Canadian Psychiatric Association
Dedicated to quality care
Association des psychiatres du Canada
Dévouée aux soins de qualité

POSITION STATEMENT

Psychiatry and the Opioid Crisis in Canada

Grainne E. Neilson, MD, MRCPsych, FRCPC, LLM[1]; Alison Freeland, BSc, MD, FRCPC, FCPA[2]; Christian G. Schütz, MD, PhD, MPH, FRCPC[3]

A position statement developed by the Canadian Psychiatric Association's Professional Standards and Practice Committee and approved by the CPA's Board of Directors on April 18, 2019.

This position statement provides a brief background of the opioid crisis in Canada, summarizing the current evidence, followed by the Canadian Psychiatric Association's recommendations. In this statement, the term "opioid" refers to all compounds that bind to opioid receptors, including:

- Natural opiates (derivatives of the opium poppy such as morphine and codeine).
- Semisynthetic opioids (synthesized from naturally occurring opiates such as heroin from morphine; oxycodone and buprenorphine from thebaine).
- Synthetic opioids (compounds formed through a chemical process such as methadone, fentanyl, and carfentanyl).

"Narcotic" is the legal term used for opioids and certain other substances. It should not be used in the clinical setting.

Since ancient times, opioids have been widely used for a variety of medicinal purposes. In addition to their medicinal benefits, opioids have a long history of recreational use due to their euphoric effects. Societal ills related to their abuse have been part of the landscape for millennia.

Ever since opioids entered the sphere of medical therapeutics in the 1800s, an uneasy tension has existed between the medicinal benefits of these drugs and their potential for abuse and addiction.[1] Indeed, only 25 years after the hypodermic needle was invented and used to inject morphine to relieve pain (in 1853), the first accurate and comprehensive monograph on opiate addiction was written by the pioneering addiction psychiatrist Eduardo Levinstein (in 1878).[2]

Throughout their history as therapeutic agents, erroneous claims that opioids had low abuse liability contributed to

[1] Staff Forensic Psychiatrist, East Coast Forensic Hospital, Dartmouth, Nova Scotia, Canada; Assistant Professor, Department of Psychiatry, Dalhousie University, Halifax, Nova Scotia, Canada.
[2] Vice-President, Quality, Education and Patient Relations, Trillium Health Partners, Mississauga, Ontario, Canada; Associate Dean, Medical Education (Regional), Faculty of Medicine, University of Toronto, Toronto, Ontario, Canada; Associate Professor, Department of Psychiatry, University of Toronto, Toronto, Ontario, Canada.
[3] Associate Professor, Institute of Mental Health, Department of Psychiatry, University of British Columbia, Vancouver, British Columbia, Canada; Medical Manager, Burnaby Centre for Mental Health and Addiction, Provincial Health Service Authority, Burnaby, British Columbia, Canada.

Suggested citation: Neilson GE, Freeland A, Schütz CG. Psychiatry and the opioid crisis in Canada. Can J Psychiatry. 2019;VV(ISS): PP—PP.

Note: It is the policy of the Canadian Psychiatric Association to review each position paper, policy statement and clinical practice guideline every five years after publication or last review. Any such document that has been published more than five years ago and does not explicitly state it has been reviewed and retained as an official document of the CPA, either with revisions or as originally published, should be considered as a historical reference document only.

enthusiastic overprescribing for a wide variety of ailments and underrecognition of the harms associated with their indiscriminate use.[3] In parallel with medicinal use of these substances, the illegal market also flourished.

At different points in ancient and modern history, governments and international organizations have intervened to limit the licit and illicit use of these potent agents.[1,4] For example, Canada was one of the first countries to ban opium for personal, nonmedicinal use with the introduction of the Opium Act in 1908 (which predated the well-known U.S. Harrison Narcotic Tax Act of 1914) in an effort to stem the use of opium among the populace.[5] More recently in April 2016, British Columbia's provincial health officer declared a public health emergency in response to the rise in drug overdoses and deaths, and in November 2016, the federal government issued a "Joint Statement of Action" to address the opioid crisis, outlining the combined response of over 30 partner organizations to address this crisis.

Although opioids constitute an established part of modern medical treatment (primarily for the management of pain, as adjunct medications in anaesthesia, and as replacement therapy for the management of opioid use disorder), the prescription of these drugs rose dramatically in the last 25 years. In the past two decades, there has again been growing worldwide concern about opioid use and related deaths and harms.[6] This has stemmed from three interrelated problems:

- The liberal prescribing of opioids for the management of chronic noncancer pain, at times leading to iatrogenic opioid dependence.
- A substantial increase in the prevalence of nonmedical use of prescription opioids,[7] through diversion and misuse.
- A larger and more diversified illicit opioid market with newly emerging powerful fentanyl-related substances.[8]

Currently in this country, opioid-related morbidity and mortality is impacting every province and territory and shows little sign of abating.[9,10] Opioids were responsible for 3,987 deaths in Canada in 2017, over 1,000 more than the previous year.[11] Every day in 2017, an average of 17 Canadians were hospitalized due to opioid poisoning,[12] which corresponds to a 53 per cent increase over the previous 10 years. The problem is particularly acute in western provinces and northern regions where the harms due to opioid poisoning are over twice the national average.[10] Of particular concern are the rising rates of harm and deaths among Indigenous populations, seniors, and youth in Canada.[13-15]

Overall, opioid users who overdose are three to four times more likely to have a comorbid mental disorder (excluding other substance use disorders) compared to matched individuals with no overdose.[16] This is not surprising, given the overlapping mechanisms of substance use disorders and other mental disorders as well as the frequent convergence of signs and symptoms of these conditions.[17,18] This highlights the importance of assessment for psychiatric comorbidity in patients with opioid use disorder in order to identify individuals at substantially elevated mortality risk and to enable a personalized approach to their care.

While the opioid crisis has affected every part of the country, there are clear differences in death rates and the substances involved across provinces and territories.[12] In western provinces and northern regions, this crisis is especially associated with synthetic opioids such as fentanyl, whereas in Atlantic Canada, the issue is mainly with misuse of prescription drugs.[19,20] This suggests that a "one-size-fits-all" approach to addressing the opioid crisis will not be effective and that psychiatrists must be aware of local issues and be prepared to respond to local needs. For example, in areas where overprescribing is substantially contributing to the opioid crisis, psychiatrists may be called upon to assist with advising about appropriate prescribing in patients with concurrent disorders, including mental health conditions and chronic pain. In areas where illicit market is very prevalent, psychiatrists may be well positioned to advocate for supervised consumption sites and provide support for the development of drug courts and other diversionary models to assist in the management of opioid users who run into trouble with the law.

More broadly, psychiatrists should support the development of robust, evidence-based strategies for identifying, preventing, treating, and reducing the harms of opioid dependence and the comorbidities. Psychiatrists must have the knowledge base and clinical training to be able to recognize risk factors for addiction during general assessment and consultation, keeping in mind that most Canadian illicit opioid users are polysubstance users,[21] contributing to morbidity and mortality. At all times, psychiatrists should be aware of the potential risk of prescribing benzodiazepines and other sedating medications in patients who are also taking opioids. Wherever possible, integrated treatment models that address underlying mental health issues that may contribute to or exacerbate substance use disorder should

be employed. Throughout Canada, psychiatrists should continue to work collaboratively with addiction medicine specialists and public health officials to enhance access to mental health care and harm reduction strategies, particularly in Indigenous and underserved, rural and remote communities.

Patients with chronic noncancer pain may benefit from an interdisciplinary model of care to allow care providers to address the multiple components of the patient's pain experience.[22,23] Such patients often have comorbid mental health and addiction issues. Psychiatrists should educate themselves about the comorbidities associated with the treatment of chronic noncancer pain and be prepared to work in a collaborative fashion with other care providers, including primary care. For those psychiatrists who already treat chronic noncancer pain and are considering use of an opioid, national guidelines[24] that outline the appropriate prescription of opioids should be followed, while at the same time ensuring that patients who have comorbid mental health conditions are not excluded from appropriate pain management. Multidisciplinary pain management programs should include mental health staff, including psychiatrists, to encourage the adoption of a multimodal approach to the management of chronic noncancer pain. This will require the collaboration across several medical specialties, including anaesthesia, addiction medicine and psychiatry.

In future, the principles of integrated treatment approaches for these complex conditions should be inculcated into residency training programs across the country. Pain Medicine is a medical subspecialty recognized by the Royal College of Physicians and Surgeons of Canada that is concerned with the prevention, evaluation, diagnosis, treatment and rehabilitation of patients with acute and chronic pain associated with cancer and noncancer diagnoses. The Canadian Psychiatric Association encourages resident psychiatrists with an interest in pain management to pursue training in this subspecialty following their specialist psychiatric training.

Given that incautious opioid prescribing practices may have contributed to the current opioid crisis and that commercial influences may affect prescribing patterns, it is imperative that psychiatrists exercise prudent clinical judgment in prescribing and be guided by evidence and treatment guidelines established independently of commercial influence.[25] Cessation of all industry-initiated marketing to physicians regarding opioid prescribing should be considered as a priority for policymakers.

Finally, psychiatrists have a critical role to play in the stigma-free diagnosis and management of opioids use disorder and comorbid mental disorders and should be actively involved in their dual management, particularly for complex cases. Reversing the trajectory of the current opioid crisis requires psychiatrists to lead the discussion in reducing the stigma associated with the diagnosis and treatment of these disorders, to ensure that they are addressed as chronic illnesses, not moral failings.

References

1. Rosenblum A, Marsch LA, Joseph H, Portenoy RK. Opioids and the treatment of chronic pain: controversies, current status and future directions. Exp Clin Psychopharmacol. 2008;16(5):405-416.
2. Levinstein E.Morbid craving for morphia. London, England: Smith, Elder; 1878.
3. Brownstein M. A brief history of opiates, opioid peptides, and opioid receptors. Proc Natl Acad Sci USA. 1993;90(12): 5391-5393.
4. Frontline. Opium throughout history [Internet]. Arlington (VA): Public Broadcasting Service [accessed 2019 July 17]. Available from: https://www.pbs.org/wgbh/pages/frontline/shows/heroin/etc/history.html. Derived from Booth M. Opium: a history. London: Simon & Shuster, Ltd; 1996.
5. Nolin PC, Kenny C, Banks T, et al. Cannabis: our position for a Canadian public policy. Report of the Senate Special Committee on illegal drugs. Summary Report [Internet]. Ottawa (Canada): Senate of Canada, 2002 [accessed 2019 Jul 17]. Available from: https://sencanada.ca/Content/SEN/Committee/371/ille/rep/summary-e.pdf.
6. United Nations Office on Drugs and Crime. World Drug Report 2018 [Internet]. Vienna (Austria): United Nations, 2018 June [accessed 2019 July 17]. Available from: http://www.unodc.org/wdr2018/index.html.
7. Zacny J, Bigelow G, Compton P, Foley K, Iguchi M, Sannerud C. College on problems of drug dependence taskforce on prescription opioid non-medical use and abuse: position statement. Drug Alcohol Depend. 2003;69(3):215-232.
8. International Narcotics Control Board. Global opioids project: operational partnerships to interdict opioids' illicit distribution and sales [Internet]. No date [accessed 2019 July 17]. Available from: http://www.incb.org/incb/en/opioids_project.html.
9. Special Advisory Committee on the Epidemic of Opioid Overdoses. National report: Apparent opioid-related deaths in Canada (January 2016 to June 2017). [Internet]. Ottawa (Canada): Public Health Agency of Canada, 2017 [accessed 2019 July 17]. Available from: https://www.canada.ca/en/public-health/services/publications/healthy-living/apparent-opioid-related-deaths-report-2016-2017-december.html.
10. Canadian Institute for Health Information. Opioid-Related Harms in Canada [Internet]. Ottawa (Canada): Canadian Institute for Health Information, 2018 December [accessed 2019 July 13]. Available from: https://secure.cihi.ca/free_products/opioid-related-harms-report-2018-en-web.pdf.
11. Special Advisory Committee on the Epidemic of Opioid Overdoses. National report: apparent opioid-related deaths in Canada (January 2016 to December 2017). Web-based Report. Ottawa (Canada): Public Health Agency of Canada, 2018 June [accessed 2019 July 17]. Available from: https://www.canada.ca/en/public-health/services/publications/healthy-living/national-report-apparent-opioid-related-deaths-released-june-2018.html.

12. Health Canada. Infographic: opioid-related harms in Canada. [Internet]. Ottawa (Canada): Health Canada, 2018 [accessed 2019 July 17]. Available from: https://www.canada.ca/en/health-canada/services/publications/healthy-living/infographic-opioid-related-harms-june-2018.html.
13. Canadian Institute of Health Information (CIHI). Opioid-related harms in Canada. Ottawa (ON): CIHI; 2017. [Internet]. [accessed 2019 July 17]. Available from: https://secure.cihi.ca/free_products/opioid-harms-chart-book-en.pdf.
14. Belzk L, Halverson J. Evidence synthesis - The opioid crisis in Canada: a national perspective [Internet]. Ottawa (Canada): Health Promotion and Chronic Disease Prevention in Canada, 2018 June; 38(6):224-233 [accessed 2019 August 21]. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6034966/.
15. Alberta Health: Analytics and Performance Reporting Branch. Opioids and substances of misuse among First Nations people in Alberta. Alberta Report, 2017 [Internet]. Alberta (Canada): Government of Alberta, 2017 [accessed 2019 July 17]. Available from: https://open.alberta.ca/dataset/cb00bdd1-5d55-485a-9953-724832f373c3/resource/31c4f309-26d4-46cf-b8b2-3a990510077c/download/Opioids-Substances-Misuse-Report-FirstNations-2017.pdf.
16. Smolina K, Crabtree A, Chong M, et al. Patterns and history of prescription drug use among opioid-related drug overdose cases in British Columbia, Canada, 2015–2016. Drug Alcohol Depend. 2019;194:151-158.
17. Pettersson E, Larsson H, Lichtenstein P. Common psychiatric disorders share the same genetic origin: a multivariate sibling study of the Swedish population. Mol Psychiatry. 2016;21(5):717-721.
18. Teicher MH, Samson JA. Childhood maltreatment and psychopathology: a case for ecophenotypic variants as clinically and neurobiologically distinct subtypes. Am J Psychiatry. 2013; 170(10):1114-1133.
19. MacDonald M. Opioid crisis: NS's battle shows progress: Strang. The Chronicle Herald. 2018;1:A10.
20. Fischer B, Vojtila L, Rehm J. The 'fentanyl epidemic' in Canada—some cautionary observations focusing on opioid-related mortality. Prev Med. 2018;107:109-113.
21. Fisher B, Rehm J. Illicit opioid use and treatment for opioid dependence: challenges for Canada and beyond. Can J Psychiatry. 2006;51(10):621-623.
22. Ashburn MS, Staats PS. Management of chronic pain. Lancet. 1999; 353(9167):1865-1869.
23. Canadian Agency for Drugs and Technologies in Health (CADTH). In brief: a summary of the evidence. Multidisciplinary treatment programs for patients with chronic non-malignant pain: a review [Internet]. Ottawa (ON): CADTH; 2018 [accessed 2019 July 17]. Available from: https://www.cadth.ca/sites/default/files/pdf/htis/2017/RC0894_in_brief_e.pdf.
24. Busse J, Craigie S, Juurlink D, et al. Guideline for opioid therapy and chronic noncancer pain. CMAJ. 2017;189(18): E659-E666.
25. Hadland SE, Cerdá M, Li Y, Krieger MS, Marshall BDL. Association of pharmaceutical industry marketing of opioid products to physicians with subsequent opioid prescribing. JAMA Intern Med. 2018;178(6):861-863.