The inquest examined the circumstances of the deaths of Dustin King and Donna Bertrand and the issue of prescription opioid diversion and abuse.
Background

- The Opioid Abuse Public Health Crisis
- Concurrent Processes
- The OCC Perspective
- Identified Issues

Prescription Drug Abuse in Ontario

- Prescription opioids are the predominant form of illicit opioid use
- Main sources of opioids are doctor’s prescriptions (37%), the street (21%), or a combination (26%), non-prescription purchases (5%), and family and friends

Prescription Drug Abuse in Ontario

Changing Patterns in Opioid Addiction, Sproule et al, Canadian Family Physician, Jan. 2009

- Described inpatients at the CAMH in Toronto
- Observed increased treatment for oxycodone addiction after controlled release formulations became available in 1995
- Total number of admissions for opioid addiction grew from 78 in 2001 to 166 in 2004
- Oxycodone addiction went from 3.8% of admissions in 2000 to 55.4% in 2004

Opioid-Related Deaths in Ontario

- 3,271 deaths between 1991 and 2004
- Opioid-related mortality in Ontario doubled from 13.7 per million in 1991 to 27.2 million in 2004
- 66.4% were seen in an outpatient setting in the 4 weeks before their deaths by a physician

Dhalla et al, Opioid analgesic prescribing and mortality before and after the introduction of long-acting oxycodone in Ontario, CMAJ Dec 2009
# Opioid-Related Deaths in Ontario

<table>
<thead>
<tr>
<th>Year</th>
<th>Oxycodone</th>
<th>Morphine</th>
<th>Hydrocodone</th>
<th>Fentanyl</th>
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<td>70</td>
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<td>10</td>
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<td>2009</td>
<td>143</td>
<td>72</td>
<td>32</td>
<td>57</td>
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<tr>
<td>Total</td>
<td>786</td>
<td>643</td>
<td>199</td>
<td>273</td>
<td>133</td>
<td>2034</td>
</tr>
</tbody>
</table>

*Does not include Methadone, Codeine, Meperidine*
Opioid-Related Deaths in Ontario

- Is it really a problem?
- 350 opioid deaths in 2008 (did not include methadone, codeine, or meperidene)
- That year, about 125 deaths by drowning
- That year, less than 350 deaths of drivers in motor vehicle accidents

- “The societal burden of opioid-related mortality and morbidity is substantial. The annual incidence of opioid-related death we observed in 2004 (27.2 per million residents) falls between the incidence of death from HIV (12 per million) and sepsis (40 million).”
  Dhalla et al, CMAJ, December 8, 2009

Opioid-related abuse and mortality is a public health crisis
How did it happen?

• “…Canada is the world’s top per capita consumer of a number of opioids (e.g. hydromorphone) which makes for an opioid-rich environment. Since prescription opioid control measures are lax and inconsistent across Canada, this approach needs to be reconsidered…”

Fischer, B. et al., Changes in illicit opioid use across Canada, CMAJ, November 21, 2006; 175(11)

How did it happen?

1. Liberalization of the utilization of opioids for the treatment of non-cancer related pain
2. Lack of knowledge on the part of healthcare providers with respect to potential toxicity
3. No dosing guidelines
4. No effective means for monitoring who was prescribing and who was using
5. Aggressive marketing campaigns by manufacturers
6. Law enforcement restricted by health privacy legislation
Avoiding Abuse,
Achieving a Balance:

Tackling the Opioid
Public Health Crisis
September, 2010

College of
Physicians and Surgeons
of Ontario

Concurrent Processes

Canadian Guideline for
Safe and Effective Use of Opioids
For Chronic Non-Cancer Pain

Part A: Executive Summary and Background
Part B: Recommendations for Practice

Published by the
National Opioid Use Guideline Group (NOUGG)
a collaboration of:

Federation of Medical Regulatory Authorities of Canada
College of Physicians & Surgeons of British Columbia
College of Physicians & Surgeons of Alberta
College of Physicians and Surgeons of Saskatchewan
College of Physicians & Surgeons of Manitoba
College of Physicians and Surgeons of Ontario
College des médecins du Québec
College of Physicians and Surgeons of New Brunswick
College of Physicians and Surgeons of Nova Scotia
College of Physicians and Surgeons of Prince Edward Island
College of Physicians and Surgeons of Newfoundland and Labrador
Government of Nunavut
Yukon Medical Council

April 30 2010 Version 4.5

http://nationalpaincentre.mcmaster.ca/opioid/
OCC perspective

- Problem cases are not coming from the cancer-care sector
- Problems are related to the treatment of chronic non-cancer pain
- Illicit diversion of legally obtained (through prescriptions) opioids
- Improperly prescribed opioids and/or improperly utilized opioids

Issues Identified

- Management of chronic non-cancer pain (indications for opioids, prescribing, documentation, security, education, etc.)
- Diversion/abuse of opioids, specifically oxycodone
- Access to prescribing information
- Legislative hurdles to sharing information
- Search for suitable inquest
On November 20, 2008, 19 year old Dustin King “snorted” cocaine and OxyContin. He was also using alcohol.

In the early hours of November 21, 2008, he went to the apartment of Donna Bertrand, a 41 year old woman who had befriended him.

He fell asleep on her couch around 0700 hours.

When Donna Bertrand checked him later in the afternoon, he was unresponsive.

A post-mortem examination determined that Dustin died as the result of oxycodone toxicity.

On December 2, 2008, a 911 call was made from Donna Bertrand’s residence.

She was unresponsive on the floor of her apartment. She was pronounced dead by paramedics.

Drug paraphernalia, pills and prescription bottles were found at the scene.

A post-mortem examination determined that she died as the result of mixed drug toxicity (paroxetine, venlafaxine).

She had been prescribed over 1400 mg/day equivalent of morphine (OxyContin) in addition to her psychotropic medications. She had been abusing cocaine and OxyContin and diverting OxyContin.
Summary:

- **Drugs:**
  - removal of sustained release products with > 100 mg morphine equivalent
  - removal of products with > 40 mg oxycodone
  - review of all approved opioids
  - inclusion of dose recommendations in monographs
  - review of tamper resistant formulations

- **Monitoring:**
  - E-health
  - NSAA

- **Treatment:**
  - comprehensive pain and addiction treatment programs/facilities

- **Education:**
  - public and professional
  - collaborative
  - national guidelines

- **Legislative:**
  - clarification of privacy issues
  - mandatory sharing of information between health care providers and between police and healthcare providers

---

**OxyContin/OxyNeo in Ontario**

- OxyContin distribution stopped March 1, 2012
- OxyNEO introduced
- OxyNEO will be funded through the Exceptional Access Program (EAP) and through the Facilitated Access to Palliative Care Drugs mechanism based on the funding criteria.
- The 60mg and 80mg strengths of OxyNEO not be funded through ODB for chronic non-cancer pain.
Narcotics Safety and Awareness Act

The health and safety of Ontarians is important to the people of Ontario and their government. Ontario has the highest per capita use of narcotics and other controlled substances in Canada, some of which is unwarranted and is adversely affecting the health and safety of Ontarians. Ontario has seen a significant increase in narcotics-related deaths and in the need for addiction treatment services. Public and private spending on narcotics and other controlled substances has increased out of proportion to that which is medically required.

In May 2010, the Government of Ontario developed a strategy to address the health and safety concerns related to the use of narcotics and other controlled substances, including a commitment to:

1. Provide for access to narcotics and other monitored drugs when they are medically appropriate to treat pain.
2. Reduce the abuse and misuse of narcotics and other monitored drugs, including reducing the diversion of narcotics and other monitored drugs from medically appropriate use.
3. Support treatment for and reduce narcotics-related addictions and reduce narcotics-related deaths.

Monitoring the prescribing and dispensing of narcotics and other monitored drugs is a key tool in the government’s strategy. The ability to collect, analyze and report on the prescribing and dispensing of narcotics and other monitored drugs will contribute to appropriate prescribing and dispensing practices and help identify and address systemic challenges that may lead to addiction and death.

Therefore, Her Majesty, by and with the advice and consent of the Legislative Assembly of the Province of Ontario, enacts as follows:

Purpose
The purpose of this Act is to seek to improve the health and safety of Ontarians by permitting the monitoring, analyzing and reporting of information, including personal information, related to the prescribing and dispensing of monitored drugs, in order to:

(a) contribute to and promote appropriate prescribing and dispensing practices for monitored drugs in order to support access to monitored drugs for medically appropriate treatment, including treatment for pain and addiction;
(b) identify and reduce the abuse, misuse and diversion of monitored drugs; and
(c) reduce the risk of addiction and death resulting from the abuse or misuse of monitored drugs. 2010, c. 22, s. 1

Ontario Regulation 381/11 under the Narcotics Safety and Awareness Act, 2010 came into force on November 1, 2011.

The approved regulation:
• requires the prescriber to include an identifying number for the patient on a prescription for a narcotic or controlled substances
• specifies the information the dispenser must record when dispensing a narcotic or controlled substances
• requires dispensers to record the name, address and identifier for persons who pick up a narcotic or controlled substance from the pharmacy
• ensures that all opioids (including those not currently listed in the Controlled Drug and Substances Act (Canada),) are monitored drugs in Ontario
• describes the content of public notices and the method of disclosure that would include:
  • information to be collected, used and disclosed under the N3AA
  • the purposes for collection, use and disclosure
  • contact information for prescribers, dispensers and public

Narcotics Safety and Awareness Act
Narcotics Safety and Awareness Act

Effective **Spring, 2012**, the **Narcotics Monitoring System** (NMS) will be activated to track prescribing and dispensing activities relating to prescription narcotics and other controlled drugs (“monitored drugs”) in Ontario. The NMS will collect dispensing data from pharmacies in relation to all monitored drugs regardless of how the prescription is reimbursed (e.g., public drug programs, private insurance and cash payments).

The NMS will serve as a central data repository to enable **retrospective reviews of prescribing and dispensing activities**. In addition, the NMS will have real-time **Drug Utilization Review** (DUR) capabilities.

The ministry intends to use the data collected through the NMS to identify drug utilization patterns and trends and to detect unusual activities. The primary use of the information is to inform **harm reduction strategies, education initiatives**, and to **improve prescribing and dispensing practices** of monitored drugs.

If there is suspected **illegal activity** or **professional misconduct**, the ministry may undertake stronger interventions, such as reporting to law enforcement and to regulatory colleges as applicable.

Office of the Chief Coroner

“We speak for the dead to protect the living.”

Thomas D’Arcy McGee

Dr. Roger P. Skinner
Regional Supervising Coroner – East Region
366 King St. East, Suite 440
Kingston, Ontario
K7E 6Y3
Telephone: (613) 544-1596
Roger.Skinner@ontario.ca
Jury Recommendations

Health Canada:

• **Fund research studies** of not less than 12 months duration to determine the long-term effectiveness of opioids for chronic non-cancer pain. Research areas could include effectiveness of high vs. low dose, opioid vs. non-opioid therapy, use of opiates with patients who have addictions, how problems with prescription opioids develop, the chronology of abuse and the link between pain and substance abuse.

• **Review all opioid products** currently approved for use in Canada. This review should include an assessment, independent from pharmaceutical manufacturers, of any proposed abuse resistant formulations of controlled release opioids prior to approval for use in Canada.

• **Withdraw approval** for all controlled release opioid formulations that exceed the equivalent of 100 mg of morphine per unit dose.

• **Review product monographs** for all opioids for use in Canada to require the inclusion of recommended dosage, maximum dose, and/or the “watchful dose” as per the Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain.

• Health Canada should provide guidance to drug manufacturers to develop abuse resistant formulations for all prescription opioid products.

• Support the development of a national guideline regarding the management of chronic non-cancer pain for use by health professionals by funding the Michael G. DeGroote National Pain Centre.

Jury Recommendations

Ministry of Health and Long Term Care (MOHLTC):

• In light of the data regarding prescription opioid abuse, **review all opioid products** on the Ontario Drug Benefit (ODB) Formulary.

• **Remove** and prohibit all controlled release opioid formulations that exceed the equivalent of 100 mg of morphine per unit dose from the ODB formulary. Require prescribers to apply to ODB Exceptional Access Program (EAP) for all prescriptions of opioids in doses exceeding the equivalent of 200 mg of morphine per day for the treatment of chronic non-cancer pain.

• The ODB system currently initiates a 30-day alert regarding inappropriate prescribing, dispensing, and use of monitored drugs. The timeframe captured should be increased to 120 days for ODB formulary drugs.

• The ODB system currently initiates a 30-day alert regarding inappropriate prescribing, dispensing, and use of monitored drugs. The timeframe captured should be increased to 120 days for ODB formulary drugs.

• The ODB system currently flags when a patient seeks the same prescription from three doctors within 30 days. A change should be made so that the “double-doctoring” flag will be triggered when a patient seeks the same prescription from two doctors within 120 days.

• **Remove** all products containing more than 40 mg of oxycodone from the ODB formulary.
Jury Recommendations
Ministry of Health and Long Term Care (MOHLTC):

• Prioritize the development of the **electronic health system** (E-health) including an integrated drug information system (DIS). This system should collect data on all prescriptions for all people and be accessible to all prescribers and all dispensers. It should be monitored for the purposes of research and for the detection of inappropriate prescribing, dispensing and drug use.

• Prioritize the enactment of Bill 101, the **Narcotics Safety and Awareness Act** (NSAA).

• Enact regulations under the NSAA that:
  - Enhance the information that must be entered into the drug database (DIS) each time a prescription for a controlled substance is written. Health practitioners who prescribe or dispense opioids in Ontario should have the ability to have ready access to detailed information setting out all opioid prescriptions filled for each patient in Ontario, the number of opioid prescriptions written by each physician in Ontario, and the dose of each prescription.
  - Mandate that prescribers note the indication for all opioid prescriptions.
  - Require a regulated health professional, the head of an institution and a health information custodian to **disclose personal information to a police service** without a warrant where he/she has reasonable grounds to believe that a patient is engaged in an illegal activity related to the diversion of opioid medications.

Jury Recommendations
Ministry of Health and Long Term Care (MOHLTC):

• Develop a coordinated and **comprehensive strategy** for the treatment of pain and addiction in the Province of Ontario to include:
  - Coverage for the provision of non-pharmacological therapies for chronic pain (e.g., physiotherapy, chiropractic, massage, and acupuncture) to all persons who are eligible for ODB coverage.
  - Resources for the development of **comprehensive pain management clinics** in Ontario.
  - Resources for the development of **comprehensive addiction treatment clinics**, including residential addiction treatment facilities, and residential treatment facilities for people with concurrent disorders (mental health and addictions).
  - Encouragement for physicians to work with addictions counsellors as part of the health care team, once a patient has authorized a sharing of information between the physician and the counsellor.
  - Support services for the family of individuals with mental health and addiction problems.
Jury Recommendations

Health Canada/Ministry of Health and Long Term Care/College of Physicians and Surgeons of Ontario:

- Create a mandatory physician/patient registry for opioids prescribed in excess of the equivalent of 200 mg of morphine per day for the treatment of chronic non-cancer pain. Mandate that physicians complete an education course approved by the College of Physicians and Surgeons of Ontario (CPSO) before being registered. The registry system should be based on that currently in use for the prescribing of methadone.
- The MOHLTC should immediately take steps to restrict the quantity of an opioid that can be prescribed in a single prescription to one month or less and should limit the amount of opioid medication that can be dispensed to a patient at one time.

Jury Recommendations

Aboriginal Affairs and Northern Development Canada:

- Develop comprehensive strategies, in conjunction with First Nations and provincial ministries of health, to address the issue of substance abuse in general, and prescription opioid abuse in particular, with First Nations communities.
Jury Recommendations

Ministry of Health and Long Term Care/Faculties of Medicine/College of Physicians and Surgeons of Ontario/Ontario College of Pharmacists/Michael G. DeGroote National Pain Centre, McMaster University/Centre for Addiction and Mental Health:

• Institute an independent comprehensive review of the Canadian Guideline for Safe and Effective Use of Opioids by 2015, including a review of the current “watchful dose” (200 mg or morphine or equivalent).
• All Ontario based medical schools should review, and where necessary, enhance their curriculum with respect to pain management. The curriculum should be mandatory and should include an increased focus on appropriate prescribing of opioids and opioid addiction and include the Canadian Guideline for Safe and Effective Use of Opioids.
• Develop and administer continual education programs (academic detailing) for all prescribers and dispensers of opioids. These programs should specifically encourage ongoing collaboration between prescribers and dispensers and emphasize the need to share information among all members of the treatment team.

Jury Recommendations

College of Physicians and Surgeons of Ontario:

• In light of data regarding prescription opioid abuse, issue a policy statement that requires all prescribers of opioids for chronic non-cancer pain initiate non-opioid therapy and/or non-pharmacological therapies before commencing opioid therapy.
• Develop a course curriculum, with reference to the Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain, and require all prescribers of opioids to complete the course. The CPSO will provide updates to the course curriculum as research findings change.
• Enforce random audits of physicians’ practices at least every 10 years similar to the auditing system of the Ontario College of Pharmacists (OCP).
• Mandate that physicians, upon initial prescribing of opioids, implement a written treatment contract between the doctor and patient that must be signed where the patient indicates that all risks of opioids have been fully explained to him/her.
Jury Recommendations

Additional recommendations for health professionals’ practice:

- Physicians must ask for patient consent to access previous medical records (if available) prior to starting treatment with opioids. If consent is not granted by the patient, this refusal must be documented in patient records.
- Health care professionals involved in the prescribing or dispensing of opioid medications must:
  - Assess the risk and minimize harms associated with opioid use by ensuring there is comprehensive documentation of each patient’s pain condition, general medical condition, psycho-social history, psychiatric status, and substance use history.
  - Use the screening and monitoring tools set out in the Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain to determine a patient’s risk for opioid addiction and consider a treatment agreement for patients either not well known to the physician or at higher risk for opioid misuse.

Jury Recommendations

Additional recommendations for health professionals’ practice:

- Recommend movement towards electronic prescription and record keeping in physicians’ offices.
- Conduct urine drug screening with chronic non-cancer pain patients prescribed opiates upon initial consult and continually on high risk patients.
- Encourage the use of the Opioid Manager tool as developed in the Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain.
- Promote the use of ACCS addictions hotline through the Centre for Addiction and Mental Health (CAMH).
Jury Recommendations

Ontario College of Pharmacists:

- Enact a standard of practice that requires pharmacists to affix auxiliary warning labels to all prescription opioid containers, warning patients that opioids are addictive and providing them with the clear directions (e.g., not to chew or crush before ingesting, not to drive and consume alcohol, may cause drowsiness) and the toll-free number for an addictions hotline.
- Enact a standard of practice that requires pharmacists to meet with each patient when dispensing the initial opioid prescription for non-cancer pain and for every subsequent modification to that prescription to highlight and discuss the risk of addiction and other side effects of opioid pharmacological therapy and the need for safe storage and disposal of narcotics.
- Develop a course curriculum, with reference to the Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain and require all dispensers of opioids to complete the course. The OCP will provide updates to the course curriculum as research findings change.

Ontario College of Dentistry:

- Ensure dissemination of the Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain to all members and encourage ongoing education in this area.

Ministry of Education:

- Develop and introduce an education program related to opioid abuse beginning in Grade 6.
Jury Recommendations

Ontario Provincial Police/Chiefs of Police/Ministry of Community Safety and Correctional Services/Ministry of Health and Long Term Care:

- Develop and properly resource a provincial prescription drug enforcement unit. This unit should include trained police investigators, employees of the MOHLTC and access to experts from the CPSO, and OCP.
- In appropriate circumstances, police officers should be required to provide information relating to the misuse or diversion of prescribed opioids to the CPSO.

Jury Recommendations

Government of Ontario:

- Amend the Regulated Health Professions Act and/or regulation to include mandatory continuing medical education for all physicians on an annual basis.
- Amend Section 36(1)(e) of the Regulated Health Professions Act (1991) to require employees, committee members, and council members of regulatory health colleges who are responsible for the administration of the Act to disclose information (including personal health information) to a police service without a warrant if he/she has reasonable grounds to believe that an illegal activity related to the diversion of opioid medication may have been committed contrary to the Controlled Drugs and Substances Act, the Criminal Code, or the law of Ontario or Canada.
- Repeal s. 36(1.3) of the Regulated Health Professions Act (1991).
- Review the issue of opioid abuse, addiction, and diversion and fund drug enforcement at the municipal and provincial level to enable officers to step up drug prevention, enforcement and investigation. Strategies should include a focus on prevention, intervention, and suppression.
- The Government of Ontario should fund a public awareness campaign which supports and promotes the appropriate use, secure storage, and safe disposal of prescription drugs. The public education campaign should also address the risk of abuse and diversion associated with prescription opioids and be available on-line.
Jury Recommendations

Michael G. DeGroote National Pain Centre:

- Support the development of a national guideline regarding the management of chronic non-cancer pain for use by health professionals.

Jury Recommendations

Recommendations for Collaboration – Government of Ontario, Ontario Provincial Police, Municipal Police Forces, College of Physicians and Surgeons, Ontario College of Pharmacists, Ministry of Health and Long Term Care, Ministry of Community Safety and Correctional Services:

- Provincial and municipal police forces who have already developed educational resources on the diversion and abuse of prescription opioids should be encouraged to share these resources with physicians. The government of Ontario should provide the resources necessary to ensure that these tools are being disseminated. This should be achieved by:
  - Conducting further educational sessions/medical symposia aimed at physicians who prescribe opioids and in particular general practitioners and family physicians.
  - Distribution of resources (e.g., brochures, powerpoint presentations).
  - Enhancing availability of these resources to physicians – e.g., making them publicly available.
Jury Recommendations

Recommendations for Collaboration – Government of Ontario, Ontario Provincial Police, Municipal Police Forces, College of Physicians and Surgeons, Ontario College of Pharmacists, Ministry of Health and Long Term Care, Ministry of Community Safety and Correctional Services:

• The CPSO and the OCP should work together to put on joint education sessions, funded by the MOHLTC, for physicians and pharmacists to promote increased cooperation and understanding between the two professions. Provincial and municipal police forces may be encouraged to participate in delivery of these sessions.

Jury Recommendations

Recommendations for Collaboration – Government of Ontario, Ontario Provincial Police, Municipal Police Forces, College of Physicians and Surgeons, Ontario College of Pharmacists, Ministry of Health and Long Term Care, Ministry of Community Safety and Correctional Services:

• Education and cooperative opportunities should be created in communities throughout Ontario and could include:
  • Training regarding proper prescribing, dispensing, and monitoring for patients who are prescribed opioids.
  • Training regarding Ontario’s privacy laws
  • Proposed collaboration to ensure that both dispensers and prescribers take full advantage of the information that will become available when the drug monitoring database set out in the NSAA is operational.
  • The CPSO and OCP should undertake ongoing joint concurrent communication to their respective members respecting the urgency of and mechanism for sharing any information which will be collected and made available through the NSAA.
Jury Recommendations

Recommendations for Collaboration – Government of Ontario, Ontario Provincial Police, Municipal Police Forces, College of Physicians and Surgeons, Ontario College of Pharmacists, Ministry of Health and Long Term Care, Ministry of Community Safety and Correctional Services:

• Police officers (both members of the OPP and community police forces) should be strongly encouraged to directly contact a prescriber and dispenser in the following circumstances:
  • Where the police officer has reasonable grounds to believe that an individual is diverting prescription medication and the officer is able to identify the prescriber and/or dispenser of that medication.
  • Where the police officer has received a report of stolen medication, and believes that report to be unfounded.
Pharmacology of OxyContin and OxyNEO, Equianalgesic Doses of Opioids and Constructing a Narcotic Contract

Sherri Elms RPh ACPR
Out with the old, in with the new
Why?

- To reduce abuse
  - Harder to break
  - Forms a gummy gel with water or alcohol – cannot be drawn into a syringe or snorted

- BUT …
  - Not all abuse is snorting or injecting
  - Reports of choking in patients with swallowing difficulties
How to tamper the new Oxyneos

2
Sasha Says:
Thursday, 9/16/2010 9:06:18 PM

All you have to do is microwave the pill for 5 minutes (Make sure the plate is microwave safe) even a paper plate is fine but careful, it gets very hot. Ok let's just list it nice and neat:

Step 1: Microwave whole pill for 5 mins
Step 2: put in freezer for 1 min 30 sec
Step 3: Grind pill into FINE powder with tool such as dremel or file (I found a like a small device I use when I cook and grind lemon peel. Like a mini cheese grater but very very fine. The finer the better, because it will destroy the time release more effectively.
Step 4: Put onto a microwave-safe plate**
Step 5: Microwave for 4 min 30 sec to 5 min.
Step 6: As SOON as you start to see the pill turn into a light brown gunk pull it out (It doesn't always happen, so don't worry if it doesn't, it still works trust me.
-- if there is some powder left its ok
Step 7: Put into your freezer for about 5 to 10 minutes- let it get really cold
Step 8: Scrape the crusted brown oxy onto a mirror or w/e and snort

Worked GREAT for me, no gelling. Put a little in your mouth to test it 😊
NOW, you might notice in the end, it looks like LESS powder, BUT, I assure you, you DON'T lose much, the reason it looks like less, is because I think the binders and gel stuff burn away. Just taste the end result, it tastes REALLY strong depending on what mg you use.

Again, Don't worry if it doesn't get brown or anything, I got the recipe from someone online and most of the time it just stays in powder form. Use a cut straw to snort it so it doesn't get caught in the dollar as much and you'll notice the lovely drip will be delayed like 5 min, but it works it works. Enjoy, be careful, sorta contradictory but ya know 😊
Pharmacokinetics

- Bioequivalent – meaning the same amount of drug is absorbed
- BUT
  - Peak is delayed (perceived as less effective?)
  - Peak is slightly higher (more adverse effects?)
# Availability

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<th>OxyNEO</th>
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<td>-</td>
</tr>
<tr>
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<td>20mg</td>
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<tr>
<td>40mg</td>
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<tr>
<td>60mg</td>
<td>60mg – not covered by ODB</td>
</tr>
<tr>
<td>80mg</td>
<td>80mg – only covered for palliative patients</td>
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Equianalgesic Doses

- 670mg: Codeine
- 100mg: Morphine
- 75mg: Oxycodone
- 20mg: Hydromorphone
- 25mcg *: Fentanyl

* topically/24hrs
Equivalences

Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain

1. **Equivalence to oral morphine 30 mg:**

   Table B Appendix 8.1 Oral Opioid Analgesic Conversion Table

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<tr>
<td>Morphine</td>
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<td>Codeine</td>
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</tr>
<tr>
<td>Oxycodone</td>
<td>20 mg</td>
<td>1.5</td>
<td>0.667</td>
</tr>
<tr>
<td>Hydromorphone</td>
<td>6 mg</td>
<td>5</td>
<td>0.2</td>
</tr>
<tr>
<td>Meperidine</td>
<td>300 mg</td>
<td>0.1</td>
<td>10</td>
</tr>
<tr>
<td>Methadone and tramadol</td>
<td>Morphine dose equivalence not reliably established.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

http://nationalpaincentre.mcmaster.ca/opioid/cgop_b_app_b08.html#table_b_app_b01_01
Easier Way

- Convert oxycodone 24 hour dose to another agent
  - Oxycodone (mg) x 0.3 = hydromorphone (mg)
  - Oxycodone (mg) x 1.5 = morphine (mg)
- Reduce dose by 25-50% for incomplete cross-tolerance
- Breakthrough? If any – 10% of the 24 hour dose – more for planned incident pain
# Policy at Queen's

## POLICY

<table>
<thead>
<tr>
<th>SUBJECT:</th>
<th>Queen's Family Health Team</th>
</tr>
</thead>
<tbody>
<tr>
<td>Controlled Substance Policy</td>
<td>NUMBER:</td>
</tr>
<tr>
<td>ORIGINAL ISSUE:</td>
<td>October 2011</td>
</tr>
<tr>
<td>APPROVED BY:</td>
<td>Department Head, QFHT Physician Lead</td>
</tr>
</tbody>
</table>

1. **Introduction**

1.1 For the purposes of this policy, any substance listed in the Narcotics Safety and Awareness Act, 2010, shall be subject to the provisions of this policy. Please see the link below.


2. **Objective**

2.1 To be in compliance with CPSO guidelines and the Narcotics Safety and Awareness Act, 2010, regarding prescribing of controlled substances for patients with chronic nonmalignant pain (CNMP).

2.2 To establish consistent expectations and processes for patients, residents and Queen's Family Health Team Members regarding the prescribing of this class of medication.
OPIOID TREATMENT AGREEMENT

- Written, signed, dated
- Only one prescriber, one pharmacy
- Consequences to early or replaced prescriptions
- Regular follow-up
- Drug testing as required
- Open communication with others including family, other doctors and pharmacy
Useful References

- Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain
  www.nationalpaincentre.mcmaster.ca/opioid/

- Urine Drug Testing in Clinical Practice
Opioid Dependency
Treatment Options

KFLA March 22, 2012
Meredith MacKenzie
Physician, Street Health Centre
Kingston, ON
Conflicts:

- NONE
1 or more in a 12 month period:
- Recurrent use resulting in failure to fulfill major roles in work, school or home
- Recurrent use in physically hazardous situations
- Recurrent substance related legal problems
- Continued use despite persistent or recurrent social or interpersonal problems caused or exacerbated by substance
Opioid Dependence:

3 or more in a 12 month period:

- Tolerance (marked increase in amount; marked decrease in effect)
- Characteristic withdrawal symptoms; substance taken to relieve withdrawal
- Substance taken in larger amounts and for longer period than intended
- Persistent desire or repeated unsuccessful attempts to quit
Treatment Options:

- Abstinence
- Psychosocial Treatment Programs
- Medical Detoxification
- Opioid Agonist Therapies
- Opioid Antagonist Therapy
Abstinence:

- Consider this option when:
  - Highly motivated
  - Good existing supports in place
Medical Detoxification:

- Consider this in patients who:
  - Are dependent only on opioids and in particular, ORAL users
  - Have a brief duration of dependence (ie less than one year)
  - Are younger
  - Have no major psychiatric comorbidity
  - Are socially stable with a supportive network
Withdrawal Management:

- Clonidine 0.1 mg 1-2 tabs po bid-qid prn agitation, diaphoresis, and sympathetic overdrive
- Dimenhydrinate 50 mg po or pr; prn nausea
- Ibuprofen 200 mg 1-2 tabs tid prn myalgia
- Loperamide 2 mg po prn (max of 6/day) prn diarrhea
- Trazodone 50-100 mg po qhs prn insomnia
Clonidine Precautions:

- Do not prescribe clonidine if BP < 90/60, patient is pregnant, on antihypertensives or has heart disease.
- Warn patients about postural symptoms and drowsiness. Postural symptoms are dose-related.
- Warn about mixing with opioids, or having prolonged hot baths (both lead to hypotension).
- Keep prescription to less than 14 days (rebound HTN).
- Warn about risk of overdose if they relapse (loss of tolerance).
- Always use clonidine in conjunction with treatment plan.
Initial dose is similar to maintenance protocol (4-8 mg per day)
Increase dose by 2-4 mg daily until therapeutic dose achieved (usually 8-16 mg)
Reduce dose by 2 mg every week
Use adjuvant medications as necessary (anti-inflam/anti-diarrheals etc.).
Psychosocial Treatment Programs:

- Inpatient and outpatient programs have similar results.
- Offer comprehensive assessment, group and individual therapy, patient education and long-term follow-up.
- [www.drugandalcoholhotline.ca](http://www.drugandalcoholhotline.ca)
Agonist Therapy: MMT and Suboxone

- Agonist therapy results in improved treatment retention and decreased substance use compared to all forms of acute opioid detoxification.
- Agonist therapy reduces mortality and drug use and retains patients in treatment.
Methadone Maintenance:

- Prescription opioids in varying forms have become the predominant form of illicit opioid use (Fisher et al. 2005).

- Prescription opioid users can be treated at least as effectively as heroin users (Banta-Green et al. 2009).
Methadone Eligibility:

- Meet DSM 4 criteria for opioid dependency for at least one year (or intermittent use for longer periods).
- Physical signs of chronic drug use (e.g., Track marks).
- Physical signs of withdrawal.
- Recently released from incarceration (relapse prevention).
- Age 18 or above (with exceptions).
MMT Pharmacology (BRIEF):

- Long acting, pure mu-agonist
- Half life 22 hours (huge variability)
- Peaks at 4 hours
- SE similar to opioids
- Prolongs QT interval
- Risk of death is highest in the first TWO weeks of treatment
- Avoid prescribing BDZ or let MMT provider know
Indications for MMT in Opioid Dependency:

- Pregnancy
- Where withdrawal during induction is clinically dangerous
- Failure of Suboxone
- History of injecting buprenorphine
- SE or allergy to buprenorphine
- Xerostomia
- Past history of success with MMT
MMT Precautions:

- Recent benzodiazepine use or use of other sedating drugs
- Respiratory illnesses
- Alcohol dependent patients
- Over 60 years old
- Respiratory Illness
- Taking drugs that inhibit methadone metabolism
- Lower opioid tolerance
- Decompensated liver disease
Suboxone:

- Buprenorphine + naloxone
- Partial opiate agonist (mu) + opiate antagonist (K)
- Naloxone addition intended to reduce IV misuse.
Suboxone Pharmacology:

- Very high affinity for mu-receptor and will displace methadone, morphine and other full opioid agonists...sits at the receptor site for a long time (binds tightly but only partially stimulates).
- Partial agonist activity means better safety profile; limited ability to cause respiratory depression.
- Withdrawal syndrome milder, therefore easier to taper off
Suboxone Pharmacology:

- Starts to work within 30-60 minutes
- Peaks 1-4 hours
- Max plasma concentration after SL ranges from 40 min to 3.5 hours.
- Elimination ½ life 24-36 hours
- Duration of action dose dependent
- Maximum daily dose 24 mg
- Probably less effective than MMT at doses above 60-80 mg.
Indications for Suboxone in Opioid Dependency:

- Good prognosticators
- Prior addiction treatment
- Those who have not done well on MMT
- Those with significant SE to MMT
- MMT contraindicated
- Patient choice
- Access (drug plans and geography)
Suboxone Contraindications:

- Pregnancy
- Allergy
- Severe liver dysfunction
- Acute severe respiratory illness
- Decreased level of consciousness
- Paralytic ileus
- Inability to provide informed consent
- Elevated transaminases (>3-5 x ULN)
### Suboxone vs Methadone:

<table>
<thead>
<tr>
<th></th>
<th>Buprenorphine</th>
<th>Methadone</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Blocks opioid effects</strong></td>
<td>At low doses</td>
<td>At low doses</td>
</tr>
<tr>
<td><strong>Mechanism of action</strong></td>
<td>Partial opioid agonist</td>
<td>Full opioid agonist</td>
</tr>
<tr>
<td><strong>Adverse events</strong></td>
<td>• Precipitated withdrawal</td>
<td>Similar to other opioids</td>
</tr>
<tr>
<td></td>
<td>• Less sedating</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Less risk of overdose</td>
<td></td>
</tr>
<tr>
<td><strong>On cessation</strong></td>
<td>Less severe</td>
<td>Severe, prolonged withdrawal</td>
</tr>
<tr>
<td><strong>Onset of action</strong></td>
<td>30 to 60 minutes</td>
<td>30 to 60 minutes</td>
</tr>
<tr>
<td><strong>Peak effect</strong></td>
<td>1 to 4 hours</td>
<td>1 to 7.5 hours&lt;sup&gt;14&lt;/sup&gt;</td>
</tr>
<tr>
<td><strong>Duration of action</strong></td>
<td>Up to 2 to 3 days at high doses</td>
<td>36 to 48 hours&lt;sup&gt;14&lt;/sup&gt;</td>
</tr>
<tr>
<td><strong>Titration</strong></td>
<td>More rapid titration to effect</td>
<td>Lengthy process</td>
</tr>
<tr>
<td><strong>Mode of administration</strong></td>
<td>Sublingual</td>
<td>Oral</td>
</tr>
<tr>
<td><strong>Metabolism</strong></td>
<td>Less clinical impact on liver function</td>
<td>Affected by liver function&lt;sup&gt;14&lt;/sup&gt;</td>
</tr>
</tbody>
</table>
Antagonist Therapy:

- Naltrexone
Resources:

- ConnexOntario Health Services Information (drugandalcoholhelpline.ca)
- DART
- ACCS 1-888-720-2227
- Suboxone and MMT guidelines available online: www.cpso.on.ca
- CAMH “toolkit” for MMT and buprenorphine providers www.camh.net
- Canadian guideline for safe and effective use of opioids for CNCP: http://nationalpaincentre.mcmaster.ca/opioid