, 2005; Canale, 2001.

[31] Ministry of Health and Long-Term Care. *Emergency Room Visits for Mental and Behavioural Disorders Due to Use of Psychoactive Substances, 2008/09 to 2011/12 (Q1 and Q2).*

[32] Local Health Integration Network Surveys on Changes to Service Use related to OxyContin, February – April 2012.

Aboriginal, First Nations, Inuit and Métis communities

Eligible First Nations and Inuit people account for 56 per cent of all Percocet and 49 per cent of all OxyContin claims made to the federal drug benefits program from the Ontario region.[33] Chiefs in some First Nations communities have raised urgent concerns about the issue of prescription drug abuse. They claim that it has reached epidemic proportions and has prompted a crisis.[34]

For example, the Nishnawbe Aski Nation (NAN) represents 49 First Nations communities covering two-thirds of Ontario. It declared a state of emergency in November 2011 due to OxyContin abuse. In February 2012, NAN Chief Stan Beardy publicly predicted mass withdrawal in communities where rates of OxyContin addiction are particularly high.[35] Also in February 2012, the 13 Independent First Nations in Ontario declared a state of emergency. They requested urgent assistance to address prescription drug withdrawal.[36]

Great concern for these issues has prompted calls for action to provincial and federal governments in partnership with First Nations. In November 2010, the Chiefs of Ontario (COO) released *Take a Stand*, a strategy paper that provides a plan to address prescription drug abuse in Ontario First Nations communities.[37] The report identifies four key areas which inform the strategy:

- health promotion,
- healthy relationships,
- reducing the supply,
- continuum of care.

The strategy also identifies an action plan for working with the federal and provincial governments to address prescription drug use within First Nations communities.

In alignment with *Take a Stand*, the Trilateral First Nations Health Senior Officials Committee has identified mental health and addictions as a first priority with a focus on prescription drug abuse. The Committee is comprised of representatives from COO and the Ontario and federal governments. See Appendix B for more information on the Trilateral Committee.

Many First Nations have expressed a strong preference for access to Suboxone as an opioid pharmacotherapy over methadone. Suboxone is easier than methadone to store and dispense in remote communities. Holistic treatment programs have been piloted that incorporate counselling and support, as well as Suboxone. These programs focus on community development, developing life skills, cultural knowledge and resiliency. They are showing promising outcomes in communities such as Dennis Franklin Cromarty High School in Thunder Bay[38] and Long Lake #58 First Nation.[39]

[33] Health Canada, *First Nations and Inuit Health Branch Oxycodone DUE & Methadone Hotspots.* 2010.
[34] Centre for Addiction and Mental Health, *Prescription Opioid Related Issues in Northern Ontario.* Northern Ontario Area, Provincial Services, 2010.
[35] *Crisis Looming for First Nations due to OxyContin.* CTV News, retrieved April 2, 2012 from: http://www.ctv.ca/CTVNews/Health/20120216/oxycontin-addiction-first-nations-120216/
[36] Independent First Nations, *Resolution to Declare a State of Emergency to Deal with Prescription Drug Withdrawal Issues,* February 2012.
[37] Chiefs of Ontario. *Take A Stand: Final Report – Prescription Drug Abuse Strategy.* November, 2010.
[38] Bruce Minore is currently completing an evaluation of the Dennis Franklin Cromarty High School Suboxone program, a pilot project primarily funded by Health Canada with support from the Province of Ontario.
[39] Judy Desmoulin, Health Co-ordinator, Long Lake #58 First Nation. Personal Correspondence, 2012.

Traditional culture, community development and engagement are important aspects of Aboriginal and First Nations-centred approaches to care. For example, many Aboriginal communities use the medicine wheel to identify the areas in need of attention in the physical, intellectual, emotional and spiritual realms. They then address the underlying individual and social factors that can contribute to mental health issues and addiction.

Use of health services by First Nations people who live in reserve communities should be addressed as people move and access services on and off reserve. There has been a heightened media focus in recent months on issues in northern and remote reserves. Yet the needs of southern and central First Nations communities must also be acknowledged and addressed.

Advice:

A34. Align activities with the addiction priorities and initiatives of the Trilateral First Nations Health Senior Officials Committee.

A35. Partner with Aboriginal and First Nations leadership in individual communities to ensure that the provincial response to opioid misuse and addiction has the right priorities and is culturally appropriate.

A36. Encourage and work with Health Canada and local leadership to:

- implement mobile treatment units;
- fast track access to Suboxone;
- train community members on withdrawal to respond to immediate needs in some remote First Nations communities.

A37. Partner with Health Canada to increase access to a broad range of harm reduction services aimed at reducing the risks and negative effects associated with drug misuse on First Nations reserves.

A38. Identify and share early successes of First Nations-centred care models and promote holistic care models for addressing opioid misuse. Examples include the Suboxone pilot programs at Long Lake #58 First Nation and Dennis Franklin Cromarty High School in Thunder Bay.

A39. Integrate cultural practices into approaches to treatment and healing in First Nations and Aboriginal communities.

Pregnant women and Neonatal Abstinence Syndrome (NAS)

It is vital to manage sudden narcotic withdrawal in pregnant women. Sudden withdrawal can put the health of both the woman and the fetus at risk. Pregnant women addicted to opioids tend to deliver earlier and faster. They also need postnatal care that is close to home.

While Methadone Maintenance Treatment is approved for use during pregnancy, it is not always available or a preferred method of treatment. Suboxone (a combination of Naloxone and buprenorphine) is unsafe for use by pregnant women. Buprenorphine alone can be used, but requires further clinical testing. For communities with urgent needs, where methadone is not feasible it is critical to streamline access to buprenorphine. The drug must be approved through the federal government's special access program and approval often takes several weeks.

Neonatal abstinence syndrome (NAS) is a set of withdrawal symptoms experienced by 55 % - 95 % of infants exposed to opioids in utero.[40] NAS in Ontario increased from 171 reported cases in 2003 to 654 cases in 2010. This number is higher than the national average, but may not tell the whole story. Doctors do not always consistently identify NAS cases, so actual NAS incidence in Ontario may be significantly higher.[41]

Advice:

A40. Increase access to treatment and care for pregnant women addicted to opioids.

A41. Work with Health Canada to prioritize the management of sudden opioid withdrawal in pregnant women. Access to buprenorphine should be streamlined for this purpose.

Families

Addiction can have a profound impact on the relationship between parent and child and can affect a parent's ability to provide adequate care. Neglect or abuse associated with substance abuse and addiction is one of the main reasons child welfare agencies intervene in Ontario families. Children who are raised with a parent who has an addiction are more likely to develop a substance abuse issue themselves. As well, the residual impacts of past trauma that contribute to drug abuse are often passed from one generation to the next.

However, it is important to balance child safety with the need to strengthen family resilience. It is also vital to lessen trauma, which can sometimes be worsened when a child is removed from the home and separated from their family.

Ontario provides several programs across the province that focus on pregnant and parenting women who have addictions. These programs support them with their unique parenting challenges and needs, including early childhood development. Further policy and services are required to help mitigate the damage to families who are affected by addiction and support them in their healing.

Advice:

A42. Ensure that children and families are integrated into addiction treatment approaches and viewed as part of the solution.

A43. Partner with the Ministry of Children and Youth Services to develop and implement policies and guidelines that will support strong relationships between child protection agencies and local addiction and harm reduction programs. This partnership is vital to address substance misuse and its impact on parenting.

Youth

According to the 2009 Ontario Student Drug Use and Health Survey, 18 per cent of students surveyed between grades 7 and 12 have used a prescription opioid in the past 12 months without a doctor's prescription. Of those, three quarters reported getting the drug from home.[42] A study on mental health and addiction found that opioid addiction is highest among the youngest age groups in Ontario, particularly between the ages of 15-29.[43]

[40] Lall, A. "Neonatal abstinence syndrome." *British Journal of Midwifery*, 16(4), 2008: 220-223.
[41] Provincial Council for Maternal and Child Health.
[42] Centre for Addiction and Mental Health, *Prescription Opioid Related Issues in Northern Ontario.* Northern Ontario Area, Provincial Services, 2010.
[43] Public Health Ontario and Institute for Evaluative Sciences (in press). *Opening Eyes, Opening Minds. The burden of mental health and addictions in Ontario*. Toronto: Public Health Ontario.

While many youth experiment with alcohol and other drugs as part of growing up, a small percentage of this population may develop a substance dependence or addiction. Opioids such as OxyContin carry increased risks because they are so potent and more addictive. It is critical that any comprehensive plan to address opioid misuse take up this issue.

Advice:

A44. Work with the ministries of Children and Youth Services and Education to create a youth-targeted campaign on narcotics education and awareness. Engage schools, school boards, school trustees, parent councils and provincial public health units to enhance uptake of educational materials.

A45. Partner with the ministries of Children and Youth Services, Community Safety and Correctional Services and the Attorney General to address substance use and addiction in the criminal justice system – for both for youth and adults.

People with chronic pain and histories of prescription opioid care

It is imperative to examine the role of opioids in pain management. Yet it should also be acknowledged that narcotic addiction is not solely an over-prescribing problem. Pain clinics are currently not well resourced to deal with the demand for their services. Addressing inappropriate use, including the misuse, diversion and abuse of prescription opioids, is an important goal, but it must be balanced with the need to provide access to medications for legitimate medical purposes. Restricting prescribing practices to reduce the supply of opioids may compromise the availability and quality of effective care, particularly for severe and chronic pain.[44]

Opioids are legitimate tools for helping to manage some types of pain and allow normal life functioning. Many people require narcotics, including oxycodone, to manage short-term/acute or long-term/chronic pain. Health care providers should not be discouraged from use of these drugs when they are medically appropriate. At the same time, their usage comes with some risk. Ongoing supervision by qualified health care providers is essential to:

- monitor factors such as underlying mental health issues that may increase the risk of developing an addiction;
- intervene when appropriate.

Another aspect of the problem is the lack of alternative treatment options for pain management. At present, opioids are viewed as one of the only choices, since prescription medications are covered by health insurance. Alternative health services that have an evidence base for treatment of pain such as physiotherapy and chiropractic care are not available in many communities, or are often not covered by health plans.

Advice:

A46. Encourage the College of Physicians and Surgeons to promote the use of non-opioid medication for pain management when clinically appropriate, in accordance with the *Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain.*

A47. Work with the Ministry of Training, Colleges and Universities, professional colleges and academic institutions to improve the development of core competencies in chronic pain management, opioid addiction and interprofessional models of care.

[44] Brennan F, Carr DB, Cousins M. "Pain Management: A Fundamental Human Right." *Anesth Analg* 2007; 105: 205–221.

"As long as you take it as prescribed, you'll be okay." That's what my doctor told me. I was told nothing about the side effects. He just described it as a painkiller. He never told me anything about becoming addicted and addiction runs in my family.

I had a major car accident in 1995 or 1996. Previously I had been an athlete and not involved in taking any kind of drugs. I was in the hospital for six weeks and in a rehabilitation centre for another six weeks. A pain specialist started me on Percocet. Within eight months my use of them had escalated. I would ask for something stronger. I became physically and psychologically addicted. You start feeling great. I was being given so much medication – 240 Percocets per month and then two other drugs were added. I was prescribed Dilaudid and towards the end hydromorphone. I was prescribed all three at the same time.

My back started going out and I would end up going by ambulance to the hospital and wait for my medication. One time my back went out and a friend of mine, who was a nurse, said I didn't have to wait. She melted a hydromorphone and injected me. I never had them injected before and I felt super high. I started regularly injecting. That's when things started to get really bad.

I went to my sister's wedding in B.C. and she found a needle and the drugs in my backpack. My parents were devastated. My sister called my doctor and had me cut off. What she didn't realize then was that it put me in more danger. It forced me on the street to supply my habit. You do things you never thought you would do. I was a slave to the drug. Nothing has controlled me, but that controlled me.

Everything you have in the world you would sell if you're on opiates or narcotics and you have to buy them. It's not like you choose. It's a need. If I didn't go through this myself, I wouldn't believe it.

I tried to come off. Imagine the worst flu you've ever had and times it by ten. You shake. You sweat. You can't eat. You can't sleep. The pain doesn't let up for weeks. I wouldn't wish it on anyone.

I went on methadone for the first time about six years ago and I was clean for about a year and a half. Then I started back on opiates. I've been on and off methadone a few times. When I'm taking methadone I don't have the sickness. But I still have that craving.

I've looked at seeing a counsellor. My parents and family are wonderful. If I knew what that last step was to take to control this, then I would take it. I'm still looking to take that last step.

Emily, 48, lives in Ottawa where she has been back on methadone since the fall of 2011. She became addicted to opiates after a serious car accident at the age of 32, which left her in chronic pain and forced her onto disability benefits. She has a 27-year-old daughter.

6. Conclusion

The Expert Working Group has worked diligently to provide the Minister with the advice she has sought to address prescription narcotic use, misuse and addiction in Ontario. In seeking solutions, the group has focused on everything from the most immediate interventions to those that will take Ontario to a new place where:

- opioids and narcotics are prescribed appropriately;
- narcotic and addiction treatment and supports are accessible, available, equitable and holistic;
- high quality treatment takes account of the latest and best evidence, addressing trauma, grief and loss, and other mental health issues;
- clients and communities have an opportunity to choose services or participate in ones that make the most sense for them;
- the system to treat prescription drug use, misuse and addiction is a unified whole, each part supporting the others.

A comprehensive approach will meet the needs of those currently needing treatment and support, as well as help prevent addiction and misuse in future generations, leading to a better quality of life for all.

Although more research is required to fully understand all the factors involved in narcotics addiction and treatment and pain management, it is clear that the key components of the approach outlined in this paper are vital to help individuals reduce the impact of narcotic misuse and addiction on their lives.

Informed by recommendations of the Expert Working Group on Narcotic Addiction, three important next steps for Ontario include:

1. Implement and provide improved access to a wider range of treatment and support services;
2. Develop outcome/success measures and an evaluation and monitoring system;
3. Improve the current data collection system.

Ensuring that all people who experience narcotic addiction and their family members have access to appropriate treatment/intervention is no small undertaking. But the way forward is clear. It will require collaboration amongst government, service providers, consumers, family members and the broader community.

"Three per cent of people prescribed pain opioids will develop a full-blown addiction if a prior risk assessment is not done. If GPs did a risk assessment before they prescribed an opioid for long-term chronic pain, it would reduce the number of people who become addicted. Before a physician prescribes a long-term opioid, they should take a drug and alcohol history. This will be the new standard of care. One also has to consider whether there is a psychiatric illness, like depression, or a psychological trauma. For example, someone with a preadolescent history of sexual abuse has a higher risk of opioid misuse. If a person is wired for fear and anxiety, opioids are great for taking away fear. Imagine being a traumatized person with no social supports. That person could be at higher risk to develop an addiction or misuse problem than someone with good emotional regulation and robust social supports. Doing a risk assessment helps GPs identify people who are at higher risk if they are prescribed opioids. Not to forget that opioid addiction can still occur in someone who is apparently low risk.

The Canadian Opioid Guideline for prescribing opioids came out on May 3, 2010 and there were hopes for wide dissemination. But the guidelines aren't being widely used. It is difficult for GPs to internalize them and apply them to practice. It takes time and effort to learn a new way of doing things. There are the issues of prejudice, ignorance and apathy. If every single doctor prescribing opioids did it according to the opioids guidelines, the magnitude of the problem would be much less.

[…..]

Methadone is a life-saving treatment. However, methadone by itself is like CPR. If you don't do the rest of the comprehensive care, it can be like doing CPR for the rest of someone's life. The first phase is that methadone saves the patient's life from out-of-control opioid addiction. The second phase is that the person fundamentally rebuilds their life. You have to address the social determinants of health. There has to be counselling to help a person learn new tools to negotiate life's problems without drugs and acquire new skills. This is true recovery from addiction. However, let's be clear that even recovered, some people will need to stay on methadone for the rest of their lives. If a person has been addicted to opioids for a long time, the brain can "forget" how to make its own opioids. We have our own natural internal pain relieving opioid system. When you're addicted to a narcotic you suppress your own internal opioid system. Your brain is handicapped. If someone has diabetes and needs insulin, we don't say now your blood sugar is in the normal range so we're going to withdraw your treatment. Why then is the expectation that if someone requires methadone treatment, once they are not using opioids any more we will withdraw the treatment? There is the attitude that if you're on methadone, you're still an addict, which is not true. But you can be dependent on the treatment like someone with diabetes is dependent on insulin.

Dr. Lisa Bromley, is an Ottawa based physician, one of the few in the city who offer methadone treatment to her patients. About 75 per cent of her practice is focused on methadone maintenance treatment.

7. Appendices

Appendix A: Members of the Expert Working Group on Narcotic Addiction

Mr. Kevin Berube Director of Treatment, Nodin Child and Family Intervention Services	Ms. Rolanda Manitowabi Executive Director, Ngwaagan Gamig Recovery Centre
Dr. Lisa Bromley Physician, Sandy Hill Community Health Centre, Ottawa	Dr. David Marsh Associate Dean, Community Engagement Senior Associate Dean, East Campus Northern Ontario School of Medicine
Dr. Claudette Chase Medical Director, Sioux Lookout First Nations Health Authority	Dr. Peter Menzies Clinic Head, Aboriginal Services, Centre for Addiction and Mental Health
Ms. Judy Desmoulin Health/Social Director, Long Lake #58 First Nation	Ms. Gillian Muckaday Community Member, Long Lake #58 First Nation
Mr. Glenn Robin Finlayson Community Member, Long Lake #58 First Nation	Ms. Anne Resnick Director, Professional Practice Programs. Ontario College of Pharmacists
Dr. Benedikt Fischer PhD Professor, Faculty of Health Sciences, Simon Fraser University & Senior Scientist, CAMH	Dr. Peter Selby Clinical Director, Addictions Program Centre for Addiction and Mental Health
Mr. Wade Hillier Associate Director, Practice Assessment & Enhancement Department, College of Physicians and Surgeons of Ontario	Mr. Ron Shore Director, Clinical Services, Kingston Community Health Centres
Ms. Betty-Lou Kristy Community member, family member	Mr. Sean Winger Community member, Opioid Dependence Consultant, Dip AC
Mr. Dennis Long Executive Director, Breakaway Addiction Services	Dr. David Williams Medical Officer of Health, Thunder Bay District Health Unit

Appendix B: Jurisdictional scan on responses to the delisting of OxyContin in Canada, March 2012

British Columbia

B.C. has communicated the change from OxyContin to OxyNEO to its health partners, addiction treating physicians and health authorities. These, in turn, are sharing information with emergency departments, pharmacies and other health care providers. Preparation for the change included review of acute withdrawal services and ensuring that pharmacological therapies used in addiction treatment, including clonodine, Suboxone and methadone, are accessible through B.C. PharmaCare benefits.

Alberta

Alberta did not change listing criteria for the OxyContin and OxyNEO products and made the two products pharmaceutical equivalents. This allows pharmacists to substitute OxyNEO for OxyContin scripts. The province is managing the change as an issue that falls within the broader context of prescription drug diversion rather than taking specific steps to communicate about or monitor the conversion.

Saskatchewan

Saskatchewan's approach to limiting access to prescription oxycodone is in line with that of other provinces and territories. Starting February 29, 2012, the Saskatchewan Drug Plan listed OxyNEO for coverage under the Exception Drug Status program. Cancer or palliative care patients receive coverage for OxyNEO under this program, but new patients who fall outside these categories will be responsible for the cost of OxyNEO prescriptions. Patients who received coverage of OxyContin in the three months prior to March 1, 2012, are eligible for coverage of OxyNEO, but the two drugs are not considered interchangeable. Saskatchewan Drug Plan beneficiaries will require new prescriptions if their physicians consider OxyNEO appropriate.

New Brunswick, Newfoundland & Labrador

Following advice of the Atlantic Expert Advisory Committee, New Brunswick, Newfoundland and Labrador issued statements that the provinces will no longer list OxyContin or OxyNEO for coverage under their provincial drug plans. In addition, the provinces are following advice to undertake a review of the use of oxycodone in treating pain within one year. People who had been previously approved for use of OxyContin will receive OxyNEO while the review is occurring to ensure they are not forced into sudden withdrawal. During the review period, coverage for new patients will only be considered in exceptional circumstances when other treatment options have failed, and will primarily be restricted to cancer patients.

Prince Edward Island

PEI Pharmacare has announced the discontinuation of OxyContin. Prior to February 29, 2012, OxyContin was available through the PEI Pharmacare Special Authorization Request process. To avoid interruption of care to clients, PEI advised all pharmacies on January 9, 2012 that effective Tuesday, January 10, 2012 new Special Authorization Requests for OxyContin would no longer be considered. In addition, the province contacted physicians that are involved with pain management to ensure they were aware of the discontinuation.

Health Canada

As of February 15, Health Canada delisted OxyContin from the Non-Insured Health Benefits (NIHB) program for First Nations people and replaced it with OxyNEO.

Canada's National Anti-Drug Strategy is comprised of three pillars:

1. prevention,
2. treatment,
3. enforcement.

Health Canada provides services and support to First Nations and Inuit people and communities who have, or are affected by, substance use or abuse problems through the National Native Alcohol and Drug Abuse Program (NNADAP). Health Canada consulted with a broad range of stakeholders in First Nations and Inuit communities to develop a framework for a continuum of services to address addictions in those communities. The framework consists of six elements of care:

1. community development, universal prevention and health promotion,
2. early identification, brief intervention and aftercare,
3. secondary risk reduction,
4. active treatment,
5. specialized treatment, and
6. care facilitation, which is integrated throughout the framework.

A key organization that is linked to implementation of this framework in Ontario is the Trilateral First Nations Health Senior Officials Committee. The Committee has identified prescription drug abuse as the top priority for Ontario, as described below.

Trilateral First Nations Health Senior Officials Committee (TFNHSOC)

In 2011, the Trilateral First Nations Health Senior Officials Committee was established by Ontario's Ministry of Health and Long-Term Care. It brings together representatives from Chiefs of Ontario, a co-ordinating body for 133 First Nations in Ontario, and from the Ontario and federal governments. The goal: to strengthen provincial, federal, and First Nations relations and improve health outcomes for First Nations people living on-reserve.

The Trilateral Committee identified mental health and addictions (with a focus on prescription drug abuse) as the priority area to be addressed first, and collaboratively developed a Work Plan that identifies immediate, short- and medium-term activities in the areas of service provision, training and education, and integration of provincial and federal services to address prescription drug abuse and improve mental health and addiction services for First Nations.

Appendix C: The Way Forward – Summary of advice to the Minister

A. Health promotion, education and provider capacity

Immediate and short-term (within three months)	Medium-term (within six months)	Long-term (six months and beyond)
A1. Develop a single web-based resource to provide educational materials to diverse audiences on the signs and symptoms of opioid withdrawal and overdose. Engage the health professional colleges, the LHINs, public health units, pain management clinics, physicians, nurses and pharmacists, addiction counsellors and peer harm reduction workers. **A2.** Partner with the LHINs, health care providers (including pain management clinics) and people with lived experience to raise local awareness through community discussions and forums about the benefits and risks of prescription opioids. **A3.** Actively promote accurate information and consistent messaging in earned media of the provincial and federal governments as well as health care providers, their associations and colleges. **A6.** Partner with ConnexOntario to develop a public education and social marketing campaign on how to access information on and referrals to addiction treatment services. **A9.** Encourage the appropriate health professional colleges, health care providers and other partners to encourage and promote best practices and recommendations as laid out in the Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain, including recommendation #10 on the watchful dose.	**A7.** Work with public health units and ConnexOntario to provide web-based access to information on harm reduction programs and services available in communities across Ontario. **A10.** Work with the health professional colleges to disseminate best practices, provide mentoring and share problem-solving strategies to ensure that health care providers are treating addictions and pain within their scope of practice. **A29.** Partner with people who have experienced addiction and their family members to address stigma and discrimination through the use of public service announcements.	**A44.** Work with the ministries of Children and Youth Services and Education to create a youth-targeted campaign on narcotics education and awareness. Engage schools, school boards, school trustees, parent councils and provincial public health units to enhance uptake of educational materials. **A46.** Encourage the College of Physicians to promote the use of non-opioid medication for pain management when clinically appropriate, in accordance with the Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain. **A47.** Work with the Ministry of Training, Colleges and Universities, professional colleges and academic institutions to develop core competencies in chronic pain management, opioid addiction, and interprofessional models of care.

B. Community development

Immediate and short-term (within three months)	Medium-term (within six months)	Long-term (six months and beyond)
A17. Integrate culturally appropriate practices to address opioid misuse and addiction in diverse populations and communities. **A18.** Continue to work with Health Canada, the LHINs and municipalities to co-ordinate federal, provincial and local initiatives to address narcotic addiction. **A34.** Align activities with the addiction priorities and initiatives of the Trilateral First Nations Health Senior Officials Committee. **A35.** Partner with Aboriginal and First Nations leadership in individual communities to ensure that a provincial response to opioid misuse and addiction has the right priorities and is culturally appropriate.	**A13.** Continue to work with the ministries of Community and Social Services, Education, Children and Youth Services, Municipal Affairs and Housing and Finance as well as the federal government to address all of the factors that affect people's health, that are often at the root of vulnerability to addiction. **A19.** Work with municipalities to eliminate barriers that prevent access to addiction services. Examples include municipal bylaws that prevent the establishment of methadone clinics or the dispensing of methadone by pharmacies. **A30.** Work with federal and municipal governments to strengthen the co-ordination of federal, provincial and local addiction treatment and harm reduction activities in the context of community crises (for example, community evacuations).	**A39.** Integrate cultural practices into approaches to treatment and healing in First Nations and Aboriginal communities.

C. Services and treatment

Immediate and short-term (within three months)	Medium-term (within six months)	Long-term (six months and beyond)
A31. Increase access to clinical consultations in remote, northern and rural communities through use of telemedicine and the Ontario Telemedicine Network. Partner with Health Canada to increase access to addiction services on First Nations reserves via telemedicine. **A36.** Work with Health Canada and local leadership to implement mobile treatment units, fast track access to Suboxone and educate community members on the withdrawal process to respond to immediate needs in some remote First Nations communities. **A40.** Increase access to treatment and care for pregnant women addicted to opioids. **A41.** Work with Health Canada to prioritize the management of sudden opioid withdrawal in pregnant women. Access to buprenorphine should be streamlined for this purpose.	**A15.** Ensure addiction training is provided to mental health counsellors, including peer counsellors, to better integrate service delivery between mental health and addictions. **A20.** Ensure that all across the province and in First Nations communities, people have access to a full range of services. These services include detox, treatment (including youth residential addiction treatment) and harm reduction programs. **A21.** Increase access to comprehensive methadone and Suboxone treatment services, consistent with practice knowledge and guidelines.	**A11.** Work with the Ontario Hospital Association to ensure that addiction is considered as a possible underlying health condition when people access health care in hospital settings. **A12.** Develop an evidence-based model specific to treatment of prescription narcotic addiction. This applies both to pharmaceutical (e.g., methadone and Suboxone) and non-pharmaceutical interventions (e.g., counselling, physiotherapy, chiropractic and ancillary services). **A22.** Continue to work with Health Canada to evaluate mobile treatment teams in First Nations communities. Assess whether this model can be adapted for use in rural and suburban communities that lack access to treatment services. **A23.** Increase access to counselling and case management to increase access to community-based services and reduce wait lists for residential addiction treatment. **A24.** Integrate addiction treatment services into family health teams and other primary care practices. **A32.** Work with Health Canada to increase access to health care providers in northern and remote communities. This includes improved access to doctors, addiction workers, counsellors, trauma workers and administrative supports. **A33.** Work with the College of Nurses of Ontario and Health Canada to extend the scope of practice for nurses, particularly in remote and isolated areas. **A42.** Ensure that children and families are integrated into addiction treatment plans and viewed as part of the solution.

D. Harm reduction

Immediate and short-term (within three months)	Medium-term (within six months)	Long-term (six months and beyond)
A8. Work with public health units and ConnexOntario to ensure that access to immediate telephone/Internet peer support is available with trained, knowledgeable people who have direct experience with addictions. **A25.** Increase and sustain the availability of Naloxone overdose prevention kits and harm reduction information and materials via public health units across the Province. **A37.** Partner with Health Canada to increase access to a broad range of harm reduction services aimed at reducing the risks and negative effects associated with drug misuse on First Nations reserves.	**A26.** Work with the public health units to ensure that Ontario residents and professionals are educated on what harm reduction is, how it is used and where to access harm reduction programs in the community. **A27.** Provide policy and resource support for peer-based interventions. These provide an entry point to harm reduction tools and interventions for highly marginalized drug users that are not able to get support through traditional types of services. **A38.** Identify and share early successes of First Nations-centred care models and promote holistic care models for addressing opioid misuse. Examples include the Suboxone pilot programs at Long Lake #58 First Nation and Dennis Franklin Cromarty High School in Thunder Bay.	

E. System supports

Immediate and short-term (within three months)	Medium-term (within six months)	Long-term (six months and beyond)
A5. Work with the Ontario Provincial Police, local police forces, including on-reserve police and the justice system, to increase monitoring of the impact of opioids on community safety.	**A4.** Undertake real-time monitoring on the impact of opioids across the province in all provincially funded hospitals, emergency departments, needle exchange sites, harm reduction programs and urgent care clinics. Share this information as broadly as possible to allow the field to respond to issues and needs as they arise. **A16.** Support and encourage research and evaluation to create an evidence base that addresses: the system impacts of prescription opioids, alternatives to opioids in pain management, support for peer-based interventions and interventions for families with addictions.	**A14.** Encourage communication, partnership and integration between community-based addiction services and doctors to improve treatment and system co-ordination. **A28.** Require that each LHIN have in place a local strategy on opioid misuse. These strategies should include information sharing across diverse service providers and reflect partnership with local public health units. **A43.** Partner with the Ministry of Children and Youth Services to develop and implement policies and guidelines that will support strong relationships between child protection agencies and local addiction and harm reduction programs. This partnership is vital to address substance misuse and its impact on parenting. **A45.** Partner with the ministries of Children and Youth Services, Community Safety and Correctional Services and the Attorney General to address substance use and addiction in the criminal justice system – for both youth and adults.

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