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PRESCRIPTION DRUG MISUSE

Caught in the web of addictive prescription medication

**Summary Report of the Focus Groups
for the
Coalition on Prescription Drug Misuse (CoOPDM)
www.prescriptiondrugmisuse.ca**

December 11, 2009

**Prepared by
Ann Goldblatt, Consultant
Edmonton, Alberta**

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Executive Summary

A. Introduction

The Coalition on Prescription Drug Misuse (CoOPDM) formed in 2008 to address 'prescription medication misuse' issues facing individuals, physicians, pharmacists, addictions and mental health service providers and the police.¹ The collaborative initiative brought together organizations with a shared interest in a better understanding of the issues and in taking action for the benefit of both those caught in the web of harmful prescription drug use and those providing services.

The coalition launched two community demonstration projects in Alberta, one of which is in the inner city of Edmonton, bringing in three additional organizations, Boyle McCauley Health Centre, George Spady Centre and StreetWorks. The inner city agency representatives joined with members of CoOPDM to form a Project Planning Committee.

Early discussions within the Project Planning Committee identified a host of issues needing attention and a desire to learn from and offer education and support to key stakeholders. CoOPDM committed to sponsoring a series of focus groups and contracted a consultant to help design and facilitate the process.

Methodology and voices represented

With the support of the CoOPDM Coordinator, Project Planning Committee members took on the role of recruiting participants and organizing the focus groups for their respective sectors. The six groups met between the end of September and the end of October 2009, engaging a total of 69 people:

As it Is People with lived experience	Law Enforcement Members	Pharmacists	Downtown Service Providers	Addiction and Mental Health Treatment Workers	Physicians
7	17	10	10	14	11

¹ Coalition members represent the following organizations:

- Alberta College of Pharmacists
- Alberta Health Services – Addictions and Mental Health Services (formerly AADAC and Regional Mental Health)
- College of Physicians and Surgeons of Alberta (Co-Chair)
- Edmonton Police Services
- Health Canada
- RCMP (Co-Chair)

For the purpose of grounding the discussions in the lived experience of people who use drugs, the facilitator began the consultation with members of *As it is*, a chapter of AAWEAR (Alberta Addicts who Educate and Advocate Responsibly). AAWEAR is a provincial network of groups formed to give voice to people with a history of drug use.

B. Key findings

The experiences that came forward during the six focus groups shed light on the circumstances of people living with prescription medication issues and on shared and unique challenges for each stakeholder group. The insights and challenges are highlighted below.

1. Who are the people with prescription medication issues? What are their circumstances?

The people who have prescription medication issues, and their circumstances, cluster into several 'groups', though individuals may fit into more than one description.

People with physical or mental health problems who are prescribed potentially addictive medications to alleviate their symptoms. Over time, the addiction takes hold and they need higher doses to deal with the symptoms and their addiction. An estimated 30% of people with a prescription addiction began by taking medication to relieve physical pain.	People who have or previously had a substance addiction develop physical or mental health problems. To alleviate health problems, they are prescribed medications that can be addictive, adding to and creating a renewed problem with substance addiction.	People who use medications in ways that are different from how the medications were prescribed, e.g. use at higher doses, use to relieve or treat other symptoms, use by injecting or snorting the medication in a powder form.
People who use other people's prescription medications.	People who sell a portion or all of the prescribed medication. The money is sometimes used to purchase other medication or street drugs.	People use prescription medications recreationally. Underlying issues and factors may be part of the picture.

2. What are the overarching challenges?

- Usage, resulting from any one or more of the circumstances described above, creates **harmful effects** for individuals. In turn, feeding the addiction can put people in **vulnerable** situations, those seeking medication and those who supply it (e.g. pharmacies). Prescription medication is legitimized by the fact that physicians prescribe it and is not recognized as a product that can be harmful.
- Individuals with an addiction to prescription medication **use more than one doctor or pharmacy** to access the medications they are seeking. Some people

who are unable to get the quantity they want from their physician **purchase it on the street** or acquire it in other ways Some are **combining** the prescribed medications with street drugs.

- **Knowledge gaps** related to prescription medication has a significant impact on physicians' prescribing practices, leading to both over and under-prescribing. Insufficient knowledge is also a concern among pharmacists, community service providers and police officers, affecting their capacity to assess problems. People receiving prescriptions are **not informed** about the addictive potential of particular medications they are taking.
- **Insufficient skills** in responding to requests and sometimes pressure for medication to relieve pain and other symptoms has an impact on physicians' prescribing practices. The time required to explore alternatives (non-addictive medication or alternative approaches) is compromised by factors that include the shortage of physicians.
- **Lack of follow-up** by physicians for people who have been prescribed addictive medications is a concern for people with addictions, fellow physicians, pharmacists, downtown service providers, addiction and mental health providers and police.
- **Communication barriers** among and between all of the providers consulted make it difficult to identify, assess and follow up on problems and to coordinate responses. Netcare, a potential source of information for medication history, is used intermittently by physicians and pharmacists due to factors that include time pressures.
- While providing prescriptions with shorter intervals (e.g. renewing weekly instead of every three months) is safer in many circumstances, **dispensing fees** are a barrier for people with low incomes. Pharmacies are challenged by **delays in coverage approval**.

3. Stakeholder-specific issues

Focus groups brought to light issues that are part of their lived and practice experience.

As it is – people with lived experience

- The language of prescription 'misuse' feels judgmental, placing the full responsibility on individuals.
- Addictive prescription medication use is often rooted in wanting to escape from painful experiences, depression and anxiety. Service providers need to take time to understand the underlying issues and make appropriate referrals for support rather than relying solely on medication.
- People with addictions develop a tolerance for medication and require higher doses for effective pain management.
- People do not feel respected by physicians and hospital staff because of their appearance, race and income level.
- Non-judgmental, mutual support groups are valuable.

Physicians

- Physicians do not receive adequate training on assessment and treatment strategies, particularly for pain management and providing services to people with addictions. Medical school includes minimal hours in these areas.
- Many physicians do not exercise good judgment in the medications they prescribe, under- or over-prescribing.

- Physicians build relationships based on trust rather than patient safety as the guiding principle. Appropriate prescription intervals and adequate follow-up with patients receiving addictive medication prescriptions are critical. Physicians need to be aware that some people sell their medications because they need instant cash.
- Dispensing fees are a barrier to shorter prescription intervals.
- Families accumulate large quantities of medication in the home following surgery or during end-of-life care, creating a temptation to divert the medication for other purposes.

Pharmacists

- When pharmacists are concerned about prescriptions, they face barriers communicating with physicians who are either difficult to reach or not receptive to being questioned about their prescribing choices. Reading physicians' handwriting can be problematic.
- Pharmacies encounter communication barriers with other pharmacies due to privacy restrictions.
- Customers questioned by pharmacists or told their prescription request cannot be met often go to another pharmacy in search of a different response.
- Pharmacies are threatened by customers seeking large quantities of addictive medication, especially Oxycontin, putting the safety of the pharmacy at risk.

Downtown service providers

- Service providers encounter communication barriers with physicians and hospital staff, receiving inadequate or incomplete medical information for people accessing their day or overnight programs and services. They would like to be able to link with a 24 hour call centre to provide advice in the event of adverse reactions.
- Service providers do not have adequate information on the effects of combining prescription medication with street drugs.

Addiction and mental health treatment providers

- Addiction treatment providers find that they have neither the assessment tools nor the training to prepare them to adequately assess for prescription drug use problems.
- Treatment providers are concerned about prescribing practices among physicians who prescribe addictive medications to address underlying issues without adequate assessment, consideration of alternatives, patient education or follow-up. People are not aware that certain prescription medications they are taking are potentially addictive.
- Funding cuts for alternative forms of treatment, including physiotherapy and massage, keep the focus on prescription medication to manage pain. People face access barriers to treatment programs, including waiting lists and inadequate program length.
- Treatment providers estimate 30% of addictive prescription medication use started out as pain control.

Law enforcement members

- Selling prescription medication on the street yields a significant return.

- Police encounter communication barriers with physicians and pharmacists due to privacy restrictions. In the absence of information about the legitimacy of prescriptions issued, it is difficult to investigate potentially criminal possession.
- Prescription medication use is socially acceptable. The laws prevent members from charging individuals with possession alone; there must also be evidence of trafficking to lay a charge.
- The federal focus for the RCMP, framed by the National Drug Strategy, is on synthetic rather than prescription medication.

C. Emerging Solutions

Participants offered a range of solutions, including strategies already in use in some circles. The solutions relate to prescribing practices, communication between providers, education for providers and access to services for people dealing with addictions.

Prescribing practice

- Shorten dispensing intervals if physician is concerned about an individual's safety.
- Shorten dispensing intervals toward the end of life to reduce the likelihood of accumulating large amounts of addictive medication in the home.
- Contract with family members to bring medications back after an individual has died.
- Include in physician guidelines for prescribing addictive medications:
 - Assessment tools, e.g. useful language to develop joint solutions with patients
 - Appropriate medications
 - Alternative methods
 - Follow-up care as an essential step in prescribing addictive medications
 - Effective approaches for treating people with addictions

Communication between providers

- Increase effective use of data base systems (i.e. Netcare, Wellnet); reduce technical challenges. Consider negative consequences if access is limited for people living with addictions.
- Clarify the kind of information that can be shared among members of a care team that respects privacy but maximizes benefits and reduces harm for individuals.
- Clarify information that the College of Physicians and Surgeons of Alberta (CPSA) can provide regarding prescribing and usage patterns.
- Communicate CPSA procedures for investigating complaints. Review gaps in follow-up on complaints filed by pharmacists.
- Provide pharmacies and physicians with information on accessible community resources; create opportunities for health professionals to develop relationships with other providers.
- Produce 'cheat sheets'/pocket-sized cards with key information about prescription medication, e.g. types, amounts, effects of combining substances.

Education

- Revisit language on prescription 'misuse' that can be perceived as judgmental by people receiving prescriptions.

- Provide tailored education on medication to the public, physicians, pharmacists, downtown service providers, addiction and mental health treatment providers, and law enforcement members.
- Provide an on-call number providers can use with queries about medication.
- Increase education for health professionals on harm reduction.
- Build into health professional education programs substantive time on addictive medications and pain management.
- Deliver the message to health service providers that addiction is a legitimate condition that needs attention. Build the capacity of health professionals to work effectively with people who have addictions.
- Build inner-city community learning into professional development of health professionals.
- Increase public education on what to do with leftover pills and what to do with medications after a family member dies.
- Pick up medications as a routine part of the process of collecting home aids on loan after a person has died.
- Promote AAWEAR and other mutual support groups for people using addictive substances.
- Open addiction treatment programs to people on methadone.

Services

- Increase funding to shorten wait periods and extend the length of addiction treatment programs.
- Advocate for restored funding for alternative treatment to manage pain (e.g. physiotherapy, massage).
- Consider ways to increase the likelihood that people will use one pharmacy.
- Create more avenues for self-referral to alternative support programs and services rather than channeling referrals through physicians.
- Address turn-around time for third party coverage approval.

D. Concluding remarks

Addictive prescription medication use, particularly opioids, creates a web of concerns among people receiving medication and those who provide health, social and law enforcement services. The focus of this consultation was been on the inner city population of Edmonton.

Pain control is often the trigger that starts an individual down the path of becoming addicted to a prescribed medication, though there may be an underlying addiction. Medication choices that result in under- or over-prescribing and gaps in the use of alternative forms of treatment reflect physician knowledge and skills as well as the availability of resources to support follow-up care and service access. Pharmacists are under pressure to respond to requests to fill questionable prescriptions. In turn, downtown service providers, addiction and mental health treatment providers and law enforcement members address the domino of consequences. All of the stakeholders consulted through the focus groups had suggestions for short and longer term strategies to mitigate the problems, addressing prescribing practices, communication between providers, education and service access. Changes in each of these areas will achieve benefits for individuals, service providers and communities.

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Table of Contents

A. Introduction	9
1. Methodology and voices represented	9
2. Report format	10
B. Overall findings	10
1. Who are the people with prescription medication issues? What are their circumstances?	10
2. What are the primary challenges?	11
3. Trends in prescription medication use	11
C. Specific focus group findings	12
1. People with lived experience	12
2. Physicians	16
3. Pharmacists	22
4. Downtown service providers	26
5. Addiction and mental health treatment providers	29
6. Law enforcement members	33
D. Emerging solutions	37
E. Concluding remarks	39
Appendices	
A. Focus group participants	40
B. Outline for focus group sessions	41

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A. Introduction

The Coalition on Prescription Drug Misuse (CoOPDM) formed in 2008 to address 'prescription medication misuse' issues facing individuals, physicians, pharmacists, addictions and mental health service providers and the police. The collaborative initiative brought together organizations with a shared interest in a better understanding of the issues and in taking action for the benefit of both those caught in the web of harmful prescription drug use and those providing services.

Coalition members represent the following organizations:

- Alberta College of Pharmacists
- Alberta Health Services – Addictions and Mental Health Services (formerly AADAC and Regional Mental Health)
- College of Physicians and Surgeons of Alberta (Co-Chair)
- Edmonton Police Services
- Health Canada
- RCMP (Co-Chair)

As one component of CoOPDM's work, the coalition launched two community demonstration projects in Alberta, one in the inner city of Edmonton and a second in the Blood Reserve near Lethbridge. Edmonton's inner city project brought to the table three additional organizations, Boyle McCauley Health Centre, George Spady Centre and StreetWorks. They joined with members of CoOPDM to form a Project Planning Committee.

Early discussions within the Project Planning Committee identified a host of issues needing attention and a desire to learn from and offer education and support to individuals using drugs, physicians, pharmacists, downtown service providers, addictions and mental health providers and law enforcement members. CoOPDM committed to sponsoring a series of focus groups with these stakeholders and contracted a consultant to help design and facilitate the process.

1. Methodology and voices represented

With the support of the CoOPDM Coordinator, Project Planning Committee members took on the role of recruiting participants and organizing the focus groups for their respective sectors. On a rotating basis, two members of the coalition participated as observers in each of the focus groups, providing a brief background on the work of CoOPDM at the outset and next steps at the conclusion. The six groups met between the end of September and the end of October 2009, engaging a total of 69 people:

As it Is People with lived experience	Law Enforcement Members	Pharmacists	Downtown Service Providers	Addiction and Mental Health Treatment Workers	Physicians
7	17	10	10	14	11

For a more detailed account of the organizations represented in each focus group, see Appendix A; for an outline of the guiding questions for the focus groups, see Appendix B.

For the purpose of grounding the discussions in the lived experience of people who use drugs, the facilitator began the consultation with members of *As it is*, a chapter of AAWEAR (Alberta Addicts who Educate and Advocate Responsibly). AAWEAR is a provincial network of groups formed to give voice to people with a history of drug use. They focus on mutual support, participant and public education and action to create change.²

2. Report format

All direct quotations appear in italicized font. Each stakeholder section is organized into the major themes that cover trends in prescription medication use, the reasons and ways people access the medications, practice issues and communication barriers. Emerging solutions are included within the respective themes.

B. Overall findings

1. Who are the people with prescription medication issues? What are their circumstances?

The people who have prescription medication issues, and their circumstances, cluster into several 'groups', though individuals may fit into more than one description.

People with physical or mental health problems who are prescribed potentially addictive medications to alleviate their symptoms. Over time, the addiction takes hold and they need higher doses to deal with the symptoms and their addiction. An estimated 30% of people with a prescription addiction began by taking medication to relieve physical pain.	People who have or previously had a substance addiction develop physical or mental health problems. To alleviate health problems, they are prescribed medications that can be addictive, adding to and creating a renewed problem with substance addiction.	People who use medications in ways that are different from how the medications were prescribed, e.g. use at higher doses, use to relieve or treat other symptoms, use by injecting or snorting the medication in a powder form.
People who use other people's prescription	People who sell a portion or all of the prescribed	People use prescription medications recreationally.

² AAWEAR groups run in Edmonton, Calgary, Fort McMurray, Grande Prairie, Red Deer, Lethbridge and Medicine Hat.

medications.	medication. The money is sometimes used to purchase other medication or street drugs.	Underlying issues and factors may be part of the picture.
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2. What are the overarching challenges?

- Usage, resulting from any one or more of the circumstances described above, creates **harmful effects** for individuals. In turn, feeding the addiction can put people in **vulnerable** situations, those seeking medication and those who supply it (e.g. pharmacies). Prescription medication is legitimized by the fact that physicians prescribe it and is not recognized as a product that can be harmful.
- Individuals with an addiction to prescription medication **use more than one doctor or pharmacy** to access the medications they are seeking. Some people who are unable to get the quantity they want from their physician **purchase it on the street** or acquire it in other ways. Some are **combining** the prescribed medications with street drugs.
- **Knowledge gaps** related to prescription medication has a significant impact on physicians' prescribing practices, leading to both over and under-prescribing. Insufficient knowledge is also a concern among pharmacists, community service providers and police officers, affecting their capacity to assess problems. People receiving prescriptions are **not informed** about the addictive potential of particular medications they are taking.
- **Insufficient skills** in responding to requests and sometimes pressure for medication to relieve pain and other symptoms has an impact on physicians' prescribing practices. The time required to explore alternatives (non-addictive medication or alternative approaches) is compromised by factors that include the shortage of physicians.
- **Lack of follow-up** by physicians for people who have been prescribed addictive medications is a concern for people with addictions, fellow physicians, pharmacists, downtown service providers, addiction and mental health providers and police.
- **Communication barriers** among and between all of the providers consulted make it difficult to identify, assess and follow up on problems and to coordinate responses. Netcare, a potential source of information for medication history, is used intermittently by physicians and pharmacists due to factors that include time pressures.
- While providing prescriptions with shorter intervals (e.g. renewing weekly instead of every three months) is safer in many circumstances, **dispensing fees** are a barrier for people with low incomes. Pharmacies are challenged by **delays in coverage approval**.

3. Trends in prescription medication use

Opioids figured highly as a prescription medication of concern in all of the focus groups. In particular, Oxycontin, as one opiate under the umbrella of opioids, was consistently named as the leading medication to which people are developing addictions or selling on the street.

- Youth workers pointed out that most of their cases of opiate use are in Sherwood Park; Oxycontin is seen as a 'cool drug' among young people. Most have been using the medication for the last year to year and half, in quantities of 80 to 320 mgs/day.
- Police are similarly seeing increasing levels of Oxycontin use among young people. Other youth are taking T3s and T4s in quantities of 130 pills/week.
- Pharmacists see prescriptions for 300 and 400 Oxycontin pills. Some people are taking 20 80 mgs of Oxycontin/day. Others are receiving prescriptions for 20 to 30 Percocet/day, adding up to 100 to 200/week.
- Pharmacists noted that the trend has shifted from Percocet (a blend of oxycodone and acetaminophen) to Oxycontin over the past two years.
- Addiction and Mental Health Treatment Providers noted that Atavin (a brand name for lorazepam) is a highly addictive form of benzodiazepine and is commonly used to treat anxiety.
- Physicians and pharmacists are seeing less use of benzodiazepines and heroin and more Oxycontin.

C. Specific focus group findings

The findings from each of the focus groups follow, organized within the primary themes introduced above. Suggested solutions are folded into the relevant discussions and summarized in section D.

1. People with lived experience

The initial focus group with *As it is* brought forward the experiences of seven individuals. All have lived with substance addictions that have involved using both prescription and street drugs over a number of years. As a general remark, participants objected to the language of prescription 'misuse'. To them, misuse sounds judgmental and assumes all the responsibility lies with the individuals receiving prescriptions.

The discussion centred on three themes: the reasons why people move into using prescription medication for reasons other than the original intention, ways in which they access the medication and their experience of interacting with service providers.

This section of the report makes heavy use of direct quotations. The voices of people who spoke from personal experience were used as the starting point for the other five focus groups.

1.1 Reasons people move into using prescription medication outside the intended purpose

The *As it is* participants offered a number explanations for why they turned to using prescription medication as a drug of choice. One simple response was that these drugs are cheap.

Coping with physical or emotional pain was a primary reason for starting to use addictive prescription medication. As tolerance went up, participants said it took higher doses to manage their pain, increasing the strength of their addiction.

- *My ex was taking hundreds of Tylenol. It was her solution to everything. She had a lot of headaches.*

- *After having eight babies, you have a lot of pain and they give you Tylenol each time you give birth. Then you just get more addicted.*
- *You use other people's pain medication because you want to solve a problem.*
- *If you get aches and pains from arthritis, and they give you pain-killers, they're not strong enough.*

Some of their reasons were more closely connected to emotional pain and gain.

- *It's an escape. You use it for depression.*
- *I realize I used them for anxiety to calm me down.*
- *Taking prescription drugs and drinking intensifies the effect – feeling high or feeling relaxed.*

Prescription drug use became a social norm in some circles and people saw it as a safer alternative to alcohol.

- *It's intergenerational. People learn that that's what you do, you take pills. My mother knew where to go to get valium so I learned from her where to go.*
- *It's social – you sit around and people talk about things like, 'how many do you have? What did they give you this time?' It's how I started out when I was young, and then I moved onto other drugs.*
- *My parents were alcoholic and I didn't want that to happen to me. I thought taking prescription pills was better.*

1.2 Ways people access prescription medication

The *As it Is* participants described ways in which they went about, or continue to go about, gaining access to larger quantities of prescription medication to deal with a growing addiction. They frame prescription use as acceptable because of the source.

- *Because it's a doctor giving you the prescription, you slip under the wire. You can justify – 'my doctor gave it to me'.*

Varying physicians are seen as more or less open to their requests.

- *By word of mouth, you find out which doctors will give you prescriptions.*
- *It's easier as females to get pills, especially from older male doctors. Younger doctors, especially females, can see through me.*
- *It's either impossible or too easy to get what you need.*
- *I went to one doctor and said I wanted a doctor who would not give me the drugs. She said she was that kind of doctor and I stayed with her.*

Participants talked openly about some of the ways people go about securing additional medication from physicians.

- *You can read on the internet about symptoms and then know what to say to a doctor to get a prescription.*
- *I tell my doctor, I lost my purse and it had my medication in it, or I lost my 'script, or the cap was off and the pill bottle fell into the toilet. I know how to talk to my dealer – my doctor is my dealer. An addict will get what they want if they have that mind-set.*
- *Some people sugar up their kids so the doctor will prescribe Ritalin because they are trying to get the drug for themselves.*

Participants said that many doctors use prescribing as a way of ending an appointment.

- *Sometimes doctors are looking for a way to get you out of the office or end an appointment so they give you a prescription.*

Once acquiring the medications, participants described rituals for mixing and distributing the drugs, or trading them for another drug.

- *Sometimes we would have parties where everyone would bring their prescription drugs and put them in the middle. People would just take handfuls for themselves. Prescriptions are easier to get than professionals think.*
- *Sometimes we'd open up the capsules and just mix them up. Then people would take what they wanted.*
- *I used to get Talwin from a doctor for my migraines and then I would trade them for heroin.*

They spoke of both the likelihood of using leftover medication for other purposes than their intended use and uncertainty about what to do with extra medication they did not want to keep.

- *If you have pills left over that you had prescribed for one problem, and something else happens, you may just use what's left in the bottle, or you throw it out, and someone bottle-picking picks it up and uses it. What are you supposed to do to get rid of them?*

1.3 Experiences interacting with service providers

As it is participants reflected on how service providers respond to their needs in terms of prescribing practices and how they are treated by professionals.

Under-prescribing is problematic among those who have developed a higher tolerance to pain medication.

- *I came into the hospital with four broken ribs. They gave me four TIs to take with me for the pain. I took them all at once. They don't understand that our bodies have built up a tolerance for these drugs and it takes more pills to deal with the pain. If you don't get enough, you have to go out on the street to get more.*
- *You can go into a doctor or the hospital with a legitimate problem – like an abscess – and they don't want to serve you because they assume you're just there to get drugs out of them. That's not right.*

In some instances, participants felt physicians were not exercising good **judgment in their prescribing decisions**.

- *A guy I know was given morphine for pain when he was in the hospital. He was already hooked on an opiate. He didn't know he could ask for alternatives.*
- *One guy has gone back into ER several times for a drug overdose. What do they do when they're sending him home? They give him a prescription for the same drug he used to overdose.*
- *I was in the IV clinic where they were giving me Percocet, 12 a day. When I finished at the clinic, they just cut me off. It should have been done gradually, to prevent things like diarrhea and sweats.*
- *Codeine is one of the hardest drugs to come off.*

Further concern surfaced about the fact that many physicians do not follow up to see how the person is doing after giving them a prescription.

Participants placed a heavy emphasis on how they are treated by physicians. Stereotyping was evident in their remarks.

- *If you are poor, marginalized, Aboriginal ... they treat you different. They stereotype. Health professionals just assume you are injecting. You don't get treated with respect.*
- *If you're dressed a certain way, you are treated differently. I could come back, same person, dressed up, and I would get better treatment.*
- *If you go to a doctor with a physical problem but you also have an addiction, you get the door slammed in your face. 'We can't help you', they say. They tell you to go to AADAC to get help. But AADAC doesn't deal with physical problems. That's what doctors are supposed to be doing.*
- *The doctors downtown are more empathetic. They understand the lifestyle. Others automatically stereotype. They have a bias and they make assumptions. Boyle McCauley Health Centre is great.*

The small **amount of time** many doctors spend with patients to learn about what is going on in their lives is a concern.

- *Doctors don't see you are a whole person. We have to get back to the whole person instead of just seeing your symptoms. They're not taking the time to find out what is going on. They don't see a human side. Maybe you're depressed because your son just got out of jail and your grandfather just died. Maybe you need someone to talk to and they should connect you with a counsellor.*
- *One doctor was let go from a clinic because he was spending twenty minutes - too much time - with his patients.*
- *I hate when health professionals give you looks of pity or disgust.*

Participants had a few remarks about the **role and practice** of pharmacists.

- *My pharmacist is great. He tells me about the side effects and what happens when you mix medications. People are asking more questions of pharmacists these days.*
- *Pharmacists have to know a lot. They deal with medications all the time, more than physicians. That's their whole job.*
- *You can say you are picking up someone else's prescription, as long as you have their phone number. I went in to pick up my prescription and it wasn't there.*
- *It's going to get worse when pharmacists can prescribe medication.*
- *Some pharmacists are crooked. Some will buy syringes and condoms from people.*

A couple of individuals spoke of strained **interactions with police**.

- *If the police find you with pills in a bottle in your pocket that doesn't have your name on it, or a few pills in your pocket, you can be charged with trafficking.*

Eligibility for treatment programs for people using methadone was raised as a concern.

1.4 Solutions

While there was limited time to explore solutions, participants did say they would like to see providers to develop a better understanding of the **context** of their lives.

- *A lot of community workers have book learning. They should come into this area of the city and work for a while to get a more realistic view.*

- *We need to educate more professionals. They need to be educated about a harm reduction approach – doctors, nurses – maybe a harm reduction boot camp. Even AADAC has to cut people more slack.*

They offered to come to future educational sessions with service providers to share their first hand experience as people who have used drugs and interacted with the system.

Participants suggested a change in **eligibility criteria for treatment programs**.

- *More addiction treatment centres should open up their eyes and accept people on methadone.*

Being part of a **supportive group** was named as a valuable resource for the members of *As it Is*.

Nearly all of the issues and some of the potential solutions named by *the As it Is* participants surfaced in the other focus groups. The alignment suggests that people's lived experience and others' perceptions of their lives and challenges are similar. The alignment opens the door to finding solutions that will address a number of the issues named in this first focus group.

2. Physicians

Physicians described challenges they face in their practice, their observations of prescribing practice issues among colleagues and strategies to mitigate the problems.

2.1 Trends

Physicians pinpointed opiates as their primary concern, particularly for non-cancer related pain. They anticipate a greater supply of opiates on the street in the foreseeable future. Drawing on the experience in eastern Canada, we will likely see the age at which youth start using drugs will drop. *Many young people at the age of 13 and 14 have already begun popping or snorting Oxycontin in the eastern provinces.*

2.2 Reasons and ways people access prescription medication

The financial incentive to sell prescribed medication is high among those seeking **instant cash**. In some instances, people are selling pills to pay off debts, or looking to purchase other drugs. People are selling prescription medications at \$1.00 per pill, with some taking in a total of \$1000 to \$2000 per month. On the reverse side are the risks for the people purchasing and using the pills.

A significant area of concern is the **availability and temptation** that comes with having a **large supply** of medication in the home if a family member has had surgery or is receiving palliative care. A quarter of children with advanced cancer in palliative care are on high doses of opioids.

Opioids are sitting in a cupboard while a person is ill and remain there after they die; family members are not obligated to give the medications back.

- *When an adult dies and the family is left with injectables, 500 preloads, at \$50 a pill, that supply is worth tens of thousands of dollars.*
- *After a child dies, there are risks that the family members will sell the remaining medication or self-medicate, sometimes leading to suicide.*

Many people do not know what they should do with prescription medications after a family member has died, even if they want to get rid of them.

In some caregiving situations, it is the people who are **providing care** who are selling or using the care recipient's medications to deal with their own addiction issues. Physicians may try to admit the individual to a facility to remove them from this environment, but the individual generally winds up returning in the absence of long-term, viable alternatives.

- *I made palliative visits to one household where the daughter in the caregiving role kept asking for more and more medication for her mother, saying nothing was working. The daughter kept dozing off on the couch and it became evident that she was taking the mother's opioids.*

Dispensing potentially **addictive medications in long intervals** invites problems. *You wouldn't give a child three months of allowance at once and ask them to use it slowly. We are setting people up for failure.* Seniors have a tendency to get medications **mixed up** and are at higher risk of taking too much or not enough of their drugs.

Sharing medications is common in the inner city. The culture is to help one another out; if a drug has worked for one person, others will seek the same solution for themselves without necessarily going through a physician.

People returning to the community after being hospitalized are supposed to get back the **medications they brought into hospital** when they are being discharged. In some situations, this puts an individual at risk of using a substance they were able to reduce or eliminate while in hospital. Unofficially, physicians acknowledged, medications are sometimes 'lost' by the institution to avoid contributing to the problem.

Physicians believe people are primarily gaining access to medication through prescriptions and not robberies.

Solutions

If physicians are concerned that an individual might take too much of a particular medication or divert it, they can take steps to **reduce the dispensing intervals**. Sometimes the ideal is dispensing the medication every few days or a week at a time. The problem in these higher risk situations is that **dispensing fees** may be prohibitive for those on a limited income, including seniors. *Dispensing fees are a huge barrier to safe prescribing.*

If income is not a limiting factor, people are more likely to accept the smaller intervals if there is a good relationship between the physician and the individual. Specific to patches, one physician requires that an individual turn in used patches before receiving replacement ones.

Physicians indicated that they shorten dispensing intervals to prevent 'stockpiling' near the end of a family member's life if that individual is dying at home. Two strategies were suggested for recovering medications, erring on the side of caution.

- *If I am worried, I contract with a family member to bring the medications back. In a more chaotic family household, they are less likely to return the medications.*
- It is common practice to collect home aids on loan after a person has passed away. The system could integrate collecting leftover medication at the same time.

Physicians expect that most people would readily respond to being asked to turn in unused medication.

2.3 Practice issues as physicians

Problematic prescribing practice stems from one or more of several contributing factors:

- Physicians do not have the time or are not taking the time required to properly **assess** what is needed and jointly develop appropriate solutions with patients.
- Physicians do not have adequate **knowledge** regarding addictive medications and safe alternatives.
- Physicians do not have the **skills** required to work through medication expectations.
- Physicians do not have the time or are not taking the time to **follow-up** after prescribing a potentially addictive medication.

The time needed to properly assess and follow up is compromised by the pressure to see as many people as possible. This is partly a function of the shortage of physicians and partly the structural issue of a largely fee-for-service system that counters spending extra time with individual patients.

Physicians receive **scant education on pain management** during their undergraduate medical school training. One physician who goes into a medical school class as a guest on the topic indicated students are exposed to a total of one hour of teaching on pain management. Research on medical education confirms that the time dedicated to pain management is low. Prescribing without adequate knowledge of pain management and addictive medications can create dire consequences, e.g. prescribing inappropriate medications, over or under-prescribing.

- *Physicians are open to being manipulated by pharmaceutical companies pushing their medications.*
- *Some doctors choose medication alternatives that are equally problematic. Where did the education go wrong?*
- *We have worked so hard to make opioids mainstream. We are not teaching this well in school. We need to properly prepare interns and residents.*
- *Opiates are being used to treat pain as the drug of first rather than last resort. I see countless people who are being treated with opiates for back pain. I wonder, 'have they tried other approaches? Is this the only solution?'*
- *I am amazed by the doses of benzos prescribed by psychiatrists. Physicians do not believe that benzos are addictive.*
- *There is a huge education deficiency, especially among junior doctors. They don't know how to assess and they are not using a common-sense approach to managing drug issues.*

For those who want to suggest alternate methods for managing pain, beyond medication, the systemic barrier of **funding cuts for massage and physiotherapy** has limited choice for those who have low incomes. There can be a waiting period to get into Opiate Dependency Program; currently there is a one month waiting period but they will admit someone faster if there is an urgent need.

Under-prescribing is a problem for people who have developed an addiction and therefore an increased tolerance over time, and for those who have an addiction at the

same time as dealing with an acute or chronic health concern, such as a serious infection or Hepatitis C.

Physicians offered examples of individuals not receiving appropriate care due to inappropriate under-prescribing.

- An individual comes into hospital because of a physical injury or illness and also has a chronic opioid addiction. The person has been injecting 400 mg of morphine/day. The doctor prescribes two mgs/day, subcutaneously; in turn, the individual person faces going into immediate withdrawal and either has to find a way to get more morphine through the back door or self-discharges without the injury or illness addressed. The individual gets sicker and then has to be readmitted.
- An individual receives a prescription for Percocet to alleviate pain. Over time, the person asks for increasing amounts. The physician catches on that the individual is now seeking the medication in response to an addiction to Percocet. The initial pain may still be a problem. The physician cuts the individual off the Percocet so as to bring the addiction to a halt. The individual either goes into immediate withdrawal without support, pursues getting the prescription from another doctor or resorts to getting the medication on the street.

Feeling inadequate with poor outcomes, *many family physicians have washed their hands in terms of dealing with chronic pain.* Participants noted that some physicians have an addiction problem of their own, influencing their prescribing practice.

Physicians have often not developed the **skills required to negotiate a safe option** with patients who ask for potentially addictive medication. Physicians have been **taught what but not how to prescribe** and are not learning by example. It has become unacceptable not to treat pain with medication.

- *We are looking for quick fixes and we are paying the price for that. We believe there is a drug solution to every problem. Your intention every day as a physician is doing good and avoiding harm. It's easier to pretend everything is fine and not ask tough questions.*
- *Medical students and residents are trained to believe that the best way is the quickest way. We are trained to say 'yes' and not ask why. We are trained to build a relationship based on trust but it is not about trust. It is about safety.*
- *It's harder to say 'no' after you have said 'yes'.*
- *Sometimes it is easier to write the prescription and get the person out of the office.*

In private practice, a physician may rely on trust to build a rapport, that is, trust that the individual is providing an accurate history and trust that they are being open about other substance use. A breach of trust sets up dilemma for the physician who feels a major responsibility.

- *We have to rely on what patients say; 70% of the information we gather is based on **self-reported history**. If the history is not reliable, you have to become a detective.*
- *I want to treat the symptoms of a real, legitimate disease. For example, I have a woman with rheumatoid arthritis. Pain was a major factor. She swore she was clean but I was uncertain that she was telling me the truth. I asked that she take a drug screening test, telling her, 'no screening, no Percocet'. I found out she*

was on cocaine and benzos. We had a confrontation. I tried to link her to the methadone clinic. I moved to prescribing pain medication for one week intervals and then built up to two weeks. It's hard to rebuild trust after it has been broken. You want the positive rapport.

- *I had a patient who was middle-aged, with cancer. She was drinking and taking pain medication. I also found out she was injecting and her boyfriend, who is a dealer, was selling a portion of the medication I was prescribing. I admitted her to hospital and transferred her to another doctor; I told her I had to fire her from my practice because I couldn't help.*
- *I stop prescribing if somebody is diverting. By saying 'no', I know some will go to another doctor.*

Ongoing follow-up after prescribing potentially addictive medications is not the norm. If people are using walk-in medical clinics, or accessing doctors in different communities, one-to-one relationships with single physicians are unlikely. Even if an individual is accessing one physician, the practice of scheduling ongoing follow-up appointments to see how well medications are working is inconsistent. The consequence is that people remain on the same addictive medication for extended periods of time even if there are risks or their efficacy is in doubt.

Solutions

Physicians in the focus group made a strong point that **addiction is a legitimate concern that needs attention**. There is also a duty to inform people being treated for a problem if a particular medication could be addictive. *It takes 60 seconds to explain. Many people receiving prescriptions have no clue that what they are taking is addictive. If they knew, they would not have agreed to that particular medication.*

One of the participants expressed an opinion that the **relationship with patients** should be built on **safety rather than trust** though this is a more difficult way to build a rapport. Trust as the basis for the relationship is a set-up for failure; if the individual violates that trust, the physician feels personally offended. Physicians cautioned that an individual's success or failure ought not to reflect upon the provider.

- *Saying 'no' may be the most helpful thing I can do. I can't prescribe in a way that I feel is unsafe.*
- *It may not be possible to decide on the right strategy in the first appointment. It sometimes takes time to come up with an approach that will work. We start on a trial and decide what will be the end point. I might start with little milestones. If they come back in a week, I get a sense of whether they are going to comply.*
- *If patient response to a question asking for information is 'you don't need to know x', I respond, 'OK, but then I can't prescribe such and such medication safely.'*
- *If the dispensing fee is a barrier, we may need to look at an alternative medication that does not pose the same kind of risk.*
- *Fear does not work as a disincentive.*

Education and opportunities to raise awareness of prescription medication issues within the medical community are critical. Conferences, workshops, continuing medical education and palliative rotation are avenues to expand knowledge and skills, and influence practice. The web site of the College of Physicians and Surgeons is a channel for physician education.

A primary care network in Edmonton introduced the Problematic Prescription Management Consultant initiative, offering physicians and other providers a resource. The service is not well used but strategies could be explored to maximize the opportunity. Physicians pointed out that ‘addiction specialists’ are not a homogenous group, given their varied approaches to working with people with addictions.

2.4 Communication

Physicians described **problems communicating with fellow physicians and across services**, including Alberta Health Services – Addictions and Mental Health (formerly AADAC), the pain clinic and palliative care. *We operate in silos. The system is not really a system. The system is broken.* As experienced by pharmacists contacting doctors, physicians do not like being questioned about their prescribing decisions by peers. They also acknowledged that it is difficult for others to reach and communicate with them.

While Wellnet and the Pharmaceutical Information Network, in collaboration with Netcare, are designed to capture a profile of medications prescribed and dispensed, not all physicians and not all pharmacists are using the system. Hence, physicians will not have the complete picture on prescription activity and pharmacists will not recognize there is a problem if an individual has filled prescriptions at several different pharmacies.

Several specific **concerns with the data base system** surfaced.

- If an individual does not have an Alberta Health Care card or provides the wrong number, the information will not appear on Netcare. Over time, people come to know this and can avoid an accurate record of their prescription activity.
- Triplicate forms do not consistently include Alberta Health Care numbers.
- Individuals raise privacy concerns if a physician reveals that a pharmacist has raised a concern about their prescription activity.

Physicians asked if pharmacists are able to view prescriptions issued and dispensed by other pharmacies.

Solutions

Physicians discussed approaches they use to made Netcare access and exchange of information more **transparent**.

- *In detox, with Netcare in front of both of us, they know I'm going to see other medications they are taking. It becomes an eye-opener for them.*
- *I call the pharmacy while the individual is in the room.*

Participants would like to see a system that requires that **all pharmacists enter dispensing information** on the data base system and expressed a hope that Netcare will eventually allow physicians to see a more complete record of prescription activity.

Physicians are aware that the College of Physicians and Surgeons of Alberta will provide a **profile** of prescription activity upon request; questions surfaced about the scope of the college data base (e.g. does it include all the information that is available on the Pharmaceutical Information Network?).

Privacy is a consideration but physicians are under the impression that they can speak with other health professionals about individuals they are serving. Taking the time to establish **relationships with other providers**, for example with local police officers and local pharmacists, makes it easier to address medication concerns.

3. Pharmacists

3.1 Trends

Pharmacists raised concerns about prescriptions they are being asked to fill.

- There has been a shift from Percocet to Oxycontin over the past two years.
- Individuals are coming in with prescriptions for various medications in quantities of 400, raising concerns about prescribing practices.
- *To see a prescription for 400 Oxycontin is a red flag. If the individual was taking two per day over 28 days, that would be fine but if it is being replaced within a much shorter period, the person is likely selling a portion. What can we do? Some people are given prescriptions for 20 80 mg Oxycontin pills, two times/day because their tolerance builds up.*
- There are a many prescriptions for T3s and Valium 10s but fewer for benzos than in the past.
- Pharmacists are also concerned about purchases of large quantities of over-the-counter medications, including T1s and Gravol.

3.2 Reasons and ways people access prescription medication

Pharmacists discussed the **context and patterns of people in the inner city** who are trying to meet their need for medications to which they have become addicted.

- Pain relief for cancer is a major factor behind opioid prescriptions.
- As expressed by physicians, the inner city culture is one where people know one other and know exactly what medications other people are taking, generating interest in acquiring those medications from the person who received a prescription or from others.
- Echoing the comments from people who use drugs, pharmacists are asked to respond to individuals who say they 'lost their prescription'.
- Among their clientele, there are people who come to pharmacy daily with a prescription, first thing in the morning, waiting for the pharmacy to open.
- People on income assistance are accessing several pharmacies with prescriptions coming from more than one doctor.
- There has been an increase in pharmacy break-ins. *One pharmacist was slashed in the arm.*

Pharmacists are aware of the temptation that arises when medications that are **no longer needed remain in people's medicine chests**. Some of those medications came into the home during a period when a family member was receiving palliative care. Many people are not aware that they can return leftover medications to pharmacies.

Financial barriers for low income seniors are a factor. When people on income support and therefore receiving coverage for prescription medication turn 65, they are required to pay for their medication. They wind up choosing to purchase those medications that control pain and forego medications that treat conditions that are not pain-focused, e.g. to treat a heart condition.

3.3 Practice issues

Pharmacists discussed both their observations and concerns about physician prescribing practices and emerging issues for their own practice.

Physician prescribing practices

Pharmacists expressed concern about inappropriate over and under-prescribing practices similar to those identified in the physician focus group. Physicians sometimes provide information to their patients about medications that differ from the intended use or characteristics.

Over-prescribing and a lack of follow-up are evident in situations where individuals are given medications meant to be taken over, for example, 28 days. *They run out after 18 days and their physician issues another prescription. Who should be watching?*

- *We were working with a patient and physician in one situation. The person had been addicted to Dexadrine. He went into hospital and got off the drug and started getting back on track with his job and family. He went back to his doctor who is now prescribing Oxycontin and the cycle starts all over.*
- *Some doctors are too easy. They don't take the time to listen.*

On the other side of the coin, some physicians appear to be **under-prescribing**.

- Individuals receiving medication for pain (e.g. Percocet) sometimes return to their physicians for refills earlier than the length of the prescription. Because physicians see these individuals as 'drug-seeking' to satisfy an addiction, they are cut off and, as a result, may turn to the street to purchase what they need.
- For people taking methadone, physicians assume their pain is under control. This may not be the case because they have a need for a much higher dose of pain medication than others.
- For people who have a previous addiction, professionals have differing ideas about the most appropriate course of action, i.e. which medications are suitable and how much should be given?

The physicians who work in the inner city are experienced in working with people with addictions and that makes a difference in how they communicate and respond to these individuals.

Some participants questioned the effectiveness of the College of Physicians and Surgeons of Alberta's process for **monitoring and following up** with physicians identified as prescribing medication inappropriately. It was explained that the College will withdraw prescribing privileges from a physician found to be incompetent in this area.

One pharmacist relayed frustration about an experience in which no action was taken.

- *I contacted the College of Physicians and Surgeons more than once to express concern about a particular physician's prescribing practice. One year later, nothing had been done. I contacted CPSA again and was told, "the doctor didn't write back when contacted" and that was the reason that the case had not moved forward.*

Ethical dilemma as professional pharmacists

The pharmacists had a lot to say about the dilemma of being **caught between questionable prescriptions and customers expecting to have their prescriptions filled**.

- *You try to do your job. I don't want someone to die under my care. If I refuse, the person tries to get the prescription filled at another pharmacy. People apply*

pressure and sometimes threaten you. I have been told, 'I am going to get someone to rob you'.

- *I don't want to support a person's habit but if an individual says they are in pain, you want to help. Sometimes you are not certain if you are working against helping by filling the prescription.*
- *You cannot know at the time a person comes into your pharmacy if the prescription is legitimate; it's a gut call each time.*
- *We wish physicians would back us up.*

Pharmacists are aware of **situations that seem out of control** but in the absence of a relationship, it is difficult to be effective. As an example, the person is taking street drugs and prescription medication, their pain control seems out of hand and they are seeing a number of doctors at the same time. Pharmacists find it more difficult if they do not know the person well.

- *For some people, it is OK to take 300 T1s but 20-30 Percocet/day, to a total of 100 to 200 in a week, raises a flag. When people are selling one medication to feed another habit, we feel as though we are tools for them to get what they want.*

Knowing when a prescription is questionable is a matter of **professional judgment**, particularly since every individual is different. Pharmacists expressed interest in acquiring a better understanding of appropriate levels of particular medications and the effect of taking concoctions (e.g. Oxycontin, benzodiazepine and alcohol). They raised other knowledge questions:

- *How much is too much? How do we know who is legitimate? When do I need to call the doctor? What is a reasonable prescription as a person's tolerance goes up?*

Solutions

In the past, pharmacists were more likely to have a steady clientele. Now, it is common for people to use multiple pharmacies, particularly if they are trying to avoid having their medication use monitored. One solution would be to restrict individuals to one pharmacy but participants were uncertain if this was feasible.

- *I can refuse to fill a prescription and the person can go to another pharmacy down the street that will. Staying with one pharmacy is preferable. On one occasion, I chased a woman for one block who left because she was upset that I would not go along with her request. I managed to calm her down and bring her back to the pharmacy so that we could try to find a medium ground. If individuals stay with me, I can monitor what they are taking.*

Some participants talked about approaches they use to establish **relationships** with individuals so that they can openly talk about the addiction and develop a plan for the individual to come in more frequently to pick up smaller quantities.

- *We need to treat each person as an individual rather than seeing situations as black and white. There is often a lot more to the story than meets the eye. These are individuals who are marginalized and disenfranchised. They are in a survival mode.*

Pharmacists suggested 'cheat sheets' and resource information would be helpful tools for addressing their medication questions. They indicated they would also like to know what police members are noticing as trends.

Other practice challenges

Pharmacists are challenged with the **timeliness of third party coverage approval** from income support. It is approved on a month to month basis after the individual has submitted their monthly income and rent report. An individual is expected to assume this responsibility but circumstances may prevent this from happening. Listing a shelter or agency as the home address helps to expedite the process for a person who does not have stable housing.

- *If I have individuals on methadone, there is a time lag between when they need to renew their prescription and when the approval comes through. Eight out of ten times, it goes through. If I choose not to fill the prescription until the approval comes through, they may go out and use injection drugs or become involved in crime or boasting, or sell their bodies to make immediate cash to buy the drug on the street. If I fill the prescription and the coverage doesn't come through, I have covered the cost.*

3.4 Communication

Pharmacists emphasized barriers to **communicating with physicians** in a timely way when customers are presenting prescriptions that raise questions or concerns. There are barriers, as well, to communication between pharmacies.

- Physicians' offices are busy. Doctors may not be available to respond to inquiries from pharmacists concerned about a prescription, sometimes for two or three days. By the time the physician is able to respond, the person who brought in the prescription has long gone.
- Easier access to physicians would make a significant difference; it is rare to be put straight through to the physician. The downtown physicians are easier to reach.
- When pharmacists question physicians about prescriptions they have ordered, physicians resent being questioned about their practice.

One of the factors for pharmacists in approaching physicians with questions is **comfort and confidence**. *Pharmacists need to be empowered to do this.*

Incomplete or illegible information on prescriptions, particularly emergency prescriptions, is problematic when individuals are discharged from hospital or come with prescriptions from physicians. Sometimes medications are on the triplicate list but there is no triplicate form. *Doctors don't carry triplicate forms in hospital; they believe they should not have to use triplicate forms in that setting.*

Communication between pharmacies used to be easier, through 'fan outs' if there was a concern, and pharmacists had a greater sense of control of the situation when individuals were coming to one pharmacy to fill all their prescriptions. Now that more people are using multiple physicians and pharmacies, and privacy laws are more stringent, the capacity to exchange information is more limited.

Wellnet is a tool for communication but there are limitations. While not every doctor or pharmacist is using Wellnet, the College of Pharmacists indicated that only 1% of

pharmacists have refused to put information onto Wellnet. Some participants talked about the cumbersome technological barriers of having to go out of one program on the computer to get into another.

Privacy is a factor that limits contacting a physician without letting the individual know. If a person perceives that the pharmacist is questioning the legitimacy of the prescription they have brought in to be filled, their response may be to go to a different pharmacy where they might not be questioned. Privacy is also a factor when pharmacists are trying to get information about third party coverage.

Solutions

On the positive side of Wellnet, pharmacists can post a note on an individual's file or contact a pharmacy that has already filled a prescription to bring to light duplicate filling of prescriptions. CPSA is a resource for requesting a profile of an individual's medication history if there is a concern.

Pharmacists made a number of suggestions that would **strengthen communication**.

- Physicians can use a stamp or computer generated prescriptions rather than hand-written prescriptions and signatures.
- Physicians need to be trained to use Wellnet on a consistent basis.
- More universal use of Electronic Health Records by pharmacists and physicians will make it more difficult to 'hide' medication use.
- Pharmacists would like to see an expansion of the triplicate program.
- Faxed triplicate forms increase the likelihood of effective communication.

As pharmacists **form relationships with individuals**, they learn about issues in their lives and identify support needs. Linking individuals with resources in the community has to go beyond suggesting someone 'call AADAC'. All pharmacies need ready access to a common list of current resources to include rehabilitation, counselling, detox and alternative therapies.

In the event of **emergencies**, i.e. when people are threatening pharmacists who are not filling their prescriptions, pharmacies need a telephone number and information on who to contact within the police force. For non-emergency linkages with police, pharmacies would also benefit from having appropriate numbers.

4. Downtown service providers

The focus group of downtown service providers was comprised of people who work in three shelters, an inner city health centre and two inner city service agencies.

4.1 Trends

Downtown service providers spoke in general terms about the types of prescription medications people are using but emphasized that people are often combining prescription and street drugs as well as alcohol.

4.2 Reasons and ways people access prescription medication

For many people, using prescription medication and substances is a way of **copng** with abuse in their lives. *This is their only way to cope, to block out their feelings.* Prescription

medications are seen as '**legitimate**' because they are prescribed by physicians and people do not see them as harmful.

People seeking additional medication will go to more than one doctor to get what they need and those who need instant cash sell their prescription medications. There are a number of explanations for why people find themselves in desperate situations.

- If people are homeless, their medication is easily **lost or stolen** because they have no place to store it.
- Individuals coming out of jail where they were receiving medication, including anti-depressants or medication to help them sleep, find themselves **cut off** 'cold turkey', without immediate access to a continuing supply and without supports. Attempts to get a prescription may be thwarted because physicians see them as inappropriately 'drug-seeking'. The situation compounds their anxiety as they make the transition back into the community.
- Doctors assume individuals are 'drug seeking', assuming they have an addiction, and deny medication that they may need to deal with a problem. A person who has developed a tolerance to pain medication will **need a higher dosage** but they are criticized by their doctor for asking for more.
- People are **anxious as they wait** for weeks or sometimes months to get into an addiction treatment program. They may take medication to help calm their anxiety which can then render them ineligible for the program.
- There are **too many medications** in a bubble pack. People wind up pulling them apart, taking some of the pills and selling others.
- People are sometimes restricted to filling prescriptions at a **pharmacy located far from the inner city**, for example, if the physician they saw was not in the downtown area or if they were in a hospital outside the inner core. Their drug coverage requires that they stay with a single pharmacy for one month. If the pharmacy is not set up to deliver medications, access becomes a barrier.

Solutions

Dispensing medication in **shorter intervals** – daily or weekly - would reduce the likelihood of people losing prescription medications, overdosing or selling them. To reduce the barrier of dispensing fees, providers suggested that pharmacists could **release parts of prescriptions at a time**. Pharmacists accepting this kind of arrangement are willing to have individuals return on a far more frequent basis.

Pharmacists apply standardized dispensing fees but have discretion in the quantities dispensed and the option to provide partially-filled prescriptions.

When individuals and agencies establish a **trusting relationship** with individual pharmacists, the connection opens up communication.

Direct Observe Treatment is helpful for people who are taking medication and have mental health issues.

4.3 Practice issues

Individuals do not have an **understanding of the harm** that could come from taking too much of one medication or mixing medications.

Downtown service providers **want more knowledge** about medications and want to be able to **access information in emergency situations**.

Physician prescribing practices

Physicians are not informed about the consequences of **combining** prescribed medication and other substance addictions.

Under-prescribing creates significant problems for people with an addiction. Many staff in hospitals do not know **how to work with people who have addictions**. When patients are admitted for treatment of an illness or injury, physicians often significantly reduce or eliminate access to a prescribed medication to which an individual has become addicted (possibly in combination with a street drug). Because tolerance for a medication to which individuals are addicted is higher, they may need a higher than average dose to manage pain.

The consequence of a drastic reduction in an addictive medication is that a person will likely go into withdrawal, their pain is not sufficiently managed and/or they may leave the hospital without treatment.

As structural issues, in a fee-for-service system coupled with a shortage of doctors, physicians are often not spending the **time** required to get to know individuals dealing with addictions and related conditions. The consequence of superficial contact is evident in the decisions about what is prescribed and the absence of follow-up.

Solutions

Downtown service providers focused their attention on how they could increase their own understanding of prescription medication. They recommended establishing and being able to link with a **call centre** to provide advice in the event of adverse reactions. Sending someone who is under the influence of alcohol and/or drugs to the nearest emergency department is not the solution.

They would like to acquire ...

- More information on medications being prescribed.
- Information on the adverse effects of combining prescription medication and street drugs (e.g. medication for mental health issues with crystal meth), and often further combined with alcohol.
- Telephone advice for overnight shelters in the event of adverse reactions (beyond the 24 hour poison control line).

To increase the effectiveness of practice within hospitals and between hospitals and community, downtown service providers put forward two suggestions.

- **Increase education for physicians, nurses and social workers** in hospitals to help them work more effectively with people who have addictions.
- **Establish a more collaborative approach** to practice that reduces the gap between those working in the hospital and those working at the street level.

4.5 Communication

The positive stories relate to physicians in the downtown core, particularly Boyle McCauley Health Centre, who **understand the life circumstances** of the individuals they are serving and recognize that prescribing is not a matter of all or nothing.

Downtown service providers experience communication problems with physicians, hospitals and pharmacists. The issues are partly related to **privacy** and partly to having the opportunity to have a conversation or receive a response to written inquiries.

If providers contact physicians about medications being prescribed to raise concerns or ask for additional information, they usually **do not get a response or the response is a rebuff**.

- *We send forms to be completed by physicians but they rarely come back.*
- *Doctors will not take advice from others. They may only see the depression side of a person who has a bipolar disorder. We see people every day but their attitude is, 'we don't know anything'. We have been sworn and yelled at by physicians and hospitals.*

People arriving at a shelter from hospital often come with **incomplete medical information** from the hospital. When workers contact physicians' offices or hospitals to ask for additional information, they encounter privacy barriers. One shelter indicated they will not accept individuals from a hospital without medical information.

Communication with pharmacists raises other issues. Individuals arrive at shelters having taken a combination of medications and street drugs. Shelter staff do not know what prescription medication an individual is taking or the quantity, making it difficult to offer appropriate support. Privacy is cited as the reason information cannot be shared.

Solutions

Downtown service providers suggested creating agreements in which some service providers would be **privy to information as part of a care team**. Individuals could be asked to provide consent and, if obtaining consent is not practical, there could be other ways to address privacy concerns.

Electronic Medical Records, i.e. **Netcare**, allow practitioners to **share information** about prescriptions prescribed and dispensed. This communication tool deals with the supply of medication but not with addictions. People who want more medication than is being dispensed **will find another way to get hold of a substance**, particularly if they are dealing with pain that is out of control.

5. Addiction and Mental Health Treatment Providers

5.1 Trends

Addiction and Mental Health Treatment providers offered the following insights about current trends.

- Addiction and mental health treatment providers are seeing an increase in the use of opiates.
- Atavin is used as the 'treatment of choice' for anxiety.
- An addictions counsellor working with youth pointed out that most of their cases of opiate use are in Sherwood Park; most have been using the medication for the last year to year and half, in quantities of 80 to 320 mgs/day.
- *Parents do not have a clue that their kids are taking this medication.* The signs are not easily recognized until their son or daughter tries to stop taking the

medication and winds up in the throes of a painful withdrawal with severe aches and pains.

- People get a prescription and rather than using it, sell it to get the drug they prefer. Some stand outside pharmacies in the inner city, waiting for people to come out, asking “hey, what did you get?”
- Small clinics in rural communities are generalists who are able to monitor trends that may move toward the larger cities.

5.2 Reasons and ways people access prescription medication

Addiction and mental health treatment workers commented on trends observed in their practice.

- Addiction and mental health treatment workers estimate approximately 30% of individuals who develop an addiction to an opiate started by taking it to manage pain.
- Oxycontin is seen as a ‘cool drug’ among young people.
- Youth find addictive medications in their parents’ medicine chest and therefore it feels less threatening. They assume the medications must be safe because they were prescribed by a doctor to help people feel better. Their reasons may be seeking relief from some kind of physical or emotional issue.
- People are selling medication to get money. This includes seniors, people sending money to family members and those who cannot access income because of fraud and have no money to live on.

The discussion emphasized trends and related issues in **accessing support services**.

- Youth workers find that youth do not want to go into adult detox or even youth detox programs. *Five to seven days in detox feels like five weeks to a young person.* The youth detox centres have no medical staff. Instead, youth turn to ‘addiction doctors’ who put them on an ‘Oxycontin plan’.
- Non-smoking rules in youth detox centres are a barrier to youth entering the programs.
- *Most people trying to move beyond an addiction need therapy and not medication but psychiatrists have long waiting lists and private therapy is costly.*
- For young people who do get in to see a psychiatrist, they may not be able to relate to the professional or don’t come to all the appointments; *doctors have a low tolerance for youth who are often ‘no shows’.* They stop going and do not seek out another doctor.
- *We have long waiting lists for support programs and services. Programs need to be there when a person is ready (e.g. treatment, psychiatrists, detox). By the time services are coordinated, the person is finished, gone.*
- People can be denied services by Alberta Health Services, for example, by losing their card ten times.
- Some youth are banned from certain areas of the city and cannot travel through that area to get to a service or program they want to attend.

During **withdrawal**, people may experience depression, anxiety and insomnia. They need support as they go through this process. *They are going to crumble during withdrawal. It gets way worse first before it gets better. People are going to finally be in touch with what they have been shoving down for years by using substances. A lot of professionals are uncomfortable.* People need the support of a therapist before and after a treatment program to help them through the process (e.g. a psychologist).

Participants identified a concern for the people who are not being seen and who are not on the radar, e.g. immigrants who are not savvy of the system. One example was an Afghani family with six children, two of whom were addicted to substances. They were not linked to any addiction-related services.

Solutions

Participants offered suggestions that would enhance the capacity of service providers to link individuals to **community supports beyond medication**.

- Ensure service providers have information about free or sliding-scale counselling services, including Jewish Family Services, Edmonton Community Services, Catholic Social Services, Aboriginal Consulting Services, The Family Centre, walk-in service at the University of Alberta, Northeast Community Health Centre and hospital-based therapy groups.
- *You have to be careful where you refer. Right now, we don't have a good feedback system to know how a referral worked out.*
- Participants said more satellite services are needed across the city. Some people do not want to come downtown for services. They are worried that people will draw them back into substance use. *Sometimes dealers stand outside the [Alberta Health Services – Addictions and Mental Health] AADAC office downstairs. The services need to be more scattered and less concentrated in the downtown area.*
- There are advantages when staff is mobile (e.g. youth program).
- One inner city agency service provider commented on a positive experience with a mental health worker from Alberta Health Services who comes into the shelter on a regular basis. She has made a difference, including getting people in to see a psychiatrist quickly.

A **collaborative approach** is needed to tap available resources. In some settings, time for networking is not considered a legitimate use of paid time. Service providers need to know the resources that exist.

- *It makes our work more effective – it is part of our work. It's not fluff to build relationships.*
- *Once you have a relationship, it is easier to know who to call. It takes leadership to support people coming together.*
- Interagency networks are valuable for learning about other resources. A 'trade-show' like venue would be advantageous.

Q: Can we get a list of physicians who have an addiction specialty?

A: Not available though the AMA has a specialty in addiction medicine.

5.3 Practice issues

Addiction counseling staff explained that they do not feel that their **assessment tools and training** adequately prepare them to assess for 'prescription drug misuse' problems. Greater access to addiction medical specialists would assist them in teasing this out.

Addiction and mental health treatment providers identified major concerns with **physician prescribing practices** and other **peer service providers**. In relation to what and how physicians prescribe medication, participants brought forward several issues.

- *We need 'smart prescribing'. People do want to get better but sometimes the physician gets in the way through benign negligence.*
- *We see individuals who were prescribed Atavin thirty years ago and do not know they are addicted. They have never gone to see a therapist or entered any kind of program. Their physicians did not suggest alternative treatments or medications that would have been non-addictive. They have not taken the time required or educated their patients.*
- A person about to begin an addiction treatment program is put on benzodiazepan by their physician to help with their anxiety but that creates a problem because they cannot be using just prior to entering the treatment program.
- After a young person is admitted to hospital, there is no follow through after they are discharged.
- Physicians often prescribe low doses of opiates for pain management. The person starts adding on and an addiction begins to take hold.

Participants also discussed concerns with peer service providers.

- *As a worker, you need the support of your peers. Providers are giving the message that people should turn to prescription medication as the answer to their problems, and continue to take addictive medications to push back the feelings that surface. As people come off of medication, they are confronting issues they have suppressed by taking medication.*
- *The only time you can do that work is when you are not numbed. Workers don't want to be around people – they feel uncomfortable - when they are working through those difficult periods. The changes take time – it's not going to happen in the next three months. It can take a year or two or more.*
- An employment counsellor suggests an individual get a prescription if they are experiencing uncomfortable flashbacks.
- A teacher gets upset because a youth is not focusing as well as before, seemingly high, having stopped taking Ritalin. If a person is feeling sad, they're told to go take a prescription.
- *My children's services worker says it's ok, I can continue to use those prescription medications.*

There is a lack of continuity between the person with the drug issues and parents and no sense of a holistic approach to tying in doctors, nurses and social workers.

Q - Why are people on methadone if they are using other drugs, such as cocaine?

A – We have to weigh out risks. Retention is important. We can help an individual use the cocaine in a safer way.

Solutions

Addiction treatment providers would like to be able to **access addiction medical specialists** to help them tease out prescription medication issues.

Asking the right questions about medication use is an important step as is **building relationships**.

- *We don't query people about prescription drug use. Some are starting as early as eight years of age. We are reluctant to just ask. Often, people are not asked the right questions. 'Are you really using this medication for pain? Do you need that*

much?' People will tell you if you ask. It's difficult to suggest moving away from prescription use, e.g. with PTSD.

- *We see fewer youth now but we do better work with each person. It had not been our practice to work with others. We worked in silos and didn't know about the vast array of services that are available for youth. John Howard Society is a good resource; for example, they will help people get identification.*

Self-referral into alternative programs and services rather than physician referral might remove barriers created by physicians not being aware or connected to non-medical resources.

5.4 Communication

Addiction and mental health service providers stress the problems associated with not being on the same page with their colleagues as mentioned above under practice issues.

Communication between addiction and mental health treatment providers and private practice physicians is problematic, except where physicians are part of the addiction and treatment program. *It can take four days to get in touch with one another, even with the best of intentions.*

Physicians are defensive. They say we are creating barriers if we raise questions. If we fax questions to them, they won't respond. An addictions counsellor working with youth tried to speak with an 'addiction doctor' to learn more about the 'Oxycontin plan' being used but the physician was not interested in the conversation. There is insufficient use of the model of conjoint practice between physicians and other practitioners.

Solutions

Participants spoke to the value of having an **addictions counsellor in a medical practice**, as is done at Boyle McCauley Health Centre. Staff may refer an individual to the counsellor before they resume a methadone program if there is a need.

Many of the participants stressed the importance of supporting staff to allocate time for **building relationships with workers in other organizations.**

6. Law enforcement

6.1 Trends

Law enforcement members offered observations of trends in prescription medication use.

- This is a new problem and some police indicated they do not yet have a lot of information on trends.
- Prescription use is not a problem in the military as yet but, with soldiers returning from Afghanistan with PTSD, there are a lot of anti-depressants in use.
- Individuals are moving between communities to get prescriptions, e.g. a person comes from Edmonton to Spruce Grove to get a prescription from another doctor.
- There has been a shift from Percocet to Oxycontin on the street because it is now easier to find.

- Prostitutes dealing with addictions are also taking pills for depression and anxiety. Some are getting the medications from seniors.
- Individuals are getting Oxycontin from their physicians while purchasing other kinds of drugs from the street, e.g. some are getting 40 mgs of Oxycontin from their physician and then going to the street and buying 80 mgs; this is a concern.
- People think it is OK because they have a prescription.
- Oxycontin is big among young people; there is a huge mark-up e.g. individual pills are selling for \$40 per pill ... Youth think Oxycontin is not a scary, dirty drug. The client base growing. Children as young as 11 and 12 are buying it.
- Some people are trafficking cocaine to support their opiate addiction.
- Large scale quantities of prescription medication generally indicate a link to organized crime.

Because prescription medication is socially acceptable, it is difficult to get a sense of the scope of the problem and whether police forces need additional resources to address the issues. Currently, the RCMP's priority is synthetic street drugs rather than prescription medication, guided by the National Drug Strategy.

6.2 Reasons and access to prescription medication

Participants noted that people who are cut off an opiate such as Percocet 'cold turkey' because the physician realizes there is an addiction turn to purchasing the medication on the street.

Because of addictions, there has been an increase in pharmacy robberies. *People are desperate. Oxycontin robberies have increased; there were more robberies of this kind by June 2009 than during all of 2008.*

Solution

The Robbery Unit, focused on the 'victim's perspective' (the business being robbed) has floated an idea with a few pharmacies, to remove Oxycontin from pharmacies. They would know where it is kept. Pharmacies were doubtful this could work because of objections from those who access the medication for 'legitimate use', from seniors with mobility issues and from drug companies.

Other strategies include:

- Installing two safes, one for daily dispensary of medication and another in a secure area where the large stock is stored. Installing timelock safes would mean that medication could not be accessed until a predetermined time period has elapsed and would cause the robbers to leave as they would not wait for the safe to open.
- Placing a sign on the window of the pharmacy to indicate Oxycontin is only available on special order.

6.3 Practice issues

Law enforcement members commented on the practice of physicians and pharmacists as well as their own practice issues, raising a number of questions.

Physician and pharmacist practice issues

Individuals are getting Oxycontin from their physician and other drugs from the street. *How do we hold physicians and pharmacists accountable? Who is monitoring and following up on these prescriptions?*

Do physicians get back to pharmacists if individuals receive a new prescription and are meant to stop the first medication? Do physicians and pharmacists communicate with one another at all if concerns arise, or is this a 'disconnect' that needs to be addressed?

Pharmacists can access triplicate system and Netcare but not all pharmacies are connected and not all physicians use the system.

Law enforcement practice issues

Law enforcement members raised a number of issues that make it difficult to carry out their role. Their focus is on gathering evidence to present to the courts to determine if people are guilty or innocent of a criminal offense.

- Medications are socially acceptable and therefore it is harder to prove possession for purposes of trafficking. There is a lack of knowledge in this area among members. It is unlike cocaine, for which police have digital scales, score sheets and other indicia. It is difficult to know if individuals are addicted to prescription medication.
- What amount of a particular prescription drug constitutes possession for the purposes of trafficking, or which combination of prescription drugs would not be provided to a client? Is it possible to obtain a list from the College of Physicians and Surgeons?
- *Because there is legitimate possession, how do you regulate? How do you head this off at the 'script level before it makes its way to the street?*
- To prove trafficking requires a direct purchase for which a police officer or a witness would have to testify that they purchased the prescription from the accused. Police cannot charge people with possession alone; it is 'all or nothing'. Unless they find a huge amount, they are not able to prove trafficking.
- There are only three prescription medication experts for the police in all of Alberta.
- FOIP is a major factor in getting information from hospitals and physicians' offices.

Robbery Unit members described challenges facing pharmacies.

- *These people are dangerous. Pharmacy staff don't know how to respond, that they should give robbers what they want. We had to go back out and do crime prevention education for each pharmacy which is not our mandate. They understand pills but not the people seeking the drugs. Many have no video equipment and therefore investigations are hampered.*

Participants said they would like to have a better understanding of the legal requirements related to prescription medication so as to know how to judge when a problem exists.

- What are you supposed to do if you suspect wrong-doing? What constitutes possession for the purposes of trafficking with prescription medication?
- Members do not know you cannot charge with possession alone.

- *The act has changed, creating confusion. What options are open to us? Can we prosecute? What are the laws?*
- As an example, members do not know that Schedule 4, possession for purpose of trafficking, can be used for prescription medication.
- Law enforcement members identified a model in the United States in which forging or altering a prescription is considered a criminal offence.

Knowledge about prescription medication is currently acquired in an ad hoc fashion. Members said what they know they learned on the street, for example, what medications are being used, how they are taken, the cost and the going rates. Some have tapped pharmacies for information. *We have been scrambling for quick reference sheets to even know what the pills look like.*

Solutions

Participants suggested tools for increasing knowledge, including ...

- A good reference document.
- Distribution of a pocket-size card to all detachments (e.g. common pills, what they look like). A resource of this kind from the U.S. is currently used by some members.
- Education for the courts on how particular prescriptions work, what they are, how often they are normally filled, in what quantities.
- An on-call number to pose questions.

6.4 Communication

Participants emphasized their need for an open line of communication in order to investigate wrong-doing. An important part of the investigation is to find the originator of medication that winds up on the street. Their focus is on trying to track usage. Is an individual selling the medication? Information-sharing with doctors would make it easier to do this.

- Because of the complications of accessing information, participants surmise these incidents are under-reported. Members do not want to get into locating the appropriate documents, and submitting them and figuring out what the medications are.
- As an example, one person traveled on a Greyhound bus across several provinces, picked up medications in each community and then sold them on a reserve. Police contacted physicians and let them know what was happening. Their reaction was, 'are you telling me how to do my job?'
- As a further consequence of communication barriers, police officers wind up charging individuals instead of following up with doctors.
- It is difficult to prosecute people on something this is considered 'for personal use'. They would like to have a way of getting information on what was prescribed and when. The last double-doctoring case was 10 years back.
- Police have found it difficult to gain access to information from methadone clinics or from shelters. *We may be looking for someone involved in harmful activity.*

Toward the end of the focus group discussion, the police raised questions with a representative from the College of Physicians and Surgeons.

- What information can we access from the College? Can we get the medication history of an individual? If pharmacists and physicians are aware of fraud, what

can they do? What are the circumstances that allow for disclosure of information?

- Does the College investigate double-doctoring and fraud? If the College suspects criminal activity, are they permitted to release this information to the police and do they? If the police suspect criminal activity and wish to establish if there is a crime, law enforcement members require a warrant to access information held with the College.
- The College does investigate double-doctoring and fraud. The Health Information Act legislation does not cover the College of Physicians and Surgeons of Alberta.

Solutions

Law enforcement members want to know who to contact to begin an investigation. They want to establish a minimal level of information that can be provided, a standard that would make reporting easier.

- If police raise a concern, the College of Physicians and Surgeons can say, "It would be useful to look at the profile of this person".
- The College can name the doctor and pull up a profile. This requires a production order (warrant) and must follow judicial requirements for privacy. The College can release information in a case of fraud.
- The College does not know when multiple doctors is legitimate. The College can go to a doctor and conduct a practice review. They can choose to focus on competence or discipline.
- Police stated that, if the College cannot release information when the police suspect criminal activity, this communication needs to improve.

The public has an expectation of privacy. If an inquiry is initiated by police, the College cannot release information without a warrant; if it is initiated by the College, the College can release information. Each needs to know who to contact and what information can be shared.

Law enforcement participants emphasized the importance of public education on the potentially harm associated with addictive prescription medication.

D. Emerging solutions

Participants offered a range of solutions, including strategies already in use in some circles. The solutions relate to prescribing practices, communication between providers, education for providers and access to services for people dealing with addictions.

Prescribing practice

- Shorten dispensing intervals if physician is concerned about an individual's safety.
- Shorten dispensing intervals toward the end of life to reduce the likelihood of accumulating large amounts of addictive medication in the home.
- Contract with family members to bring medications back after an individual has died.

- Include in physician guidelines for prescribing addictive medications³:
 - Assessment tools, e.g. useful language to develop joint solutions with patients
 - Appropriate medications
 - Alternative methods
 - Follow-up care as an essential step in prescribing addictive medications
 - Effective approaches for treating people with addictions

Communication between providers

- Increase effective use of data base systems (i.e. Netcare, Wellnet); reduce technical challenges. Consider negative consequences if access is limited for people living with addictions.
- Clarify the kind of information that can be shared among members of a care team that respects privacy but maximizes benefits and reduces harm for individuals.
- Clarify information that the College of Physicians and Surgeons of Alberta (CPSA) can provide regarding prescribing and usage patterns.
- Communicate CPSA procedures for investigating complaints. Review gaps in follow-up on complaints filed by pharmacists.
- Provide pharmacies and physicians with information on accessible community resources; create opportunities for health professionals to develop relationships with other providers.
- Produce 'cheat sheets'/pocket-sized cards with key information about prescription medication, e.g. types, amounts, effects of combining substances.

Education

- Revisit language on prescription 'misuse' that can be perceived as judgmental by people receiving prescriptions.
- Provide tailored education on medication to the public, physicians, pharmacists, downtown service providers, addiction and mental health treatment providers, and law enforcement members.
- Provide an on-call number providers can use with queries about medication.
- Increase education for health professionals on harm reduction.
- Build into health professional education programs substantive time on addictive medications and pain management.
- Deliver the message to health service providers that addiction is a legitimate condition that needs attention. Build the capacity of health professionals to work effectively with people who have addictions.
- Build inner-city community learning into professional development of health professionals.
- Increase public education on what to do with leftover pills and what to do with medications after a family member dies.

³ The national initiative to create Opioid guidelines for physicians is cited in the recent in-depth newspaper article, *Canada, you need an intervention*, by Anna Mehler Paperny, Globe and Mail, November 14, 2009
<http://v1.theglobeandmail.com/servlet/story/LAC.20091114.PAINKILLERS14ART1446/TPStory/Comment/>

- Pick up medications as a routine part of the process of collecting home aids on loan after a person has died.
- Promote AAWEAR and other mutual support groups for people using addictive substances.
- Open addiction treatment programs to people on methadone.

Services

- Increase funding to shorten wait periods and extend the length of addiction treatment programs.
- Advocate for restored funding for alternative treatment to manage pain (e.g. physiotherapy, massage).
- Consider ways to increase the likelihood that people will use one pharmacy.
- Create more avenues for self-referral to alternative support programs and services rather than channeling referrals through physicians.
- Address turn-around time for third party coverage approval.

E. Concluding remarks

Addictive prescription medication use, particularly opioids, creates a web of concerns among people receiving medication and those who provide health, social and law enforcement services. The focus of this consultation was been on the inner city population of Edmonton.

Pain control is often the trigger that starts an individual down the path of becoming addicted to a prescribed medication, though there may be an underlying addiction. Medication choices that result in under- or over-prescribing and gaps in the use of alternative forms of treatment reflect physician knowledge and skills as well as the availability of resources to support follow-up care and service access. Pharmacists are under pressure to respond to requests to fill questionable prescriptions. In turn, downtown service providers, addiction and mental health treatment providers and law enforcement members address the domino of consequences.

All of the stakeholders consulted through the focus groups had suggestions for short and longer term strategies to mitigate the problems, addressing prescribing practices, communication between providers, education and service access. Changes in each of these areas will achieve benefits for individuals, service providers and communities.

Appendix A

Focus group participants

People with lived experience

As it is, AAWEAR chapter

Physicians

Alberta Hospital, Alberta Health Services
 Boyle McCauley Health Centre, Alberta Health Services
 Detox, Alberta Health Services
 Edmonton Regional Palliative Program, Alberta Health Services
 Pain Clinic, Alberta Health Services
 Palliative ICU, Alberta Health Services
 Private practice physician
 Opiate Dependency Program, Alberta Health Services

Pharmacists

Private practice pharmacists
 Royal Alexandra Hospital

Downtown service providers

Bissell Centre
 George Spady Centre
 Operation Friendship
 StreetWorks
 Women's Emergency Accommodation Centre (WEAC)
 YMCA Housing

Addiction and mental health treatment workers

Alberta Health Services - Addiction and Mental Health

- Adult Counselling and Prevention Services
- Addiction and Mental Health Outreach (Boyle Street Community Services)
- Addiction Recovery Centre
- Henwood Treatment Centre
- Opioid Dependency Treatment Program
- Youth Services

Boyle Street Community Services
 George Spady Centre

Law enforcement

Canadian Forces
 Edmonton Police Services
 RCMP
 Public Prosecution Service of Canada

Appendix B

Outline for Focus Group Sessions

A. Welcome and introductions to ...

1. Participants in the focus group.
2. Purpose, the participants (list of partners) and the activities of the Coalition on Prescription Drug Misuse.
3. Intentions and plan for the focus groups.

B. How do we experience and see the issues as [stakeholder]?

Begin with quotations from AS IT IS, a chapter of AAWEAR – people with a history of drug use; focused on mutual support, education and action.

What would be a typical situation that you encounter as a [stakeholder] coming into contact with people using medications other than for what they were intended (not their prescription, not in the dosage prescribed, not for the intended purpose, selling) ? How do you deal with that?

What do you see as key issues that need to be addressed?

What frustrations and challenges do you experience? What strategies are you using?

What would make it easier to do your work?

What do you see as potential solutions?

15 minutes at the end for a 'Q and A' on prescription drugs that could be answered by one of the participating health professionals.

C. Concluding remarks and next steps