Nishnawbe Aski Nation
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BRIEFING NOTE

OxyContin change & Impact on NAN First Nation members

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Date:	February 11, 2012
cc:	David Fletcher, Executive Director Jason Smallboy Sandra Brown, Special Projects Director NAN Health Policy & Planning Staff Claude Chum, NAPS Chief of Police

ISSUE SUMMARY

Potential for Mass Involuntary Opioid Withdrawal in Nishnawbe Aski Nation (NAN) Territory due to OxyContin change, where up to 50% of First Nations youth and adults are Opioid addicted/dependent. Involuntary mass withdrawal creates risks of competition for substitute drugs (including heroin) carrying higher risks of accidental overdoses, violence to obtain drugs, more needle-sharing, or severe withdrawal symptoms (nausea, vomiting, shaking, bone pain, muscle spasms, etc.); miscarriage risks; and health and safety risks among: individuals, families and First Nation communities as a whole.

BACKGROUND

OxyContin (Oxycodone) – the opiate that is almost exclusively used in NAN First Nations – will not be manufactured in Canada after February 29th, 2012. There is widespread addiction to this drug among NAN First Nations members. On March 1st, 2012, OxyContin will be replaced by a new formulation of Oxycodone called, 'OxyNEO'; the new formation contains 'remoxy' to reduce misuse and illicit black-marketing. Purdue Pharma is the same producer of OxyContin and OxyNEO.

Purdue Pharma in a series of clinical trials on OxyNEO demonstrated a reduced drug-liking for OxyNEO and less tolerability to nasal residue when drug fragments were administered in the nose. This means that people snorting OxyNEO will not get the same high as the drug cannot be as easily absorbed through the nose and cannot be injected; users of OxyNEO and/or those no longer able to access OxyContin will begin to experience withdrawal symptoms; onset of withdrawal varies among individuals and can occur within 12-72 hours following last OxyContin usage (withdrawal occurs sooner among individuals using a higher dosage of OxyContin).

In Canada, it is estimated there is a 2-month supply of OxyContin; supplies currently held at warehouses and Pharmacies will be depleted by the end of April 2012. Unfortunately, the supply of OxyContin is considerably less in northern Ontario. It is estimated that local Pharmacies in Thunder Bay, Ontario will only have a 2-3 week supply of OxyContin before they have to start dispensing the new OxyNEO. This pushes current OxyContin illicit users into withdrawal with no safety net. This creates unacceptable public health risks of seeking substitute narcotics such as heroin, codeine and Percocet, or other dangerous behaviours including child neglect/abuse and domestic violence.

An identical formulation of the OxyNEO was marketed in the USA in April 2010, (called OxyContin OP). When only the OP version was available, heroin took its place slowly over 8 months and became the drug of choice among opiate users. Heroin poses a high-risk for overdose among users – it is not known what it is mixed with or how strong it is, contrasted with prescription drugs with precise drug levels.

CURRENT STATUS

Health Canada FNIH-OR reports there are currently approximately 200 NAN First Nation clients receiving coverage for OxyContin through NIHB for legitimate health reasons – coverage will continue to be provided by NIHB. Clients prescribed OxyContin within the last three (3) months will transition to OxyNEO on March 1st, 2012 – interruption in clients' pain management/ treatment is not expected.

New prescriptions for OxyNEO will only be considered as an exception under NIHB for patients under Palliative Care and/or for pain management due to cancer.

The number of NAN First Nation community members addicted to OxyContin at risk for involuntary withdrawal as a result of the change from OxyContin to OxyNEO is staggering, with up to 50% or more of adults and adolescents addicted to OxyContin – those addicted to OxyContin include children as young as 11 (eleven) years old. This prevalence rate can be easily validated by NAN First Nation leadership, community health workers/frontline workers, Health Directors, Tribal Councils, and NAN Health Authorities.

For example, at a Matawa First Nations meeting on February 6th, 2012, it was reported that almost **2000 people** have an Opioid addiction in Matawa First Nation communities. It should be noted this estimate is based on actual survey responses from First Nation members, therefore, there is a likelihood the number of people addicted is actually higher.

On Monday January 23, 2012, Chief Matthew Keewaykapow, Cat Lake First Nation declared a State-of-Emergency due to widespread Opioid addiction. The First Nation was no longer able to 'cope with the demands, community security, and health and safety issues placed on the Chief and Council, band Staff, existing Health Clinic/Nursing Station and Nishnawbe Aski Police Service Resources.'

Cat Lake has a population of 480 – 150 people are registered as addicted to opiate drugs – namely, OxyContin – and another 120 people are suspected of using this drug. With a total of

270 people addicted to OxyContin, Cat Lake First Nation will have a difficult time managing once OxyContin supplies are exhausted.

Shibogama Tribal Council reports that there are an approximate 600 people addicted to opiate drugs in the four (4) First Nation communities of: Kasabonika Lake, Wunnimun Lake, Kingfisher Lake and Wapekeka.

POINTS FOR DISCUSSION

Posed Threats to NAN First Nation Members

Dr. Benedikt Fischer, a senior scientist at the Centre for Addictions and Mental Health says:

> *"In the absence of any regular treatment, a public health catastrophe is imminent, as there are thousands of prescription opioid addicted individuals with rapidly shrinking supplies – likely leading to massive increases in black market prices, use of other drugs, needle use/sharing and subsequent infectious disease transmission, overdoses and crime."*

Mass Involuntary Opioid Withdrawal

Without OxyContin availability, individuals now using opiate drugs will undergo withdrawal symptoms. These vary in intensity, but are primarily: muscle and bone pain; stomach cramps, nausea, vomiting, diarrhea; restlessness, irritability, anxiety; sleeplessness; chills, sweats, hot flushes; tremors and involuntary leg movements; watery eyes, runny nose, goose bumps; increased heart rate blood pressure; depression and; suicide ideation.

Prenatal Women undergoing Opioid Withdrawal are at risk for miscarriage and/or premature labour. Methadone Maintenance Treatment (MMT) programming is the preferred treatment for prenatal women within mainstream society – MMT is not available in more than 90% of NAN First Nation communities.

Replacement Substances

Withdrawal symptoms alone will not cause death, however, individuals will be unable to function for a period of symptom intensity – up to 7 to 10 days. The risk is the replacement drugs that individuals will use as an alternate that are easily obtained illicitly, such as: (Percocet (5 mg oxycodone and 325 mg Tylenol), Tylenol #1, # 2, # 3 (codeine), Morphine, Heroin, Crack, Cocaine, and solvents. People will also be likely to use alcohol mixed with other drugs.

Other Substance Abuse

At the community level now where the illicit supply has sporadically "dried-up", more people use alcohol and/or other prescription medications and/or illicit drugs to cope with withdrawal symptoms.

This increase brings social and mental health problems: inappropriate sexual encounters; assaults; child neglect; increased child apprehensions; increased suicide attempts; promiscuity; marital breakdown; and boot-legging.

Other Risks

- With the winter road system open now, an influx of alternate drugs (both prescription and other illicit drugs) in NAN First Nation communities may occur.
- Increased injection drug use and needle-sharing may also occur which increases risks for HIV/AIDS or Hep C.
- Increased air medivacs in NAN territory, i.e., suicide attempts and/or pre-term labour among Prenatal women.

DECISION/DIRECTION REQUIRED

Communications Plan:

Communication with NAN Chiefs and Tribal Councils and NAN Health Authorities so they can develop Withdrawal Management Plans:

1) Advising those on OxyContin to wean down slowly on their own so their withdrawal symptoms are not so severe;
2) Harm Reduction strategies in the community (Education and Awareness; Needle Exchange programming, etc.);
3) Ensure adequate stock of ancillary medications at Nursing Stations that decrease withdrawal symptoms (Clonidine for irritability, anxiety and restlessness); Ibuprophen (aka Advil for pain); Gravol (for nausea and vomiting); Trazadone (sleeplessness); Imodium (diarrhea);
4) Ensure that Health Canada FNIH-OR provides direction to its nursing staff to allow them to dispense needed withdrawal medications.

Media Release to highlight:

1) Problem and risks to people addicted in the remote northern communities who are addicted to OxyContin and do not have access to drug treatments programs.

2) Funding required for the preferred treatment at the community - using the substitution drug Suboxone combined with land-based recovery, cultural programming, and more intensive follow up - as it has been used successfully and safely in six (6) NAN communities and a NAN high school with approximately 200 clients undergoing Suboxone Detoxification/Treatment/Maintenance since February 2011 at the high school and since September 2011, in community-based programs.

3) Need for Emergency Planning by First Nations, Tribal Councils, NAN and Health Canada FNIH-OR health staff, involving Ontario Ministry of Health and hospital networks.

4) The need for both levels of government to respond with programs and services urgently required to implement the NAN Prescription Drug Abuse framework of: Treatment, Security, Prevention and Addressing Root Causes.

5) Funding required for the NAN Prescription Drug Abuse Task Force (comprised of First Nation Leadership, Community Development and Mental Health & Addictions experts, and NAN Health Advisory Group representatives) to: implement the NAN Prescription Drug Abuse framework. Representation on the NAN Task Force includes both levels of government to resolve jurisdictional issues between Ontario and Canada for Opioid Treatment programming in NAN territory, with medical supports and appropriate mental health services and aftercare programming.

6) Funding requirements for Security and increased Policing resources in NAN territory.

FOLLOW UP TO BE COMPLETED

- Contact with all NAN Tribal Councils and First Nation Health Directors by NAN PDA Team to develop emergency response plans.
- Convening of the NAN PDA Task Force on an emergency basis, using telecommunications or internet-based communications as necessary to support development of an evidence-based response plan for First Nations and their Tribal Council health support staff.
- Contact of both Canada and Ontario governments by NAN Leaders and Chiefs on the proposed PDA Task Force (NAN Executive Council and Chiefs Eli Moonais, Connie Gray-McKay, Adam Fiddler, Gordon Beardy, Lorraine Crane and Walter Naveau).
- Extensive media contact by PDA Task Force Chiefs and NAN Executive Council to apply pressure on FNIH/Health Canada and the Ministry of Health and Long-Term Care to respond to repeated requests for assistance to the NAN State-of- Emergency declared by NAN Chiefs in November 2009.
- Test emergency triage arrangements to ensure local protocols will work.

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