RNAO Registered Nurses' Association of Ontario
L'Association des infirmières et infirmiers autorisés de l'Ontario

RNAO Submission on:

Bill 101, Narcotic Safety & Awareness Act, 2010
to the Standing Committee on Social Policy

Registered Nurses' Association of Ontario (RNAO)

October 18, 2010

158 Pearl Street, Toronto, ON M5H1L3 ■ Ph. 416 599 1925 ■ Toll-free 1 800 268 7199 ■ Fax 416 599 1926
www.RNAO.org

Recommendations
RNAO calls for:

1. Support for Bill 101 as an important first step and recommends attentiveness to privacy/confidentiality safeguards; lessons to be learned from CPSO monitoring of clients on methadone maintenance treatment as well lessons from other jurisdictions; and urges further consultation with rural, remote, and Aboriginal communities and their front-line clinicians in order to address challenges that could hinder the Bill's effective implementation.

2. Development of an integrated and seamless mental health-care system for all Ontarians, with interprofessional collaboration, delivered at the individual's preferred location, with special consideration for members of Aboriginal communities, older adults tackling both new and ongoing mental health and addictions challenges, people from racialized communities, new Canadians, people with disabilities, discharged members of the Canadian Forces, children and youth requiring increased and enhanced mental health and addiction services, inmates in correctional facilities, and rehabilitated ex-convicts.

3. Implementation of the approach of the Select Committee on Mental Health and Addictions outlined in **Navigating the Journey to Wellness: The Comprehensive Mental Health and Addictions Action Plan for Ontarians**.

4. In addition to supporting utilization of non-commercial, evidence-based guidelines such as the **Canadian Guidelines for Safe and Effective use of Opioids for Chronic Non-Cancer Pain** and RNAO's Nursing Best Practice Guideline on **Assessment and Management of Pain**, RNAO recommends the government of Ontario continue its leadership on pharmaceutical issues by advocating for a national Pharmacare program.

5. Ensuring a robust and multi-disciplinary range of perspectives on the Narcotics Advisory Panel that currently seems to be comprised of one police officer, one MOHLTC official, two representatives from the Ontario College of Pharmacists, and eight physicians. Addressing pain control and addiction and mental health issues in a comprehensive way requires multi-faceted, multi-disciplinary approaches.

6. Implementing RNAO's comprehensive set of policy recommendations on improving access to mental health and addiction services, enhancing medicare, improving access to primary care, and improving health equity by addressing the social determinants of health as set out in **Creating Vibrant Communities: RNAO's Challenge to Ontario's Political Parties 2011 Provincial Election.**

Bill 101, Narcotic Safety and Awareness Act, 2010
Submission to the Standing Committee on Social Policy
Registered Nurses' Association of Ontario
October 18, 2010

The Registered Nurses' Association of Ontario (RNAO) is the professional association for registered nurses who practise in all roles and sectors across Ontario. We work to improve health and strengthen our health-care system. Nurses believe that health is a resource for everyday living and that access to the conditions that permit health, including access to health care, are universal human rights.[1] RNAO appreciates the opportunity to present this submission on Bill 101, Narcotic Safety and Awareness Act, 2010 to the Standing Committee on Social Policy.

> Canada has the unenviable distinction of being the world's third largest per capita consumer of opioids and is the top per capita consumer of a number of opioids such as hydromorphone.[2]
>
> College of Physicians and Surgeons of Ontario, **Avoiding Abuse, Achieving a Balance: Tackling the Opioid Public Health Crisis**
>
> In Canada, Ontario is at the top of the list of narcotic use per capita.
>
> Since 1991, prescriptions for oxycodone-containing medications rose by 900 per cent.[3]
>
> Ministry of Health and Long-Term Care, **Rising Use and Abuse of Narcotics**

Bill 101, if passed, would allow the Ministry of Health and Long-Term Care (MOHLTC) to collect, monitor, and analyze information related to prescription narcotics and other controlled substances dispensed to anyone in Ontario through an electronic database.[4] When the Bill was introduced, the Minister of Health, Deb Matthews, explained "there is absolutely nothing stopping people now from visiting multiple pharmacies or doctors over and over again to gain access to drugs. This has resulted in unrestrained and excessive quantities of prescription narcotics and controlled substances being prescribed and dispensed with minimal oversight."[5]

According to data from the Office of the Chief Coroner, deaths in Ontario due to oxycodone have risen 240 per cent from 35 deaths in 2002 to 119 deaths in 2006.[6] Oxycodone was involved in 464 deaths in the five-year period between 2004 and 2008 in Ontario compared with 49 deaths for heroin, 366 deaths for methadone, and 641 deaths for cocaine for the slightly earlier five-year time period of 2002-2006.[7] The Medical Withdrawal Management Service at the

Centre for Addiction and Mental Health (CAMH) reported in the context of steadily increasing admissions each year for opioid detoxification, the admissions for those related to controlled-release oxycodone increased from 3.8 per cent of opioid admissions in 2000 to 55.4 per cent in 2004.[8] The 2007 Ontario Student Drug Use and Health Survey found that 20.6 per cent of the 12 to 19 year old students surveyed had used opioid analgesics at least once for non-medical reasons during the past year, with 72 per cent reporting obtaining them from home.[9] This may be contrasted with the 12 per cent of students who reported smoking in 2007.[10]

Particularly hard hit are a number of First Nations communities that have declared a state of emergency due to prescription narcotics, particularly oxycodone-containing drugs.[11] Addiction rates in some of the First Nations communities in Kenora-Rainy River are 30 or 40 per cent[12] and the MPP for Nickel Belt visited isolated First Nations communities where the rate of addictions stands at 70 per cent.[13]

> The average pharmacy price for one 80 mg OxyContin tablet is $4. The average street price for the same pill is $80. Therefore, a bottle of 100 pills costing about $400 has a potential street value of $8,000. In northern Ontario, Ontario Provincial Police (OPP) reports have shown a single 80 mg OxyContin pill selling for as high as $400-$600 in some First Nations communities, increasing the potential profit to over $38,300 for a one hundred table bottle in those areas.[14]
>
> College of Physicians and Surgeons of Ontario, **Avoiding Abuse, Achieving a Balance: Tackling the Opioid Public Health Crisis**

> …I was there when Chief Adam Fiddler talked to us about some of the families, saying they couldn't give them money because they used it for drugs, so they started giving them vouchers, but they would sell the vouchers and buy drugs. So they started giving them food so they wouldn't sell the vouchers, but they sold the food to buy drugs. At the end of the day, it always ended with 12 little children hungry and empty cupboards and an empty fridge in the house, if they still had a house. So, yes, we need to move forward.[15]
>
> France Gélinas, MPP, member of Select Committee on Mental Health and Addictions

RNAO supports Bill 101 as an important first step to address this urgent situation causing death and misery across the province. Safeguards to ensure confidentiality and privacy are essential for all Ontarians when data is collected. There is even more at stake for those with actual or perceived mental health and addiction challenges who already experience societal stigma and discrimination. There are potential lessons to be learned from patient safety critiques of the College of Physician and Surgeons of Ontario (CPSO) monitoring of clients on methadone maintenance treatment as a disincentive to continuing treatment.[16] [17] Ontario also has a great opportunity to learn from the experiences of other Canadian and American jurisdictions that have already implemented systems to

monitor, use, and disclose prescription information for improved patient safety. To take but one example, only about two per cent of physicians in Saskatchewan actually looked at the Drug Information System available to them for clinical purposes because it was a separate system from their Electronic Medical Records.[18] Of particular importance is the need to consult with front-line clinicians and community leaders in rural, remote, and Aboriginal communities to better understand the realities and challenges of providing health care in order to facilitate implementation of Bill 101.

Recommendation: RNAO supports Bill 101 as an important first step and recommends attentiveness to privacy/confidentiality safeguards; lessons to be learned from CPSO monitoring of clients on methadone maintenance treatment as well as lessons from other jurisdictions; and urges further consultation with rural, remote, and Aboriginal communities and their front-line clinicians in order to address challenges that could hinder the Bill's effective implementation.

Ontario Needs a Comprehensive Mental Health and Addiction Strategy

> I currently work in a hospital-based community mental health and addictions program and many of the clients I see have a history of sexual violence…The average wait time for counseling is nine to ten months. Research provides the evidence that people will access services when their symptoms are most acute. Imagine being a single mother of three kids with no supports and with symptoms of depression/anxiety trying to kick an addiction while trying to maintain in the community. Now imagine being told you have to wait nine months before treatment can be initiated.[19]
>
> Registered Nurse with clinical expertise in community mental health

RNAO congratulates the Select Committee on Mental Health and Addictions for their attentive listening in their travels across the province resulting in their thoughtful final report, **Navigating the Journey to Wellness: The Comprehensive Mental Health and Addictions Action Plan for Ontarians**. Bill 101 is a direct response to the Select Committee's recommendation 11 that "The Ministry of Health and Long-Term Care should immediately address the problem of addiction to prescription painkillers."[20]

As the Select Committee on Mental Health and Addictions has found[21] and too many inquests have confirmed, there is no coherent mental health system to help the one in five Ontarians living with mental illness and addiction problems.[22] It is perhaps not surprising that only three in ten Ontarians living with mental illness and addictions problems are able to access any help as Ontario and Canada rank lowest of OECD countries in terms of spending on mental health services.[23]

Ontario cannot afford not to act on a comprehensive mental health and addiction strategy—the human toll in suffering touches every family. The economic cost is also significant: in total, including lost productivity, law enforcement, disability claims, drug costs, and employee assistance claims, mental health and addictions cost Ontario at least $39 billion per year.[24] Every dollar spent on mental health and addictions saves $7 in health costs and $30 in lost productivity and social costs.[25]

RNAO continues to recommend/advocate for the development of an integrated and seamless mental health-care system for all Ontarians, with interprofessional collaboration, delivered at the individual's preferred location, with special consideration for members of Aboriginal communities, older adults tackling both new and ongoing mental health and addictions challenges, people from racialized communities, new Canadians, people with disabilities, discharged members of the Canadian Forces, children and youth requiring increased and enhanced mental health and addiction services, inmates in correctional facilities, and rehabilitated ex-convicts.[26]

Consistent with this advocacy, RNAO recommends implementation of the approach of the Select Committee on Mental Health and Addictions' outlined in **Navigating the Journey to Wellness: The Comprehensive Mental Health and Addictions Action Plan for Ontarians**.

The mission statement for the proposed Mental Health and Addictions Ontario is a vision that could well serve to inspire all of us in our collaborative efforts:

Mission Statement for Mental Health and Addictions Ontario

To reduce the burden of mental illness and addictions by ensuring that all Ontario residents have timely and equitable access to an integrated system of excellent, coordinated and efficient promotion, prevention, early intervention, treatment and community support programs.[27]
Select Committee on Mental Health and Addictions, Navigating the Journey to Wellness

A Narcotic Strategy Needs To Address More than Misuse and Abuse

The title page of the provincial Narcotic Strategy describes it as "Ontario's plan to reduce the misuse and abuse of prescription narcotics and other controlled substances."[28] Although there is a stated benefit that the strategy will "ensure those with legitimate medical needs get the medications they require,"[29] the five key elements of 1) proposed monitoring database and proposed legislation; 2) partnering with the health care sector to educate on appropriate prescribing; 3) partnering with the health care sector to educate on appropriate dispensing; 4) education to prevent excessive use of prescription services; and 5) treatment of

addictions[30] could be interpreted and implemented to overshadow pain control needs of those with cancer and chronic health conditions.

The World Health Organization has observed that 50 years of a focus on the prevention of drug abuse has resulted in severe under-treatment of severe pain in more than 150 countries, both industrialized and developing.[31] The **New York Times**, for example, recently reported on how patients in nursing homes "have become unintended casualties in the war on drugs because of a new level of enforcement intended to prevent narcotics from getting into the wrong hands."[32] Canada and the United States both rank ninth in the Quality of Death Index that compares end-of-life care across 30 OECD countries and ten selected others.[33] The United Kingdom ranks first in quality of end-of-life care as a result of its hospice care network, statutory involvement in end-of-life care, access to painkillers, training availability, public awareness, and physician-patient transparency.[34]

At the September 2010 Assembly meeting of the Registered Nurses' Association of Ontario, a number of nursing leaders from different geographical areas working in various sectors expressed concern about inconsistent and inequitable access to palliative care services across the province. Compassionate, knowledgeable skilled nurses spoke of their frustrations in knowing that those in their care were not receiving the care they felt ethically obligated to provide at the same time as they were struggling with long hours, disproportionately low wages, and the need to engage in fundraising for what should be essential health services. These system gaps, including difficulties with poor pain and symptom management, have also been documented by the Ontario End of Life Strategy[35] and Cancer Care Ontario.[36] Nurses expert in palliative care are skilled at a wide variety of comfort and care measures to address pain and other symptoms. Narcotics are one of the essential interventions for pain control. Independent nurse prescribing has been well established in the United Kingdom since 1992 and within a decade they had more than 22,000 community nurses educated as prescribers.[37] Lessons from extended independent nurse prescribing in palliative care in the United Kingdom is an area worth exploring for its potential contribution to holistic, seamless palliative care for patients as well as for insight into challenges.[38]

While it is obvious that we have a societal responsibility to ensure that those who are dying are as comfortable as possible, we must also be responsible in addressing the needs of the 2.4 million to 3.6 million who live with chronic pain in the province.[39] People in pain need to be able to access what they need without stigma—this includes people with addiction and mental health issues who also have pain control needs. While there may be a temptation to try to divide people into two distinct groups ("legitimate patients with pain" and "abusers"), this divide is unlikely to exist in reality while seeking it works against the interests of public health.[40]

While much of the misuse and abuse discourse is directed to drug-seeking behaviour by individuals, it might be helpful to revisit the profit-seeking behaviour of the pharmaceutical industry. The United States General Accounting Office found that from the onset of the introduction of OxyContin in 1996, Purdue promoted the drug to physicians for noncancer pain conditions caused by arthritis, injuries, and chronic diseases as well as cancer as both "the drug to start with and stay with."[41] Purdue expanded its sales force and used multiple approaches to market and promote OxyContin including: expanding its physician speaker bureau, sponsoring pain-related educational conferences, issuing OxyContin starter coupons for patients' first prescriptions, sponsoring pain-related Web sites, advertising OxyContin in medical journals, and distributing OxyContin marketing items to health care professionals.[42] Purdue compiled detailed prescribing profiles of individual physicians in order to identify and target physicians who were the highest prescribers of opioids in the country.[43] This database combined with a lucrative bonus system for their sales staff helped to make OxyContin a "blockbuster" with sales escalating from $44 million in 1996 (316,000 prescriptions) to a 2001-2002 combined sales of nearly $3 billion (over 14 million prescriptions).[44]

A consistent feature in their marketing was a systematic effort to minimize the risk of addiction for the treatment of non-cancer related pain.[45] Written and video-taped promotional materials for physicians and patients developed by Purdue emphasized the claim that risk of addiction from OxyContin was extremely small while sales representatives were trained to say that the "risk of addiction was less than one per cent."[46] In 2007, Purdue pleaded guilty in federal court to criminal charges of "misbranding" OxyContin and agreed to pay $600 million in fines and three executives of the company agreed to pay $34.5 million in fines.[47] Included in the $600 million is $470 million in payments and fines to a variety of federal and state agencies such as $19.5 million to 26 states and the District of Columbia to settle complaints that it encouraged physicians to overprescribe OxyContin.[48]

Recommendation: In addition to supporting utilization of non-commercial, evidence-based guidelines such as the **Canadian Guidelines for Safe and Effective use of Opioids for Chronic Non-Cancer Pain**[49] and RNAO's Nursing Best Practice Guideline on **Assessment and Management of Pain**,[50] RNAO recommends the government of Ontario continue its leadership on pharmaceutical issues by advocating for a national Pharmacare program.[51] A standardized, national, publicly funded and publicly controlled pharmaceutical program would improve equitable access, address escalating costs, and facilitate evidence-based prescribing with a formulary and decision-tools.

The current Narcotics Advisory Panel seems to be comprised of one police officer, one MOHLTC official, two representatives from the Ontario College of Pharmacists, and eight physicians.[52] As addressing pain control and addiction and mental health issues in a comprehensive way requires multi-faceted, multi-

disciplinary approaches, it would be helpful to add a more robust range of perspectives. In addition to exploring possibilities generated by nursing knowledge and expertise of palliative care, chronic disease management, and mental health and addictions, additional consultation with nursing stakeholders would be helpful in two areas. The College of Physicians and Surgeons' **Avoiding Abuse, Achieving a Balance: Tackling the Opioid Public Health Crisis** report frames family physicians as "the gatekeepers to the health system" and restricts discussion of primary care structures that promote multi-disciplinary care to Family Health Teams and Community Health Centres.[53] While family physicians often are gatekeepers, it is essential to reflect the evolving challenges of ensuring access to primary care for all Ontarians through the new configuration of NP-lead clinics as well as the ongoing service of community health nurses in rural, remote, and Aboriginal areas who are often the gatekeepers and the gate.

A second example arising from the same report that would benefit from additional consultation with nursing and other stakeholders is recommendation 27 that would amend the *Personal Health Information Act* and the *Freedom of Information and Privacy Act* "to require a regulated health professional, the head of an institution and a health information custodian to disclose personal information to a police service without a warrant where he/she has reasonable and probable grounds to believe that a law of Ontario or Canada, including the *Criminal Code* or the *Controlled Drugs and Substance Act*, has been contravened."[54] While enabling legislation that would permit disclosure might be welcome in some circumstances, the use of language that denotes a mandatory duty such as "require" is a threat to the exercise of professional judgment. This would be a concern to nurses and other health professionals in a variety of settings who work with already marginalized people. Instead of putting clients and nurses in a situation where they would have to choose between truthful, therapeutic communication to achieve health goals and interactions with the criminal justice system, the focus should be on prevention, education, treatment, and harm reduction with responsibility for interdiction elsewhere.

Reducing Health Inequities by Creating Vibrant Communities

Approximately 66 per cent of First Nations people believe that the relatively poor state of Aboriginal health is caused by, or linked to, the residential school experience and/or the loss of traditional cultures and lands.[55]

National Aboriginal Health Organization, **Broader Determinants of Health in an Aboriginal Context**

A history of oppression, the consequences of residential schooling, unemployment, isolation, and other factors contribute to higher rates of trauma, grief, mental illness and addictions among First Nations people.[56]

Interim Report of the Select Committee on Mental Health and Addictions

> When an entire society is drowning in addiction—to gambling, sex, dysfunctional relationships, computer games, pornography, work, shopping, credit, exercise, ideological fanaticism and much more—we must think beyond supposedly addictive substances and individual genetics. We must look for social factors that make some societies more vulnerable to addiction than others and that, historically, have transformed cultures that were almost addiction free into populations that are engulfed by addictive misery.[57]
>
> Professor Bruce Alexander, **Canadian Nurse**

RNAO's comprehensive set of policy recommendations on improving access to mental health and addiction services, enhancing medicare, improving access to primary care, and improving health equity by addressing the social determinants of health are available in **Creating Vibrant Communities: RNAO's Challenge to Ontario's Political Parties 2011 Provincial Election.**[58]

Pertinent resources available to be downloaded without charge from the website of the Registered Nurses' Association of Ontario (www.rnao.org) include:

- Best Practice Guideline on Assessment and Care of Adults at Risk for Suicidal Ideation and Behaviour[59]
- Best Practice Guideline on Assessment and Management of Pain[60]
- Best Practice Guideline on Client Centred Care[61]
- Best Practice Guideline on Crisis Intervention[62]
- Best Practice Guideline on Embracing Cultural Diversity in Health Care: Developing Cultural Competency[63]
- Best Practice Guideline on Enhancing Healthy Adolescent Development[64]
- Best Practice Guideline on Establishing Therapeutic Relationships[65]
- Best Practice Guideline on Interventions for Postpartum Depression[66]
- Best Practice Guideline on Strategies to Support Self-Management in Chronic Conditions: Collaboration with Clients[67]
- Best Practice Guideline on Supporting and Strengthening Families Through Expected and Unexpected Life Events[68]
- Best Practice Guideline on Supporting Clients on Methadone Maintenance Treatment[69]

Thank you for the opportunity to present to the Standing Committee on Bill 101, the Narcotic Safety and Awareness Act.

References

[1] Registered Nurses' Association of Ontario (2010). **Creating Vibrant Communities: RNAO's Challenge to Ontario's Political Parties 2011 Provincial Election Technical Backgrounder**. Toronto: Author, 1. http://www.rnao.org/Page.asp?PageID=122&ContentID=3176&SiteNodeID=472&BL_ExpandID=

[2] College of Physicians and Surgeons of Ontario (2010). **Avoiding Abuse, Achieving a Balance: Tackling the Opioid Public Health Crisis.** Toronto: Author, 12. http://www.cpso.on.ca/policies/positions/default.aspx?id=4324

[3] Ministry of Health and Long-Term Care (2010). **Rising use and abuse of narcotics**. August 27, 2010. http://news.ontario.ca/mohltc/en/2010/08/rising-use-and-abuse-of-narcotics.html

[4] Matthews, D. (2010, Sept. 15). First Reading, Narcotic Safety and Awareness Act, 2010. **Official Report of Debates (Hansard**). Legislative Assembly of Ontario. Second Session, 39th Parliament, 2114. http://www.ontla.on.ca/

[5] Matthews, D. (2010, Sept. 15). First Reading, Narcotic Safety and Awareness Act, 2010. **Official Report of Debates (Hansard**). Legislative Assembly of Ontario. Second Session, 39th Parliament, 2114. http://www.ontla.on.ca/

[6] College of Physicians and Surgeons of Ontario (2010). **Avoiding Abuse**, 12.

[7] Donovan, K. (2009). Oxycodone found to be more deadly than heroin. **Toronto Star**. February 10, 2009. Data was released to the Toronto Star from the Office of the Chief Coroner of Ontario.

[8] Sproule, B., Brands, B., Li, S. & Catz-Biro, L. (2009). Changing patterns in opioid addiction: Characterizing users of oxycodone and other opioids. **Canadian Family Physician**. 55, 68.

[9] Brands, B., Paglia-Boak, A., Sproule, B., Leslie, K. & Adlaf, E. (2010). Nonmedical use of opioid analgesics among Ontario students. **Canadian Family Physician**. 56 (3), 256.

[10] Centre for Addiction and Mental Health (2007). **News Release: 2007 Ontario Student Drug Use and Health Survey.** November 20, 2007. http://www.camh.net/News_events/News_releases_and_media_advisories_and_backgrounders/OSDUHS_2007.html

[11] Ministry of Health and Long-Term Care (2010). **Rising use and abuse of narcotics**. August 27, 2010. http://news.ontario.ca/mohltc/en/2010/08/rising-use-and-abuse-of-narcotics.html

[12] Hampton, H. (2010, Sept. 15). First Reading, Narcotic Safety and Awareness Act, 2010. **Official Report of Debates (Hansard**). Legislative Assembly of Ontario. Second Session, 39th Parliament, 2115. http://www.ontla.on.ca/

[13] Gélinas, F. (2010, Sept. 27). Second Reading, Narcotic Safety and Awareness Act, 2010. **Official Report of Debates (Hansard**). Legislative Assembly of Ontario. Second Session, 39th Parliament, 2312. http://www.ontla.on.ca/house-proceedings/transcripts/files_pdf/27-SEP-2010_L047.pdf

[14] College of Physicians and Surgeons of Ontario (2010). **Avoiding Abuse**, 35.

[15] Gélinas, F. (2010, Sept. 27). Second Reading, Narcotic Safety and Awareness Act, 2010. **Official Report of Debates (Hansard**). Legislative Assembly of Ontario. Second Session, 39th Parliament, 2319.

[16] Berger, P. (2009). Opinion: Heavy-handed rules harm methadone treatment. **Toronto Star**, November 22, 2009.

[17] Tyler, T. (2009). Addicts protest 'double standards.' **Toronto Star,** February 14, 2009.

[18] College of Physicians and Surgeons of Ontario (2010). **Avoiding Abuse**, 32.

[19] Anonymous response to RNAO Survey Used to Inform RNAO's submission on Ontario's Sexual Violence Action Plan. Registered Nurses' Association of Ontario (2010). **Submission to the Ontario Women's Directorate on a Sexual Violence Action Plan.** Toronto: Author, 8. http://www.rnao.org/Storage/73/6758_RNAO_on_sexual_violence_plan_Sept_24_2010.pdf

[20] Ontario Legislative Assembly. Select Committee on Mental Health and Addictions (2010). **Final Report Navigating the Journey to Wellness: The Comprehensive Mental Health and Addictions Action Plan for Ontarians.** Toronto: Author, 20. http://www.ontla.on.ca/web/committee-proceedings/committee_reports.do?locale=en

[21] Ontario Legislative Assembly. Select Committee on Mental Health and Addictions (2010). **Final Report Navigating the Journey to Wellness: The Comprehensive Mental Health and Addictions Action Plan for Ontarians,** 3.

[22] Lurie, S. (2010). Mental health needs a long-term strategy. **Toronto Star**, October 15, 2010.

[23] Lurie, S. (2010). Mental health needs a long-term strategy. **Toronto Star**, October 15, 2010.

[24] Ministry of Health and Long-Term Care (2009). **Every Door is the Right Door: Toward a 10 year Mental Health and Addictions Strategy—A Discussion Paper**. Toronto: Author. http://www.health.gov.on.ca/english/public/program/mentalhealth/minister_advisgroup/minister_advisgroup.html

[25] Ministry of Health and Long-Term Care (2009). **Every Door is the Right Door: Toward a 10 year Mental Health and Addictions Strategy—A Discussion Paper.** Toronto: Author.

[26] Registered Nurses' Association of Ontario (2010). **Creating Vibrant Communities: RNAO's Challenge to Ontario's Political Parties 2011 Provincial Election Technical Backgrounder**. Toronto: Author, 45.

[27] Ontario Legislative Assembly. Select Committee on Mental Health and Addictions (2010). **Final Report Navigating the Journey to Wellness: The Comprehensive Mental Health and Addictions Action Plan for Ontarians,** 3.

[28] Ministry of Health and Long-Term Care (2010). **Narcotic Strategy: Ontario's plan to reduce the misuse and abuse of prescription narcotics and other controlled substances**. Toronto: Author, 1. http://www.health.gov.on.ca/en/public/programs/drugs/ons/resources.aspx

[29] Ministry of Health and Long-Term Care (2010). **Narcotic Strategy: Ontario's plan to reduce the misuse and abuse of prescription narcotics and other controlled substances**. Toronto: Author, 11.

[30] Ministry of Health and Long-Term Care (2010). **Ontario's Narcotic Strategy**. Toronto: Author. http://www.health.gov.on.ca/en/public/programs/drugs/ons/

[31] World Health Organization (2010). **Access to Analgesics and to Other Controlled Medications.** Geneva: Author. http://www.who.int/medicines/areas/quality_safety/access_Contr_Med/en/print.html

[32] Leland, J. (2010). A Battle Against Prescription Drugs Causes Pain. **New York Times**. October 2, 2010.

[33] Economist Intelligence Unit (2010). **The Quality of Death: Ranking End-of-Life Care Across the World.** London: Author, 11.

[34] Economist Intelligence Unit (2010). **The Quality of Death: Ranking End-of-Life Care Across the World.** London: Author, 6.

[35] Figure 2, Ontario's Palliative Care System—Today and Tomorrow. Adapted with permission from the Ontario End-of-Life Strategy. Cancer Care Ontario (2006). **Improving the Quality of Palliative Care Services for Cancer Patients in Ontario.** Toronto: Author, 10.

[36] Cancer Care Ontario (2006). **Improving the Quality of Palliative Care Services for Cancer Patients in Ontario.** Toronto: Author, 6. http://www.cancercare.on.ca/ocs/clinicalprogs/pallcareprog/

[37] Mula, C. & Ware, S. (2003). Extended independent nurse prescribing in palliative care. **Nursing Times**. 99 (18), 30. http://www.nursingtimes.net/nursing-practice-clinical-research/extended-independent-nurse-prescribing-in-palliative-care/205532.article

[38] Mula, C. & Ware, S. (2003). Extended independent nurse prescribing in palliative care. **Nursing Times**. 99 (18), 30-32.

[39] Gélinas, F. (2010, Sept. 27). Second Reading, Narcotic Safety and Awareness Act, 2010. **Official Report of Debates (Hansard**). Legislative Assembly of Ontario. Second Session, 39th Parliament, 2313.
[40] Fischer, B., Goldman, B., Rehm, J., & Popova, S. (2008). Non-medical use of prescriptions opioids and public health in Canada: An urgent call for research and interventions development. **Canadian Journal of Public Health**. 99 (3), 183.
[41] United States General Accounting Office (2003). **Prescription Drugs: OxyContin Abuse and Diversion and Efforts to Address the Problem.** Washington: Author, 17.
[42] United States General Accounting Office (2003). **Prescription Drugs: OxyContin Abuse and Diversion and Efforts to Address the Problem.** Washington: Author, 21.
[43] Van Zee, A. (2009). The promotion and marketing of OxyContin: Commercial Triumph, Public Health Tragedy. **American Journal of Public Health**. 99 (2), 222.
[44] Van Zee, A. (2009). The promotion and marketing of OxyContin: Commercial Triumph, Public Health Tragedy. **American Journal of Public Health**. 99 (2), 223.
[45] Van Zee, A. (2009). The promotion and marketing of OxyContin: Commercial Triumph, Public Health Tragedy. **American Journal of Public Health**. 99 (2), 223.
[46] Van Zee, A. (2009). The promotion and marketing of OxyContin: Commercial Triumph, Public Health Tragedy. **American Journal of Public Health**. 99 (2), 223.
[47] Meier, B. (2007). Narcotic maker guilty of deceit over marketing. **New York Times**, May 11, 2007.
[48] Meier, B. (2007). Narcotic maker guilty of deceit over marketing. **New York Times**, May 11, 2007.
[49] National Opioid Use Guideline Group (2010). **Canadian Guide for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain.** http://nationalpaincentre.mcmaster.ca/opioid/
[50] Registered Nurses' Association of Ontario (2007). **Assessment and Management of Pain**. Toronto: Author. http://www.rnao.org/Page.asp?PageID=924&ContentID=720
[51] Registered Nurses' Association of Ontario (2010). **Creating Vibrant Communities: RNAO's Challenge to Ontario's Political Parties 2011 Provincial Election Technical Backgrounder**. Toronto: Author, 36.
[52] Ministry of Health and Long-Term Care (2010). **Ontario's Narcotics Strategy: Frequently Asked Questions.** Toronto: Author. http://www.health.gov.on.ca/en/public/programs/drugs/ons/ons_faq.aspx
[53] College of Physicians and Surgeons of Ontario (2010). **Avoiding Abuse**, 23.
[54] College of Physicians and Surgeons of Ontario (2010). **Avoiding Abuse**, 38.
[55] National Aboriginal Health Organization (2007). **Broader Determinants of Health in an Aboriginal Context**. Ottawa: Author, 10. http://www.naho.ca/english/pub_determinants.php
[56] Ontario Legislative Assembly (2010). **Select Committee on Mental Health and Addictions Interim Report.** Toronto: Author, 9. http://www.ontla.on.ca/web/committee-proceedings/committee_reports.do?locale=en
[57] Alexander, B. (2010). Treatment and harm reduction professionals need to make peace. **Canadian Nurse**. 105(4), 40.
[58] Registered Nurses' Association of Ontario (2010). **Creating Vibrant Communities: RNAO's Challenge to Ontario's Political Parties 2011 Provincial Election Technical Backgrounder**. Toronto: Author. http://www.rnao.org/Page.asp?PageID=122&ContentID=3176&SiteNodeID=472&BL_ExpandID=
[59] Registered Nurses' Association of Ontario (2007). **Assessment and Care of Adults at Risk for Suicidal Ideation and Behaviour**. Toronto: Author. http://www.rnao.org/Page.asp?PageID=924&ContentID=2744

[60] Registered Nurses' Association of Ontario (2007). **Assessment and Management of Pain**. Toronto: Author. http://www.rnao.org/Page.asp?PageID=924&ContentID=720
[61] Registered Nurses' Association of Ontario (2006). **Client Centred Care**. Toronto: Author. http://www.rnao.org/Page.asp?PageID=924&ContentID=798
[62] Registered Nurses' Association of Ontario (2006). **Crisis Intervention**. Toronto: Author. http://www.rnao.org/Page.asp?PageID=924&ContentID=799
[63] Registered Nurses' Association of Ontario (2005). **Embracing Cultural Diversity in Health Care: Developing Cultural Competency.** Toronto: Author. http://www.rnao.org/Page.asp?PageID=122&ContentID=1200&SiteNodeID=241&BL_ExpandID=
[64] Registered Nurses' Association of Ontario (2002). **Enhancing Healthy Adolescent Development.** Toronto: Author. http://www.rnao.org/Page.asp?PageID=924&ContentID=800
[65] Registered Nurses' Association of Ontario (2006). **Establishing Therapeutic Relationships.** Toronto: Author. http://www.rnao.org/Page.asp?PageID=924&ContentID=801
[66] Registered Nurses' Association of Ontario (2005). **Interventions for Postpartum Depression.** Toronto: Author. http://www.rnao.org/Page.asp?PageID=924&ContentID=806
[67] Registered Nurses' Association of Ontario (2010). **Strategies to Support Self-Management in Chronic Conditions: Collaboration with Clients.** Toronto: Author. http://www.rnao.org/Page.asp?PageID=924&ContentID=3320
[68] Registered Nurses' Association of Ontario (2006). **Supporting and Strengthening Families Through Expected and Unexpected Life Events.** Toronto: Author. http://www.rnao.org/Page.asp?PageID=924&ContentID=819
[69] Registered Nurses' Association of Ontario (2009). **Supporting Clients on Methadone Maintenance Treatment.** Ontario: Author. http://www.rnao.org/Page.asp?PageID=122&ContentID=2946