Patients with Pain Media Relations Kit

November 6 - 12 2016

Key messages, tips and guidelines for a successful media interview. Now more than ever it is important that the patient voice be heard. During Pain Awareness Week, reaching out to your local MP, MPP and/or media outlets in your surrounding area can help raise awareness and educate the public about stigmas that exists for chronic pain patients in Canada.

National Pain Awareness Week

Our moral responsibility is not to stop the future, but to shape it. To channel our destiny in humane directions and to ease the trauma of transition.

– Alvin Toffler
I) CONSIDERATIONS:

Recent media headlines have blurred the lines between legitimate and illegal prescription drug use and confused completely different issues of traffic and sale of imported fentanyl powder and the necessary use of prescription pain medications.

Of particular note, on November 18, 2016 the Ministers of Health, co-hosted by Federal Health Minister Dr. Jane Philpott and Ontario’s Health Minister, Honorable Eric Hoskins, will meet in Ottawa to discuss the future of health policy as it relates to both the legal and illegal use of opioid medications. The Ontario Minister of Health claims to be committed to evidence based decision making, however their government is pushing forward radical changes that will affect the lives and treatment of chronic pain patients without research or evidence that these drastic measures will be effective.

Over the next three months it will be extremely important to coordinate communications efforts in order to prevent a series of knee-jerk policy decisions that will cause incalculable hardship for individuals living with pain. Governments have established February 2017 as their timeline for revised prescription guidelines. Pain management is not a one-size-fits-all solution; rigid standards will leave little room for doctors to use their clinical judgement or to respond to specific patient needs. Denying patients access to appropriate options for pain relief will drive people to the street-based trade in pain pills. An unintended consequence may be an increase in overdoses as desperate pain patients seek medication through illicit sources.

Public awareness is muddled and conflicted. People are not sure what to believe and their loved ones are suffering. Those who have obtained balance in their lives with the use of opioids are being subjected to abuse and ridicule by the medical community. Their care is being adversely affected.

The timing and the manner of the provincial government’s release of their narcotics strategy is political. It is a strategy used over and over by the Ontario government in power to force the federal government’s hand. Ontario has just recently taken over the chair of the Federal/Provincial/Territorial table and on the agenda are negotiations of a new health accord. BC (a former chair) was out of the gate first with their strategy to address the growing problem of opioid overdoses. ON is hoping to come out as a leader and be recognized for their initiative. Shortly afterwards the federal government announced they would be holding a summit on opioids in the fall.

Before the ON govt made their announcement there was considerable coverage about the Liberal Party’s fundraising tactics which included a high priced exclusive evening with the
Premier and her cabinet. One of the largest contributors being the insurance industry. It is not a huge leap to consider who stands to gain the most from the ON government’s move to delist medications.

Because the release was done in the summer most doctors, clinics and pharmacies are on their summer vacation rosters and are short staffed. Information about the government’s narcotics strategy was released in a national financial based newspaper with a very exclusive readership. Not one typically read by clients that are suffering from intense chronic pain. Many people have no idea what is being implemented on January 1, 2017.

To be blunt, the measures are a social experiment not based on any practical evidence that it will even achieve the objectives it has established. In fact, this strategy will only fuel the underground market for prescription medications and turn back the clock nearly twenty years in the treatment of chronic pain. The rates of suicide will increase as a result and the number of doctors specializing in pain management will dwindle making waiting lists for treatment even longer!

It is imperative that we break through the media barrier and expose to the public the realities of the medical system, the hurdles and challenges chronic pain patients experience living in their communities, and the abuse, discrimination and ridicule that individuals are forced to endure.

To ensure that your experience is a positive one, this kit includes key messages that you can incorporate into your story and shape around it with your first-hand experiences. While it is difficult to talk about one’s past – particularly when it involves prolonged periods of suffering and extreme loss, it is an opportunity to remind public authorities that patients are people. Patients pay taxes. Patients have human rights and deserve to be treated with fairness, equality and respect.

When government leaders push through public policy and make rash decisions there are always consequences. It is more important now than ever before that we reach out to our communities and help them to understand that not all patients who take opioid medications are addicts and that there are several medical conditions for which opiate therapy is the only form of compassionate care available. Not only cancer patients experience excruciating symptoms that limit mobility and restrict the patient to unthinkable conditions.
II) STRATEGY

It is important to understand how media works in order to break through with the messages that we hope to deliver. A ‘good’ news editor will give priority to stories that are fresh or a new take on an already existing story. Don’t be offended that the ‘good news’ story has not resonated. It has been done before... Preference will be given to a story that has legs.

- Share practical examples (linked with real people where possible) of what will happen to patients/doctors targeted by these new measures.

- Provincial by-elections – provides an opportunity to raise issues that might otherwise not get discussed.

- Getting on the agenda at City Council to bring the inevitable fallout of the January 2017 decision to their attention – the provincial government has not allocated funds (that I know of) for counselling or social services associated with helping individuals who cannot afford their medications.

- Sending invitations to local media to do a story.

- Sending a letter/email to your local MP or MPP.

- Post web-based material that provides a more balanced reporting for individuals who have loved ones living with chronic pain.
III) KEY MESSAGES

- Public authorities are meeting in Ottawa later this month to discuss issues that directly affect the health care and quality of life of hundreds of thousands of chronic pain patients in Canada.

- The Ontario government has recently introduced new measures that will drastically change the way doctors prescribe pain medications, including delisting strong narcotics for patients with exceptionally painful chronic medical conditions. Many doctors are choosing to stop treating chronic pain patients all together.

- Patients with a long history and solid reputation are suddenly being subject to inhumane conditions and have little or no recourse and/or assistance.

- Doctors who believe in use of prescription drug medications for the treatment and relief of non-malignant pain conditions are being subject to investigation, and strong-arm tactics in efforts to deter other doctors - which amounts to harassment and a gross invasion of privacy.
IV) COMMUNICATIONS OBJECTIVES

When writing down your story, keep in mind the broader communications objectives of this year’s National Pain Awareness Week:

- Generate awareness and empathy for the challenges of living with pain

- Draw attention to the inequities that exist within the system, and how they contribute to the suffering of patients, their care givers and their loved ones:
  - Lack of research – evidence to support recent changes
  - Waiting times, quality of care and access
  - Lack of funding for alternative therapies
  - Restrictive cost of pain therapies – be they prescription or otherwise
  - Delisting of medical costs and challenges with access to financial assistance
  - Lack of mental health support for patients living with pain and their families
  - Treatment and care of pain patients, their privacy and access to information considerations (abuse, discrimination and harassment within the medical system)

- It is imperative that the patient voice is at the table when discussing policies that affect their lives in such profound ways.

- It is by working WITH the pain community that all levels of government/public authorities are most likely to find a successful strategy for addressing the opioid crisis.

- We must separate the addiction issue from legitimate users and ensure that the right stakeholders are present.
V) TIPS FOR A SUCCESSFUL MEDIA INTERVIEW

If you are considering contacting your federal or provincial representative and/or talking with the media, below are a few things you might want to take into consideration as you prepare:

- Always write out what you want to say ahead of time. Practice several times before you do your interview. Enlist someone you know to practice with you if it is your first time.
- Do your research: before you reach out to a journalist, check online to see what type of stories he/she and their media outlet has published.
- Look for local stories (recent arrests or other related coverage on the opioid crisis) in your area; it will help you be prepared for questions that may relate to the abuse of prescription pain medications locally.
- You can bring someone (have an advocate present) with you if you feel the need for moral support and/or guidance. This is strongly recommended for individuals who are not accustomed to speaking with the media.
- If you submit your story to the written media, there are a few things to keep in mind:
  - If you send a pdf format they cannot edit your document and are less likely to print it
  - If there is a particular sentence or portion of what you are saying that you do not want them to edit, use quotation marks
  - At the end of your story, include your contact information so they can follow up if they have any questions
  - Do not send anything that you are not comfortable with them publishing, for example: your home address, your medications and or personal information that you do not wish to be made public
- If you are meeting a journalist:
  - It is ok to ask for a meeting in a neutral location (for your personal safety and to protect your privacy)
  - It is ok to ask for anonymity (although some journalists will not pursue the story if they cannot substantiate the facts)
  - It is ok to refuse to answer a question you do not feel comfortable answering, even if they insist
  - It is ok to admit you don’t know the answer – at times we are encouraged to speculate, but often this is a trap to draw the individual into a different line of questioning or to catch a headline
VI) ARTICLES OF INTEREST:

CHRONIC PAIN PATIENTS FEAR SIDE EFFECTS OF OPIOID ABUSE CLAMPDOWN
– Group calls for more non-medical treatment support, seat at table for talks

- Interview with Terry Bremner (President, CPAC), touches on issues of care, availability of services, potential consequences and the desire to be part of discussions

ALBERTA PATIENTS WITH CHRONIC PAIN WORRY ABOUT PROPOSED NEW RULES ON OPIOIDS

- Interview with Barry Ulmer (Executive Director, CPAC), touches on fears among chronic pain patients, the fear of repercussions among doctors, and the need to distinguish between illicit opioid use and the legitimate use of medication for the treatment of chronic pain.

PAIN SUFFERERS TURNING TO STREET DRUGS AS B.C. DOCTORS PRESCRIBE FEWER OPIOIDS – Pain BC says new regulations on opioid prescriptions are having unintended side effects

- Interview with Maria Hudspith (Executive Director, Pain BC) and Owen Williamson (president of the Pain Medicine Physicians of B.C. Society), includes concerns of access and availability of much needed medications

COLLEGE OF PHYSICIANS AND SURGEONS DEFENDS OPIOID PRESCRIPTION STANDARDS – List of standards puts physicians in tight position when prescribing opioids to chronic pain patients

- Interview with Maria Hudspith (Executive Director, Pain BC) and chronic pain patient Hugh Lampkin on new standards introduced in BC earlier this summer
VII) THE ONTARIO NARCOTICS STRATEGY

Uncomfortable truths the Ontario Government does not want you to know about their decision to delist strong prescription pain medications in January, 2017

Research and modern thinking on the treatment of chronic pain is that it manifests in a manner akin to a disease in its own right. To deny treatment on the grounds of the ‘greater good’ is little consolation for the individual who is staring at a future of dependence on others to survive...

- Most chronic pain patients exist in poverty, not because of their station in life (although further exacerbated by socio-economic challenges and genetic predisposition to chronic illnesses). These people exist month-to-month scraping by because of their associated health care costs – they have long since depleted their rainy-day fund;

- Isolated by limited mobility, many are not connected. They can’t afford Internet and/or the modern equipment required to communicate online, many also have lost touch with newer technology and the online interface which further alienates them from society and loved ones;

- Pain does not discriminate. Opponents scoff when told that intense and persistent pain has measurable biological effects on the body that impair judgment, cognitive ability and physical function equally if not more than pain-medication;

- Due to protracted and chronic illnesses, many patients suffer from varying degrees of depression and mental illness in addition to their physical ailments - after years of enduring conditions that under a different lens would be considered torture;

- In some jurisdictions, governments are working with multiple other stakeholders as well as prescribers to implement community measures to curb the misuse of prescription medications without penalizing people with pain. The most successful example of this has been Project Lazarus in Wilkes County, North Carolina, where a community approach to the problem of opioid overdose reduced the death rate by 69% with only a very small change in the opioid prescribing rate. The keys to success were education of the whole community and liberal dispensing of the opioid overdose antidote naloxone.

- The Ontario Liberal government has prepared a hasty policy decision that leaves doctors in the dark, families confused about their loved ones and patients panicked over what this means for their treatments. Imagine being the patient who shows up for their appointment to find a notice posted that their doctor will no longer prescribe narcotics...;
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- Patients with chronic pain on any amount of opioid pain medication will find it almost impossible to find a new doctor willing to take on their care. If a patient must start anew, the trust and knowledge that the patient has earned with his/her health practitioner over the years (both essential to the successful treatment of chronic pain) are lost. Patients are subjected to terms and conditions that by their very nature foster discrimination. When seeking a new source of health care, health care workers across the spectrum are increasingly unprofessional when it comes to treating a patient with chronic pain. Some harbor negative stereotypes and subject their patients to verbal abuse. Others are so overwhelmed by the management of a patient’s pain that the patient’s other medical needs are neglected;

- Communities across the province will scramble to meet the (unbudgeted) needs of these individuals who previously lived with some degree of financial independence. Areas most impacted will be the rural and remote regions where doctors and health professionals are scarce and support programs non-existent;

- Doctors that have a focused practice in pain management are subjected to increased scrutiny and sometimes even harassment by medical regulators, having to defend their practice while absorbing the financial and administrative burden of increased accountability and the extra time required to address patient concerns. These physicians have to constantly be on alert and re-evaluate their treatment plans in response to patient behaviours. Many doctors lack knowledge regarding options for treating pain, such as medicinal marijuana, which further limits the treatment options they can offer to patients;

- Alternative therapies such as chiropractic care, massage therapy, acupuncture, physiotherapy, psychology and other recognized pain control methods are typically not affordable for individuals not covered by private insurance;

- By implementing “No Narcotics” policies hospitals across the province turn away chronic pain patients from the ER. This spells catastrophe for individuals who’ve lose both doctors and funding for their medications;

- Calculations of the number of individuals that will be impacted by this move are premature. If the Ontario Government successfully delists certain pain medications, it sets a very dangerous precedent. Insurance companies and disability compensation providers are likely to follow suit. Chronic pain patients everywhere in every profession and every walk of life will face the same predicament.
VIII) LETTER TO THE MINISTER

October 5, 2016

Honorable Minister Eric Hoskins
Ministry of Health and Long Term Care
10th Floor, Hepburn Block
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Dear Honourable Minister Hoskins:

Re: ILC as National Voice for Children and Families with Pain – Request for Your Leadership as Co-Chair of the Federal Provincial Territorial Ministers of Health

Dear Honourable Minister of Health & Long Term Care, Dr. Hoskins:

As you know, the ILC Charitable Foundation has three divisions i) Chronic Pain; ii) Ehlers Danlos Syndrome; iii) Education and Research. The ILC charitable programs have been organized in response to the identified gaps in healthcare, in education and research and in the community to improve the lives of children and families affected by debilitating and misunderstood chronic pain.

The purpose of this correspondence is to appeal to your current role as co-Chair of the Federal/Provincial/Territorial Ministers of Health as an ideal means to champion the shift that must take place in order to address the current opioid and chronic pain crisis in Canada. Your leadership in mandating care to Ontario residents living with misunderstood, underserviced chronic pain and chronic conditions by utilizing Ehlers Danlos Syndrome (EDS) as a model of optimal care, is unprecedented on a national scale.

The ILC’s success has been built upon our guiding principles of collegial cohesive collaborations while advocating for all stakeholders including the Ministry of Health. We are inviting you to take a leadership role, acting upon what needs to be done for Ontario, meanwhile providing a model that embodies these guiding principles for other provinces to follow that will i) turn pain on its axis ii) give voice to the patient population that the ILC has championed (children and individuals) by appointing community stakeholders that have proven track records and capacity, and iii) give voice to and help address the issues arising from the opioid crisis.

The ILC has a track record in i) successfully having child and youth pain on the map with increased services through Ontario hospitals through outcome meetings with Dr. Gary Salisbury and Pauline Ryan (January 2013) - Hon. Deb Matthews March 2014 announcement, including a 21-Day Program championed by the ILC for McMaster; and ii) ILC funding of CME accredited conferences bringing multidisciplinary specialists together to begin addressing the misconceptions of pain and influencing a shift in how healthcare can be delivered; and iii) successfully influenced the development of healthcare systems and methodologies of a multidisciplinary Centre of Excellence utilizing EDS as a model of optimal care for a broad group of chronic and chronic pain conditions. As such, we have been contacted by several stakeholders with requests of support for communications on the opioid crisis.
With your government’s plan to delist certain narcotics in January, 2017, the issue of access to care in this patient population will yet again hit another barrier. The ILC has identified the following challenges to addressing this issue:

- Current capacity among historic community based pain organizations is not sufficient to support a large scale awareness and education campaign with longstanding issues of accountability both respectively and collectively resulting in a polarized and divisive climate
- There is a gap in healthcare systems which provide support to healthcare providers as they adapt their practice and service delivery to modern standards
- Pain experts have championed pain as a disease in its own right without i) giving consideration to underlying potential genetic conditions; ii) knowing there is an enormous gap in evidence based diagnostic and treatment criteria for a broad group of chronic pain conditions
- Pain management is noted as the “3P’s” being Pharmaceuticals, Physiotherapy and Psychology, where family physicians and pain specialists oftentimes prescribe opioids without i) diagnostics to rule out a physical reason for pain; ii) if patient has a protein or enzyme deficiency, impacting its effectiveness; iii) if individual absorption rate is too great causing potential of overdose

It is important to note that the ILC has committed in-kind contributions of over $2M over five years in support of the Canadian Institute for Health Research Strategic Patient Oriented Research (CIHR-SPOR) Chronic Pain Network. We have facilitated research funding from Aniara Diagnostica for Thrombosis in EDS. Together with our medical advisers, we have facilitated discussions and are working towards funding of an Upright MRI machine for research on supine vs upright diagnostics. In so doing, the ILC are working to give hope to 20% of the population living with chronic pain while managing financial stewardship to support the greatest outcome on patient need. Lastly, in my nominated roll as Co-Chair of Pain Action Canada together with Maria Hudspith of Pain BC, we have developed a plan to revitalize a national pain strategy and campaign.

I look forward to the opportunity of discussing the ILC’s position and suggested Strategic Plan. Please feel free to contact me at your convenience at 416-822-3494.

Yours truly,

Sandy Smeenk
Founder & Executive Director
www.theilcfoundation.org
www.caneds.org

CC:
Dr. Norm Buckley, ILC Medical Director
Dr. Juan Guzman, ILC Medical Advisor, Chair Annual CME Conference
I am a patient advocate from Ottawa. I was recently in TO meeting with members of the Chronic Pain Association of Canada. I have also had discussions with the Chronic Pain Coalition of Canada. In this province patients are at a disadvantage because they do not have a provincially mandated organization to represent the interests of chronic pain patients.

I am deeply saddened to advise that there will not be a coordinated support system in place for patients affected January 1st, 2017. The media coverage and lack of awareness is causing undue hardship for individuals already suffering with traumatic illnesses and the resulting financial burden.

I myself am a MS patient and former federal government employee. I have learned to live a productive life and can now contribute back to society. Strong opioids are the only reason I am not in a wheelchair. I was recently chosen as one of four to represent patients on the SPOR Network - Patient Oriented Research Committee. Without these medications I would last no more than six months before I would need assisted living accommodations. After my surgery, when doctors needed to wean me off the very high dose needed to control the pain pre-op, it took an entire summer in the hospital. The only bed available was on the psych ward. Even though my discharge papers clearly state I was not mentally ill, I have faced discrimination multiple times within both health and justice systems.

Doctors and patients are confused; the announcement was made during the summer when most clinics and pharmacies were on summer holiday schedules. Many are just getting up to speed and there is only 14 weeks left.

Awareness in communities is low and support groups are not equipped to help. ER staff have a no-treat policy for chronic pain patients and some doctors are choosing to stop prescribing narcotics altogether, leaving patients in the lurch.

I am willing to travel to Toronto to share with your staff a presentation I will be giving at a Pain Management Conference here in Ottawa for Chronic Pain Awareness Week in early November. I encourage you to consider the ethical issues that will result from the decision to delist medications January 1st... at a time when ER rooms are already overwhelmed and patients are struggling emotionally, physically and financially.

For a Minister with a history of human rights and commitment to evidence based decision making, I am hoping I can appeal to your sense of humanity in helping these patients achieve the goals you have identified in the Narcotics Strategy.

I hope to hear from your office soon to discuss how patients can best be supported within their communities.

Sincerely,

Billie Jo Bogden, Patient Advocate, Ottawa, ON
IX) ONTARIO NARCOTICS STRATEGY – IN SHORT


[Excerpt from the site] Ontario’s strategy to prevent addiction and overdose includes:

- Designating Dr. David Williams, Ontario’s Chief Medical Officer of Health, as Ontario's first-ever Provincial Overdose Coordinator to launch a new surveillance and reporting system to better respond to opioid overdoses in a timely manner and inform how best to direct care.

- Developing evidence-based standards for health care providers on appropriate opioid prescribing that will be released by end of 2017-18 to help prevent the unnecessary dispensing and over-prescribing of pain killers.

- Delisting high-strength formulations of long-acting opioids from the Ontario Drug Benefit Formulary starting January 1, 2017 to help prevent addiction and support appropriate prescribing.

- Investing $17 million annually in Ontario's Chronic Pain Network to create or enhance 17 chronic pain clinics across the province, ensuring that patients receive timely and appropriate care.

- Expanding access to naloxone overdose medication, available free of charge for patients and their families through pharmacies and eligible organizations to prevent overdose deaths.

- Increasing access to Suboxone addiction treatment and improving patient outcomes and integration of care for those using this treatment.

- Beginning October 1, 2016, stricter controls on the prescribing and dispensing of fentanyl patches took effect. Patients are now required to return used fentanyl patches to their pharmacy before more patches can be dispensed.
Both the FDA and the CDC have recently taken steps to address an epidemic of opioid overdose and addiction, which is now killing some 29,000 Americans each year. But these regulatory efforts will fail unless we acknowledge that the problem is actually driven by illicit—not medical—drug use.

You’ve probably read that 80 percent of heroin users started with prescription medications—and you may have seen billboards that compare giving pain medication to children to giving them heroin. You have probably also heard and seen media stories of people with addiction who blame their problem on medical use.

But the simple reality is this: According to the large, annually repeated and representative National Survey on Drug Use and Health, 75 percent of all opioid misuse starts with people using medication that wasn’t prescribed for them—obtained from a friend, family member or dealer.

And 90 percent of all addictions—no matter what the drug—start in the adolescent and young adult years. Typically, young people who misuse prescription opioids are heavy users of alcohol and other drugs. This type of drug use, not medical treatment with opioids, is by far the greatest risk factor for opioid addiction, according to a study by Richard Miech of the University of Michigan and his colleagues. For this research, the authors analyzed data from the nationally representative Monitoring the Future survey, which includes thousands of students.

While medical use of opioids among students who were strongly opposed to alcohol and other drugs did raise later risk for misuse, the overall risk for this group remained small and their actual misuse occurred less than five times a year. In other words, it wasn’t actually addiction. Given that these teens had generally rejected experimenting with drugs, an increased risk of misuse associated with medical care makes sense since they’d otherwise have no source of exposure.

But for the majority of students, who weren’t morally opposed to recreational chemicals, medical use made no difference. Here, heavy recreational drug use was what mattered, and that was probably a sign that this group was at highest risk of addiction in the first place.

In general, new addictions are uncommon among people who take opioids for pain in general. A Cochrane review of opioid prescribing for chronic pain found that less than one percent of those who were well-screened for drug problems developed new addictions during pain care; a less rigorous, but more recent review put the rate of addiction among people taking opioids for chronic pain at 8-12 percent.
Moreover, a study of nearly 136,000 opioid overdose victims treated in the emergency room in 2010, which was published in *JAMA Internal Medicine* in 2014 found that just 13 percent had a chronic pain condition.

All of this means that steps to limit prescribing opioids for chronic pain run a great risk of harming pain patients without doing much to stop addiction. The vast majority of people who are prescribed opioids use them responsibly—recent research on roughly one million insurance claims for opioid prescriptions showed that just less than five percent of patients misused the drugs by getting prescriptions for them from multiple doctors.

If we want to reduce opioid addiction, we have to target the real risk factors for it: child trauma, mental illness and unemployment. Two thirds of people with opioid addictions have had at least one severely traumatic childhood experience, and the greater your exposure to different types of trauma, the higher the risk becomes. We need to help abused, neglected and otherwise traumatized children before they turn to drugs for self-medicatation when they hit their teens.

Further, at least half of people with opioid addictions also have a mental illness or personality disorder. The precursors to these problems are often evident in childhood, too. For example, children who are extremely impulsive are at high risk—but on the opposite end of the scale, so, too are children who are highly cautious and anxious. To reach these kids, we don’t need to label them, but we do need to provide tools that are tailored to their specific issues to prevent them from using drugs to manage those issues.

The final major risk factor for addiction is economic insecurity and poverty, particularly unemployment and the hopelessness, social marginalization and lack of structure that often accompany it. For example, heroin addiction rates among people who make less than $20,000 a year are 3.4 times higher than in people who make over $50,000. To those who study the effects of inequality on health, it is no coincidence that the collapse of the white middle class has been accompanied by a rise in all types of addictions, but especially addiction to opioids.

Many people would prefer it if we could solve addiction problems by busting dealers and cracking down on doctors. The reality, however, is that as long as there is distress and despair, some people are going to seek chemical ways to feel better. Only when we can steer them towards healthier—or at least, less harmful—ways of self-medication, and only when we reach children before they develop this type of desperation, will we be able to reduce addiction and the problems that come with it.

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ABOUT THE AUTHOR(S)

Maia Szalavitz

Maia Szalavitz is a neuroscience journalist and author or co-author of seven books. Her most recent, *Unbroken Brain: A Revolutionary New Way of Understanding Addiction*, was published in April, 2016. She writes for major publications including *TIME*, the *New York Times*, *Scientific American*, *The Washington Post*, *VICE* and *Pacific Standard*. 
Canadians Deserve a National Pain Strategy

Stakeholders converge in the nation’s capital to discuss the critical issues of pain

Toronto, ON – April 24, 2012 – Today international medical, ethics and human rights experts will join the Canadian Pain Society (CPS), the Canadian Pain Coalition (CPC), members of the pain community, various stakeholder groups and federal officials in Ottawa for the first-ever Canadian Pain Summit.

Pain is one of the most common reasons for a patient to consult a healthcare professional and yet numerous studies have concluded that both acute and chronic pain is not well managed. Even in large urban centres across Canada there are long waits for the few available chronic pain clinics, while most people living in rural Canada are forced to go without adequate treatment or face wait times up to five years.

“Unfortunately, most health care professionals have not received adequate training on appropriate pain management and are therefore at a loss when trying to help their patients. Veterinary students receive five times as much undergraduate teaching on pain than do medical students. The implementation of a National Pain Strategy would target this knowledge gap by insisting on minimum training requirements for all Canadian health professionals. This, along with better access to appropriate, coordinated pain management services could reduce the costs in other parts of our healthcare system,” says Dr. Mary Lynch, Co-Chair of the Canadian Pain Summit.

The National Pain Strategy is a call to action developed by clinicians, researchers, stakeholder groups and people living with pain to address the social, economic and personal impact of pain on Canadians. To date, over 4,000 Canadians and more than 100 organizations have shown their support for a National Pain Strategy. The Strategy identifies four key target areas for change, including: awareness and education, access, research and ongoing monitoring. The Strategy has been reviewed and contributed by various stakeholders such as Health Canada, The Canadian Medical Association, The Royal College of Physicians and Surgeons of Canada, the Canadian Nurses Association, the Canadian Pharmacists Association, the Arthritis Alliance and The Canadian Association of Retired Persons to address the gaps that exist in pain management and to minimize its burden on Canadians living with pain, their families and society.

“People forget just how widespread and costly the problem of chronic pain is. The 6 million Canadians who suffer from this condition include victims of motor vehicle accidents, workplace injuries, illness, arthritis, cancer patients, and veterans,” explains Lynn Cooper, a chronic pain sufferer and President of the Canadian Pain Coalition. “In 2010, the international pain community approved the Declaration of Montreal which states that ‘Access to pain management is a fundamental human right,’ and this is a right not being met.”

Pain costs the economy an estimated $56-60 billion dollars in lost wages and direct health care costs, and in addition each pain sufferer waiting for treatment pays an estimated $17,544 annually in costs not funded publically or by insurance.
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The total spent in Canada on pain research is inadequate, compared to huge impact of pain on Canadians. Between 2006 - 2007 and 2010 - 2011, the Canadian Institutes of Health Research (CIHR) funded approximately $54.7 million of pain-related research⁵ – or less than one per cent of total research funding from the CIHR. Across the country, only 0.25 per cent of total funding for health research in Canada, was spent on pain-related research.⁶

Pain Summit attendees will have the opportunity to hear the personal stories of patients living in pain and learn from national and international experts why having a National Pain Strategy is so important and fundamental for our policy makers to adopt. Canadians can show their support for the National Pain Strategy and rise up against pain by endorsing the call for a National Pain Strategy at www.canadianpainsummit2012.ca. Together we can make a difference.

Pain Facts

- One in five Canadian adults suffer from chronic pain⁷
- 15-30 per cent of children experience recurring or chronic pain and the prevalence increases with age⁸
- Chronic pain is associated with the worst quality of life as compared with other chronic diseases such as chronic lung or heart disease⁹
- Based on Canadian and U.S. survey data, the cost of chronic pain in adults, including health care expenses and lost productivity, is an estimated $56-60 Billion dollars annually ⁷,¹⁰
- People living with pain have double the risk of suicide as compared with people without chronic pain¹¹
- Although we have the knowledge and technology, Canadians are left in pain after surgery, even in our top hospitals. Only 30% of ordered medication are given, 50% of patients are left in moderate to severe pain after surgery and the situation is not improving¹²

About the Canadian Pain Society

The Canadian Pain Society has been a chapter of the International Association for the Study of Pain since 1982. The aim of the CPS is to foster and encourage research on pain mechanisms and pain syndromes and to help improve the management of patients with acute and chronic pain by bringing together the basic scientists and health professionals of various disciplines and backgrounds who have an interest in pain research and management. www.canadianpainsociety.ca / www.twitter.com/canadianpain

About the Canadian Pain Coalition

The Canadian Pain Coalition (CPC) THE National Voice of People with Pain. Incorporated in 2004 as a non-profit organization, the CPC is a partnership of pain consumer groups, individuals, health professionals who care for people in pain and scientists studying better ways to treat pain. CPC promotes sustained improvement in the understanding, prevention, treatment and management of all types of pain in Canada. CPC accomplishes this through pain education, awareness activities and advocacy initiatives. CPC obtained the Senate Declaration of National Pain Awareness Week in 2004. www.canadianpaincoalition.ca

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For further information or to schedule an interview, please contact:

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References

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