



Hope in Fort Hope

First Nations community is winning the battle against prescription drug abuse

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It's a challenge, but I rise up to meet this challenge every morning." My last patient of the day wanted me to know this and to share it with all of you. He wanted to share how amidst all the darkness, a light was being spread candle to candle, from one person to the next, in his small northern Ontario community. He wanted me to tell you about the flame of hope burning brightly in Fort Hope, Ont.

"What made the difference?" I found myself asking again and again, asking each person sitting across from my desk in the nursing station. How are they doing it? How is this small First Nations community of 1200 people—reachable only by air or ice road—winning its fight against prescription drug abuse? How is each person making that pivotal change in his or her life, taking that leap to leave addiction behind? So often what one reads about First Nations communities is rife with despair and hopelessness. What I was left with at the end of my week in Eabametoong First Nation, also known as Fort Hope, was an overwhelming sense of hope and admiration.

For 5 days in April 2012 I assisted Dr Claudette Chase, the community physician in Eabametoong and a leading voice speaking to indigenous health issues. I was the second physician deployed as part of an initiative known as the Northern Ontario Suboxone Support program, an association of physicians—most with a special interest in addiction medicine—who are going to remote northern communities to assist with community drug treatment programs.

The scale of the issue is what compelled me to go north. If you are not already aware, the province of Ontario is in the midst of a public health crisis stemming from the inappropriate prescribing and dispensing and the illicit use of opioid drugs. In a study involving First Nations communities in the Sioux Lookout Zone (one of which is Eabametoong), anecdotally, as much as 80% of the adult population uses prescription drugs illicitly.¹ The epidemic is so virulent that in November 2009 the Nishnawbe Aski Nation, consisting of 49 communities in northwestern Ontario, declared a state of emergency regarding prescription drug abuse.²

How did it come to be this way?

The answer to this question is a sad one. As a primary care physician and a gatekeeper to the health

care system, I must confess that part of the blame lies within my profession. In the late 1990s, Purdue Pharma initiated an aggressive marketing campaign for the drug OxyContin (timed-release oral oxycodone), extolling its virtues as a non-addictive opioid that could be safely prescribed in high doses. Since then, physicians in Ontario and throughout North America have greatly increased the prescribing of OxyContin and other opioid medications for chronic pain.³ This increased prescribing has come at a great cost, as the final portrait of OxyContin is quite different from the one painted initially by Purdue.

As it turns out, OxyContin—or Oxys, as they are known to the people I met in Eabametoong—are actually quite addictive, and in recent years they have become an important drug of abuse. Since 2004, the number of OxyContin-related deaths in Ontario has doubled, and on February 29, 2012, the drug was taken off Ontario's drug benefit formulary. For those currently being prescribed OxyContin, a new formulation called OxyNEO (also timed-release oral oxycodone) has been created and will replace OxyContin on the formulary for 1 year before it becomes available only through special access. Purdue claims the new drug is tamper proof, but already there are videos on YouTube showing how to microwave it, freeze it, and crush it so it can be snorted or injected.

Although OxyContin has been by far the biggest culprit among prescription narcotics when it comes to addiction and abuse, all narcotics have abuse potential, and the abuse of any narcotic can lead to the same negative outcomes. One young woman explained:

I started using Percocets [oxycodone and acetaminophen tablets] first, and then I started Oxys in 2008. At first they made me sick and I stopped, but then in 2009 they stopped selling Percs and I could only get Oxys.

She told me about how at first she took the drugs orally, and then quickly transitioned to snorting, and finally to injecting. This progression from oral to nasal to intravenous use of the drug was the same for each person I saw. At first, taking the pills by mouth is enough. Pretty soon, the high only comes with snorting and eventually only with injection. In the depths of addiction, most are no longer even getting a high, but are injecting the drug to stave off the misery of withdrawal.

This article has been peer reviewed.
Can Fam Physician 2013;59:391-3

Health and social risks

The health risks of prescription drug abuse are obvious. Injecting with shared needles or snorting with shared straws poses known risks of HIV and hepatitis C. For those attempting to quit on their own without medical assistance, withdrawal itself poses increased risk of suicide and overdose.

Less obvious are the social risks of OxyContin addiction that are prevalent in small, isolated First Nations communities. It is difficult to capture in numbers the devastating effect of prescription drug abuse on the established social fabric, the family, and the community.

Before, I used to sleep all day and leave my kids in the living room. When money came around, I would just buy drugs with it. Eighty percent would be used for drugs and the rest for food. The drugs would always be first.

Life was crappy ... My finances weren't good. Everything was falling apart—my life, my relationships.

Drug treatment pilot program

In the summer of 2011, Fort Hope decided it was time to do something. After requesting assistance from all levels of government and being met with a wall of silence, the community, with the help of addiction consultants like Karen O'Gorman, implemented its own drug treatment program. This program, a pilot that has since been adopted in other Nishnawbe Aski Nation communities, is helping people get off OxyContin with great success using Suboxone (buprenorphine and naloxone).⁴ Unlike methadone, which is a restricted medication dispensed only at specialty clinics, Suboxone can be dispensed in the community by physicians, nurses, and trained laypeople. Until Suboxone was covered by the Ontario Health Insurance Plan and the Non-Insured Health Benefits program in 2011, those seeking help to overcome their addiction would have to leave their families and support systems and fly to special programs in Sioux Lookout and Thunder Bay, Ont. For most, this was not a feasible option. When Suboxone became accessible in Ontario, Eabametoong and other Nishnawbe Aski Nation communities were at the cutting edge of innovation, seizing the opportunity to lead their communities out of the darkness of addiction.

"Fort Hope's program started with 4 people going through detox every 7 days," Dr Chase remembered. "Now it has grown to 90 people, with many more on the waiting list." Indeed, the success of the program is how I came to be in Fort Hope. With so few resources, the program is growing beyond its capacity. There are not enough physicians to start people on Suboxone and follow them as they go through the process of quitting. Most continue on maintenance therapy but some are

successfully weaned from opioids altogether. There are not enough mental health workers to provide adequate aftercare and relapse prevention counseling. In a larger sense, the economic opportunities and community programming necessary to ensure continued community and individual engagement are not available.

Why the demand for treatment?

I asked the people I met in Eabametoong what drove them to enrol in the program—to make that decision to quit. The answers revealed an overwhelming sense of fatigue, and concern for the community's children: "I have 4 kids: 2 boys and 2 girls. I want to get them back," one young father told me. "I want to bring my family back together."

A grandfather told me something similar: "The whole point is to get my life back, for my daughter and my 2 grandkids. I don't want my daughter to do it. I'm talking to her and trying to get her to not do what I did."

The word *tired* kept coming up—people were tired of being broke, tired of losing people, tired of seeing children grow up too fast, tired of cravings, tired of withdrawals, and tired of being a statistic: "I got tired of watching families break apart."

As I spoke to more people, it became clear to me why the program has been so successful. The answer is simple and profound. The success is rooted in the community's ownership of the program. It is a program designed for the people of Eabametoong, by the people of Eabametoong. Wanda Sugarhead, the community's mental health and addictions coordinator, explains that

The clinical team, the detox intake workers, the Suboxone dispensers, the community nurse, Ontario Works, the band chief and council, the school staff, and basically all programs in the community have put some time, money, and volunteer work into the programming.

The team that runs the program is intimately aware of the challenges faced by the people of Eabametoong and has a keen sense of what is necessary for the program's success. The aftercare part of the program has been uniquely developed by community support workers who have incorporated cultural values such as the medicine wheel concept of health to ensure the program's success. In Eabametoong, there is an understanding that the addiction epidemic is undermining the physical, mental, spiritual, and emotional well-being of the people and that the healing must also be physical, mental, spiritual, and emotional.

As I left Eabametoong on a bright, crisp northern Ontario morning, the faces of the people I met and their stories about the difference the program had made in their lives were running through my mind.

"Now I work, I can buy things for my kid ... I feel better. I feel healthier," said one young man.

"The kids are noticing that I've stopped doing drugs," said another. "They interact with me more now. And, I do a lot more outdoors stuff now. I like to go hunting, chopping wood."

What I want to leave you with, in the end, is a sense of hope. I want to leave you feeling the incredibly positive momentum that propelled me to share this story. There is transformation happening in the north. The communities are throwing off the shackles of addiction and moving forward. We can either stand with them in solidarity and help, or we can be on the wrong side of history.



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Competing interests

None declared

The opinions expressed in Reflections are those of the authors. Publication does not imply endorsement by the College of Family Physicians of Canada.

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