

Five-Year Summary of Responses to Recommendations
Regarding the Inquest into the Deaths of:

Dustin Nicholas King

Donna Marie Bertrand

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Disclaimer

This report was an investigator-initiated study, conducted by Master of Public Administration students at Queen's University, and lead by Dr. Kieran Moore, Associate Medical Officer of Health at KFL&A Public Health.

As this is a rapidly moving issue, and the government continues to implement new policies, this research was restricted to a five-year follow-up analysis determining implementation progress of the jury recommendations, and identifying policy gaps that have yet to be addressed.

The analysis in this report is presented to encourage review and comment. All feedback received regarding the analysis will be carefully considered and used to inform the drafting of the final publication.

Introduction

In 2011, a coroner's inquest lead by Dr. Roger Skinner was held at the Brockville courthouse to examine the circumstances surrounding the deaths of Dustin Nicholas King and Donna Marie Bertrand, as well as the issue of prescription opioid diversion and abuse. The verdict of the coroner's jury was that Mr. King died on November 21, 2008 of an accidental overdose of oxycodone, and Ms. Bertrand died on December 2, 2008 by means of suicide after mixing paroxetine and venlafaxine. Following the inquest, the jury provided recommendations on the prescribing and monitoring of opioids demonstrating the need for a comprehensive chronic non-cancer pain management strategy in Ontario. Due to the complexity and magnitude of the opioid epidemic, the inquest heard from 39 witnesses over 12 days of testimony. The jury deliberated for 3 days deciding on a total of 48 recommendations involving 18 agencies at federal and provincial levels.

The recommendations can be categorized under the framework of the "Four-Pillar Approach to Drug Problems in Vancouver" (Figure 1); a coordinated, comprehensive approach that balances public order and public health to create a safer and healthier community. From a policy instrument perspective, the 48 recommendations could be formulated into projects, programs, regulation, and legislation. The following report is the result of a five-year follow-up with lead agencies, ministries, and organizations completed by students in the MPA program at Queen's University under the supervision of Dr. Kieran Moore, Associate Medical Officer of Health at KFL&A Public Health. This report supersedes the initial one-year follow-up completed by the coroner's office in 2011. It is worth noting that the opioid crisis and policy recommendations discussed here refer to chronic non-cancer pain management.



Figure 1. A four pillar approach to drug problems. The four pillars work in conjunction for the successful management of an outbreak.

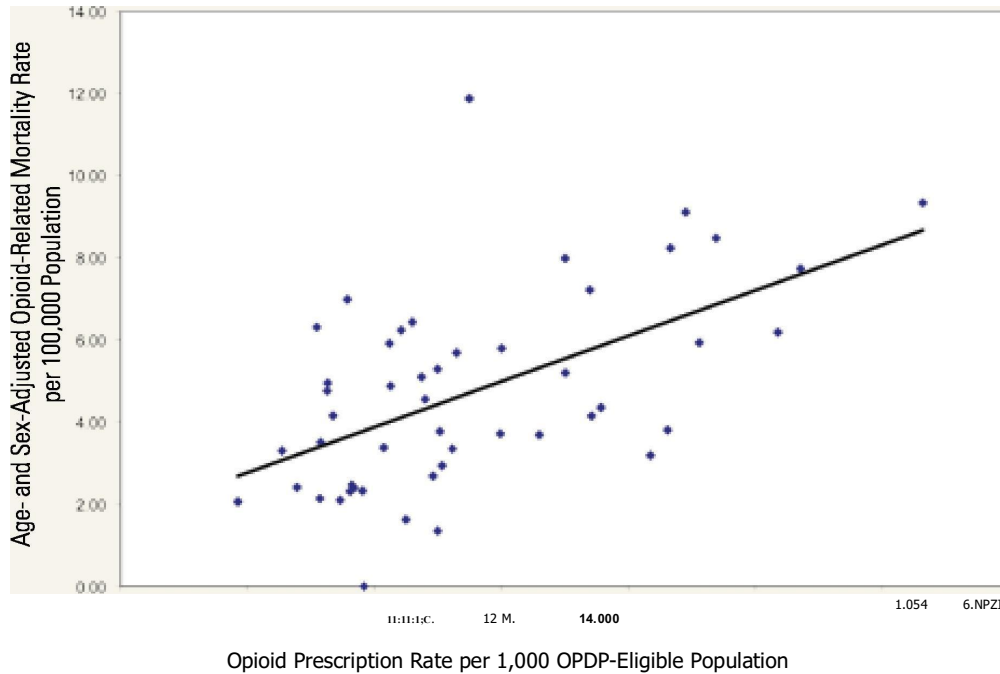
Background

The deaths of Mr. King and Ms. Bertrand, and the subsequent jury recommendations, created an opportunity for policy intervention in the opioid crisis that Ontario has been facing over the past two decades. In 2011, the global consumption of prescribed opioids in morphine equivalents (ME) was 62mg per person (UNODC, 2014). In comparison, Canada's ME in 2011 was 812mg per person, 13 times higher than the global average. When compared to other OECD countries, Canada's ME was still almost twice as high as Denmark's (483mg) and Australia's (427mg) (UNODC, 2014).

According to the *Canadian Rx Atlas* (2nd ed., 2008), Ontario is becoming a hub for opioid use in Canada, and per capita spending on opioids in the province around the time of the inquest was approximately 29% higher than the national average. The epidemic in Ontario has increased to the degree that opioid prescription rates have exceeded 600 per 1,000 population (Gomes & Juurlink, 2016). Prescription rates are even higher among those who receive public drug plans, with an increase in opioid prescriptions from 1,848 to 2,148 per 1,000 population between 2003 and 2008 (Gomes et al., 2011a). This is worrisome as opioid prescribing rates are found to be positively correlated with opioid-related mortality in Ontario (Figure 2) (King, Fraser, Boikos, Richardson, & Harper, 2014).

Between 2000 and 2013, the annual number of opioid-related deaths in Ontario increased 463% (Office of the Chief Coroner, 2015), totalling 5000 deaths, with another 680 deaths in 2014 (Fischer, Rehm, & Tyndall, 2016). In the illustration below, opioid-related deaths in Ontario are broken down by the type of opioid associated with the cause of death, where fentanyl was associated with the most deaths in 2014, and codeine the least (Figure 3). It was reported that 56% of individuals, out of the 1095 opioid-related deaths in Ontario between 1991 and 2007, received an opioid prescription within 4 weeks prior to their death (Dhalla, Mamdani, Gomes, & Juurlink, 2011). The Office of the Chief Coroner has determined that the top 20% of Ontario physicians who most frequently prescribe opioids have written the final opioid prescription in 62.7% of opioid-related deaths (Dhalla et al., 2011).

By 2010, Ontario witnessed 42 opioid-related deaths per million (or 550 deaths) annually (Gomes & Juurlink, 2016). In a release from the Municipal Drug Strategy Co-ordinators Network of Ontario, it was reported that an Ontarian dies from an opioid-related death every 14 hours. Most opioid-related deaths in Ontario are unintentional and occur amongst individuals receiving opioids via prescription (Dhalla et al., 2011). The impact of opioid abuse is felt most strongly amongst vulnerable populations including youth, seniors, First Nations, and those living in poverty. Despite expert-driven policy recommendations to address the epidemic, prescribing habits in Ontario have not changed significantly. There has not been a decisive decrease in opioid-related morbidity or mortality rates, and the ongoing epidemic demonstrates the failure to implement effective health policy in a timely fashion.



OPDP= Ontario Public Drug Program.

Figure 2. Relationship between opioid prescribing rate (per 1,000 OPDP eligible population) and opioid-related mortality rate (per 100,000 population) among Ontario counties.

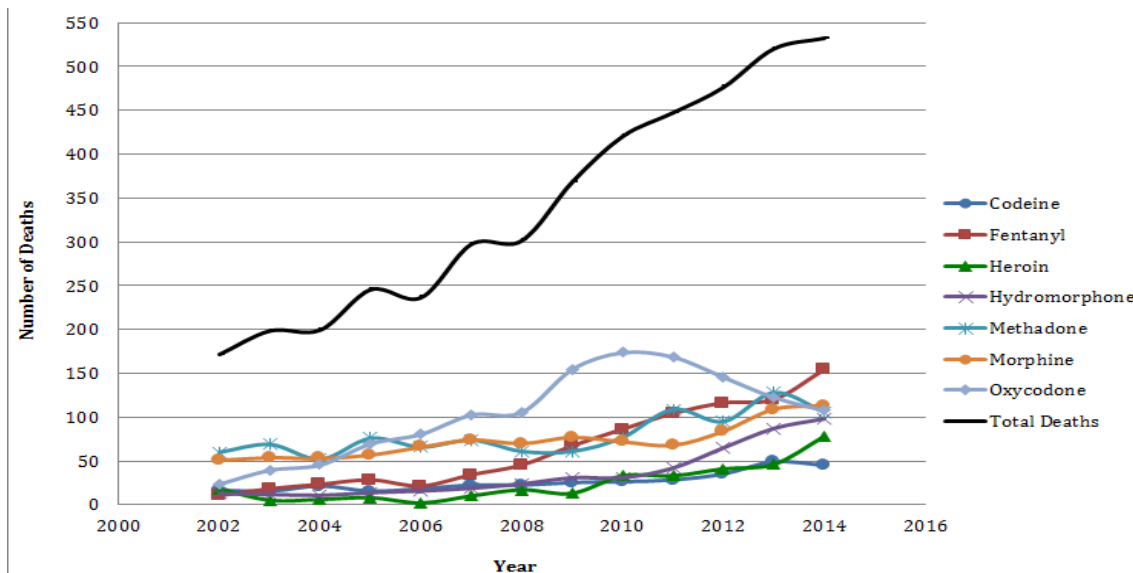


Figure 3. Yearly number of opioid related deaths by drug, 2002-2014. From coroner's data, KFL&A Public Health.

Policy Context

The implementation of the jury recommendations into health policy needs to be examined within the context of Ontario's health structure and how federalism is intertwined with health policy formation. The federal government is responsible for foreign affairs, defense, and criminal law, while the provinces are responsible for health care, education, and social services. The federal government and the provinces share authority over public health. The 1982 Constitution enshrines equality between the ten provinces and three territories, with the exception of Quebec. The challenge of any health policy implementation is often about where the funding comes from and how the major systems of governance can be integrated.

In Ontario, the Population and Public Health Division of the Ministry of Health and Long-Term Care (MOHLTC) provide funding, policy direction, and monitoring for harm reduction programming and services in Ontario. The public health units and their respective harm reduction partners implement and maintain each program. The Local Health Integration Networks (LHINs) provide funding to addiction treatment programs including withdrawal management services. Ontario also has the Drug and Pharmacies Regulation Act (DPRA) which governs the accreditation, ownership, and operation of pharmacies. The DPRA and its regulations provide a legal framework under which the Ontario College of Pharmacists (OCP) holds owners and operators of pharmacies accountable for safe and secure operation of their businesses. The Regulated Health Professions Act (1991) covers 21 health regulatory colleges which govern 23 health professions in Ontario. These colleges have the authority to develop regulations for a variety of subject matters, including prescribing and dispensing of drugs, subject to the prior review of the MOHLTC and the approval of the Lieutenant Governor in Council.

The World Health Organization (WHO) defines health policy as an agreement or consensus on health issues, goals and objectives to be addressed, the priorities among those objectives, and the main directions for achieving them. The issue identified by the inquest was the increasing rate of high dose opioid prescriptions for chronic non-cancer pain and the associated diversion and abuse of prescribed opioids leading to high levels of opioid-related mortality in Ontario. Most policy analysis models identify the importance of narrowing down the problem, and the inquest narrowed down the issue to liberal prescribing of opioids by physicians, poor narcotic monitoring, and a lack of alternative management options for chronic non-cancer pain. The recommendations resulting from the inquest provided an immense opportunity for Ontario to develop an integrated health policy framework for chronic non-cancer pain management and opioid use in Ontario. The inquest called for the utilization of a variety of policy instruments, including legislation, to address the identified problems of prescribing, monitoring, and diversion of opioids.

Retrospectively, and evidenced by this follow-up, the challenge to implement the jury recommendations was due to a lack of coordination between agencies necessary to adopt, implement, evaluate, and continuously improve policy measures (Figure 4). This resulted in delayed and disjointed efforts to bring the opioid crisis under control, which has now become an epidemic. Deaths resulting from opioid overdoses have increased by 250% over the past two decades (Gomes & Juurlink, 2016) requiring immediate attention and collaboration at the federal and provincial/territorial levels in the same manner as one would address an outbreak of an infectious disease.

This follow-up reveals the many policy gaps that remain to be addressed five years following the initial inquest. Given the complexity of this issue and the multiple areas of government involved, there is a need for a central secretariat to coordinate a government response (Figure 4). They should be given the mandate, staffing, budget, and data outlets to enable them to accomplish a decrease in the overall community opiate load resulting in a decrease in harms and death associated with opioids. The policy cycle must be followed - from problem identification, to policy evaluation and improvement (Figure 5) - to monitor and measure policy outcomes using indicators for performance management and continuous quality improvement principles.

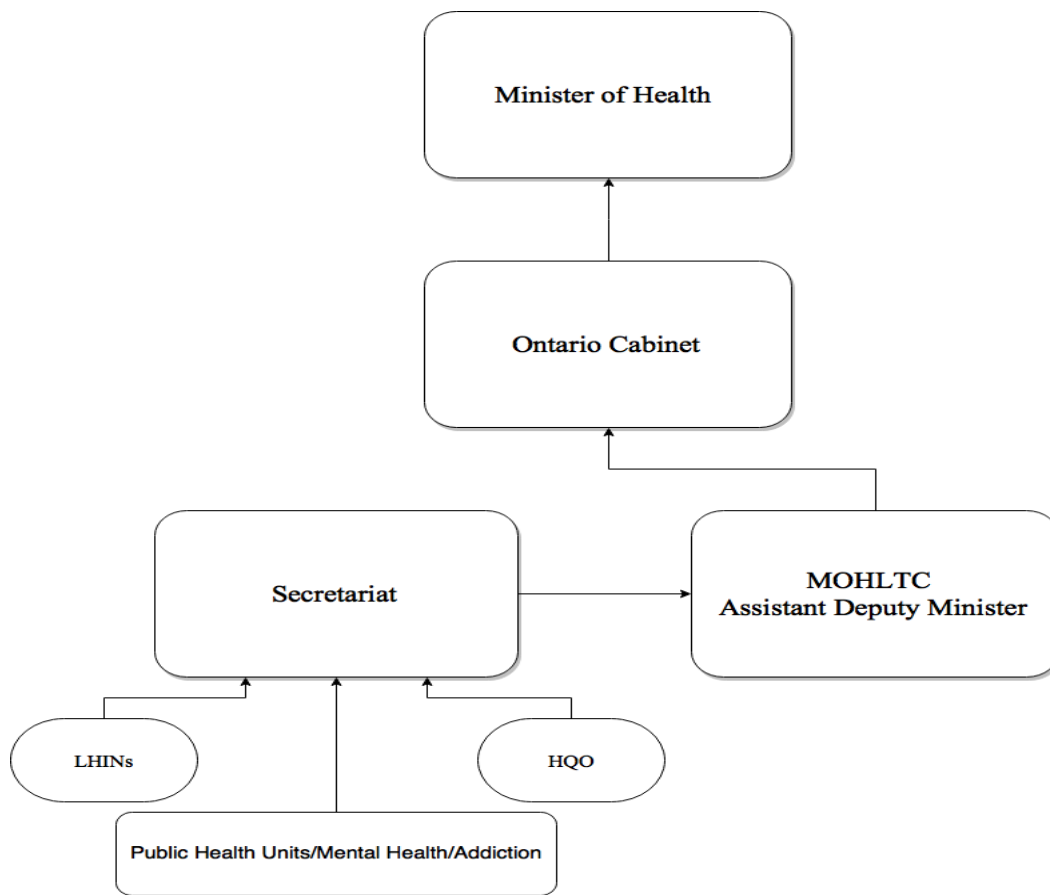


Figure 4. Governance Structure for the introduction of a secretariat.

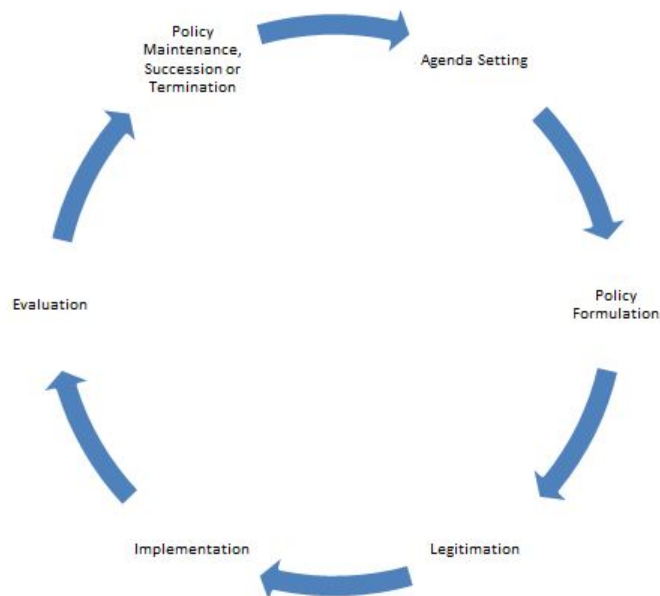


Figure 5. Heuristic policy cycle. The image displays the policy process as a continuous process. Retrieved from <https://paulcairney.wordpress.com/tag/stages-heuristic/>

Methods

Using an action research approach, we followed-up with lead agencies, ministries, and organizations that were assigned recommendations from the initial inquest completed in 2011. Agencies that were contacted had recommendations where: an alternate was implemented (1B), recommendations were under consideration (2), recommendations were rejected due to flaws (4A), or recommendations did not apply to the assigned agency (5) (see Appendix A for response legend). Agencies with recommendations that were implemented (1) at the one-year follow-up were also contacted to determine whether they have continued to update their policies in accordance with emerging guidelines. We reached out to each agency with an initial letter sent out on March 9, 2016. In some cases, subsequent letters were delivered and phone calls were made in order to elicit a response. In-person interviews and teleconferences were held with registrars of regulated health professional organizations. The first response was received on March 24, 2016, and last response received on October 27, 2016. All the composite responses were aggregated and summarized, and remaining policy gaps identified.

Discussion

The following report is a summary of the 48 jury recommendations and an analysis of the policy gaps that remain to be addressed five-years following the inquest. See Appendix B for a table summary of recommendations comparing the one and five-year follow-up responses.

Jury Recommendations for Health Canada

1. 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.

The above recommendation has not been adopted into a policy or program, however Health Canada launched a \$44 million initiative in 2014 to address prescription drug abuse by increasing public awareness, enhancing addiction prevention and treatment services in First Nation communities, and improving prescribed narcotic data surveillance. The federal government via the Canadian Institutes of Health Research (CIHR) supports research to increase evidence related to the safety and effectiveness of opioids in the treatment and management of chronic non-cancer pain. However, details regarding this research are not easily accessible or readily available. On March 31, 2016, the Government of Canada announced an investment of \$25 million to establish a new Chronic Pain Research Network at McMaster University. This network will be dedicated to increasing access to the best possible care for people suffering with chronic pain and speed up the introduction of the most current research findings into clinical practice.

2. 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.

The above recommendation could be adapted into a policy using regulation as a policy instrument. Follow-up at the one-year mark showed that the above had not been implemented. At the five-year mark, Health Canada posted a guidance document entitled "Guidance document: Tamper-resistant formulations of opioid drug products" on March 20, 2016. The document is intended to provide guidance to sponsors seeking statements or claims of tamper resistance aimed at reducing abuse of controlled release opioid products. Health Canada also introduced labelling changes to the Product Monographs of all controlled release opioids products in 2014. These labelling changes restrict the indications and clinical use of these products and standardized wording has been introduced to clearly outline the risks and safety concerns associated with these products.

Health Canada has a Marketed Health Products Directorate (MHPD) and their role is to conduct post-market surveillance monitoring, assessment, and intervention for all regulated marketed health products, including opioids in Canada. It is unclear what evaluation studies the MHPD has done regarding opioids to show the effectiveness of the guidance document and the changes to product monographs. According to Leece, Orkin, and Kahan (2015) "regulations requiring tamper resistance will likely do little to address the opioid epidemic and may serve merely to line the pockets of drug companies while diverting policy-makers' attention away from more meaningful and effective interventions" (p. 717). The key is to have well integrated policy solutions that are monitored and evaluated to ensure ongoing quality improvement and sustainability.

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

The above recommendation, at the time, was based on the Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain concept of a "watchful dose." Health care practitioners

prescribing anything above a “watchful dose” should exercise caution because of the increased risk of abuse, addiction, and death. The “watchful dose” is set at the equivalent of 200mg of morphine per day in the guideline. Extended release preparations are generally intended for use twice daily, therefore the jury believed there should be no need for products that exceed the equivalent of 100mg of morphine per unit dose. The jury also heard evidence that the availability of higher dose products might falsely reassure physicians that they are using a low dose. The expert witnesses also presented evidence that the availability of high doses increases the risk of death in recreational users as illustrated in Figure 6.

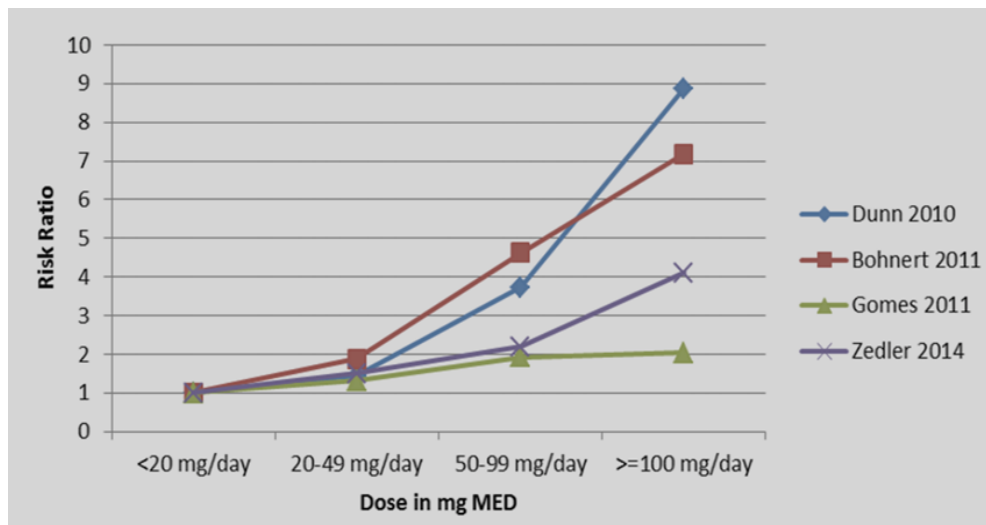


Figure 6. Risk of an overdose event. ICES report.

At the one-year mark the above recommendation had not been adopted into policy. Five-year follow-up found that Health Canada had adopted an alternate approach described under recommendation 2. Their policy formulation for improving the safety of opioid use was to update the labelling for the controlled release opioids. Health Canada stated that only when the risks associated with a product's use outweigh the benefits can regulatory action be taken to withdraw market authorization.

Health Canada's policy interpretation of the recommendation is not evidence-based. The latest Centre for Disease Control and Prevention (CDC) guidelines recommend that “when opioids are started, clinicians should prescribe the lowest effective dosage.” In fact, evidence suggests that harms associated with doses above 200mg of morphine (or equivalent) outweigh the benefits and increase risk of opioid-related mortality (Gomes et al., 2011b).

The CDC guidelines, as well as the new 2017 Draft Recommendations for Use of Opioids in Chronic Non-Cancer Pain, clearly indicate that clinicians should use caution when prescribing opioids at any dosage and should carefully reassess evidence of individual benefits and risks when increasing dosage to ≥ 50 morphine milligram equivalents (MME)/day. Furthermore, clinicians should avoid increasing dosage to ≥ 90 MME/day without careful justification. The College of Physicians and Surgeons of British Columbia have also adapted the CDC guidelines as far as the dose recommendation is concerned. The CDC guidelines report that the clinical evidence review group found that higher opioid doses are associated with increased risks for motor vehicle injury, opioid use disorder, and overdose resulting in

death. The clinical and contextual evidence reviews found that opioid overdose risk increases in a dose-response manner, and dosages of 50–<100 MME/day have been found to increase risks for opioid overdose by factors of 1.9 to 4.6 compared with dosages of 1–<20 MME/day. Dosages \geq 100 MME/day are associated with increased risks of overdose 2.0–8.9 times the risk at 1–<20 MME/day.

4. 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.

At the one-year mark this recommendation was not implemented. At the five-year follow-up, Health Canada’s position was that any changes to the Dosage and Administration section of the Product Monographs for a marketed product would require the sponsor to file scientific evidence based on clinical trials to support the change. Health Canada also indicated that the Canadian Guideline for Safe and Effective Use of Opioids for chronic non-cancer pain had been developed by the National Opioid Use Guideline Group in collaboration with the provincial and territorial colleges of physicians and surgeons; their preference would be to have the CPSO formulate the policy for prescribing of a “watchful dose.”

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

At the one-year mark Health Canada was still considering this recommendation. Five years later, as mentioned in recommendation 2, they released a document related to the above. In terms of evidence-based policy, Abuse Deterrent Formulations (ADF) of opioids have not been proven to reduce the harmful effects of opioid abuse. Gomes and Juurlink (2016) report that “this change was associated with some reductions in opioid-related harm, the move was also associated with a marked increase in heroin use, most likely reflecting the transition of abusers from OxyContin to heroin because of the latter’s ready availability and low cost.” They go on to discuss that “experts have expressed concern that ADFs represent a ‘gimmick’ of primary benefit to the pharmaceutical industry and that undue focus on them may undermine more meaningful policy measures aimed at reducing the harm associated with opioids and that the opioid epidemic can only be addressed by physicians prescribing opioids far more cautiously, and through the provision of support to those already suffering from addiction” (Gomes & Juurlink, 2016). This highlights the importance of policy evaluation and aligning the change or shift in policy instruments to predetermined health indicators and measurable outcomes.

6. 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. DeGroot National Pain Centre.

At the one-year mark, Health Canada stated this had already been implemented, referring to the 2010 publication of the above guide. In September 2016, Health Canada informed that it had funded McMaster University to update the above guideline, which is now available as a draft. Given the significant harm related to this class of drug, it may be prudent for Health Canada to provide ongoing funding with a dedicated plan to review and update the guidelines every 3 years to ensure continuous improvement of best practices.

Jury Recommendations for the Ontario Ministry of Health and Long Term Care

7. Considering the data regarding prescription opioid abuse, review all opioid products on the Ontario Drug Benefit (ODB) Formulary.

At the one-year mark, the Ministry of Health and Long Term-Care (MOHLTC) stated this will be implemented. The MOHLTC was to assess the opioid products that were funded as benefits under the ODB program to determine the most appropriate products to fund. At the five-year follow-up, and effective January 2017, there was an ODB Formulary update where higher strengths of long-acting opioids have been delisted from the ODB Formulary including: Morphine 200mg tablets, Hydromorphone 24 and 30mg capsules, Fentanyl 75mcg/hr and 100mcg/hr patches, and Meperidine 50mg tablets. This is a step in the right direction as three of the four narcotics listed above are associated with the most opioid-related deaths (Figure 7). Along with the above changes, the MOHLTC could consider reviewing the CDC guidelines as British Columbia did and incorporate them into a policy direction for Ontario physicians mandating them to follow a new threshold for the watchful dose of 50mg as opposed to the 200mg.

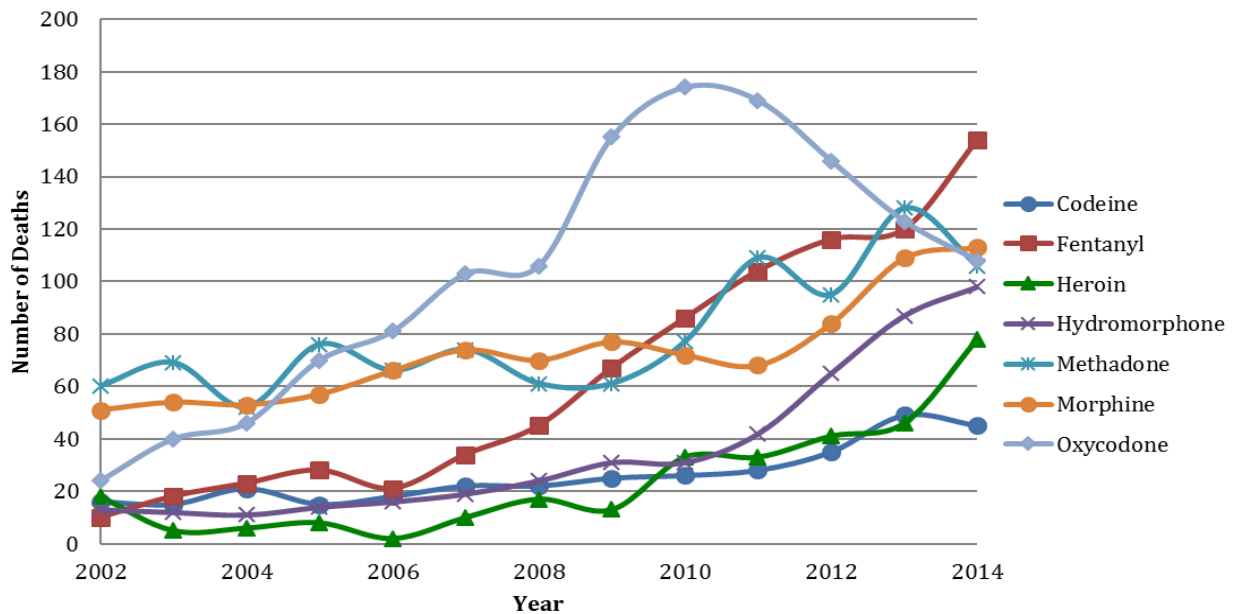


Figure 7. Drugs contributing to opioid related deaths in Ontario per year from 2002-2014. From coroner’s data.

8. Remove and prohibit all controlled release opioid formulations that exceed the equivalent of 100mg 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 200mg of morphine per day for the treatment of chronic non-cancer pain.

At the one-year mark the MOHLTC was still looking at policy shifts it could make in relation to the above recommendation. By the five-year point, the MOHLTC had convened a subcommittee of clinical experts specializing in pain, addiction, palliative care, clinical pharmacology, internal medicine, family

practice, and pharmacy. The subcommittee's discussions considered the inquest's recommendations and the implementation of some of the policy shifts began in early summer 2016. The major policy shift that needs to occur is to align the 200mg ME with the current evidence-based guideline from the CDC of 50mg ME.

9. 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.

Around the one-year point in spring of 2012, the MOHLTC had implemented the Narcotic Monitoring System (NMS), as part of Ontario's Narcotics Strategy. The NMS monitors and alerts the MOHLTC on trends relating to inappropriate or excessive prescribing and dispensing of narcotics and other controlled substances in both the public and private markets. It also issues Drug Utilization Reviews to pharmacists at the time of dispensing when attempts to obtain prescription narcotics from multiple prescribers or multiple pharmacies are detected. Dispensers are required to use their professional judgment to determine the appropriate action in each case, such as not filling the prescription or alerting prescribers. At the five-year mark, the MOHLTC had not implemented the timeframe shift to 120 days.

10. The ODB system currently flags when a patient seeks the same prescription from 3 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.

This recommendation has not been implemented. The rationale is that of alert fatigue resulting in an unresponsive system.

11. Remove all products containing more than 40mg of oxycodone from the ODB formulary.

At the one-year point, the MOHLTC had removed OxyContin from the ODB Formulary and replaced it with a process whereby it would reimburse the new formulation, OxyNEO, through the Exceptional Access Program (EAP) effective February 29, 2012. Since this change, the MOHLTC reported a significant reduction in the total number of oxycodone claims. Between April 1, 2012 and March 31, 2016, the total number of claims decreased from 311,863 to 111,347 (approximately 64%). The opioid load has continued to increase and shows geographical variations which allows for follow-up targeted policy interventions in certain areas.

12. 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.

Ontario does not yet have a province-wide electronic medical record system. In support of the Medication Management System (MMS) Strategy, eHealth Ontario intended to deliver a Drug Information System (DIS) as a provincial repository for patient drug history information. In 2013 eHealth Ontario decided it would not proceed with the procurement of a DIS. The MOHLTC has laid the foundation for the Comprehensive Drug Profile Strategy (CDPS) and work is currently underway to

make the MOHLTC dispensed drug data - data collected under the Ontario Drug Benefit Act, 1990, and the Narcotics Safety and Awareness Act, 2010 - available to health care providers for clinical use at the point of care. It is expected that there will be expanded access to provincial drug data holdings, followed by additional data elements and data sources.

13. Prioritize the enactment of Bill 101, the Narcotic Safety and Awareness Act (NSAA).

The NSAA received royal assent on November 29, 2010 and came into force on November 1, 2011 followed by the implementation of the Narcotics Monitoring System (NMS) in May 2012. The objective was to promote appropriate opioid prescribing and dispensing in Ontario. The Ontario Drug Policy Research Network (ODPRN) evaluated the impact of these legislative interventions and found from October 2011 to May 2013, inappropriate opioid prescribing had dropped from 1.6% (12,346 of 777,950 prescriptions) to 1.0% (9138 of 959,898 prescriptions).

14. Enact regulations under the NSAA that:

- a. 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 written by each physician in Ontario and the dose of each prescription;***
- b. Mandate that prescribers note the indication for all opioid prescriptions;***
- c. 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.***

The jury heard from several witnesses, including police, physicians, pharmacists, and the developers of the document “Tackling the Opioid Public Health Crisis 2010,” that health professionals currently feel restricted by privacy acts for sharing information regarding drug abuse and diversion with the police. Even though the Freedom of Information and Protection of Privacy Act, the Personal Health Information Protection Act, and the Regulated Health Professionals Act can be interpreted as allowing the release of this information, the wording is not clear. However, a legislated requirement could increase the rate the sharing of this information and allow police to improve public safety through prevention, intervention, and suppression of prescription opioid abuse.

The MOHLTC reported that the NMS collects and records information about all prescription narcotics and other controlled substances that are dispensed in Ontario. The NMS serves as a central database to enable reviews of prescribing and dispensing activities related to monitored drugs within the community health care sector. The NMS collects dispensing data from pharmacies in relation to all monitored drugs irrespective of whether the prescription is paid for under a publicly funded drug program, through private insurance, or by cash.

Since May 14, 2012, all dispensers/pharmacies in Ontario are required under section 8 of the NSAA to submit the following prescription information to the NMS when dispensing a monitored drug:

- Prescriber's registration number issued to the prescriber by the College of which he or she is a member
- Prescriber ID reference (identifying the professional College to which the prescriber belongs, e.g., member of CPSO, RCDSO, etc.)
- Identifying number of the patient
- Type of identifying number provided by the patient (e.g. driver's license, Ontario Health Card, etc.).
- Name of the person for whom the monitored drug is prescribed
- Date of birth and gender of the person for whom the monitored drug is prescribed
- Date on which the monitored drug is dispensed
- Drug identification number
- Quantity of the monitored drug dispensed
- Length of therapy, in number of days, of the monitored drug
- Prescription number
- Pharmacist ID (registration number from the Ontario College of Pharmacists)
- Pharmacy ID

The NMS has real-time Drug Utilization Review (DUR) capabilities. When a dispensing record is submitted by a pharmacy to the NMS, the system conducts DUR checks. If potential issues such as double-doctoring and polypharmacy visits are detected, the NMS will issue an alert to the pharmacy at the time that the prescription is being dispensed. However, the NMS does not provide electronic access to patient records at the point-of-care; eHealth Ontario is still working on this initiative. The MOHLTC reported that amendments to regulation are not required to implement recommendation 14(c), where there are reasonable grounds to suspect professional misconduct by a health care provider or illegal activity on the part of a patient. The MOHLTC may consider disclosing information collected by the NMS to a professional regulatory body or the police, as appropriate. The MOHLTC has recently announced that Health Quality Ontario will be providing peer-based comparison data to prescribers about their opioid prescribing patterns to increase self-awareness without regulatory intervention. The Canadian Guidelines for Opioid Prescribing recommend that all physicians record the reason for opioid use, something that has not been mandated but is best practice. Currently, no physician in Ontario has access to the narcotic monitoring system.

15. Develop a coordinated and comprehensive strategy for the treatment of pain and addiction in the Province of Ontario to include:

- a. 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.***
- b. Resources for the development of comprehensive pain management clinics in Ontario.***
- c. 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).***
- d. Encouragement for physicians to work with addictions counselors as part of the health care team, once a patient has authorized a sharing of information between the physician and the counsellor.***
- e. Support services for the family of individuals with mental health and addiction.***

The context for the above recommendation is based on evidence the jury heard from numerous witnesses that Ontarians have very limited access to comprehensive addiction and pain treatment. They did hear that those with such access often have significant benefit. The jury heard from practitioners that the lack of affordable alternatives to drug treatment for chronic pain has contributed to the over-prescribing of opiates for this condition.

At the one-year mark, the MOHLTC informed that a strategy for the treatment of pain and addiction was already in place. In October 2016, the Government of Ontario announced that it will invest \$17 million annually in multi-disciplinary care teams, including 17 Chronic Pain Clinics across Ontario, to ensure that patients receive timely and appropriate care to help them manage chronic pain. However, if patient care in these clinics is provided by physicians who are high prescribers of opioids, we will only be left with the same problem we are trying to fix. In order for these multi-disciplinary health teams to be effective, physicians must abide by the guidelines as set out in the Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain.

The MOHTLC also intends to expand access and availability of health care services for more Ontarians who suffer from low back pain. This comprehensive model of care includes a rapid low back pain assessment within an average of two weeks, as well as evidence-based management plans and educational tools to help patients manage pain. Along with the above, it plans to expand training and support for primary care providers, including in rural and remote communities, to enable them to safely and effectively treat chronic pain. This will be done utilizing case-based learning and video-conferencing sessions with pain, addiction, and mental health experts. In terms of a policy approach a detailed implementation plan and measurable targeted health outcomes have not been identified, sustainability of policy shifts requires focused coordination as per the policy cycle model.

Jury Recommendations for Health Canada/MOHLTC/CPSO

16. Create a mandatory physician/patient registry for opioids prescribed more than the equivalent of 200mg 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.

At the one-year point, the MOHLTC responded that in Ontario, under the Regulated Health Professions Act, 1991 and the Medicine Act, 1991, the College of Physicians and Surgeons (CPSO) is responsible for regulating the practice of medicine to protect and serve the public interest, therefore this recommendation was referred to the CPSO. The CPSO cautioned that the creation of such a registry, in combination with the requirement to complete a mandatory course, has the potential to decrease the number of physicians who are willing to prescribe opioids, with an associated decrease in access to appropriate medications for some patients. Voluntary educational sessions are available on safe opioid prescribing through the University of Toronto, the Centre for Addiction and Mental Health, and the Toronto Rehabilitation Institute.

Voluntary education for physicians prescribing opioids as a policy intervention has not been proven beneficial. A report by the Ontario Drug Policy Research Network (ODPRN) found that voluntary

education programs are not as effective as physician directed interventions for prescribing habits that go beyond the recommended dose. The review team for the current Canadian Guideline could consider revising this dose, based on the extensive evidence collected by the CDC. As an alternative to education, the MOHLTC could have regulation in place whereby a physician would be required to get a second specialist opinion or and that of a local opioid regulatory body prior to prescribing a dose beyond what is recommended in the guideline. Future reports by Health Quality Ontario (HQP) can utilize data from the current NMS such that it can flag the physicians who are not following the dose guidelines for non-cancer pain management and are not using evidence based multidisciplinary approach to pain management. Keeping the opioid load controlled will improve health outcomes because it has been shown that the mortality from opioid overdose is related to the amount prescribed.

17. 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.

At the one-year mark this had not been implemented and the MOHLTC stated it would be considered. However, such limits would only apply to ODB patients (i.e. seniors, social assistance recipients, residents of long-term care homes, home care patients, etc.). They would not preclude prescribers from prescribing additional quantities of opioids, nor would they prevent pharmacies from dispensing additional quantities to ODB patients who are willing to pay for them privately. The MOHLTC identified that this recommendation would fall under the jurisdiction of the Ontario College of Pharmacists (OCP) due to the Drug and Pharmacies Regulation Act. The imposition of any restrictions on the quantity of opioids that could be prescribed or dispensed by physicians or dentists would fall under the purview of the regulatory colleges such as the College of Physicians and Surgeons of Ontario, the Royal College of Dental Surgeons of Ontario, and the Ontario College of Pharmacists.

At the five-year mark, the MOHTLC reported that based on the Ontario Drug Policy Research Network's (ODPRN) analysis of claims data, this did not appear to be a problem with ODB recipients as most opioid claims for ODB recipients are for a one-month supply or less. The responses from the colleges are discussed later.

Jury Recommendation for Aboriginal Affairs and Northern Development Canada

18. 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.

At the one-year mark this was referred to Health Canada which in turn stated that the government is working towards solutions. There was no direct five-year response about this, however the federal government has announced investment to address this problem.

On October 12, 2016, the Government of Ontario announced investments to address the opioid crisis including Indigenous Mental Health and Addiction Initiatives. It has promised to continue to work with Indigenous partners to identify community mental health and addictions priorities and ensure that culturally appropriate investments are made both on and off reserve to improve mental health and

addiction issues in Indigenous communities. A secretariat dedicated specifically to Indigenous communities while working in collaboration with stakeholders utilising the management principles of an outbreak would be helpful.

**Jury Recommendations for MOHLTC/Faculties of Medicine/CPSO/OCP/Michael G. DeGroot
National Pain Centre, McMaster University/Centre for Addiction and Mental Health**

19. 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” (200mg of morphine or equivalent).

At the one-year mark this had not yet been implemented, however a draft of the guideline recommendations was released in January 2017. In terms of policy instruments, guidelines provide movement to shift policy with evidence, the key is to follow the policy cycle such that guidelines are regularly evaluated to stay current. The MOHLTC and Health Canada need to support funding for the revisions of the Canadian Guidelines on a regular basis, at a minimum every three years, and provide the financial support for its dissemination and training.

20. 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.

All medical schools including postgraduate programs now provide curricula on pain management and substance abuse. Appropriate opioid prescribing is also covered. Once the current Canadian Guideline for Safe and Effective Use of Opioids has been reviewed medical schools should be expected to incorporate that into the curriculum.

21. 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.

At the one-year and five-year mark, the MOHLTC and the aforementioned colleges identified extensive resources that are available to both prescribers and dispensers regarding opioid prescription. Education alone without monitoring and regulation may fail to achieve the intended outcome. The ODPRN assessed the effect of a two-day course run by the CPSO designed to promote appropriate opioid prescribing habits. They found that “voluntary enrollment in the course did not show a decrease in opioid prescribing rates during the two-year period following course attendance”. The report stated “if a physician was referred to attend the course by CPSO (e.g. following a complaint), there was a marked decrease in opioid prescribing following referral by the CPSO, but prior to the prescriber completing the course.” This finding has policy implications that entails better legislation and monitoring as opposed to just voluntary education. CPSO oversight and compliance monitoring would help curb prescriber habits.

Jury Recommendations for the College of Physicians and Surgeons of Ontario

22. Considering 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.

At the one-year mark, the College of Physicians and Surgeons of Ontario (CPSO) policy review working group, had considered the above recommendation and did not feel that this requirement would be in the public interest. Their rationale was it may not be the best approach to all cases and could create delays in treatment for severe pain.

The CPSO recommended that the MOHLTC review the accessibility of non-pharmacological approaches to pain management. These approaches often involve unfunded services, which limit the ability of patients to access them, and thus limit the utility of physicians recommending them. The CPSO did not provide a five-year response. The MOHLTC, as mentioned earlier, announced in October 2016 that it plans to develop a chronic pain network and will invest in the provision of alternate services for treating chronic pain.

23. 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.

Currently, physicians who are not members of the Royal College of Physicians and Surgeons of Canada, or the College of Family Physicians of Canada, are not required to complete any continuing education to maintain their license. A policy that requires continuous education in order to be permitted to prescribe opioids will better inform physicians of the harms associated with the prescribing of opioids for chronic non-cancer pain, and reduce overprescribing of opioids.

At the one-year mark, the CPSO stated that developing and updating an educational course is beyond the College's scope, resources, and expertise. Rather, the CPSO's approach is to support those best positioned to develop and offer courses. The CPSO's role in continuing education has been to represent the needs of physicians and work with experts in course development to ensure availability and access for physicians. A five-year response was not provided by the CPSO or the McMaster Pain Center.

As previously mentioned, voluntary education has been found not to be effective in changing prescribing behavior. To address this gap, specific guidelines for chronic non-cancer pain medication, and a national pain management strategy with policies mandating education and monitoring, would be the surest way to address this epidemic. In addition, mandatory second opinion via local community-based chronic pain networks or council will facilitate peer reviews and a more holistic approach to pain management.

24. Enforce random audits of physicians' practices at least every 10 years like the auditing system of the Ontario College of Pharmacists (OCP).

At the one-year mark, this recommendation remained one of CPSO's organizational strategic priorities. CPSO is committed to assessing physicians at least once in every ten-year period which, considering the gravity of the opioid crisis, is not often enough. CPSO reported that through its Out-of-Hospital Premises Inspection Program, it carries out inspection assessments of all interventional pain management clinics every five years which demonstrates the College's commitment to safe and appropriate pain management in the province.

The College did not provide a five-year response. From a policy instrument and policy choice perspective this approach has not worked considering the dose related deaths associated with opioids. As mentioned already, the government has recently announced that HQO will have a role in providing prescribers with data about their prescribing habits in comparison to their peers. A partnership between HQO and CPSO could be an effective method of auditing physicians in real time with prescribing patterns that do not align with the future revised guideline allowing for swift intervention.

25. 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.

Contract approaches are used in other forms of intervention and are effective methods for ensuring equal responsibility of both the physician and the patient when deciding to use opioids. The Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain supports the use of treatment contracts suggesting "a treatment agreement may be helpful, particularly for patients not well known to the physician or at higher risk for opioid misuse." At the one-year mark, the CPSO stated that it supports the use of written treatment contracts where appropriate, however it does not believe that a specific policy for a contract is appropriate in all circumstances. Instead, efforts are focused on promoting the Canadian Guideline and sharing best practices when performing physician assessments. The CPSO did not provide a five-year response.

To address this issue, the CPSO could be more stringent with their members around prescribing policies as prescribing patterns are a root cause of the high rate of opioid misuse in any given community. The CPSO can create training specific to improving screening for patients, improving prescribing, developing narcotic contracts, etc. Once a narcotic contract has been developed, it should be distributed within the circle of care in the event that a patient accesses another health care service.

26. 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.

Physicians should seek as complete a picture of the patient as possible when prescribing opioids. Obtaining patient medical records would be of benefit to both caregivers and patients seeking treatment. Patients who request opioids but decline access to their records might be concealing information that would reduce their chance of obtaining opioids.

At the one-year mark, the CPSO provided information demonstrating that there is an explicit expectation in the College's current Prescribing Practices policy that an appropriate assessment, which would

include a patient history, must be undertaken in advance of prescribing. Also, under the current College Confidentiality of Personal Health Information policy, physicians are advised to document in the medical record any restrictions placed by patients on access to their personal health information.

27. Health care professionals involved in the prescribing or dispensing of opioid medications must:

- a. Assess the risk and minimize harms associated with opioid use by ensuring there is a comprehensive documentation of each patient’s pain condition, general medical condition, psychosocial history, psychiatric status, and substance use history.***
- b. 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 a higher risk for opioid misuse.***

At the one-year mark, the CPSO provided their Medical Records policy that recommends physicians use a Cumulative Patient Profile (CPP) to provide a summary of essential information about the patient. As mentioned before there is an expectation in the College’s current Prescribing Practices policy that an appropriate assessment must be undertaken in advance of prescribing; this would include an appropriate history and physical examination, a diagnosis or differential diagnosis, and a plan for treatment, including follow-up investigations.

The CPSO could play a major role in requiring all physicians to use the available tools in the current opioid guideline. In terms of policy intervention, when best practices are not effectively integrated into medical care, regulatory interventions become essential to protect the health and safety of the community.

28. Recommend movement towards electronic prescription and record keeping in physicians’ offices.

Electronic prescription and record keeping would allow physicians to effectively and efficiently share information regarding patient prescription history, and to set the groundwork for an integrated electronic medical record system. In the 2010 report, Tackling the Opioid Public Health Crisis, the 25th recommendation reads: “Health regulatory colleges should make computer literacy a standard of practice and should educate healthcare professionals on the benefits of EMRs and privacy best practices.”

At the one-year mark, the College fully supported this recommendation and laid the groundwork to make computer literacy a standard of practice for physicians. The College did not provide a five-year response. One of the ways to influence policy is to use already existing structures to align them with policy shifts. The College and the MOHLTC could collaborate to have physician service agreements include the expectation of electronic record keeping for their respective clinics.

29. Conduct urine drug screening with chronic non-cancer pain patients prescribed opiates upon initial consult and continually on high-risk patients.

A policy that mandates unannounced urine screens for new and high-risk repeat patients would aid in the detection and prevention of some of the misuse of prescribed narcotics. At the one-year mark, the College supported the use of urine drug screening, in an informed and appropriate manner, where the health professional is aware of its benefits and limitations. From an evidence based policy perspective it should become standard practice to create a narcotic contract with each patient which would include unannounced urine screening for both new and returning patients. The CPSO did not provide a five-year response.

30. 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.

The Opioid Manager is designed to be used as a point of care tool for health care providers prescribing opioids for chronic non-cancer pain. The tool condenses key elements from the Canadian Opioid Guideline and can be used as a chart insert.

At the one-year mark, the College reported that it had already begun promoting the use of the Opioid Manager and the larger Canadian Guideline Practice Toolkit to its members. The CPSO did not provide a five-year response. Once the current guidelines have been revised, the CPSO and the National Pain Centre can mandate training for the Opioid Manager tool, and the tool kit could include a template of the recommended narcotic contract.

31. Promote the use of ACCS addictions hotline through the Centre for Addiction and Mental Health (CAMH).

Physicians can be more effective in assisting and supporting patients with addiction concerns by utilizing the ACCS addictions hotline as a coordinated resource. At the one-year mark, the College reported that it promotes this resource, for example in the series of community workshops it provides and in the web-based practice resources for physicians. The hotline is also promoted routinely in the methadone newsletters, a publication that goes to physicians with exemptions to prescribe methadone. The CPSO did not provide a five-year response. There is a long list of key resources, it may be helpful and more appealing to physicians if all resources could be accessed under one web-based listing, for instance on the local LHIN's website.

Jury Recommendations for the Ontario College of Pharmacists

32. 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.

At the one-year mark, the Ontario College of Pharmacists (OCP) stated its awareness of the need for balance between the amount of information attached to prescription container and the patient's ability to identify critical components such as identity of medication and directions for use as directed by the prescriber. Auxiliary labels are generally used at the pharmacist's discretion, however to address this

policy gap, the College should make opioid warning labels a standard practice for all opioid prescriptions. The OCP did not provide a five-year response.

33. 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.

Enacting a policy that requires pharmacists to meet with each patient for subsequent refills, as well as prescription modifications, would provide a higher level of consistency in pharmacist/patient consultations. In the one-year response, the OCP stated that it is not only a requirement for pharmacists to discuss initial prescriptions with the patient, but this responsibility extends to all prescriptions. When there is no change to the prescription, the pharmacist must ensure an opportunity for consultation is offered to the patient. If a modification is made to a prescription, it is the duty of the pharmacist to initiate a discussion where the content of the discussion is based on the professional judgment of the pharmacist and may vary under specific considerations. The OCP did not provide a five-year response.

34. Develop a course curriculum, regarding 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.

A course curriculum would provide ongoing training and up-to-date evidence-based information to pharmacists on best practices for appropriate dispensing and utilization of opioids.

In the one-year response from the OCP, it was affirmed that the OCP does not develop or update courses for members, however it will support organizations best positioned to do so. The OCP believes that a requirement for pharmacists to complete a mandatory course would have the potential to restrict the ability of pharmacists presented with a prescription to provide care to the patient. The OCP did not provide a five-year response.

To address the current policy gap, upon revision of the new Canadian Guideline, a mandated educational plan should be implemented for physicians and pharmacists to receive consistent educational programming surrounding the prescription, dispensing, and utilization of opioids.

Jury Recommendation for the Ontario College of Dentistry

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

In the one-year response, the College indicated that they held a symposium on the effective use of opioids for chronic non-cancer pain. An expert panel has also been struck to address the development of advice, practice advisories, and information for the effective use of opioids for chronic non-cancer pain. In the five-year response, it was indicated that the Royal College of Dental Surgeons of Ontario (RCDSO) released a guideline in November 2015 to direct the proper use of opioids within the profession. The Role of Opioids in the Management of Acute and Chronic Pain in Dental Practice

provides guidelines on when it is acceptable to introduce opioids as a pain management technique, and provides information on when it may be appropriate to consult with other medical professionals.

Jury Recommendation for the Ministry of Education

36. Develop and introduce an education program related to opioid abuse beginning in Grade 6.

It was indicated in the one-year follow-up, that in 2007, the Health and Physical Education, Grades 1-12 curriculum, entered the review process. In developing a revised curriculum, the Ministry of Education considered research and held consultations and focus groups with stakeholders. As part of the revised curriculum, consideration was given to strengthening the information and skill-building for students connected to the dangers of prescription drug abuse. Considering the extent of this epidemic, the Ministry of Education should prioritize policy to mandate the implementation of prescribed opioid education in all Ontario schools.

Jury Recommendations for the Ontario Provincial Police/Ontario Association of Chiefs of Police (OACP)/Ministry of Community Safety and Correctional Services/MOHLTC

37. 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.

The one-year response from the OPP stated that there were three officers funded by MOHLTC to investigate double doctoring offences only. Officers received files from MOHLTC and only dealt with members of the Ontario Drug Benefit Plan, not members enrolled in private drug plans. The MOHLTC provided a one-year and five-year response stating that this recommendation falls outside of the purview of the Ministry and should be directed to the Ministry of Community Safety and Correctional Services (MCSCS). The OACP did not provide a one-year response.

The OPP provided a five-year follow-up outlining a MOHLTC/OPP service agreement that funds one detective constable from the Organized Crime Enforcement Bureau-Drug Enforcement Unit who responds to MOHLTC fraud-line reports, and narcotic monitoring system referrals. There is a concern that with only one officer, the needs are not met.

38. In appropriate circumstances, police officers should be required to provide information relating to the misuse or diversion of prescribed opioids to the CPSO.

At the one-year mark, the MCSCS stated it has general authority over the delivery of police service in Ontario; however, it is not a police agency and does not have a mandate to intervene regarding policies and procedures of individual police services. It is the responsibility of the Chiefs of Police to manage day-to-day operations including providing information relating to misuse or diversion of prescribed opioids to the CPSO. The decision to provide information on the misuse or diversion of prescribed opioids to the CPSO rests solely with the OACP and the Commissioner of the OPP.

The one-year response from OPP demonstrated their rejection of this recommendation stating that officers are able to provide information regarding suspects involved in potential diversion of prescribed opioids to the CPSO once information is sworn. In the five-year response, the MCSCS developed guidelines as a primary tool to assist police services with their understanding and implementation of the Police Services Act.

From January 1, 2013 to December 31, 2015, there has been a rise in incidents of the OPP dealing with prescription narcotics occurrences. During that time, OPP fostered a working relationship with the CPSO. When OPP recognizes information received is no longer covered under specific legislative frameworks, such as the Criminal Code of Canada or the Controlled Drugs and Substances Act (CDSA), information is sent to the investigative branch of CPSO for regulatory investigation in respect to schedule 1 to 4 of CDSA (prescription narcotics, prescription opioids).

In terms of policy intervention, KFL&A Public Health has formed a community council that acts as a resource so physicians can have a platform for seeking second opinions and troubleshooting various opioid related scenarios they face in practice. This model can be replicated in all other health units or at a minimum in those communities with high opioid prescribing rates. These communities are already identified by the ODPRN, and this initiative could be coordinated in each public health unit.

Jury Recommendations for the Government of Ontario

39. Amend the Regulated Health Professions Act and/or regulation to include mandatory continuing medical education for all physicians on an annual basis.

The one-year response received by the CPSO states that under current statutory frameworks, all physicians are expected to actively engage in lifelong learning. In Ontario, there is now a specific regulation that requires physicians to demonstrate to the College that they meet the national expectations for continuing professional development. A five-year response was not provided.

Although continuing education is essential, research findings from the ODPRN reveal that it is more effective in combination with a monitoring system where physicians not adhering to the opioid guidelines are required to take mandatory continuing education to change their practice habits.

40. 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.

It was stated at the one-year follow-up that the CPSO would support an enhanced flow of information regarding these serious activities, provided the appropriate safeguards are in place regarding personal health information. A five-year response was not provided. Amendment to this act has not yet occurred, confidentiality could be made into a barrier for intervention.

41. Repeal s.36 (1.3) of the Regulated Health Professions Act (1991).

In the one-year response, the MOHLTC stated they would consider the recommendation and seek additional information through the Federation of Health Regulatory Colleges of Ontario. The MOHLTC will also consider referring this matter to the Health Professions Regulatory Advisory Council (HPRAC) for review.

It was indicated in the five-year response that this will be considered as part of the MOHLTC's Transparency and Openness Strategy for Health Regulatory Colleges, which envisions increased sharing of information between colleges and other regulatory organizations, including the police.

42. Review the issue of opioid abuse, addiction, and diversion and fund drug enforcement at the municipal and provincial levels to enable officers to step up drug prevention, enforcement, and investigation. Strategies should include a focus on prevention, intervention, and suppression.

Limited resources are currently restricting the effectiveness of police efforts to reduce prescription opioid diversion and abuse. The issue of drug enforcement has not been addressed consistently and each police force implements this differently. Policy changes and investment into a narcotic officer role in every community, especially in the identified geographical municipalities, needs to be considered.

43. 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 online.

The government of Ontario has, on October 12th, 2016, released a plan and investment into the opioid crisis that includes efforts related to the above recommendation.

Jury Recommendation for the Michael G. DeGroot National Pain Centre***44. Support the development of a national guideline regarding the management of chronic non-cancer pain for use by health professionals.***

At the one-year follow-up, it was affirmed that this is the mission and vision of the Pain Centre. In the five-year follow-up, it was indicated that this work is currently ongoing within the Pain Center. The MOHLTC is also involved in supporting a multidisciplinary pain management support program. However, Ontario still lacks a provincial holistic pain management strategy that relies less on opioids for pain management and this should be a priority.

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

45. 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:

- a. Conducting further educational sessions/medical symposia aimed at physicians who prescribe opioids and general practitioners and family physicians.***
- b. Distribution of resources (e.g., brochures, PowerPoint presentations).***
- c. Enhancing availability of these resources to physicians – e.g., making them publicly available.***

In the one-year follow-up, the CPSO fully supported this recommendation and had made initial contact with the Royal Canadian Mounted Police, to work toward ensuring physicians can benefit from these existing materials. Although this recommendation does not address pharmacists, the OCP supports its intent and has participated in a meeting organized by the CPSO to bring together health care educators and police service educators to exchange ideas and resources.

In the one-year follow-up, the OPP Drug Enforcement Unit (DEU) with crime prevention section developed two versions of educational presentations for Community Service Officers to deliver to communities, one version intended for a teen audience, and one for adults/parents. The DEU developed pamphlets and also presents to community groups and health care professionals regarding prescription drug abuse.

At the five-year follow-up, the OPP recognized the need to share experience and information regarding prescription drug diversion therefore the OPP/MOHLTC prescription drug diversion officer is also utilized as an educator for the medical community across the province and North America. This member provides lectures on Prescription Drug Diversion, Patch for Patch return program, fentanyl, counterfeit prescriptions, and drug analogues. Groups receiving lectures include but are not limited to the MOHLTC, CPSO, OPC, Criminal Intelligence Service Ontario (CISO), Ontario universities, and private health insurers.

A report is underway in conjunction with the following stakeholders: MOHLTC, Ontario Drug Policy Research Network, and the Coroner's Office of Ontario which will include empirical measurements of the following items: police incidents involving offences related to Fentanyl (21 Ontario Police Agencies), opioid toxicity-related hospital admissions in Ontario, opioid toxicity-related hospitalization rates in Ontario, opioid toxicity-related emergency department visits, dispensing numbers for the identified counties, and fentanyl related decedents in 2014/2015.

46. 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.

At the one-year follow-up, the MOHLTC had been engaging and working closely with the regulatory colleges and associations on implementation issues relating to the Narcotics Strategy, and will consider this recommendation in the context of that work.

The CPSO and OCP work closely on several issues including the use and misuse of opioids. The CPSO and the OCP hosted eight half-day workshops on the Canadian Guideline for approximately 750 physicians and pharmacists across the province, and have also developed joint member communications. Plans are underway for a pilot project addressing collaboration in the provision of methadone, specifically communication between physicians and pharmacists with the goal of improving patient care.

At the five-year follow-up, the MOHLTC continues to work with the Colleges to identify potentially inappropriate prescribing and dispensing. The Ministry has convened the Provincial Opioid Education Working Group (POEWG) and meets bimonthly to facilitate exchange of information and promote collaboration with key stakeholders. Stakeholders were notified that they may be asked to incorporate recommendations into their work plans pertaining to knowledge exchange, training, and new guidelines that could emerge from the Methadone Treatment and Services Advisory Committee and a more comprehensive approach to addressing the issue of problematic prescription opioid use in Ontario.

The report from the above committee was released in June 2016 proposing that Health Quality Ontario, in collaboration with the MOHLTC, CPSO, and other professional organizations and regulators, should develop standards on opioid prescribing.

47. Education and cooperative opportunities should be created in communities throughout Ontario and could include:

- a. Training regarding proper prescribing, dispensing, and monitoring for patients who are prescribed opioids.***
- b. Training regarding Ontario's privacy laws.***
- c. 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.***
- d. The CPSO and OCP should undertake ongoing joint 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.***

The CPSO supported this recommendation at the one-year mark and stated they continue to collaborate with the OCP as they communicate new requirements under the NSAA with respective members through their websites and member magazines. The OCP also strongly supports this recommendation and has met with CPSO and MOHLTC to gain a better understanding of the data which was recently collected and made available. Both colleges anticipate developing a joint communication to make expectations clear to all parties involved in the handling of prescribed opioids.

The latest news release from the government related to Health Quality Ontario providing feedback to physicians about prescribing practices will be one of the ways to close the loop on their practice habits as compared to peers. As previously mentioned, public health units are well positioned within the community to lead collaborations, and KFL&A Public Health can be used as an example with a developed action plan.

48. 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:

a. Where the police officer has reasonable grounds to believe that an individual is diverting prescription medication and the officer can identify the prescriber and/or dispenser of that medication.

b. Where the police officer has received a report of stolen medication, and believes that report to be unfounded.

At the one-year follow-up, the MCSCS provided the same response as received for recommendation 38. However, the OPP stated that officers can engage health care providers regarding diversion of medication. However, contacting a prescriber outside appropriate circumstances may cease or jeopardize an ongoing investigation, and doing so without sworn information may lead to civil liability.

At the five-year follow-up, the OPP indicated that a MOHLTC position member participated in a pilot project within the Ontario Narcotics Monitoring System in finding fraudulent prescriptions. OPP adopted investigative procedure of contacting physicians regarding stolen/diverted medication. Non-scheduled medications are checked through physicians to verify the person in possession is authorized, or stolen property investigation is commenced.

In order to address an epidemic of this proportion, this recommendation requires a multidisciplinary approach. Assigning each police service a narcotics officer would support the above collaboration. If that is not achievable, the OPP should provide narcotics officers to geographical areas in Ontario with the highest rates of narcotic prescriptions.

Conclusion

The five-year follow-up analysis reveals that only 19 of 48 recommendations have been fully implemented. Despite expert-driven policy recommendations to address the epidemic, prescribing habits in Ontario have not changed significantly. There has not been a decisive decrease in opioid-related morbidity or mortality rates, and the ongoing epidemic demonstrates the failure to implement effective health policy in a timely fashion. A recent report released from the MOHLTC using data from the Narcotic Monitoring System revealed that 1.96 million Ontarians were dispensed an opioid in 2014/15; the data is broken down by each LHIN. A public health crisis of this magnitude calls for a robust response from the federal and provincial/territorial governments. It needs a focused, integrated, long-term intervention based on the managing principles of a public health outbreak. There is a need for an effective dashboard that monitors the success of policy intervention, including drug-related infections, the narcotic monitoring system prescribing data, and the maps and analysis provided in the Ontario Narcotic Atlas. Given the complexity of this issue and the multiple areas of government involved, there will be an ongoing requirement from a central secretariat to coordinate a government response. They should be given the mandate, staffing, budget, and data outlets to enable them to accomplish a decrease in the overall community opiate load resulting in a decrease in harms and death associated with opioids. These components will provide a greater ability to collect, analyze, and report on the prescribing and dispensing of narcotics, and assist in identifying and addressing the systemic challenges that may lead to addiction and death.

APPENDIX A

**SUMMARY OF RESPONSES TO RECOMMENDATIONS
REGARDING THE INQUEST INTO THE DEATH OF:
Dustin Nicholas KING
Donna Marie BERTRAND**
Date of Death: November 21, 2008
December 2, 2008
Date of Inquest: May 30, 2011 – July 5, 2011
Inquest number: Q2011-22
Presiding Coroner: Dr. R. Skinner

Recommendation Number	Ministry(s)/Organization(s)/Subject Areas Assigned Recommendation	Lead Agency(s)/Ministry(s)/Organization(s) responding to Recommendation	No Response	Date of Response	CMM Tracking Number	Response Analysts
1	Health Canada	Health Canada		14 February 2012		8
2	Health Canada	Health Canada		14 February 2012		1B
3	Health Canada	Health Canada		14 February 2012		4A
4	Health Canada	Health Canada		14 February 2012		5
5	Health Canada	Health Canada		14 February 2012		2
6	Health Canada	Health Canada		14 February 2012		1
7	Ministry of Health and Long Term Care	Ministry of Health and Long Term Care		12 July 2012		1A
8	Ministry of Health and Long Term Care	Ministry of Health and Long Term Care		12 July 2012		2
9	Ministry of Health and Long Term Care	Ministry of Health and Long Term Care		12 July 2012		2
10	Ministry of Health and Long Term Care	Ministry of Health and Long Term Care		12 July 2012		2
11	Ministry of Health and Long Term Care	Ministry of Health and Long Term Care		12 July 2012		2
12	Ministry of Health and Long Term Care	Ministry of Health and Long Term Care		12 July 2012		2
13	Ministry of Health and Long Term Care	Ministry of Health and Long Term Care		12 July 2012		2
14	Ministry of Health and Long Term Care	Ministry of Health and Long Term Care		12 July 2012		1
15	Ministry of Health and Long Term Care	Ministry of Health and Long Term Care		12 July 2012		8
16	Health Canada	Health Canada		14 February 2012		5
	Ministry of Health and Long Term Care	Ministry of Health and Long Term Care		9 May 2012		5
17	College of Physicians and Surgeons of Ontario	College of Physicians and Surgeons of Ontario		12 July 2012		1B
	Ministry of Health and Long Term Care	Ministry of Health and Long Term Care		12 July 2012		2
18	Ministry of Aboriginal Affairs and Northern Development Canada	Ministry of Aboriginal Affairs and Northern Development		9 January 2012		5

LEGEND: 1 Has been implemented 1A Will be implemented 1C Alternate will be implemented
 2 under consideration 3 unresolved issues 4 rejected 4A rejected due to lack of resources
 5 did not apply to assigned agency 6 no response 7 unable to evaluate 8 Content or intent of recommendation already in place

19	Ministry of Health and Long Term Care College of Physicians and Surgeons of Ontario Michael G. DeGroote National Pain Centre Queen's University Department of Medicine Faculty of Medicine, University of Ottawa Northern Ontario School Of Medicine Faculty of Health Sciences, McMaster University Faculty of Medicine, University of Western Ontario Faculty of Medicine, University of Toronto Ontario College of Pharmacists Centre for Addiction and Mental Health	Ministry of Health and Long Term Care College of Physicians and Surgeons of Ontario Queen's University Department of Medicine Faculty of Health Sciences, McMaster University Faculty of Medicine, University of Toronto Ontario College of Pharmacists	12 July 2012 9 May 2012 3 August 2012 18 September 2012 1 November 2011 1 August 2012	2 1 & 1A 2 1A 5 1 8
20	Queen's University Department of Medicine Faculty of Medicine, University of Ottawa Northern Ontario School Of Medicine Faculty of Health Sciences, McMaster University Faculty of Medicine, University of Western Ontario Faculty of Medicine, University of Toronto	Queen's University Department of Medicine Faculty of Health Sciences, McMaster University Faculty of Medicine, University of Toronto	3 August 2012 18 September 2012 1 November 2011 12 July 2012 9 May 2012 3 August 2012	8 1A 1 2 1 & 1A 8
21	Ministry of Health and Long Term Care College of Physicians and Surgeons of Ontario Michael G. DeGroote National Pain Centre Queen's University Department of Medicine Faculty of Medicine, University of Ottawa Northern Ontario School Of Medicine Faculty of Health Sciences, McMaster University Faculty of Medicine, University of Western Ontario Faculty of Medicine, University of Toronto Ontario College of Pharmacists Centre for Addiction and Mental Health	Ministry of Health and Long Term Care College of Physicians and Surgeons of Ontario Queen's University Department of Medicine Faculty of Health Sciences, McMaster University Faculty of Medicine, University of Toronto Ontario College of Pharmacists	18 September 2012 1 November 2011 1 August 2012	1 & 1A 1 1B
22	College of Physicians and Surgeons of Ontario	College of Physicians and Surgeons of Ontario	9 May 2012	1C
23	College of Physicians and Surgeons of Ontario	College of Physicians and Surgeons of Ontario	9 May 2012	1B
24	College of Physicians and Surgeons of Ontario	College of Physicians and Surgeons of Ontario	9 May 2012	1A
25	College of Physicians and Surgeons of Ontario	College of Physicians and Surgeons of Ontario	9 May 2012	4A
26	College of Physicians and Surgeons of Ontario	College of Physicians and Surgeons of Ontario	9 May 2012	8 & 1C
27	College of Physicians and Surgeons of Ontario	College of Physicians and Surgeons of Ontario	9 May 2012	8 & B
28	College of Physicians and Surgeons of Ontario	College of Physicians and Surgeons of Ontario	9 May 2012	1A
29	College of Physicians and Surgeons of Ontario	College of Physicians and Surgeons of Ontario	9 May 2012	8
30	College of Physicians and Surgeons of Ontario	College of Physicians and Surgeons of Ontario	9 May 2012	1
31	College of Physicians and Surgeons of Ontario	College of Physicians and Surgeons of Ontario	9 May 2012	8

LEGEND: 1 Has been implemented 1A Will be implemented 1B Alternate has been implemented 1C Alternate will be implemented
 2 under consideration 2A rejected 2B rejected due to lack of resources 2C rejected due to lack of resources
 3 did not apply to assigned agency 3A unable to evaluate 3B content or format of recommendation already in place

32	Ontario College of Pharmacists	Ontario Provincial Police	Ontario Provincial Police	1 August 2012	4A
33	Ontario College of Pharmacists	Ontario Provincial Police	Ontario Provincial Police	1 August 2012	8
34	Ontario College of Pharmacists	Ontario Provincial Police	Ontario Provincial Police	1 August 2012	1B
35	Royal College of Dental Surgeons of Ontario	Ministry of Education	Royal College of Dental Surgeons of Ontario	30 September 2011	1
36	Ministry of Health and Long Term Care	Ministry of Health and Long Term Care	Ministry of Health and Long Term Care	13 October 2011	8
37	Minister of Community Safety and Correctional Services	Ontario Provincial Police	Ontario Provincial Police	12 July 2012	5
38	Ontario Association Of Chiefs of Police	Ontario Provincial Police	Ontario Provincial Police	25 April 2012	1B
39	Minister of Community Safety and Correctional Services	Ontario Provincial Police	Minister of Community Safety and Correctional Services	11 May 2012	5
40	Ontario Association Of Chiefs of Police	Ontario Provincial Police	Ontario Provincial Police	25 April 2012	4A
41	*College of Physicians and Surgeons of Ontario (not required)	Ministry of Health and Long Term Care	*College of Physicians and Surgeons of Ontario	9 May 2012	2
42	*College of Physicians and Surgeons of Ontario (not required)	Ministry of Health and Long Term Care	Ministry of Health and Long Term Care	12 July 2012	1B
43	*College of Physicians and Surgeons of Ontario (not required)	Ministry of Health and Long Term Care	*College of Physicians and Surgeons of Ontario	9 May 2012	8 & 1B
44	Ministry of Health and Long Term Care	Ministry of Health and Long Term Care	Ministry of Health and Long Term Care	12 July 2012	2
45	Ministry of Health and Long Term Care	Ministry of Health and Long Term Care	Ministry of Health and Long Term Care	9 May 2012	2
46	Minister of Community Safety and Correctional Services	Ontario Provincial Police	Minister of Community Safety and Correctional Services	12 July 2012	2
47	Ontario College of Pharmacists	Ontario Provincial Police	Ontario College of Pharmacists	12 July 2012	5
48	Minister of Community Safety and Correctional Services	Ontario Provincial Police	Minister of Community Safety and Correctional Services	12 July 2012	1A
4	Health Canada	Health Canada	Minister of Community Safety and Correctional Services	18 September 2012	1A
	Health Canada	Health Canada	College of Physicians and Surgeons of Ontario	12 July 2012	5
	Health Canada	Health Canada	College of Physicians and Surgeons of Ontario	9 May 2012	4A

APPENDIX B

Table Summary of Recommendations Comparing One and Five-Year Follow-Up Responses

Organization and # of Recommendations	1-year	5-year
<p>Health Canada (HC) - 6 Recommendations (1-6)</p> <ol style="list-style-type: none"> 1. Fund research into opioids 2. Review all opioids products 3. Withdraw approval of >100 mg ME 4. Review product monograph for adequate warnings 5. Provide guidance to develop abuse resistant formula 6. Support for developing a national guideline for chronic non-cancer pain 	<p>1 out of 6 Implemented at 1 Year</p> <ol style="list-style-type: none"> 1. Content in place 2. Alternate implemented 3. Rejected due to flaws 4. Did not apply to agency 5. Under consideration 6. Implemented 	<p>3 out of 6 Implemented at 5 Years</p> <ol style="list-style-type: none"> 1. HC has funded research into effectiveness of opioids in the Rx of chronic back pain via the CIHR and facilitated the ease of naloxone kits. It has funded the new Chronic Pain Research Network at McMaster University. 2. A guidance document has been developed for TR formulations and changes to product monographs have been introduced. 3. Not implemented yet, Ontario delisted 200 mg ME from ODB in Jan 2017. 4. Partially in place. 5. Not implemented, however guidelines have been provided by HC. 6. Implemented. Provided funding and support for a revised national guideline, McMaster Pain Centre has released a draft of the document in Jan 2017.

<p>Ministry of Health and Long Term Care (MOHLTC) - 9 Recommendations (7-15)</p> <ul style="list-style-type: none"> 7. Review all opioids on the ODB 8. Remove from ODB opioids that exceed >100 mg ME 9. Increase current 30-day inappropriate prescribing alerts to 120 days 10. Double doctoring flags to last for 120 days 11. Remove >40mg oxycodone products from the ODB 12. Prioritise electronic drug information system 13. Prioritise Bill 101 (NSA) 14. Enact regulations to monitor prescription and dispensing, and sharing of information with police 15. Develop a strategy to treat pain and addiction in Ontario 	<p>2 out of 9 Implemented at 1 Year</p> <ul style="list-style-type: none"> 7. Will be implemented 8. Under consideration 9. Under consideration 10. Under consideration 11. Under consideration 12. Under consideration 13. Implemented 14. Implemented 15. Content in place 	<p>5 out of 9 Implemented at 5 Years</p> <ul style="list-style-type: none"> 7. Implemented. Effective Jan 2017, higher strengths of long-acting opioids have been delisted from the ODB Formulary: Morphine 200 mg tablets; Hydromorphone 24 mg and 30 mg capsules; Fentanyl 75 mcg/hr and 100 mcg/hr patches; and Meperidine 50mg tablets. 8. Not implemented. MOHLTC sub-committee to consider recommendation. 9. Not implemented. Working on electronic monitoring. 10. Not implemented. Working on electronic monitoring. 11. Implemented. Oxycontin was removed from the ODB Feb 2012, Oxyneo was moved to special access. 12. Not fully implemented. 13. Implemented. 14. Implemented. Regulation not required, information can be shared. 15. Implemented. In October 2016, the government announced support and investment for alternate therapy for pain management.
<p>HC/MOHLTC/CPSO- 2 Recommendations (16-17)</p> <ul style="list-style-type: none"> 16. Mandatory registry for opioids prescribed >200 mg ME per day and Physicians to be mandated to take a course 17. MOHLTC to limit amount of prescription dispensed 	<p>0 of 2 Implemented at 1 Year</p> <ul style="list-style-type: none"> 16. Not implemented 17. Under consideration 	<p>0 of 2 Implemented at 5 Years</p> <ul style="list-style-type: none"> 16. Not implemented. Currently education is voluntary 17. Not implemented.
<p>Aboriginal Affairs and Northern Development Canada: 1 Recommendation (18)</p> <ul style="list-style-type: none"> 18. Address substance abuse in general and opioids abuse 	<p>0 of 1 Implemented at 1 Year</p> <ul style="list-style-type: none"> 18. Did not apply, deferred to HC. 	<p>0 of 1 Implemented at 5 Years</p> <ul style="list-style-type: none"> 18. Partially implemented. Federal government announced investment to address addiction

<p>MOHLTC/Faculties of Medicine/CPSO/OCP/Michael G. DeGroote National Pain Centre, McMaster University/Centre for Addiction and Mental Health - 3 Recommendations (19-21)</p> <p>19. Update the current Canadian Guideline for opioid use and the watchful dose by 2015 20. All Canadian medical schools to review their curriculum on pain management and mandate the training on Canadian opioid guidelines 21. Academic detailing for prescribers and dispensers</p>	<p>0 of 3 Implemented at 1 Year</p> <p>19. Not implemented 20. Not Implemented 21. Not Implemented</p>	<p>1 of 3 Implemented at 5 Years</p> <p>19. A draft of the guideline has been released. 20. Has been implemented. 21. Partially Implemented. Ongoing education and resources available, however not mandated for all prescribers and dispensers.</p>
<p>College of Physicians and Surgeons of Ontario (CPSO) - 10 Recommendations (22-31)</p> <p>22. Issue policy statement that all Opioid prescribers to consider other options for pain management first 23. Develop a curriculum for the Canadian opioid guidelines and ensure all prescribers take it 24. Enforce random audits for physicians at least every 10 years 25. Mandate physicians use of opioid contracts with their patients 26. Physicians to get consent and seek previous medical records 27. Prescribers/dispensers to use the opioid screening tools, assess risks and minimize harm 28. Electronic prescriptions/record keeping 29. Conduct urine drug screening 30. Physicians to use the opioid manager tools 31. Promote use of addiction hotline</p>	<p>1 of 10 Implemented at 1 Year</p> <p>22. Not implemented 23. Alternate was implemented 24. Will be implemented 25. Rejected due to flaws 26. Content in place 27. Content in place 28. Will be implemented. The CPSO supports this recommendation and has made computer literacy a requirement 29. Content in place 30. Implemented 31. Content in place</p>	<p>3 of 10 Implemented at 5 Years</p> <p>22. Not implemented. No five-year response, however CPSO has reviewed their policies. 23. Not implemented. No five-year response, the CPSO sees curriculum development as beyond their scope and is not in favour of mandating courses. 24. No five-year response. 25. Not implemented. No five-year response. 26. Implemented. No five-year response, Ontario is working on an EMR. 27. Content in place. No five-year response. 28. No five-year response but the college is supportive of this. 29. No five-year response but the College supports the practice. 30. Implemented and supported. 31. Implemented and supported.</p>
<p>Ontario College of Pharmacists (OCP) - 3 Recommendations (32-34)</p> <p>32. Affix auxiliary warning labels and give hotline number 33. Initial and subsequent patient counselling 34. Dispensers to be mandated to take the course on Canadian opioid guideline</p>	<p>1 of 3 Implemented at 1 Year</p> <p>32. Rejected due to flaws 33. Implemented/Content in place 34. Alternate has been implemented. Continuing education is required but not mandated, beyond the scope of the OCP.</p>	<p>1 of 3 Implemented at 5 Years</p> <p>32. Not implemented. No five-year response. Auxiliary labels used at pharmacist's discretion. 33. Implemented. Pharmacists are required to consult with patient for all prescriptions and ensure opportunity for consult is provided for subsequent refills. 34. Not Implemented. Supported but not mandated.</p>

<p>Ontario College of Dentistry - 1 Recommendation (35)</p> <p>35. Disseminate the opioid guideline and ensure education on same</p>	<p>1 of 1 Implemented at 1 Year</p> <p>35. Implemented</p>	<p>1 of 1 implemented at 5 Years</p> <p>35. Implemented</p>
<p>Ministry of Education - 1 Recommendation (36)</p> <p>36. Start early education on opioid from grade 6</p>	<p>0 of 1 Implemented at 1 Year</p> <p>36. Content in place. The Ministry has an educational program in place, it is up to the school to deliver it.</p>	<p>0 of 1 Implemented at 5 Years</p> <p>36. Content In place. However, programming varies by school board.</p>
<p>Ontario Provincial Police/Ontario association of chief of police(OACP) Chief of Police/Ministry of Community Safety and Correctional Services/MOHLTC- 2 Recommendations (37-38)</p> <p>37. Resource a provincial drug enforcement unit 38. Require police officers to provide misuse/abuse/diversion info to CPSO</p>	<p>0 of 2 Implemented at 1 Year</p> <p>37. Alternate has been implemented 38. Rejected due to flaws. Information may be provided once an information is sworn.</p>	<p>0 of 2 Implemented at 5 Years</p> <p>1. Alternate has been implemented. Only one officer funded, down from 3 officers at 1 year mark. 2. Content in place. Information can be provided to CPSO when no longer covered under specific legislative frameworks (ex. CCC, CDSA). However, not a requirement.</p>
<p>Government of Ontario - 5 Recommendations (39-43)</p> <p>39. Amend the RHPA to mandate annual medical education for physicians for opioid 40. Amend Section 36(1)(e) of the Regulated Health Professions Act (1991), to facilitate action by the police for opioid abuse 41. Repeal s.36(1.3) of the Regulated Health Professions Act (1991) 42. Fund drug enforcement units at municipal and provincial level 43. Fund a public education campaign</p>	<p>0 of 5 Implemented at 1 Year</p> <p>39. Alternate has been implemented. Not amended but the CPSO has this expectation. 40. Under consideration 41. Under consideration 42. Did not apply 43. Alternate has been implemented</p>	<p>1 of 5 Implemented at 5 Years</p> <p>39. Not implemented. Continuous education is expected but not mandated. No five-year response. 40. Not implemented. No five-year response. 41. Under consideration. 42. Not Implemented. Currently up to individual police services to provide funding. 43. Implemented. Government has announced more funding for this.</p>
<p>Michael G. DeGroote National Pain Centre - 1 Recommendation (44)</p> <p>44. Support the development of a national guideline for chronic non-cancer pain management</p>	<p>0 of 1 Implemented at 1 Year</p> <p>44. Will be implemented. Current guideline being reviewed</p>	<p>1 of 1 Implemented at 5 Years</p> <p>44. Implemented. Draft guideline was released in Jan 2017.</p>

<p>Government of Ontario, Ontario Provincial Police, Municipal Police Forces, College of Physicians and Surgeons, Ontario College of Pharmacists, MOHLTC, Ministry of Community Safety and Correctional Services - 4 Recommendations (45-48)</p> <p>45. Distribute educational resources related to opioids to physicians and others.</p> <p>46. Put on joint education sessions for physicians and pharmacists by CPSO, OCP and police.</p> <p>47. Educational and cooperative opportunities to be created across Ontario communities.</p> <p>48. Police officers should collaborate with physicians</p>	<p>2 of 4 Implemented at 1 Year</p> <p>45. Implemented</p> <p>46. Content in place</p> <p>47. Implemented</p> <p>48. Rejected due to flaws</p>	<p>3 of 4 Implemented at 5 years</p> <p>45. Implemented. There is ongoing collaboration and sharing of educational resources</p> <p>46. Implemented. The MOHLTC has a Provincial Opioid Education Working Group and it works with all parties to provide education, and has published a report in June 2016.</p> <p>47. Implemented. In progress and collaboration are occurring, a good example of community level is that of KFLA health unit.</p> <p>48. Rejected due to flaws. Act of notifying a prescriber may jeopardize an investigation.</p>
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