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## **CROSSTALK: OXYCONTIN ADDICTION AND PRESCRIPTION DRUG ABUSE**

ANNE BUDGELL (Host): Welcome to the second hour of Radio Noon on CBC Radio One in Newfoundland and Labrador. I'm Anne Budgell in St. John's and it's time for Crosstalk now. Today on Crosstalk my guest in the studio is Dr. Simon Avis. He is the province's chief medical examiner and we've invited him here today to talk about the drug abuse that's causing deaths in our province. Dr. Avis, this is something that worries you greatly, isn't it?

DR. SIMON AVIS (Chief Medical Examiner, Newfoundland & Labrador): It's certainly something that has become very concerning to our office. We've been tracking deaths for a variety of causes ever since the medical examiner system was initiated in 1996. And it's become quite apparent that accidental drug overdoses are on the increase. This is something that is quite new. Prior to 1996 we would occasionally find an accidental drug overdose. It was usually with a drug known as Fiorinal, Fiorinal-C, which is a combination of aspirin, a barbiturate...

BUDGELL: It's a painkiller.

AVIS: It was a painkiller. And we would occasionally get an accidental overdose of, of that drug. Roundabout 2001 we started to notice an increase in the number of deaths due to oxycodone. Oxycodone is a very powerful narcotic. And if you want to compare it with morphine, it's probably about twice as strong as morphine. And we noticed a number of individuals were dying and it's been expanding since that time.

BUDGELL: Oxycodone, is that the name of the drug that's found in many different painkiller products?

AVIS: Yeah, oxycodone is the active ingredient in OxyContin and it's also the active pain ingredient, one of the active pain ingredients in a drug called Percocet and Percodan. Now it's interesting, because Percocet and Percodan have been available on the market for a long time, yet we didn't see any deaths related or very few deaths related to the accidental overdose ingestion of those drugs. OxyContin, which is a pure form of oxycodone, I'm not quite sure when it became available, but it's only sort of recently on the market and since that drug has been available we have noticed that the number of oxycodone deaths have increased.

BUDGELL: Is this a new drug? I mean, is that why it was only since the last four years or so that you've seen these deaths?

AVIS: I can't remember, I can't recall when it was actually introduced to the market. I think it was in the late nineteen nineties. OxyContin is a drug that is designed to be taken on a twice-a-day dosage and it's a slow release. As such, it is a pure drug. Drugs like Percodan and Percocet actually contain either acetaminophen or acetylsalicylic acid, aspirin or Tylenol. And so if you try and, or try and take too many of those you actually get sick from the aspirin and the Tylenol before the narcotic does any problems. But the pure form of OxyContin, oxycodone and OxyContin is unquestionably a problem.

BUDGELL: Well the, but can you get specific with me now about the number of deaths that you can directly attribute to that drug?

AVIS: We can now state that we have had seven oxycodone- related deaths. Now, by related what I mean is that not all of these deaths are due to an overdose in terms of being toxic from the drug. Some of them have taken so much of the drug that they have become unconscious and subsequently vomited and aspirated the vomit. So, had they not been on oxycodone at the time they wouldn't have died. So we consider that a drug-related death as opposed to a pure overdose.

BUDGELL: Yes.

AVIS: Some of them have unquestionably been due to the amount of drug ingested. Some of them have just been due to the fact that an individual may not be as tolerant to the drug, takes a bit too much, goes unconscious. Vomiting is one of the side effects of these pills.

BUDGELL: Regardless of the circumstances, the drug is responsible.

AVIS: The drug is responsible.

BUDGELL: And how many deaths is it then?

AVIS: There's seven.

BUDGELL: In what period of time?

AVIS: Since 2001.

BUDGELL: Okay. I thought there were more than that actually. I thought there were more like fourteen. I guess they're not all OxyContin.

AVIS: Yeah. Now, that's drug-related, that's accidental drug deaths that we've seen since 1997. It's actually gone up to twenty.

BUDGELL: Right.

AVIS: We have had twenty accidental ingestions. Now, what I mean, accidental, what I'm implying is people are taking these drugs for the purpose of getting high.

BUDGELL: Yeah.

AVIS: We consider that to be accidental in the manner of death. So we have had twenty. Of those, seven have been OxyContin.

BUDGELL: They've been people of all ages too, haven't they?

AVIS: Yes. It doesn't, it doesn't seem to be any one particular age group. We haven't had any teenagers yet with OxyContin or oxycodone. The most recent death we had, which was a 17 year old, we believed based on the evidence that it was in fact morphine that the individual was injecting.

BUDGELL: Okay. And it was, can you tell me? Well, you mentioned injecting. Are people swallowing tablets in most cases? Are they injecting it? What do they do with it usually?

AVIS: Again, it's sometimes difficult for us to determine how the individual ingested it. We know with absolute certainty that some have ingested it by mouth and we also know that some have injected it. The problem – I shouldn't say the problem – but one of the factors we have to deal with is these individuals are often taken to an emergency room prior to being pronounced dead. Resuscitative measures are undertaken when needles are stuck in them. So it's often difficult for us to tell, is this a needle mark from drug injection or is it a needle mark from attempted resuscitation. But certainly injecting it is a far more dangerous behaviour than taking it by mouth.

BUDGEELL: Now, I'm chatting with Dr. Simon Avis. But if people have questions about these accidental drug overdoses, about the drug oxycodone, OxyContin, these kinds of drugs and how they're getting into people's hands. There may be parent listening to us today who have reason to be concerned about young people that they know, maybe their own children, maybe friends of their children. If you want to question Dr. Simon Avis, he's the province's chief medical examiner and today is your day to do it. The St. John's area number is... And we're talking about the deaths caused by accidental drug overdoses and especially about the drug, OxyContin. And here in our province, as Dr. Avis was just explaining, it's something that's just happened over the last few years. But it seems like it is happening more here than it's happening in other provinces of Canada or maybe here and Cape Breton are two areas that seem to have a particular problem with this. At least this is what I'm, I'm reading about it. Is that right or wrong?

AVIS: Well actually, the OxyContin problem is throughout North America. The thing is, that in other provinces and other states of the US it's, it's sort of diluted by the drug problems that they have endogenously.

BUDGEELL: It gets lost.

AVIS: It gets lost in the statistics. Although, I can recall a few years ago, when we started noticing OxyContin deaths, that on a chat line that the medical examiners have, we noticed that they, they were also reporting an increased number of OxyContin deaths. So it is a, it is a problem for North America. I think it becomes more apparent in Newfoundland and smaller communities because we haven't had what we call a large drug problem in terms of people dying of drug overdose deaths and it sort of comes to the forefront. You know, seven deaths since 2001 would not even register in New York City, for example.

BUDGEELL: No. They probably have seven deaths in a month.

AVIS: Oh, easily.

BUDGEELL: Now, how are people getting the drugs? These are prescription drugs.

AVIS: Well this is an area, I think, of considerable concern, is how these drugs are actually getting, being made available. They are prescription drugs and since there is no, since I have no knowledge that there have been pharmacy break-ins or illegal trafficking of the drug itself, one has to assume that they are entering the underground via prescriptions. And unfortunately, I think a lot of prescription medications are being abused and forwarded to, to people who shouldn't be taking it.

BUDGEELL: Now, the fact is – and I was looking at the interim report of the OxyContin Task Force, which I guess people can certainly get online. I believe this report is available online. And it points out that there is a lot of this drug prescribed here and it's really increased, the amount of the drugs being prescribed have increased. And even, I mean they've, they've itemized it here.

There are ten times the amount of 40-milligram tablets, eight times the amount of 80-milligram tablets, three times the amount of ten and twenty-milligram tablets in just two or three years.

AVIS: I think we're seeing a phenomenon that is something I wasn't used to. I was, I was in family practice before I went into pathology. I went into pathology in 1994, sorry, 1995. When I was in general practice the use of strong narcotics for non-malignant pain was something that was just considered a no-no. You may prescribe 30 milligrams of codeine, either as an (inaudible) 30 or 292 for short-term pain. But you would never consider using these powerful narcotics. Sometime, between the time I gave up family practice and came out as a pathologist, that changed. It is now acceptable to use these medications on a long-term basis for people with non-malignant pain. By non-malignant pain, we're talking about someone who's going to have chronic pain for a number of years. I think we need to revisit that. Is that really appropriate?

BUDGEELL: Because if it's so addictive, it can also be addictive to the person who's on the prescription taking the drug prescribed properly by the doctor, I suppose, is it?

AVIS: The argument has been – and I have no information one way or another – that individuals can be controlled very well on these powerful narcotics without becoming addicted. So you know, there is some evidence that they can be used. The problem is that these individuals have to take it for such a long period of time. I don't know that we've studied as to what's going to happen over the long time. And I think we need, really need to review our philosophy about the use of these medications because, you know, there are other things we can do for people with, with long-term chronic pain. I mean, just writing a prescription and getting them out of your office is one thing. But it's not really attacking the problem.

BUDGEELL: Yeah.

AVIS: And the other interesting thing is that of all the deaths we've investigated, none of these individuals have actually been, or any one of them was actually prescribed the drug. So individuals who are dying of this drug are not being prescribed it. So it's not a direct prescription overdose. It's a prescription to someone and that is somehow being diverted to other people. As I say, none of these people, except for one, they were not actually prescribed the drug.

BUDGEELL: Well if you're listening to us today and you have a question for Dr. Simon Avis about the drug OxyContin and how it is causing deaths – it's causing deaths in Newfoundland and Labrador and elsewhere in the world too and something that's been happening, well, fairly, in fairly recent years. It's a fairly new phenomenon. But we want to talk about it here today just so that you understand, you people listening to us today, that it's, it's out there and perhaps you want to talk to your kids about it. You say Dr. Avis we haven't had a teenager die yet.

AVIS: We haven't have a teenager die from oxycodone. We have recently had a teenager die of a narcotic.

BUDGEELL: Morphine.

AVIS: We believe, based on the circumstances of the death that morphine accounted for the death.

BUDGEELL: Yeah. Our number in the St. John's area is... So we want to get this information out there so that people can talk to their kids about it, make sure that everybody understands how dangerous these drugs are. We have Ron Fitzpatrick on the line calling us in the St. John's area. Good afternoon.

RON FITZPATRICK: Good afternoon.

BUDGEELL: Yes sir.

FITZPATRICK: I just wanted to make a comment to Dr. Avis. I'm a chaplain here in the city with Metro Chaplaincy and I've been working since October past with many individuals who are addicted to OxyContin. And it was only a few hours ago I was down at the penitentiary down at HMT here in the city and speaking to an individual down there. There's an awful lot of young men down at the HMT right now who are in because of stealing to try to support their habits for OxyContin. And as the doctor knows, there's no medical treatment whatsoever for substance abuse or especially drug abuse when you're in a provincial prison. And I mean, most of these people are in for five to eight months, kind of thing. And when they get out, you know, if I had any money, which I don't, I'd bet every cent of that within a couple of hours they're all going to be using again and they're going to be back to their, their normal way of life, breaking into whatever they can break into to steal. I mean they're just down there resting up now to start all over again.

BUDGEELL: Dr. Avis, can you talk about that?

AVIS: Well I think that's a, a very interesting comment. Certainly there is no provisions for treatment of drug addiction in the province and that's certainly something that we really need to address and it's something I'm hoping that the Task Force on OxyContin will be addressing. And that is, how do we treat individuals who are addicted to these medications? I think there are several points. First of all, we have to appreciate that addiction is a disease. It is not a personality flaw. And individuals who become addicted, whilst it might have been under their own volition that they became addicted, their addiction is fed by a disease process. We don't quite know what the disease process is. It might be a biochemical abnormality. But it's not a personality flaw. And so we have to view drug addiction as a disease. Unfortunately, a lot of people view drug addiction as more of a personality flaw and an individual is reaping their own, reaping what they sowed. And as a result, it doesn't get the attention that it needs. So there definitely has to be some treatment programs. I'm very concerned that we read in the paper where individuals have asked for federal time so that they can get drug addiction treatment, only to be refused. And that has to be addressed. There is a considerable concern. And what the gentleman said is quite true. These individuals, unless they're treated, are going to come back out and they're going to start feeding their addiction again.

BUDGEELL: Mr. Fitzpatrick, what do the men that you're working with say to you about that? What do they say they are going to be doing when they get out of jail?

FITZPATRICK: Well, they tell the truth. And what they say is that unless they get help – the doctor himself just said, it's a medical illness. If you have any kind of medical illness in a country such as Canada you should be able to get treated for it. If you go into the penitentiary down there and you're on the streets for six or eight months and you've got about a 300 dollar a day habit using probably six or seven or eight, 80-milligram OxyContin tablets a day, and then you've got to go cold turkey, I mean, to begin with you're going through hell. And you know, you're just waiting to get out. I don't care how much you may think it's out of your body, it's not out of your mind. And the reason that caused you to use drugs in the first place is still in your head and prison time doesn't do anything. It only makes another, makes an individual more determined to be worse that he was before he went in there. I mean, methadone is being used, like the doctor said, in all our federal penitentiaries and it's been used since '96 in British Columbia provincial prisons. And as early as this week, in Nova Scotia, in Glace Bay, they've decided to use the methadone treatment in their provincial prisons. Methadone is not the answer (inaudible). But at least it'll give an individual a chance to level-off so he can get down the root problem of their, why they're using and help them to overcome that problem and to give up their life of crime.

BUDGELL: Go ahead Dr. Avis.

AVIS: The other thing we have to appreciate is that addiction is a lifelong problem. It's not something that just going to be cured over a matter of months. These individuals need lifelong treatment available to them and there has to be a willingness in society to provide the funds for that type of treatment. The problem right now is I don't know that we really appreciate how big this problem is. I mean, we're talking here about the deaths. The deaths, I believe, are only the tip of the iceberg. There are, for every one death there's probably at least ten or fifteen individuals who are also addicted to, to these drugs. So, I don't even know yet whether we're aware as to how big this problem really is.

BUDGELL: Mr. Fitzpatrick, do you have any idea of that? You're seeing a segment of the population. It sounds like they're, they're fairly large users.

FITZPATRICK: Yeah, well right now I'm working with several individuals. So, several, who have at least a 300-dollar a day habit and each one of those tell me that, well all their friends they say, everybody they know is usually up, are up to the same, same level of abuse as they are.

BUDGELL: But aren't they concerned...

FITZPATRICK: And the word is that everybody wants to get off it, but nobody wants to torture themselves. Most of them have gone to the recovery centre or even in hospital, where they had to go like, total abstinence. And they put themselves through hell for five or six days, done it on a couple of occasions. Each time they get out, they just go back using it and use more than they did before they went in for detoxification. So, you know, like the doctor says, there's no short-term cure for it. It's long-term. It is an illness and everybody I know wants to get off it. It's got such a hold on them that they, that they're going crazy with it. But, they're not prepared to suffer it out for five or six days knowing that they're going to go back again. So I haven't met anyone yet who told me they would not try to get off it if they could be medically treated.

BUDGELL: Dr. Avis, are these the people who are likely to become the next death statistics though?

AVIS: Well...

BUDGELL: Who are using it as often as that?

AVIS: I think when we're looking at 300 dollars a day, if you're looking at it, that works out to maybe a dollar per milligram. If you're using doses of 300 milligrams of oxycodone, it's only a question of time before you will overdose. The overdose may not necessarily end up in death, but it's certainly a potential. And that's very high levels to be taking.

BUDGELL: Anything else you want to tell us Mr. Fitzpatrick?

FITZPATRICK: I'd just like to thank you and the doctor for giving me the opportunity to speak to you about it. But, I'm losing you here on the cell phone. I'm (inaudible) on the side of the road. As much as I want to, I don't think I could say anything else. I can hardly hear you now.

BUDGELL: Thank you very much for your call today. Thanks a lot.

FITZPATRICK: Thank you very much.

BUDGELL: Thank you. Bye, bye now. Well, there you go. I mean he works directly with a population of people who are admitted addicts and say they'll probably be using again the first chance they get.

AVIS: Yeah. And that's, as I say, that's a frightening thought. Again, when people become addicted to it or when they start using it, they start off taking it orally. Oral use of these drugs is not very efficient because in order to get to the brain, which is what causes the high, it has to go through the liver and the liver starts extracting the drug before it even gets to the brain. So these individuals learn very quickly that the best way to take it is intravenous. And as I say, if you're using doses of up to 300 milligrams a day, you are in, you're in peril.

BUDGELL: And you're probably going to start doing it intravenously rather than swallowing it because you want to get a bigger kick out of smaller amounts of the drug.

AVIS: Well you know, where does someone get 300 dollars a day to...

BUDGELL: Yeah, unless they're very busy robbing. Yeah.

AVIS: Well, unless they either have a very good job, which they won't have for long, or they're getting money from other means. And you know, whilst treatment is expensive and one has to really, you know, commit funds to treating individuals, these individuals are getting their 300 dollars a day from somewhere.

BUDGELL: Let's talk with our next caller. Tri Walsh is in St. John's. Good afternoon.

TRI WALSH: Good afternoon.

BUDGELL: What would you like to say on this topic today?

WALSH: Well I work at the AIDS Committee of Newfoundland and Labrador. And we've recently begun a project working with intravenous drug users to find out what the needs are, not only with users, but with the greater community with a view to introducing some harm reduction services in the city and hopefully throughout the province. We found that, we do offer a needle exchange service here, which the seeds of, came from reducing the harm of HIV and hepatitis-C and other infections. In recent years we found that more people are coming to use the needle exchange and this has spurred the need that we've seen to some research. As it happens, the whole OxyContin thing has come along at the same time, actually, after we applied for funding to do this research and work within the community. We see a dire need, as Dr. Avis has suggested, for treatment and other services to reduce the harm, here and now, with the individuals and to the greater community from the obvious increase in drug use.

BUDGELL: Tell us what you found out then. If you were doing research and you say there is a dire need, what, what numbers have you got here?

WALSH: Well we, we're just at the very beginning stages of doing this work. But what we do see are people coming to get the needles, talking about their own fears and their own experiences with OxyContin and other substances as well. But you know, in the greater community we see, you know the increase in crime. We know the increase in demands of services in our health care system. And it will only multiply as time goes on. If we can bring in some harm reduction services now to help the individuals and then, you know, in the matter of doing this to reduce harm in the community. And you know, there's absolute need for treatment. For years, (inaudible), people have been leaving this province to receive treatment. And the problem is,

when they do, if they return back, the follow-up services aren't there to help them maintain their abstinence. And in between active using and abstinence, there is a huge gap, where harm reduction services and counselling services need to be at least available to those who want to make the changes to be healthier.

BUDGELL: Dr. Avis?

AVIS: Well I think that's a very interesting point that the caller makes. We assume with drug addiction that the harm comes from the drug, which is quite true. But also, when you're looking at intravenous drug use there are other things that the individual is exposing themselves to or the potential, particularly when it comes to sharing needles. And that is, blood-borne diseases such as HIV and hepatitis B and C, all of which can have catastrophic effects on an individual who suffers from those infections. I don't know at this point how much needle sharing is going on. I think it would naïve to think that it isn't. But that again, highlights again, a very important point, that the drug itself is only one of the issues we need to deal with. What is happening? Are they showing needles? Do we need a needle-sharing program? The other thing is, in all fairness to, to the health departments, at this point in time I don't know – if you asked me five years ago if we needed a drug addiction program in this province, I would probably say well, I don't see any evidence of it. So I think this is something that's sort of relatively new and I'm hoping there will be a response. The fact that we don't have long-term treatment centres now I don't think necessarily reflects what will happen in the future. And I'm hoping this is going to be an eye-opener to the Health Department to offer this type of treatment program. I mean, we've seen so many failures when people go away to get treatment and come back. I mean the people up in Davis Inlet, for example. I mean, millions of dollars spent trying, to come back gas sniffing and I don't think it made the slightest bit of difference because there is no continuation of treatment.

WALSH: Absolutely. You know, the actual treatment, which is 21 days roughly in most programs – some are longer – they are just the beginning steps of making the changes. There's a need for ongoing counselling for at least a year. That's a minimum. More is more desirable. More treatment in terms of counselling and support enables the individuals to build a healthier lifestyle. On the issue of needing treatment, I mean I know of individuals 15, 20 years ago who left just to get treatment for maybe not injection drug use, but substance use problems that they couldn't find treatment for in St. John's. And there's the Humberwood in Cornerbrook, which they didn't see as an option. So they went off to institutions in Ontario and even in the United States to get treatment. And again, the problem is there. If they want to come home to live, there are no supports. What we are hoping to learn from this project that we've just begun is, what the needs are in terms of the drug use in, in St. John's right now. And not only with the users, but with all the, the agencies and services that people end up having interactions with. And then come up with some solid recommendations that we can bring to the powers that be around what will make St. John's and Newfoundland much more caring for this population.

BUDGELL: Thanks for your call today.

WALSH: Thank you.

BUDGELL: Thank you very much. Dr. Avis, is it mainly a St. John's or a city or metropolitan area problem or do you think it's all over the place?

AVIS: Again...

BUDGELL: Drugs would certainly be available everywhere, wouldn't they? They're prescription drugs.

AVIS: That's an interesting question and that's something that our office is looking into. At this point in time the problem appears to be centred around the St. John's area. Most of the drug deaths we have, except for one or two, have come from St. John's. The other two have come from Cornerbrook. So it definitely appears to be more of an urban problem than a rural problem. But the problem is, we haven't looked at the rural populations as to what, what medications they're exposed to or in fact what they, what they may be dying from. So our office has started a program now where anyone who is being prescribed these medications, we've listed a number medications which include morphine, oxycodone, dilaudid and codeine. If anyone is being prescribed these medications and they die, no matter from what cause, whether it be from natural causes, accidental or what have you, our office is notified, blood is drawn and we have the option to do blood levels. We also have the, we're asking our medical examiners in the field to forward the drugs to us so that we can check the medications, look at the prescription numbers and if necessary get a prescription history on these individuals. Again, more of it as a monitoring, because it has become quite apparent that, you know, in the small communities outside of St. John's it doesn't appear at this point in time to be a problem. But, it may.

BUDGEELL: Okay, we'll find out I guess. We have a caller on the line from here on the Avalon Peninsula. Her name is Janet. Good afternoon.

JANET: Yes, hello. I have a question for Dr. Avis.

BUDGEELL: Go ahead.

JANET: Yes doctor, you were saying if a person uses this drug through injection that it causes death, right?

AVIS: No, it, by using it by injection the drug becomes more efficient as opposed to taking it by mouth, because by mouth, in order to be absorbed into the blood it has to go through the liver. And the liver removes some of it.

JANET: Okay the, what if a person uses the pill, like crushes them and snorts them up their nose?

AVIS: Again...

JANET: I know people who, who've done that. Would that cause death?

AVIS: Well again, when you, assuming now that it's absorbed from the mucus membranes of the nose, what you're doing is you're making it into a very fine powder and then putting it up to your, up your nose, where it's absorbed from the mucus membrane of the nostril. Again, if that is being, if it's being absorbed efficiently – and that would depend on how fine you grind it up – then again, that will bypass the liver. So, it has a potential to cause high blood levels. So yes, it's, in terms of what is it safer to do, is it safer to take it by mouth or snort it up your nose? I would have to say taking it by mouth would be safer because the liver will remove some of it before it gets to the brain. Snorting may end up with levels that are quickly lethal.

JANET: Yes, I'm sure you've heard also of morphine patches?

AVIS: Yes I have.

JANET: Would say, an amount of four to five morphine patches at 25 milligrams each, I've heard that they take, first of all, 72 hours to work. Okay, if the person were to put on, say, four or five patches, would that alone cause death?

AVIS: It could. I'll tell you right now, we had a case recently of a fentanyl death.

JANET: Of a, pardon me?

AVIS: Fentanyl. This is also a drug that's available in patches.

JANET: Oh, okay.

AVIS: In which the individual came in with about ten fentanyl patches on them. So, yes the potential for absorbing it through the skin and creating high levels is definitely there, regardless of how you take it, whether it's by mouth, whether it's by nose, whether it's by injection or whether it's by absorption through the skin. They do say that skin absorption is slower. But again, it depends. You're only supposed to have one patch every three days. If you're got four patches on you, then there is the potential to absorb it in high doses. The other thing of course, that will determine how a person is affected by the drug is how used to it they are. If a person's started off with low doses and worked their way up, they are more resistant to the drug than an individual who were to take a large dose initially. So, most people who take this drug tend to become accustomed to the level that they're taking and they tend to increase it. And that's when they really run into problems, when they start to increase it because all they sometimes do is increase it a little bit, one extra pill, one extra patch, one extra snort up the nose and they have tipped the balance and they end up going into an overdose situation. So there is really no safe way to abuse these medications.

JANET: No, okay. Yeah, well you've answered my questions.

BUDGEELL: Thank you for your questions.

JANET: Okay, thank you very much.

BUDGEELL: Thank you very much. Bye, bye. Dr. Simon Avis, the chief medical examiner in our province, is our guest on Crosstalk today. And we're talking about the accidentally overdoses that have caused deaths in our province, and especially overdoses of the drug, oxycodone, OxyContin. And we've got a caller on the line now. Beverly Clarke in St. John's. Good afternoon.

BEVERLY CLARKE (Chair, OxyContin Task Force): Hi Anne. It's Beverly Clarke. I'm the chair of the OxyContin Task Force.

BUDGEELL: Of course you are, yes. And I'm using the information from your interim report here today.

CLARKE: Yes, and it is available online through the government website. I just wanted to let you know that as well.

BUDGEELL: Yeah, good.

CLARKE: A couple of comments I wanted to make just listening to Dr. Avis there talking and to your guests. One is, in terms of looking at the whole issue of drug treatment. I mean, there are

programs available in the province. I think we need to be careful. There are programs available. The Humberwood program in Cornerbrook is a provincial in-patient addictions program. And you know, it is a program that's had 1,700 people use it in the last ten years. So certainly that program is available to people and it's modelled on the programs that are available in places like Ontario. I think one of the difficulties we have is that, particularly now, as Simon was talking about, particularly with OxyContin, people are finding the withdrawal to be so painful for them that they're not wanting to start even the process of withdrawal so that they would actually go to treatment. And that's where our gap is right now. We really need to work on getting the proper protocols in place and looking at, what is it people need during that withdrawal process so that we can actually get people past that so they'll be willing to go into treatment. So that's one of the things, actually, we've been talking a lot about on the task force and looking at some protocols and looking at what is done in other places to see if we can put some things in place in this province as well.

BUDGEELL: Did you happen to hear our first caller today, the chaplain who's been working with people in the penitentiary?

CLARKE: Yes, and actually he and I had a discussion this morning.

BUDGEELL: Oh, okay.

CLARKE: And you know, I think that's really an area where there are, the issue of what kinds of services should be available in prisons is, I think, an open question. It's not one that we've explored to any great degree at this point with the task force because it's a bit outside of our, our, our mandate. But certainly, when you look, you know, methadone maintenance programs that are available in federal prisons, you, you know, I think it deserves a question and a discussion about what should be available in prisons in this province as well. So I think that's something that we should have more discussion about. And you know, this task force is in place with the Minister of Health and Community Services, Education and Justice, wanting to work together. So I think that's something we could have some discussion about as well.

BUDGEELL: Yeah. Dr. Avis? Any comments?

AVIS: Hi Bev. I just, a question I might pose to you, which is something I should have asked when I had the opportunity. Do we know the extent of the use of OxyContin? I mean, I know from, from my end of the equation. But has the task force been able to, to put into, into figures, exactly how abused this drug is? Do we know how many people are using?

CLARKE: Well, I think Dr. Avis that's, that's the difference. We know, for example, how much of the drug is being prescribed. You know, we do have a little utilization data and we know it has increased, you know, 400 per cent over the last four to five years. It's been available since 1997. But of course we don't know how many people are actually abusing it. I mean, that's a figure that, I mean this is a hidden population. And we're, we have talked to lots of families. We've had 22 different groups come to our task force and present to us. We've talked to young people about what they're seeing, you know, in their experience and on the streets. And they're telling us that it's out there and that it is available. But how many people actually have an addiction to OxyContin? I don't think we're going to be able to give those numbers. What we know is obviously, they have people dying from overdose deaths, that it is a real problem in our community.

BUDGEELL: You've got to be concerned about the increase in the prescribing of it though. I mean that's just so much more drug out there.

CLARKE: Well, certainly, I mean Anne, I think Simon covered this very well. I mean, when you have, narcotics are now being used for both malignant and non-malignant pain and that's sort of a new regime for us, you're going to see increases in these drugs in terms of their prescribing. But you know, the question really is, how, why is so much of it being diverted to the street? And are we, as a result, over-prescribing in our community? So that's a question. And we've had some very good discussions with both the medical association, the medical board and the pharmacists about this. So I think, you know, with further education, with further discussion around this issue we should start to be able to at least bring the question to the forefront. I think we already have physicians and pharmacists thinking about this. What we don't want to do is, people who need the drug appropriately, you know, we don't want that prescribing to go down. We need to look at the cases where maybe, you know, there is another regime that could be used here.

BUDGELL: Anything else from Dr. Avis?

AVIS: Well, and I think that last point is very important, because we're looking at OxyContin as if it's a very, very bad thing, when in actual fact, the number, a number of physicians are prescribing it appropriately and for individuals who are getting great benefit from it. So, you know, I think it's, it's a mistake to look at OxyContin as perhaps being the problem. It's just part of the equation.

CLARKE: Right, right.

BUDGELL: Beverly Clarke, anything else from you?

CLARKE: No, I just wanted to certainly say, you know, we're, we're on the case, we're working away and hopefully in the not-to-distant future you'll see some recommendations from us.

BUDGELL: Thank you very much for calling today.

CLARKE: You're quite welcome. Bye, bye.

BUDGELL: Thank you. Bye, bye. And as she mentioned, the interim report of the OxyContin Task Force is available on the web under the Health and Community Services Department of the Government of Newfoundland and Labrador. Our next caller is Alex McGruer. Good afternoon.

ALEX MCGRUER: Hi. Actually, Beverly Clarke just stole my thunder. I was going to say, what about people that actually need this drug or could take great benefit from it? Isn't this going to scare the devil out of them to the point where they won't be using it, which would aggravate other situations?

BUDGELL: I wonder if that's already happened? I mean, because the drug is getting a bit of reputation. I don't know if Dr. Avis can talk about that.

AVIS: Well of course I don't know if people who are actually taking it are getting scared. I, again, I think they should be reassured by the fact they're, if they're taking it as their physician prescribed it, appropriately, that there is no danger to them. This is not a drug that's going to kill when it's used in an appropriate fashion. So all those individuals who are taking OxyContin for medically viable reasons and are doing it under the auspices of a physician have nothing to worry about. What I would be concerned about is frightening physicians off from prescribing it and I think that's a potential danger. Again, in appropriate situations this drug is of great benefit to people. I can't imagine the suffering that it is relieving. And so I don't think patients who are

taking it appropriately or doctors who are prescribing it appropriately should be scared off. But I do acknowledge that that may be a bad side effect of the whole issue of OxyContin.

MCGRUER: It has to be a terrible side effect. As well as that, I'm wondering, how many of the people that have come to grief, either died or have become addicted to it are actually using it appropriately or having it prescribed appropriately?

AVIS: Well as I mentioned, of the deaths we've investigated, very few, in fact only one so far, was actually prescribed the drug. The other individuals have obtained it through other means. The same applies to the morphine. We've identified what we believe to be two morphine overdoses. In one case the drug was prescribed to the individual. In the second case, it wasn't. So people who are taking it appropriately aren't the people who are dying. It's the people who are getting it from illicit sources that are suffering.

MCGURER: And the folks that were, that had it prescribed for themselves, what did they do? Overdose on it?

AVIS: We've had one case where an individual was prescribed Percodan and they died as a result of an overdose of Percodan, we believe, accidentally. And again, you're always going to have a background where one or two people are going to die each year as a result of accidental drug overdose. But you know, we have yet to see someone who was prescribed this medication, who was taking it appropriately, who died as a result of it. That we have not seen.

MCGRUER: Excellent. Thank you very much.

BUDGEELL: Thanks for your call today. Bye, bye now. Yeah, I'm sure it's, it is a good idea to make that point, that now that there are good drugs to deal with extreme pain, it would be a shame if a chill was put on and doctors didn't prescribe them to people who desperately need them. They don't want to see people suffering, right?

AVIS: Absolutely. And I've spoken to some physicians who prescribe OxyContin and they've made it quite clear to me, appropriately I believe, that they are not going to change their prescription habits and I don't think they should.

BUDGEELL: Let's talk with our next caller. Paul Partoff is Pouch Cove. Good afternoon.

PAUL PARTOFF: Good afternoon Anne.

BUDGEELL: Yes sir?

PARTOFF: You know, once upon a time, like all good stores start, there was a treatment centre, up at St. Claire's Hospital, for alcohol and drug abuse. I went there. They're treatment centre was run by a lady named Barbara Avis. And she had a 65 per cent recovery rate for alcohol and drug abuse. Now, we're probably talking about different drugs, but drug abuse is drug abuse. I'm not sure if that treatment centre is still open. But the way that was run and the people that went through it, a lot of us owe to that treatment centre and especially that lady, Barbara Avis, our lives. It was a hard-nosed treatment centre that was really, Mrs. Avis had a very special way to deal with people. But, you know she used reverse psychology. But there was, it worked. And lately it seems like everything is backing away from that form of treatment centres. I know in Cornerbrook, the centre in Cornerbrook is open. But, you know, a lot of people can't afford to go there (inaudible) in the community for alcohol and drug addictions. (Inaudible) in that community. And I also know that a lot of people can't afford to go there. So I don't know if there's anything in

town anymore compared to the treatment that St. Claire's had in those days. But all I have to say, you know, is that lady, she saved a hell of a lot of lives, mine included. And we had, when we sat back and we looked at it, I was up there for a year. And when we sit back and look at it, and the people that are still around that went to that treatment centre, 22 years later we are, up to 65 per cent, still hanging around. So, maybe it's time to revisit what they did in those days and hopefully get back to that kind of recovery.

BUDGELL: Dr. Avis?

AVIS: Well I'd like to thank the gentlemen very much. The lady he's referring to was actually my mother. And she did, she did have a treatment source. She was in charge of the treatment centre at St. Claire's. I know she felt very, very much for individuals who were addicted to alcohol and it was mostly alcohol back then. And she did have some ideas about, about treating and I believe she did a very good job. It was, it was her, something she was very proud of and I'd just like to thank the gentleman for mentioning, for mentioning it to us. My mother died a few years ago, which is unfortunate because I think she could perhaps give us some insight into how to go about the treatment. I believe she did have a modicum of success. But yes, we do need a few more treatment centres. I mean the one in Cornerbrook is fine, but we need, we need detoxification centres and we need long-term treatment centres if we're going to handle this problem. And alcoholism and drug addiction are the same. It's just a different drug.

BUDGELL: Anything else from our caller?

MCGRUER: No, not really. It's just, that you know, I appreciated what she did for us. I mean there's nothing worse, when I'm looking back, we were, I mean, when you come into a treatment centre with an addiction you know best. There's nothing wrong with you. There's a whole world, the whole world is sick and that's the attitude we come in with. And when there's people like your mother, kind of knew exactly where we were coming from and what our next step was going to be before we even did it. You know, it worked.

BUDGELL: Thank you very much for you call.

MCGRUER: You're welcome.

BUDGELL: Thank you. Bye, bye now. We're going to speak now with Bill Garland in St. John's. Good afternoon.

BILL GARLAND: Hi, how are you?

BUDGELL: Good. How are you?

GARLAND: Good. I wanted to address something one of your earlier callers said. How are these drugs getting on the street? Now I suffer from peripheral neuropathy, which is a complication of diabetes and the cause of severe pain and I need painkillers all day long. Now, I, I'm prescribed codeinecontin, which is a similar drug to OxyContin. But could go to my doctor very easily and say look, codeine is not quite working. Give me some oxies. And I could get a bottle of them and have enough leftover codeines from my prescription that I, I could get by a month, for instance. Now if the doctor gave me a bottle of oxies, say 60 pills in a 30-day prescription, twice a day, you realize those pills are worth 50 bucks each on the street? Now one little bottle like that could get me 3,000 dollars.

BUDGELL: There you go.

GARLAND: There you go. For me, for somebody on the street, that's an immense fortune. And you know, I mean I wouldn't do it. I spend a lot of my time talking to 18 year-old kids trying to get them to stay clear of them pharmaceutical drugs because they're so, so badly addictive. I mean if you had to pay and you were willing to pay 50 bucks a shot for one of those pills, wow, they must be powerfully addictive. I wouldn't want to touch one. I wouldn't even take the oxies for my pain, from what I hear. And, but there it is. I mean 3,000 dollars for a little tiny bottle of 60 pills. I mean, good grief. That's just totally ridiculous. We need some legitimate way to handle this drug so that all these guys aren't out blasting the pharmacies looking for morphine and oxies and everything else. There's got to be a better way to treat this problem.

BUDGELL: Dr. Avis?

AVIS: I think that's again, a very interesting point. And that's removing the criminal element from drug addiction. The problem is, as you mentioned, you go to a doctor and get, say, 100 pills of 80 milligrams. That's 8,000 bucks in your pocket. There is a tremendous reason to sell the medications. We have to remove the criminal element. Once the criminal element's removed from drug addiction and drug provision...

GARLAND: So how do you do that? I mean if they're worth 50 bucks to a junkie, he's going to steal someone's DVD and sell it for 50 bucks to get one pill and that'll do him for a couple of hours. Then he's going to have to go rob something else. What are we going to do? Give them free pills?

AVIS: Well, not necessarily free pills, but addiction treatment.

GARLAND: Yes.

AVIS: Again, the problem here is that people have to, (A), acknowledge that they have a problem, which is sometimes very difficult. And (B), they have to want to solve the problem. There's always going to be an element of individuals who, (A), don't notice they have a problem and even if they do, they don't want to get rid of it. And they're always going to be a background nuisance.

GARLAND: Yeah.

AVIS: However, what we're hearing certainly here today is – and I have reason to believe this is true – that most people who are actually addicted to something oxycodone don't really want to be addicted and would take the opportunity, if they had, to, to get off the addiction. I mean, the number of people who are asking for federal prison terms. I mean, how often do you see someone asking for more prison term instead of less? I mean, I think that again underscores the desperation that these individuals are facing who have this addiction.

GARLAND: It's a powerful one, that's for sure.

AVIS: And again, if we can remove the criminal element – that applies to all, all drugs. I mean, whether it's marijuana or whether it's OxyContin or heroin, if we can remove the criminal element I think we can make strides in dealing with the problem. As long as the criminals are there making a profit, they're going to make a profit.

BUDGELL: Mr. Garland, thank you so much for your call today.

GARLAND: Thanks.

BUDGELL: Thank you. I'm going to try and fit it one more call before we finish up. And we have Darryl calling from St. John's. Good afternoon.

DARRYL: Hey, how are you doing?

BUDGELL: Good. How are you today?

DARRYL: Good. I've been listening to your program. It's very informative. I just wanted to touch on a couple of points. You know, as a rule most doctors are doing their best to prescribe the best drug necessary for a patient. But I believe that there's a small amount of doctors – and they know who they are – who are over-prescribing this drug and they're, in effect, creating the problem. At the same time, because of doctor-patient confidentiality, they're basically kept safe from being the pushers of this drug, which is causing these kids to, you know, overdose. And I think that's the really ridiculous part of this whole procedure. That's the first thing. The other point I'd like to make is that, you know, is with regards to treatment. Yes, there is a program in Humberwood. But, there's quite a waiting list to get in and of course people have already mentioned the cost that's involved. There's also programs that are available in St. John's, whether it's at Pleasantville, which I hear is a good one and at the Waterford Hospital. But they are cold turkey problems and the people who have the problems with OxyContin do not want to take the cold turkey route. So, it seems that one solution to this would be a methadone program that's available in St. John's. It's available in other parts of Newfoundland, but not here. And you know, I'd hate to be a person to suggest prescribing a drug to rid people of a problem. But you know, methadone is a drug that people can take in front of the pharmacist and it can eliminate all the cravings that they have and then they can go ahead and, you know, do the counselling, get the treatment. There's people who really want help, but they don't want to take the cold turkey method to do it.

BUDGELL: We're almost out of time. I want to give the doctor a chance to respond to what you've said and thank you very much for your call today.

DARRYL: Thank you.

BUDGELL: Thank you.

AVIS: Yeah, as with any barrel of apples, there's always a few bad ones. And the same is for the medical profession. You're right. The majority of doctors, by far the majority of doctors, are prescribing drugs in an appropriate manner and they sometimes get fooled by professional patients and that happens to all of us. But you are right. There are some physicians who are prescribing these pills in an inappropriate manner. They know who they are. We know who they are. And you're very right. It's difficult to, to get them. They cover their tracks very well. But we know who they are.

BUDGELL: Dr. Avis, I want to thank you very much for your time here today. I hope it does some good. I guess getting a bit more information out there won't hurt.

AVIS: No, the more information, I think, the better prepared people are to deal with the problem.

BUDGELL: Thank you again for your time today.

AVIS: Thank you.

BUDGE: Dr. Simon Avis is the province's chief medical examiner. Again, if you want to look-up the interim task force report on OxyContin, go to the government's webpage, Health and Community Services, and you will find it there. That's it for our program for today.