THE NATIONAL OPIOID CRISIS

Delegate Backgrounder

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CFMS Canadian Federation of Medical Students

FEMC Fédération des étudiants et des étudiantes en médecine du Canada

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Asha Behdinan
Jessica Bryce
Alexander Bourdon
Jacqueline Carverhill
Koray Demir
Nadia Demko
Julianna Deutscher
Kia Dullemond
Yipeng Ge
Finola Hackett
Haniya Khan
Teagan King
Emma Mitchell
Anna McLean
Sam Nordlund
Lauren Strasser
Vivian Tam
Jovi Wong
Charles Yin

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EXECUTIVE SUMMARY

Since emerging as a means to manage chronic, non-cancer pain more than two decades ago, opioid drugs have become one of the most widely-prescribed class of medications in Canada. Canadians are the second highest per capita consumers of prescription opioid drugs in the world, with physicians writing 53 prescriptions for opioid drugs for every 100 people in the country.

Unfortunately, the widespread availability of opioids and their addictive nature have resulted in increasing rates of opioid dependency and a demand for illicit opioids, especially fentanyl - a synthetic opioid 50 to 100 times more potent than morphine. This has in turn fuelled a growing crisis where fentanyl overdoses resulted in at least 655 deaths in Canada between the years 2009 and 2014. In British Columbia, which has been the hardest hit by opioid-related overdoses and deaths, a public health emergency was declared in April 2016. Alarmingly rapid increases in rates of opioid misuse across Canada have prompted calls for the federal government to follow suit.

From a healthcare perspective, there have been numerous major factors that have resulted in and exacerbated the growing opioid crisis. We are focusing on three of the major factors that the federal government can play a key role in addressing. First and foremost is a lack of an effective means to properly manage chronic pain. Multidisciplinary chronic pain centres, which offer specialized pain management strategies that incorporate both pharmacological and non-pharmacological modalities, though effective in controlling chronic pain, are few in number and availability of these centres is severely limited in sub-urban and rural areas. Second, there is a serious lack of infrastructure and resources both in treating patients with opioid dependency and caring for those with mental health disorders - who are twice as likely as the general population to develop substance use problems - in general. Third, decades of treating illicit drug use solely through criminalization has impeded the growth of effective harm reduction programs that aim to reduce the health risks of drug use. Although attitudes are beginning to change, with substance use now being viewed primarily as a public health issue, harm reduction programs have remained underdeveloped.

There have been repeated calls over the past decade for a greater federal role in changing our approach to the management of chronic pain. The Canadian Medical Association, Canadian Pain Coalition and Canadian Pain Society have all advocated for a national strategy that would see comprehensive and accessible pain management for all Canadians. A multidisciplinary approach was identified as being key in any proposed national strategy, with multiple organizations in agreement that non-pharmacological treatment of pain is effective and that a lack of access to these resources was a cause of physician over-prescription of opioid medications. Simultaneously, there is acknowledgement that prescription opioid medications should remain available to those patients who actually need them, but that better prescribing practices are

required. The Royal College of Physicians and Surgeons of Canada and the College of Family Physicians of Canada have both committed to improving opioid prescription guidelines to assist providers in determining how to better prescribe these drugs.

The opioid crisis has underscored a lack of adequate access to mental health for many Canadians. Organizations such as the Centre for Addiction and Mental Health and the Canadian Mental Health Association view chronic pain, opioid dependency and the development of addiction as fundamentally interrelated problems that need to be solved together. They are amongst many organizations that have called for improved access to addiction treatment programs. The Mental Health Association, as part of their pan-Canadian mental health strategy, has advocated for services that can provide integrated treatment for mental health problems and substance use disorders concurrently.

In the face of rising numbers of Canadians suffering from opioid-related overdose and death and amidst urgent calls to action from multiple actors, the federal government in November 2016 took the first steps towards national action on the growing opioid crisis. First, the House Standing Committee on Health released an interim report on the opioid crisis, where it released a set of 18 recommendations on action to be taken. Significantly, the interim report recommends that the federal government declare a state of national emergency and provide leadership in the creation of a task force to combat the crisis. Second, the federal government hosted a national summit on the opioid crisis, where it was able to bring together provincial health authorities, regulatory bodies and professional organizations in crafting a joint statement on taking action. The federal government has further signaled that it is willing to make the necessarily legislative changes to help stem the opioid crisis, beginning with the introduction of Bill C-37, which reversed a number of bureaucratic barriers put in place by the previous administration to halt the development of supervised consumption sites and other harm reduction programs. Current federal action on the opioid crisis has focused on improving access to harm reduction services, including expanding naloxone programs in rural areas and within Indigenous communities. And in pushing for the development of improved opioid prescribing guidelines and improved means to track the prescription of opioid medications.

Nevertheless, these actions and developments, while positive and worthy of applause, in our opinion do not go far enough in addressing the root causes of the opioid crisis: namely, a lack of effective treatment for chronic pain and a lack of understanding between the complex interactions between mental health problems and substance use. As today's medical students and tomorrow's physicians, we believe that more should be done to address these upstream causes of the opioid crisis.

In addressing the national opioid crisis, the Canadian Federation of Medical Students calls on the Government of Canada to

1. **Prioritize increased access to multidisciplinary chronic pain centres by supporting provincial/territorial efforts to establish and expand these treatment programs.**
2. **Increase investment in research and funding to better understand the interactions between mental illness and opioid misuse**

The Canadian Federation of Medical Students also supports the passing of Bill C-37: An Act to amend the Controlled Drugs and Substances Act and to make related amendments to other Acts.

PROBLEM DEFINITION

Opioids are a class of natural or synthetic drugs that are often prescribed for pain relief and, as a side effect, often produce euphoria. For these reasons, common opioid drugs include both prescription painkillers such as morphine, oxycodone, codeine, and fentanyl, and illicit street drugs, such as heroin. Currently, Canada is second only to the United States as the world's largest per capita consumer of prescription opioids. One contributing factor to the opioid crisis is the vast over-prescription of opioids by physicians for the treatment of chronic pain. In 2015, physicians wrote 53 prescriptions for opioid medications for every 100 people in Canada (Howlett & Grant, 2016). This, in turn, contributed to a substantial increase in opioid addiction within the population. Government spending on opioid treatment and addiction programs has also increased as a result. Public drug programs in 2014 spent $300 million on opioid and opioid-affiliated prescriptions, including $93 million on opioid addiction medications, representing an increase of over 50% from 2011 (Howlett, 2017). The high rate of opioid dependence is responsible for approximately 13 hospitalizations per day due to opioid poisoning, with nearly half of these poisonings deemed accidental (Canadian Institute for Health Information, Canadian Centre on Substance Abuse, 2016). Between 2007 and 2015, the hospitalization rate for opioid poisoning rose by over 30%, reaching nearly 14 per 100,000 Canadians during this time period Canadian Institute for Health Information, Canadian Centre on Substance Abuse, 2016).

Illicit opioid use, however, has also become a major contributing factor to the national opioid crisis—stemming largely from the importation of illicit fentanyl from China and other international sources. These street drugs are often of unknown potency, meaning that consumers are at substantial risk for overdose and death. Between 2009 and 2014, fentanyl overdoses specifically accounted for at least 655 deaths in Canada, and was implicated in an additional 1,019 during post-mortem toxicology screenings (Canadian Centre on Substance Abuse, 2015). These statistics translate to an average of 1 to 2 fentanyl-related deaths every 3 days. A recent report by the Canadian Centre on Substance Abuse (CCSA) and the Canadian Institute for Health Information (CIHI) found that 13 Canadians are hospitalized each day from an opioid overdose (Canadian Institute for Health Information, Canadian Centre on Substance Abuse, 2016). In B.C. and Alberta, provinces particularly hard-hit by opioid addiction, the rate of fatal fentanyl overdoses increased tenfold between 2012 and 2015 alone (Howlett, 2017). In April 2016, the province of British Columbia, which has been particularly impacted by the crisis, announced a public health emergency. Many public health experts have called for the federal government to follow suit. Saskatchewan, which also has the highest rate of new cases of HIV, a phenomenon closely connected to injection of drugs, also has the highest rate of hospitalization from opioid poisoning (CBC News, 2016).

THE NATIONAL OPIOID CRISIS AND CHRONIC PAIN

The current opioid crisis can in part be attributed to the inappropriate prescription of opioids for patients suffering from chronic, non-cancer pain. In Canada, undertreated or poorly managed pain is enormously consequential, costing $60 billion per year (Canadian Pain

Coalition, 2011). This does not account for the cost of suffering for those awaiting proper treatment. Access to interdisciplinary pain management programs have been shown to reduce the inappropriate use of pain medications, including opioids, in addition to improving pain treatment outcomes, such that expanding access to such programs should be a priority for the federal government (Canadian Pain Coalition, 2011).

In the context of chronic pain, the terms "multidisciplinary" and "interdisciplinary" treatment are often used interchangeably, despite technically being two distinct concepts. Interdisciplinary pain treatment involves numerous medical and allied health disciplines operating within the same facility with shared accountability for patient outcomes and a high degree of internal communication. This model of care facilitates holistic, coordinated treatment for patients, in addition to shared goal-setting between disciplines. The more common model is that of a multidisciplinary program, whose multiple health disciplines occupy more distinct roles in patient treatment and may often operate in relative isolation from one another. The administrative systems and schedules may be less integrated as well, entailing a lower degree of inter-coordination for patients (Turk et al., 1992). However, the International Association for the Study of Pain recommends "multidisciplinary" treatment for chronic pain problems (International Association for the Study of Pain, 2009). This treatment modality has been endorsed by several Canadian provincial colleges of physicians and surgeons and is considered by experts as best practice (Peng et al., 2007). For our purposes, we will consider the "interdisciplinary" denotation as the aspirational model of care although we will use both terms interchangeably.

Numerous studies of Interdisciplinary Pain Treatment Centres (IPTCs) have reported consistently remarkable patient outcomes across multiple domains, ranging from pain control through to subjective well-being. In a systematic review involving 3089 patients in total, patients participating in an IPTC experienced 37% pain reduction vs. 4% in the unimodal treatment group (McCracken & Turk, 2002). This finding was replicated by a meta-analysis of 65 studies, which reported a 20% average reduction in pain for patients undergoing treatment by an IPTC (Flor, Fydrich & Turk, 1992). These results may in part be explained by an IPTC's biopsychosocial approach to pain management. The programs adopt the view that chronic pain is produced and perpetuated by more than physical injury alone. In addition to traditional pain management through prescription medication, common to most IPTCs are therapy modalities that target multimodal mediators of pain. For example, cognitive-behavioural therapy is intended to alter thought patterns that exacerbate a patient's perception of pain, in addition to imparting coping skills such as relaxation, mindfulness, and the interpretation and use of biofeedback (Moore Jefferey et al., 2011; Stanos, 2012). Another common component of many IPTC's are vocational counselors, who provide techniques to improve workplace ergonomics and pacing exertion to produce less physical strain over the long-term (Stanos, 2012). Consequently, instead of simply attempting to treat and eliminate physical symptoms, the IPTCs take an approach to healthcare that address some of the socioeconomic determinants of health, such as an individual's employment circumstances, social supports and emotional resilience. With many IPTCs also

assisting patients in simplifying their medication regimens, the model attempts to be comprehensive in its approach to tackling both immediate pain, as well as its upstream causes.

The benefits of such a whole-of-person approach to chronic pain management are reflected in the literature. A recent Danish study randomized patients to chronic pain treatment through their GP, the wait list, or an IPTC. At the 6-month point, patients assigned to the IPTC arm demonstrated, "significant pain reduction, improved physical function, improved psychological well-being, and improved quality of sleep" (Becker et al., 2000). In contrast, patients assigned to treatment by their GP demonstrated no improvement, and perhaps unsurprisingly, patients on the waitlist deteriorated according to the above indices (Becker et al., 2000). Improvement in such indicators is a marker of the fact that chronic pain can have a pervasively negative influence on an individual's quality of life, where conversely, pain that is well-controlled can produce marked improvements in an individuals overall well-being. Accordingly, in a study by Flor et al. (1992), 65% of patients treated through an IPTC reported an increase in their level of overall physical activity, compared to 35% in the unimodal treatment group.

Yet beyond these subjective indicators are also markers of proven benefit that have significant economic implications: McCracken and Turk's systematic review (2002) demonstrated that the number of patients returning to work after undergoing treatment through an IPTC more than doubled that of those treated with unimodal therapy (68% vs. 32%); the figure tripled in terms of patients reducing the quantity of medications they were taking to control their pain (63% IPTC vs. 21% unimodal). And, directly consequentially, only 17% of IPTC patients required further hospitalization from pain, compared to 47% of those patients treated conventionally (Okifuji et al., 1999). These statistics provide mounting evidence for the idea that investing in long-term management of chronic pain in Canada could not only drastically reduce the burden of debilitating pain, but also produce significant cost-savings in healthcare expenditure and through restoring some of the lost workforce productivity produced annually by unmitigated chronic pain.

The consequence of increased access to IPTC's on the opioid crisis could be particularly striking. A review by Okifuji et. al, (1999) showed that only 20% of patients were using opioids to treat their pain at discharge from an IPTC, compared to 65% prior to enrollment. Another study demonstrated that 73% of patients had reduced their opioid use while undergoing treatment at an IPTC. These significant differences demonstrate a strong correlation between under- and/or poorly-treated chronic pain and ongoing opioid use. Taken together with the significant economic and health benefits of the IPTCs, it seems matter-of-fact that IPTCs are an indispensable part of the solution to Canada's existing opioid crisis.

The CPC maintains a list online of chronic pain centres across the country.[1] It uses the term "multidisciplinary." Here, a multidisciplinary pain treatment facility is defined as one that is "staffed with health care professionals who…specialized in the diagnosis and management of patients with chronic pain." The facilities listed have advertised themselves as a pain clinic, are

[1] Canadian Pain Clinic Listing: http://www.canadianpaincoalition.ca/downloads/pain_clinics.pdf

staffed with three or more healthcare disciplines and manage cancer as well as non-cancer pain. The list was last updated in 2015.

The distribution of multidisciplinary chronic pain centres appears to be heavily concentrated in urban areas. Of particular note are Manitoba and Prince Edward Island, where facilities exist in the provincial capitals only. Newfoundland and Labrador only has one facility outside the capital of Saint John. As noted by one 2007 study, a lack of multidisciplinary chronic pain centres, especially in rural areas, forces chronic pain sufferers that reside in those areas to rely heavily on their family physicians for care (Peng et al., 2007). A lack of access to pain specialists combined with scarcity of family physicians makes this patient population more at risk to prolonged suffering from chronic pain. Furthermore, according to the same study, wait-times for multidisciplinary pain clinics average 6 months, but can take up to 5 years in certain circumstances. Finally, it is important to note that many of the facilities included in the CPC's list are privately-funded and may present a financial barrier to accessing care.

There is thus a clear need for improving access to multidisciplinary treatment options for chronic pain. While this may include the establishment of more pain clinics or the expansion of existing ones, it may also include support for better coordination between pain centres and primary care providers. For example, the province of Ontario instituted the ECHO (Extension for Community Healthcare Outcomes) Ontario Chronic Pain and Opioid Stewardship project as a method of training primary care providers in the management of chronic pain. The initiative uses telehealth technologies to help overcome geographical barriers and has been replicated by such organizations as the US Department of Veteran's Affairs and the National Institute of Mental Health and Neurosciences in Bangalore, India (Dubin et al., 2015).

Some groups, including the McMaster Health Forum, have suggested the creation of "a national network of centres with a coordinating "hub" to provide chronic pain- related decision support" (Lavis et al., 2009). There is precedent in asking the federal government to fund a Network of Centres of Excellence for the Management of Chronic Pain, as they have previously funded such networks for Arthritis and Stroke. Much of the focus of such centres is on research and training, rather than direct delivery. This includes the development and dissemination of practice guidelines, offering continual professional development, and provide support for already existing local programs.

THE NATIONAL OPIOID CRISIS AND MENTAL HEALTH

When discussing the opioid crisis, it is important to distinguish between addiction and tolerance. The Fifth Edition of the Diagnostic and Statistical Manual of Mental Disorder (DSM-V), defines substance use disorder by the impaired control, social impairment, risky use, and pharmacological criteria. Impaired control involves taking higher doses for a longer period of time than was originally intended (American Psychiatric Association, 2013). A large amount of time is spent acquiring the substance, using the substance, and recovering from its effects. There is a battle with craving the substance, especially when exposed to environmental factors that remind the patient of the drug. Social impairment looks at the decline in ability to function

adequately at work, home, or school. Risky use is defined as using the substance in an unsafe environment or under unsafe circumstances, such as an underlying mental health condition that may be worsened by substance use. Finally, the pharmacological criteria include tolerance and withdrawal. Tolerance is defined as the need to increase the dose of the substance in order to achieve the desired effect and withdrawal is a series of symptoms experienced when levels of the drug decrease in the body. The DSM lists specific points within each of these categories in order to help classify the mild, moderate, or severe stage of the disorder. Often, those addicted to opioids will seek alternate methods of consumption, such as snorting or injection to amplify the effect of a single dose of the drug. This increased tolerance is a key contributor to opioid overdose, especially when combined with other drugs, such as benzodiazepines.

Another key factor in opioid addiction is the concept of withdrawal. When opioid use is suddenly terminated, receptor alterations still persist in the short-term. This leads to widespread effects that counter those induced by consumption of the drug. For sedating drugs, this can result in autonomic hyperactivity, and the presence of these withdrawal symptoms can force the patient to resume drug use in order to avoid the cessation consequences. With opioids in particular, the physical withdrawal symptoms can vary in severity but usually include myalgia, chills and vomiting. The psychological symptoms are equally if not more distressing, including depression, insomnia, and drug craving.

Mental illness in itself is also a crucial aspect of the opioid crisis. Patients with other mental health disorders are twice as likely to develop a substance use problem (Centre for Addiction and Mental Health, 2012). In fact, recent numbers estimate that up to 20% of individuals facing a mental health disorder also have a substance use disorder. Certain medical conditions can drive the substance use rate up to even 50 percent, as seen with schizophrenia. The Centre for Addiction and Mental Health of Canada reports that in Ontario for example, the burden of mental health and addictions is 1.5 times that of cancer and more than 7 times that of infectious disease. They define burden as the number of years lived with decreased function and the number of years lost to premature death. It also reported that in Ontario, 1 in 8 deaths of individuals aged 25 to 34 is due to opiate use. Psychiatric risk factors for opioid overuse include a feeling of relief immediately after drug consumption, as well as a diagnosis of a variety of conditions, such as anxiety, mood, and post-traumatic stress disorders.

Mental health services not only treat the problem of addictions itself, but also treat the many other mental health disorders that put patients at increased risk of developing a substance use problem. They serve as both a treatment and preventative measure in battling the opiate crisis. In Canada, mental health services remain inaccessible to many. Only 75 percent of children with a psychiatric condition access specialized mental health services (Waddell et al., 2005) and out of the 17% of Canadians aged over 15 that admitted of having a mental health condition, one third reported that their mental health needs were not being met fully (Pearson et al., 2013).

The interaction between substance use and other mental illness is clear. While the Minister of Health has committed to prioritizing mental health in her mandate, it is still unclear

whether substance use will receive sufficient funding and attention. Furthermore, while short-term solutions to the crisis have been proposed, the interaction of mental health and opioid use necessitates long-term and upstream problem solving.

THE NATIONAL OPIOID CRISIS AND HARM REDUCTION

Although there is no one standard definition, harm reduction is characterized by the intention to reduce individual and societal harm, without requiring abstinence or reduction in the addictive behaviour (Centre for Addiction and Mental Health, 2002). The term generally refers to the policies, programmes and practices aiming to primarily work to reduce the adverse health, social and economic consequences of psychoactive drug use without necessarily reducing or discontinuing usage (Harm Reduction International, 2016). There are five guiding principles of harm reduction: pragmatism, focus on harm, autonomy and respect, dignity and compassion, and flexibility and maximization of intervention options.

Since the 1960s, there has been a growing awareness that the adverse effects of illicit drugs could no longer simply be addressed at the individual level, but now required a broader societal response (James, 2007). Rates of illicit drug use increased throughout the 1960s and 1970s, despite the Canadian government having allotted high amounts of enforcement resources towards combating drug use (Cavalieri & Riley, 2012). The increased criminalization of drug use resulted in large costs to individuals and to society. In response to this, the first harm reduction programmes in Canada began in the early 1980s in Toronto as controlled drinking programs, closely followed by a syringe exchange programs in 1988 (James, 2007).

Today, harm reduction programs and policies exist and thrive across Canada and take many different shapes. Safe injection sites, methadone maintenance programs, crack pipe distribution, heroin prescription, and overdose prevention programs all represent direct interventions in improving health outcomes in psychoactive drug users. These programs are often accompanied by distributing information on testing and safety in relation to HIV, HCV, and AIDS. These programs reduce the incidence of HIV and hepatitis C in those who use IV drugs by reducing needle sharing and other unsafe practices (Gowing et al., 2011). These programs are administered and funded by both public health authorities (e.g. Insite in Vancouver), and non-governmental organizations (e.g. No Fixed Address Outreach Van in Whitehorse).

Safe injection sites are one of the most well-known examples of harm reduction. Insite, North America's first legal supervised injection site, opened in Vancouver in 2003. In January 2017, the provincial government of Ontario agreed to partner with the city of Toronto, as well as with the city of Ottawa, to fund safe injection sites (The Canadian Press, 2017). The three small sites planned in Toronto, as well as four sites in Montreal, two in Vancouver, two in Surrey and one in Victoria, have all submitted applications to Health Canada, with Ottawa's on the way.

Methadone maintenance treatment prevents opioid withdrawal and reduces or eliminates drug cravings. It was first developed in the 1960s and is another hallmark of harm reduction (Centre for Addiction and Mental Health, 2012). Buprenorphine/naloxone (Suboxone), another

treatment for opioid addiction, was approved for use in Canada in 2008. Both treatments are used in cities all across Canada. In cities where supervised injection sites do not yet exist, mobile distribution of needles and other drug use equipment do exist. Examples include The Outreach Van in Whitehorse, which engages in programs of needle exchange, safer crack kit distribution, and hygiene supplies. Programs and initiatives focusing on information, empowerment, and connecting individuals with appropriate resources are also common, and there is almost always significant overlap between these programs with the distribution of materials with the purposes of harm reduction.

While some residents and community stakeholders sometimes voice concern that safe injection sites have the potential to increase crime, evidence has consistently shown this not to be true (Heimer et al., 1998). In general, injection drug users have not been found to travel long distances to reach a safe injection site, and most live in the neighbourhood. In fact, injection drug users are more likely to use a safe injection site if they already live in the neighbourhood (Rockwell et al., 1999). When crime rates are compared between areas close to safe injection sites and areas further away, no significant difference in arrest rates over time has historically been found (Marx et al., 2000).

Harm reduction has been shown to effectively save lives. Fatal overdoses within a 500 metre range of InSite decreased by 35% after it opened, whereas only a decrease of 9% was seen in other areas of Vancouver without proximity (Marshall et al., 2011). New HIV infections amongst injection drug users in Vancouver dropped by almost 50% a year in part due to InSite's services, and patients who used their services.

THE NATIONAL OPIOID CRISIS AND STAKEHOLDERS

When addressing the opioid crisis, the patients at risk can be divided into three groups. The first group being patients who are already addicted to opioids and therefore at risk of overdose. The second group consisting of patients who have chronic pain and are being treated with opiates, but not yet addicted. And the final group being patients with chronic pain who are not yet being treated with opiates. Although there are individual risk factors for each group, all three can greatly benefit from improved access to chronic pain specialists and mental health services. The first group has the greatest need for immediate mental health assistance in tackling substance abuse. If their initial use of opiates was for chronic pain, they will also benefit from accessing a pain clinic. The second and third groups are in need of improved chronic pain management to prevent opiate use. As mental health also contributes to pain tolerance, these groups would also benefit from having access to more mental health services.

Chronic Pain

The Canadian Medical Association (CMA) has expressed deep concern about the harms caused by opioid use in our society and has issued a clear policy statement on their recommendations for addressing *Harms Associated with Opioid and Other Psychoactive Prescription Drugs* in Canada, noting the scale and severity of the issue (Canadian Medical

Association, 2015). The policy statement broadly recognizes that a multi-pronged, national, and comprehensive strategy is necessary, an important part of which includes the scaling-up of access to specialized treatment for pain. In particular, the CMA report noted that a significant contributing factor for increasing prescription of opioids by Canadian physicians is a"lack of supports and incentives for the treatment of complex cases, including availability and funding for treatment options for pain and addictions."

The CMA has endorsed a 2011 proposal for a National Pain Strategy by the Canadian Pain Coalition (CPC) and the Canadian Pain Society. A National Pain Strategy, they argue, must be headed by federal and provincial governments, allowing for a coordinated approach to pain at the national level. They propose four key target areas for better management of pain for Canadians: community awareness and education, access to best practice care, enhancing Canada's pain research capacity, and ongoing monitoring of timely access to care, patient experience, quality of life and level of function. However, a National Pain Strategy has yet to be developed and endorsed by the Canadian government.

The CPC proposed increased access to publicly-funded, evidence-based pharmaceutical and non-pharmaceutical interventions, and strongly supports basing such programming on best practices, including utilizing multidisciplinary teams, recognizing the continuum of pain, and emphasizing the role of the patient and family in their care. To date, there have been several barriers in accessing comprehensive pain management, including the insufficient availability of pain treatment programs, particularly in rural areas; as well as the cost, as visits to non-physician health professionals is typically paid through private-sector insurance or out-of-pocket, prohibiting many from accessing necessary treatment. In addition, the 2010 *Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain* states that referral to multidisciplinary pain programs is recommended for patients with long-term opioid use and under-managed pain, showing improved outcomes over standard primary care. However, access to and funding for these programs are lacking.

Many organizations are careful to address the "double-edged sword" aspect of opioid drugs, referring to their benefits and risks, or their medical use and non-medical use. The CPC in their *Position Statement on Opioid Analgesics: 2015 Update* recognizes that opioids serve an important role in pain management, stating we must ensure they are available to those who need them, while supporting practices that prevent the diversion and misuse of opioids (Canadian Pain Society, 2015). The Canadian Drug Policy Coalition shares this sentiment in their 2013 *Policy Brief: Opioid Overdose Prevention and Response in Canada*, recommending that implementing guidelines for opioid prescribing must not limit their access to those who need them for pain management, and must not lead to further discrimination against people who use drugs.

In the Canadian Centre on Substance Abuse (CCSA) landmark report: *First Do No Harm: Responding to Canada's Prescription Drug Crisis (2013)*, they too recognize the inherent challenge of prescription drugs that are both helpful and harmful, and the strong interplay between prescription drug use and misuse and mental health, addictions, concurrent disorders and pain, and that all these issues must be addressed to create an effective strategy. The Strategy

calls on the federal and provincial governments to be involved in many aspects of the five strategic themes of the plan: prevention, education, treatment, monitoring and surveillance, and enforcement. Namely, they propose the federal/provincial/territorial governments:

"Improve access and provide budgetary allocation to services and supports in all communities and settings (including rural and remote) along the full continuum of addiction, mental health and pain management services" [*Prevention Recommendation 12*] and

"Align current investments in the treatment sector that are working towards common aims." [*Treatment Recommendation 9*]

Further, the Strategy notes the critical nature of offering multidisciplinary, non-pharmacological, pharmacological, psychosocial and withdrawal management treatment options for chronic pain, mental health issues and other concurrent disorders.

The data showing the extent to which opioid use, mental illness and chronic pain overlap is not well established, but the connection is certainly recognized. The Centre for Addiction and Mental Health (CAMH), in their 2016 *Opioid Policy Framework*, makes recommendations that fall into three broad categories: scaling up of prevention, including improving prescribing practices and treatment for pain; improved treatment for addictions; and scaling up harm reduction strategies to address the opioid crisis (Centre for Addiction and Mental Health, 2016). Regarding pain treatment, the Framework concludes that increasing access to non-opioid, non-pharmacological and interdisciplinary pain management is of critical importance, and assert that a National Pain Strategy led by the federal and provincial governments would further support such efforts.

Many other organizations in Canada are creating a similar narrative: that the opioid crisis must be met with an interdisciplinary, multi-pronged strategy that emphasizes harm reduction, pain management and mental health supports. The Canadian Pharmacists Association (CPhA) note their role in improving access to overdose-related medications, and providing counselling for people using opioids or its derivatives (Canadian Pharmacists Association, 2016).

The College of Family Physicians of Canada (CFPC) works with provincial regulatory colleges to regulate and implement educational courses and initiatives to help physicians follow safer prescribing practices. However, the CFPC in November 2016 stated that they did not support making safe opioid prescribing courses mandatory, so as to avoid punishing physicians who don't comply (Weeks, 2016). CFPC has not made public policy statements on opioids, other than endorsing the Centre for Addiction and Mental Health's 2012 clinical practice guidelines on buprenorphine/naloxone for opioid dependence, which makes recommendations for safer opioid prescribing and improving access to opioid dependence (College of Family Physicians of Canada, 2012). The CFPC has an addiction medicine program committee and a chronic pain program committee, which represent family physicians who include these areas as part of their practice (College of Family Physicians of Canada, 2017; College of Family Physicians of

Canada, 2017). Despite this, it has not made public statements specifically related to chronic pain management or pain treatment in multidisciplinary clinics.

The Royal College of Physicians and Surgeons of Canada participated in the November 2016 opioids summit hosted by the federal government. The Royal College is working with the CFPC and CMA, and its plan on opioid prescribing practices focuses on "developing a statement of principles on safe opioid prescribing practices" and "creating an online resource for Fellows, including reference materials related to pain management and safer opioid prescribing practices, in consultation with relevant Royal College committees and experts across Canada" (Royal College of Physicians and Surgeons of Canada, 2017). The Royal College has not made any public statements or positions specifically related to chronic pain management, but the Royal College's forthcoming resource on opioid prescribing practices will include reference materials related to pain management, accessible to practitioners across specialties.

The Canadian Public Health Association (CPHA) provides public health information related to substance use and addictions.[2] In its summer 2016 digest, the CPHA published an article describing the severity of the fentanyl overdose crisis in Canada and advocating for a public health approach to harm reduction and avoiding opioid-related overdoses and deaths (Govindaraj, 2016). The CPHA has not published any policy statements, reports, or websites specifically on chronic pain management. According to a 2004 study published in the Canadian Journal of Public Health, a significant proportion of patients who report pain as present felt that needed health care was not received in 2000-2001, indicating significant gaps in pain management and care for chronic pain sufferers. In fact, the strongest health status predictor for unmet health care needs was found to be pain (Kasman & Badley, 2004).

Health Canada and the Public Health Agency of Canada (PHAC) issued a joint statement in 2015 expressing deep concern about the increase in opioid-related overdoses and deaths, specifically overdoses using fentanyl (Sharma & Taylor, 2015). Both were also major partners included in the federal government's summit on the opioid crisis in November 2016. During the summit, concerns were raised regarding why PHAC has not been more actively involved in addressing the opioids crisis. Canada's Chief Public Health Officer, Gregory Taylor, stated that further steps such as declaring a national public health emergency would only be warranted as a last resort if provinces needed additional federal assistance.

The argument for chronic pain centres may extend to that of a human rights issue. The *Declaration of Montreal*, established at the International Pain Summit in 2010 of the International Association for the Study of Pain (IASP), representing the position of 250 professional and legal organizations, affirms that access to pain management is a fundamental human right. The Declaration recognizes that globally, pain is under-managed thus leading to unnecessary suffering. The Summit cites inadequate access to treatment and inadequate national policies on pain management as some of the key contributing factors. Creating and preserving opportunities for people to access needed pain management without discrimination serves to uphold their rights under the *International Covenant on Economic, Social and Cultural Rights*

[2] Canadian Public Health Association: http://www.cpha.ca/en/programs/portals/substance.aspx

(ICESCR) (1966), which recognizes "the right of everyone to the highest attainable standard of physical and mental health" (Article 12); as well as the *UN Universal Declaration of Human Rights (1948)* (Article 5): "No one shall be subjected to torture or to cruel, inhuman or degrading treatment…"

Mental Health

The Canadian Mental Health Association (CMHA), citing a 2015 report by Statistics Canada, notes the link between chronic pain and poor psychological health. Chronic pain was shown to have both an effect on mental health by limiting daily activities, and an independent negative effect on flourishing mental health. An individual's mental health is said to be flourishing when they are emotionally well and functioning at a psychosocially high level (Gilmour, 2015). Of the 6 million Canadians reporting chronic pain in 2012, 69% reported flourishing mental health, as opposed to 79% of the general population, even after controlling for various social determinants.

It was the Mental Health Commission of Canada (MHCC) that first created a pan-Canadian mental health strategy, whose objectives spanned from 2007-2017. While the report has a strong focus urging for improved access to both community and acute care services which integrate mental health and substance use disorders or addictions, the Commission acknowledges that progress towards the goals of the strategy has been slow, underscored by their recently launched Strategic Plan 2017-2022.

Similarly, the recent 2016 *Interim Report and Recommendations on the Opioid Crisis in Canada* by the Standing Committee on Health recognized that mental health has a complex relationship with the opioid crisis. Witnesses purportedly acknowledged "the importance of improving access to evidence-based treatment for individuals who misuse drugs and to mental health and pain management services more broadly." The Committee issued two direct recommendations for the government surrounding mental health supports:

- Recommendation 29: That the Government of Canada work with the provinces and territories to ensure treatment for active drug users is available to address the underlying mental health issues that may contribute to or exacerbate drug addiction.
- Recommendation 30: That the Government of Canada work with the provinces and territories to develop a national strategy to provide better training and mental health services for front-line workers and first responders.

The Canadian Psychiatric Association (CPA) and the College of Family Physicians of Canada (CFPC) issued a joint position paper on collaborative mental health care in Canada, which makes reference to integrating mental health and addictions services in primary care, but does not specifically reference the link between mental health and use of substances such as opioids (Kates et al., 2011). The Royal College, CFPC, CPA, CMA, and Mental Health Commission's 2014 publication on mental health core competencies for physicians makes reference to addictions, recognising its close relationship with mental health conditions.

However, no specific reference is made to the use of opioid drugs in relationship with mental illness (Royal College of Physicians and Surgeons of Canada, 2014)..

No information on specifically relating mental health to opioid or narcotic drug use was found in PHAC web pages and publications. PHAC published an analysis of mental health in Canada in 2006, including a section on substance use [3] and a national report on mental illnesses in 2002 [4], but no more recent materials are available. The 2006 report notes that "The relationship between mental illnesses and problematic substance use is complex. For some people, mental health problems can be risk factors for problematic substance use; for others, problematic substance use contributes to the development of mental health problems. Substance use, which is neither abuse nor dependence, may also interfere with the recovery of some people with mental illness and is therefore an important consideration in treatment" (Public Health Agency of Canada, 2011).

THE NATIONAL OPIOID CRISIS AND THE POLITICAL PARTIES

All of the major political parties except for the Conservatives have expressed written support for safe consumption sites such as Insite (AIDSLAW, 2015).

Bloc Quebecois

No official written policy was found on the official party website. The Bloc Quebecois appears to be pro-harm reduction strategies and has also argued for safe injection sites in Montreal when Bill C-2 was in effect (Hughes, 2015; Elliot, 2015). Notably, as all parties in Quebec agreed for a safe injection site in Montreal despite disagreement from the federal government in power at the time (Conservative government under Stephen Harper), the Bloc Quebecois argued that this was another reason why Quebec should not stay as a province, as it had consensus within the province that could not be taken further because of the federal government.

There is a report from 2002 regarding the Bloc Quebecois' position on the "non-medical use of drugs", referring mostly to the issue of harm reduction and cannabis (The Bloc Quebecois, 2002). In this report, the Bloc states it is pro-harm reduction strategies and against criminal charges for cannabis possession. It states that it is against the Conservative government (in power at that time) anti-drug strategy. Instead, the Bloc Quebecois would like to see increased funds for public awareness and education programs, treatment and development of awareness of marginalized clientele, and rehabilitation programs. These areas fall under provincial jurisdiction and therefore the Bloc Quebecois argued that the federal government has the least expertise in this subject.

Conservative Party of Canada

No official written policy was found on the official party website. An official Conservative Party news release was made in response to proposed changes that would make prescription-grade heroin more available for people with addictions, whilst also increasing

restrictions to access 500mg acetaminophen (Conservative Party of Canada, 2016). This release argued that increasing access restriction to acetaminophen could mean that chronic pain patients turn to opioids, and that increasing access to medical-grade heroin sends a 'troubling mixed message' to Canadians.

Historically, the Conservative Party of Canada has been against any increase in accessibility to substances and clean substance-use equipment, even if for harm reduction reasons. The Conservative Party of Canada's general policies have aligned more with increasing punishment for drug offences, and measures to prevent illegal fentanyl and other drugs from entering Canada from abroad by increasing border security. This has been summed up as a 'harm elimination' policy. Its strategy has been to remove the root causes of addiction by supporting policies that reduce/stop drug imports into Canada and supporting serious punishments for drug offences. It supports barring/reducing access to drugs and increasing the negative consequences to using drugs, in order to prevent addiction and overdose. The Conservative Party has generally been against increasing harm-reduction options, often questioning the evidence behind and efficacy of 'safe'-injection sites (O'Neil, 2016). The Conservative party is against government regulation of substances (such as the legalization of marijuana and legalization of medical-grade heroin). Notably, the federal Conservative Party (when in power) passed Bill C-2 which significantly increased the criteria needed to open safe injection sites (Smith, 2015). Also note that the current leader of the Conservative Party, Rona Ambrose, is the former federal Health Minister.

Green Party of Canada

The Green Party of Canada has a written policy on its official party website with its stances on drug policy in general (Green Party of Canada, *year unknown*). This is copied as follows:

'Green Party MPs will:

- Legalize marijuana by removing marijuana from the drug schedule;
- Create a regulatory framework for the safe production of marijuana by small, independent growers;
- Develop a taxation rate for marijuana similar to that of tobacco;
- Establish the sale of marijuana to adults for medicinal or personal use through licensed distribution outlets;
- Educate the public about the health threats of marijuana, tobacco, and other drug use;
- Launch a public consultation on the decriminalization of illicit drugs, considering the current high costs of the law enforcement effort;
- Provide increased funding to safe injection sites, treatment facilities, and addict rehabilitation.'

Liberal Party of Canada

The Liberal Party of Canada is currently in power under Prime Minister Justin Trudeau. The current federal Health Minister is Dr. Jane Philpott. The Liberal Party has taken several steps to incorporate expert advice from scientists and health professionals throughout the opioid crisis. This culminated in an opioid crisis conference, and a joint statement describing the government's commitment to addressing the crisis (Philpott and Hoskins, 2016).

The Liberal Party has previously stated its support for harm reduction strategies such as safe consumptions sites like Vancouver's Insite. It has also stated its support for 'harm reduction' as one of the key pillars of the government's anti-drug strategy, as well as for making alternative non-medication pain management strategies more available for all Canadians. The Liberals have previously called for a Health Canada assessment of resources for pain management resources in rural and remote areas, particularly First Nations communities. Furthermore, the federal Liberal party has called for Bill C-2 to be repealed, and to stop production of generic OxyContin tablets (initiated by the Conservative party).

Currently, Health Minister Philpott has sponsored Bill C-37 which would amend the Controlled Drugs and Substances Act. The passing of Bill C-37 would simplify the process of opening safe injection sites. In addition, the Customs act will be amended to allow Customs and Border Services Agency to inspect mail packages weighing less than 30 grams. Furthermore, pill presses and encapsulators will require stricter proof of approval before import is allowed. The Health Minister has called for this bill to be passed in an expedient manner to prevent further opioid-related deaths.

The current Liberal Government is also creating a new drug policy strategy called the Canadian Drugs and Substances Strategy, for which the pillars are Prevention, Treatment, Harm Reduction, and Enforcement all supported by a Strong Evidence Base. The government has also now implemented a task force working on issues related to the opioid crisis. The government has not declared the opioid crisis a national emergency.

New Democratic Party of Canada

The NDP has long been an advocate of harm-reduction strategy. Current NDP Health Critic is Don Davies (Vancouver-Kingsway). The NDP has made an official statement on the opioid crisis (Davies, 2016). In this statement, the NDP calls for the opioid crisis to be declared a national emergency. It also calls on the current Liberal government to create a national multi-sectoral taskforce on opioid overdose and to repeal or amend Bill C-2 to remove barriers to opening new harm reduction facilities. Prior to the Opioid Crisis Summit, the NDP health critic called for an emergency study on the opioid crisis to be conducted by the House of Commons Standing Committee on Health. The results of this study were included in the recommendations made at the end of the Summit.

Recently, the NDP has attempted to bring Bill C-37 forward faster by seeking unanimous consent for a motion to send the bill to Senate (Kupfer, 2016). However, this motion failed. The NDP has also stated that deeming the opioid crisis a national emergency would also allow

quicker passage of Bill C-37, thus preventing further deaths from occurring during the time it takes for the bill to be passed.

THE NATIONAL OPIOID CRISIS AND THE FEDERAL GOVERNMENT

Despite evidence that opioid drug use in Canada has reached crisis proportions, the federal government has to date been slow to act, taking no action to push for improved prescribing practices on opioid drugs (unchanged since 2010), nor significantly improving access to addiction treatment or harm reduction programs for users. Despite a Supreme Court ruling in 2011 (*Canada (Attorney General) v. PHS Community Services Society*) highlighting the importance of safe consumption sites in reducing the rate of opioid-related overdoses and deaths (Canada (Attorney General) v. PHS Community Services Society, 2011), the former Conservative government nevertheless passed Bill C-2 (*Respect for Communities Act*), which significantly increased the barriers towards establishing and renewing the licenses for these programs. Under Bill C-2, organizations that wanted to establish or renew the license of a supervised consumption site was required to provide 26 items of evidence to demonstrate that the program would bring benefits and would not be a risk to community safety before their application could even be reviewed by the Minister of Health. Many organizations have argued that these requirements were overtly onerous and were too much of a barrier towards establishing these much-needed programs at the rate needed to combat the opioid crisis (Canadian Nurses Association, 2015).

The Liberals, since being elected as a majority government in 2015 under Prime Minister Justin Trudeau, have taken some steps towards reversing the previous federal stance on opioid drug use. In December 2016, Federal Minister of Health Jane Philpott introduced Bill C-37, which reduced the barriers needed to establish and renew safe consumption sites (Bill C-37, 2015). The proposed Bill has reached first reading in the House of Parliament as of December 12, 2016. The federal government has also released a number of reports and statements addressing the opioid crisis. Two marquee documents are the Standing Committee on Health *Interim Report and Recommendations on the Opioid Crisis in Canada* and the *Joint Statement of Action to Address the Opioid Crisis* released by the National Conference & Summit on Opioids.

HESA

The Standing Committee on Health (HESA) is a multi-partisan committee of the federal Parliament that deals specifically with issues on health policy. In November of 2016, HESA released the *Interim Report and Recommendations on the Opioid Crisis in Canada* and the *Joint Statement of Action*, which put forward 38 specific recommendations on how the federal government should begin to address the opioid crisis in Canada. These recommendations fall under four broad categories: 1) Harm reduction, 2) Prevention, 3) Treatment, and 4) National leadership/strategy. Importantly, the HESA report recommended that the federal government declare a national public health emergency and create a multi-sectoral taskforce that would take the lead in addressing the opioid crisis. The report emphasized better coordination between the

federal government and its provincial counterparts in taking action, especially in creating a pan-Canadian surveillance system for opioid overdoses. It specifically recommended lowering the barriers to establishing supervised consumption sites and for the federal government to work with provincial and territorial governments to create a network of harm reduction facilities, and called for an expansion in the availability of naloxone, especially in First Nations, Inuit and Métis communities. The report highlighted a need for new guidelines for opioid prescription to be created and for prescription of opioids by physicians and pharmacists be reduced and monitored through a real-time electronic prescription monitoring system. Finally, HESA also recommended that the federal government expand funding and access to addiction treatment and detoxification programs and called for greater access to Suboxone and other effective medications to treat opioid addiction not currently widely available in all jurisdictions in Canada (Casey, 2016).

Joint Statement

The *Joint Statement of Action to Address the Opioid Crisis* was the result of a national Conference & Summit on Opioids that took place on November 18, 2016. This conference brought together a number of key stakeholders at the federal and provincial/territorial levels that each took on specific commitments to help address the opioid crisis. Forty-one organizations from across Canada took on such commitments, including Health Canada, the Health Ministries of several provinces, national and provincial medical associations and colleges and various organizations with a special interest in chronic pain.

Health Canada, representing the federal government, has made the most extensive set of commitments. It committed to providing leadership to the provinces, territories and other stakeholders to implement an Opioid Action Plan. In particular, the agency committed to increasing access to naloxone, buprenorphine, and other harm reduction tools, especially in First Nations communities.

Under the Opioid Action Plan, Canada would see increased public awareness, better prescription practices, reduced ability to access unnecessary opioids, better treatment options, and more research on opioid misuse. Important aspects of this plan includes public awareness campaigns on the dangers of opioid addiction and overdose, a coordinated monitoring and inspection plan for the prescription and dispensing of medically-indicated opioid medications and updating prescription and handling guidelines for opioid medications. Improvements on treatment of opioid addictions and increased access to Suboxone and diacetylmorphine through Health Canada's Special Access Program were also key components of the plan.

The Health Ministries of the Northwest Territories and each province with the exception of Quebec and Alberta have made commitments to: 1) Create or expand existing prescription monitoring networks, 2) Increase access to naloxone, and 3) Implement public awareness campaigns on opioid use.

The Associations of the Faculties of Medicine, Dentistry and Pharmacy of Canada, along with the Canadian Association of Schools of Nursing, have each committed to ensuring that the

respective curriculums of each professional schools across Canada reflect the latest evidence-based recommendations on opioid use and to education medical, dental, pharmacy and nursing students on the potential harms associated with opioid use. Further, the national and provincial associations of medicine, pharmacy and nursing have each agreed to provide updated guidelines on how practitioners should prescribe, administer and monitor opioid medication use (Philpott & Hoskins, 2016).

Existing policy on chronic pain management

Although the HESA Interim Report on the opioid crisis acknowledges that misuse of prescription opioids first emerged as a significant problem in Canada due to their widespread use for chronic pain (Casey, 2016), it puts forward no recommendations that specifically address the need for better treatment of chronic pain. The Joint Statement places greater emphasis on the role of chronic pain treatment. The Ontario Ministry of Health and Long-Term Care specifically committed to investing $17 million annually in multi-disciplinary care teams, including 17 chronic pain clinics (Philpott & Hoskins, 2016). However, although various stakeholders committed to improving education on pain management, there were no other specific commitments on created better chronic pain management programs.

Of existing policy on chronic pain management, the *First do No Harm: Responding to Canada's Prescription Drug Crisis* reported released by the National Advisory Council on Prescription Drug Misuse in 2013 is the first to put forward a specific recommendation for an interdisciplinary approach to pain management that involves both pharmacological and non-pharmacological modalities, with an emphasis on using non-medical approaches where possible. This report further acknowledges the significant costs of chronic pain, which it notes to be the leading cause of healthcare costs and lost income in Canada. It also notes that 1 in 5 Canadians live with chronic pain and that chronic pain is associated with the worst quality of life of any chronic medical condition and is associated with a doubled risk of suicide as compared to the general population (Ulan *et al*., 2013).

There have been several calls for a national strategy on chronic pain in the past six years. In 2010, the Canadian Pain Coalition released a set of recommendations on chronic pain treatment. Chief amongst these recommendations is official recognition of pain as a chronic disease and the implementation of a national Canadian Pain Strategy that would see the federal government take a leadership role in working with the provinces and territories to reshape chronic pain management in Canada. Within this pain strategy, the federal government would support the creation of community networks of multidisciplinary pain clinics and ensure that education on effective pain management is included in the curricula of health professionals. The same report points out that access to multidisciplinary pain treatment programs is limited and plagued by long waiting times, sometimes up to five years in duration. Access to these programs is also unevenly geographically distributed, with patients in BC, Alberta and Atlantic Canada having easier access than other patients in Canada (Canadian Pain Coalition, 2010).

A separate call for a Canadian Pain Strategy was advanced by the Canadian Pain Society in 2011. The CPS paper points out that public funding for multidisciplinary pain treatment programs remains spotty, with no such programs being completely publically-funded in Ontario. An interdisciplinary approach to chronic pain management is important because of the significant morbidity and disability associated with chronic pain. Patients living with chronic pain often have unmet mental health needs and frequently need support to return to full function at home and work (Lynch, 2011).

Unfortunately, uptake of these recommendations and concrete improvements in chronic pain management has been slow. The current guidelines on treatment of non-cancer chronic pain (*Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain*) remains focused on the use of opioids for pain management, and, further, has not been updated with the latest evidenced-based recommendations since 2010 (National Opioid Use Guideline Group, 2010).

Existing policy on addiction and mental health

There is a growing recognition amongst medical professionals and policy-makers on the role of mental illness as both an upstream factor and a downstream consequence of opioid drug misuse. As an upstream issue, it is recognized that mental illness is a risk factor for opioid addiction. A combination of poor mental health, a lack of supports and inadequate control of pain creates a potent environment for addiction to develop.

Much of the federal government's plan on the opioid crisis has addressed mental health through the lens of supported better access to treatment for opioid dependency. The HESA report puts forward two specific recommendations on mental health. The first recommendation is that mental health care be available to active drug users while the second recommendation calls on the federal government to take a leading role in ensuring proper training on mental health is provided to first responders (Casey, 2016). While these recommendations are commendable, they do not directly address upstream mental health factors that contribute to the growing opioid crisis. In the Joint Statement, while many stakeholders made commitments to improve quality and access to addiction treatment programs, none have made a commitment to improve mental health care for those at risk of addiction (Philpott & Hoskins, 2016).

Mental health care should be an integral aspect of any comprehensive treatment program for chronic pain. The Canadian Medical Association policy on opioid drug misuse recommends that therapy and increased social supports be made available for patients with chronic pain to help address trauma and social pain (Canadian Medical Association, 2015). The *First Do No Harm* report further recommends that risk-reduction programs be created for individuals using opioids to prevent the development of dependence and addiction. Such a program must include adequate mental health support. The same report takes care to include mental health into each aspect of its recommendations on prevention, education and treatment, clearly stating that mental health care is integral to not only the treatment of addiction but to preventing the development of addiction in the first place (Ulan *et al*., 2013).

Of note, the Minister of Health's emphasis on mental health in this coming year demonstrates her interest in the topic responsiveness to the issues. In January, the Minister of Health announced a $5 billion investment over 10 years to further research mental health and, in particular, its ties to addiction. Thus, much of what we as the CFMS were asking for was fulfilled at this time and we will continue to support this government initiative. Continuing investment over the long-term is an important approach to developing long-term solutions to the problem.

Existing policy on harm reduction

The Canadian National Drug Strategy was a five-year strategy addressing the concerns relating to drug abuse in Canada launched in 1987. The key pillars of the strategy included: education and prevention, treatment and rehabilitation, harm reduction, and enforcement and control (Collin, 2006a; Zilkowsky, 2001). The federal government proceeded to renew funding in 1992, and merged it with the National Strategy to Reduce Impaired Driving, creating the Canadian Drug Strategy (CDS) (Collin, 2006a; Cavalieri & Riley, 2012). The objective continued to be the reduction of the harmful effects of substance abuse by addressing the supply and demand for both licit and illicit substances. The federal government renewed its commitment to the principles of the CDS in 1998 with a focus on the same four pillars, however the funding was substantially reduced. In May 2003, the Canadian government announced additional funding for the CDS for another five years following calls for a comprehensive renewed drug strategy (Collin, 2006a; Cavalieri & Riley, 2012). The four pillars remained prevention, treatment, harm reduction and enforcement, but it was broadened to include four new areas: leadership; research and monitoring; partnerships and intervention; and modernized legislation and policy.

Despite harm reduction being one of the four pillars of the strategy, there was an overall lack of governmental support. Harm reduction programmes and services were forced to prove their worth, and funding continued to be difficult to receive (Zilkowsky, 2001). Importantly, little was done to address underlying issues that support substance dependency including: poverty, trauma, mental illness, lack of compassion, inequity, and disrespect (Zilkowsky, 2001).

In 2008, the federal government under the Conservatives announced a $64 million National Anti-Drug Strategy, which stripped all mention of harm reduction, and more specifically any mention of needle exchange programs (Cavalieri & Riley, 2012). An end was also placed to the previous Liberal government's plan to decriminalize possession of small quantities of marijuana. Drug issues were removed from the control of the Ministry of Health and left under the jurisdiction of the Ministry of Justice. The beliefs behind the Anti-Drug Strategy were clear – drugs were a principal cause of crime and the best approaches to counter this was incarceration, long prison sentences, property seizure and a 'just-say-no' approach to education. Under the Anti-Drug Strategy, 70% of funding was allocated to law enforcement, compared to 4% for prevention, 17% for treatment and just 2% to harm reduction (Cavalieri & Riley, 2012).

Bills C-2 & C-37

In 2015, the House of Commons passed Bill C-2 (*Respect for Communities Act*), which lays out a series of new regulations that a community organization must meet in order to obtain or renew the license for a supervised consumption site (Government of Canada, 2015). This greatly complicated the process by which existing supervised consumption sites had to apply for exceptions to operate from the Controlled Drugs and Substances Act. Under Bill C-2, any facility that wished to run a supervised consumption site must first meet a list of 26 requirements including: a letter from the head of the local police force, a report on consultations with a 'broad range of community groups', and background checks for those working at the facility (Woo, 2015).

In December 2016, Minister Philpott announced a series of legislative changes, which would speed up the process for opening harm reduction sites (Zimonjic & Kupfer, 2016). The government indicated that the existing National Anti-Drug Strategy would be replaced with a more balanced approach – the Canadian Drugs and Substances Strategy, which would have harm reduction as one of its core pillars. The most significant of these changes is the tabling of Bill C-37 (*An Act to amend the Controlled Drugs and Substance Act and to make related amendments to other Acts*). Under Bill C-37, community service providers would be required to meet just five requirements as opposed to the 26 previously outlined under Bill C-2. Page 43 of the Act details the five criteria that now needed to be met in order to establish a safe consumption site. An application for a safe consumption site (i.e. an exemption under the Controlled Drugs and Substances Act) must include evidence of intended public health benefits of the site, and information related to:

(a) The impact of the site on crime rates,
(b) The local conditions indicating a need for the site,
(c) The regulatory structure in place to support the site,
(d) The resources available to support the maintenance of the site, and
(e) Expressions of community support or opposition.

A complete list of the criteria are available on page 22 of Bill C-37.

These criteria are in place primarily as a result of the Supreme Court ruling in *Canada (Attorney General) v. PHS Community Services Society*, which states in section 153 that "'The factors considered in making the decision on an exemption must include evidence, if any, on the impact of such a facility on crime rates, the local conditions indicating a need for such a supervised injection site, the regulatory structure in place to support the facility, the resources available to support its maintenance, and expressions of community support or opposition." These criteria are therefore the minimal acceptable criteria under the law.

Despite the Supreme Court ruling, it is important to note that evidence has consistently shown that safe consumption sites do not increase crime (Heimer et al., 1998). In general, injection drug users have not been found to travel long distances to reach a safe injection site, and most live in the neighbourhood. In fact, injection drug users are more likely to use a safe

injection site if they already live in the neighbourhood (Rockwell et al., 1999). When crime rates are compared between areas close to safe injection sites and areas further away, no significant difference in arrest rates over time has been found (Marx et al., 2000).

In addition to this amendment to the Controlled Drugs and Substances Act, Bill C-37 makes a number of other changes to the Act, including prohibiting unregistered importation of pill presses, and removes the exception on border officers to only open mail weighing more than 30 grams (now officers can open international mail of any weight if they have reasonable grounds to suspect the item may contain prohibited, controlled or regulated goods). Furthermore, the Bill proposes amendments that make it a crime to possess or transport anything intended to be used to produce controlled substances and support faster and safer disposal of seized chemicals.

THE NATIONAL OPIOID CRISIS AND THE CANADIAN FEDERATION OF MEDICAL STUDENTS

Although we may not yet be prescribers, we are not removed from the topic of the National Opioid Crisis. As students, we have come into contact with many of those suffering from chronic pain and substance abuse. We have been the ones who answer the call when yet another victim is brought in with an opiate overdose. We have been the ones who are struggling to manage a patient's pain when the wait list for a chronic pain specialist is too long. We have been the ones trying to find mental health assistance for patients struggling with a substance abuse problem. We are aware that there is much work currently being done to combat this horrific crisis, but we also recognize that it is an ongoing process that will benefit greatly from tackling the upstream causes including pain management and mental health. As medical students, we are also sensitive to the role physicians have played in the development of the crisis. However, this gives us the opportunity, particularly as future practitioners, to reform practice and be part of developing a solution.

In addressing the national opioid crisis, the Canadian Federation of Medical Students calls on the Government of Canada to

3. **Prioritize increased access to multidisciplinary chronic pain centres by supporting provincial/territorial efforts to establish and expand these treatment programs.**
4. **Increase investment in research and funding to better understand the interactions between mental illness and opioid misuse**

The Canadian Federation of Medical Students also supports the passing of Bill C-37: An Act to amend the Controlled Drugs and Substances Act and to make related amendments to other Acts.

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Appendix: A Province-by-Province Breakdown

Health care in Canada, is, in essence, provincial. The Canada Health Transfer provides funds for each independent provincial system. Each province in the country has experienced the crisis differently and has different resources available for developing a solution. Before meeting with any Member of Parliament, it is important to understand the local context and advocate for practical, regional solutions.

Alberta

The Alberta government's opioid crisis response is focused on four key areas namely, collecting and publishing data, expanding access to opioid replacement therapy, funding community agencies in establishing supervised consumption services and improving prescription drug monitoring in partnership with the College of Physicians & Surgeons of Alberta [1]. From 2012 to 2015, opioid prescriptions in Alberta increased by 100 000, including thousands over the Canadian recommended maximum dose of 200 mg [2]. The College of Physicians & Surgeons consulted from October through December 2016 on a set of new draft opioid prescribing practices [3]. However, chronic pain patient advocacy groups have cited concerns that new more restrictive regulations could decrease access to pain treatment [2]. In Alberta, there are nine clinics for opioid dependency treatment and the government is expanding treatment options, including a $3 million grant in 2016 [1]. The Alberta minister of health has stated the government's plan to expand opioid replacement therapy as quickly as possible [4, 5].

Chronic pain

In some regions, Primary Care Networks (PCNs) have standardized chronic pain treatment with primary care pain clinics [6]. For instance, the Chronic Pain Management Program of the Calgary Foothills Primary Care Network offers therapy focused on self-management techniques, group sessions, and access to multidisciplinary health professionals [7]. Thus, there has been some success in integrated pain treatment in Calgary, but this has not extended widely to other urban areas or to rural regions of Alberta [6]. The University of Alberta is home to a multidisciplinary pain centre, along with two other public funded chronic pain treatment centres in Edmonton, whose catchment area covers Northern Alberta, portions of Northern British Columbia and Saskatchewan and the Western Arctic. The average wait time in February 2012 was 23 to 38 months [8]. Gaps and barriers to consistent pain management, cited by the Alberta Pain Strategy 2015 include poor access to chronic pain management in rural and parts of urban Alberta among others.

The strategy recommends an integrated province-wide strategy for chronic pain. It also lists specific recommendations for increased access for primary care providers to access pain specialists and improved access to addiction services, as well as improved pain education programs and mentorship throughout clinicians' careers [6].

Mental health

Alberta's 2015 Mental Health Review was accepted by the government with a commitment to immediate action on several recommendations. The recommendations included expanding access to addiction treatment, including three new detox beds for children and youth in Calgary and new detox beds for adults in Lethbridge and Red Deer. Working with First Nations, Metis, and Inuit communities on an opiate addiction plan was also included in the review.

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See also:
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https://painsocietyofalberta.org/

British Columbia

British Columbia has seen climbing rates of illicit drug overdose deaths since 2007, with 755 illicit drug overdose deaths in 2016 including over 600 in which fentanyl was detected [1]. The opioid overdose crisis was declared a Public Health Emergency by the provincial health officer on April 4th, 2016. In February 2016, the Drug Overdose and Alert Partnership at the BC Centre for Disease Control released an opioid overdose response strategy which outlined four immediate recommendations for action [2]:

- Increasing access to naloxone through the BC Take Home Naloxone Program
- Change policy to improve access and coverage to naloxone as a non-prescription medication
- Improve overdose prevention through increasing awareness of best practice for prescribing, providing training for trauma-informed discussion of substance use, expanding access to supervised consumption site, and expanding access to support services including but not limited to substitution therapy
- Expand monitoring and utilization of overdose data

Progress towards these goals was reviewed in October 2016, at which time the Take Home Naloxone program had been expanded to 328 locations, including hospital emergency departments, community-based services, and First Nations communities. Naloxone was removed from the prescription drugs list and can now be bought from behind the counter at pharmacies [3]. In addition, the College of Physicians and Surgeons of BC released new professional standards and guidelines in June 2016 for drugs that may be misused or diverted [4].

The City of Vancouver has two supervised consumption sites, open since 2002 and 2003 respectively. Vancouver Coastal Health has opened five additional overdose prevention sites as well as a Mobile Medical Unit that functions as a pop-up emergency department [5]. Per capita rates of drug overdoses in other health authorities in the province are just as high and harm reduction policies and services are far less developed. In response to the overdose crisis, additional supervised consumption sites have been proposed in Victoria, Surrey, Kelowna, and Kamloops, as well as two new permanent sites in downtown Vancouver [6].

Chronic pain

British Columbia has 20 interdisciplinary community- or hospital-based chronic pain clinics [7]. Pain BC is the provincial non-profit organization that advocates for best policies, services, and empowerment for people living with chronic pain in BC. The College of Physicians and Surgeons of BC has endorsed the Center for Disease Control and Prevention Guideline for Prescribing Opioids for Chronic Pain released in March 2016 [4].

Mental health

In 2010, the BC Ministries of Health and of Child and Family Development released a 10 year strategic plan for mental health and substance use, *Healthy Minds, Healthy People,* which

aims to "improve the quality and accessibility of services for people with mental health and substance use problems" [8]. One of the specific milestones targets the integration of primary care with mental health and substance use services, and there is emphasis on reducing harms associated with substance use as well as stigma and discrimination. More recently, Vancouver Coastal Health published a guideline for clinical management of opioid addiction for navigating the spectrum of existing services, the first line recommendation being agonist treatment with combination buprenorphine/naloxone [9]. The availability and accessibility of opioid addiction services varies greatly between health authorities across the province.

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Manitoba

As of November, Manitoba had confirmed at least 24 deaths from opioid overdose in 2016, including 9 in which fentanyl as a contributing factor. In response to the opioid crisis and following the November National Opioid Summit, the Manitoba government committed to four

actions: improving data collection, expanding the provincial naloxone distribution program, improving drug monitoring, and providing education for service providers and parents [1].

The capacity to monitor prescription drugs, including opioids, was improved in 2012 with changes to the *Prescription Drugs Cost Assistance Act*. These changes included establishing a new category of "monitored drugs". Manitoba Health also has an existing prescription-monitoring program that conducts monthly reviews of opioid prescribing patterns using pharmacy-level claims data. This audit-based system provides feedback to the prescriber when prescribing patterns deviate from best practices. An additional level of monitoring occurs at point of sale when pharmacists enter prescriptions into the Drug Prescriptions Information Network, a system capable of registering an alert to reject the claim based on the patient's drug history or potential adverse effects [2].

Chronic pain

Manitoba has two interdisciplinary pain clinics, both located in Winnipeg [3].

Mental health

In Manitoba, the average wait time for access to inpatient provincially-funded drug treatment facilities is 66.8 days [4]. According to the Addictions Foundation of Manitoba, there are 427 people on the waitlist for residential treatment programs 120 people waiting for opioid replacement therapy [4]. Despite increasing numbers of deaths due to fentanyl overdoses and growing demand for addictions treatment services, there has been no increase in funding to the addictions system in the last year.

In 2008, Manitoba announced a five-point strategic plan to improve the network of addictions treatment services in the province. The goals outlined in this plan were: improving coordination of services, streamlining assessment and service navigation, increasing both residential and community-based treatment, and developing provincial addictions research. Neither a timeline nor evaluation plan was included with the release of the strategic plan [5]. In 2011, however, the province put out a six-point five-year strategic plan to direct improvement in mental health and well-being [6]. The plan does not make specific recommendations on the integration of mental health and addiction services but does acknowledge the intersection.

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New Brunswick

In 2015, New Brunswick reported seven opioid-caused deaths, and ten cases involving opioids and other substances [1]. New Brunswick launched its prescription monitoring program in 2014, which includes narcotics, and benzodiazepine-like agents, and monitors prescriptions on a retroactive basis. Registered patients are limited to one prescriber and one pharmacy. Pharmacists can register a 'refusal to fill' for prescriptions in the online system, to help identify illegitimate prescriptions. The system also includes annual quantity limits to the drugs covered, so if a beneficiary reaches the quantity limit, a prescriber must call the system to override it [2].

Chronic pain

New Brunswick has a tertiary interdisciplinary pain management clinic in Moncton, an interdisciplinary interventional pain clinic in Moncton, a multidisciplinary pain clinic in Campbellton, and a pain clinic in Dieppe, which does not manage methadone or addictions [3]. The Action Atlantic patient advocacy group partners with the Chronic Pain Association of Canada to advocate for improved access to chronic pain treatment [4], and the Atlantic Mentorship Network links primary health care providers to mentors who are experts in chronic pain and addiction, in order to improve provider education on safe opioid prescribing and other aspects of pain management [5].

Mental health

New Brunswick has an existing action plan for mental health for 2011-2018, which aims to restructure the addiction and mental health treatment system, focusing on a multifaceted recovery approach. In 2005, mental health and addiction services in the province were integrated under regional health authorities. In 2013, addiction services were integrated into a client information system, improving continuity of care between providers [6]. Following the recent breakdown of multilateral Health Accord talks, the New Brunswick government negotiated a bilateral agreement with the federal government, which includes funding for home care and mental health. The agreement includes $104.3 million in support of mental health initiatives, particularly for children and youth [7].

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Newfoundland and Labrador

There were 18 opioid-related fatal drug overdoses in Newfoundland in 2015, an increase from previous years [1]. In response to the growing concern, naloxone kits were distributed to community health centres and public health offices in Newfoundland in the second half of 2016 [2]. The province also employs tamper-resistant prescription drug pads with features that decrease the likelihood of duplication or editing [3]. However, the tamper resistant prescription pad program is not combined with a program that would allow for opioid prescription monitoring [4].

Chronic pain

Pain centres in Newfoundland and availability of different types of pain management. There are two secondary pain clinics in Newfoundland and one tertiary interventional pain management centre. Two of the three pain clinics are based in St. John's with the other in nearby Mount Pearl, and none will see patients for methadone or marijuana prescriptions [5]. CSPNL guideline on the use of controlled substances for the treatment of pain emphasizes that pain management be based on the best evidence for pharmacologic and non-pharmacologic modalities and not on fear of investigation or sanction by regulatory bodies. The document recognizes the important role of controlled substances in pain management and outlines steps to ensure appropriate use including proper evaluation, written treatment plan, monitoring in high risk patients, periodic review, and accurate recording of these steps [6].

Mental health

The College of Physicians and Surgeons of Newfoundland and Labrador (CPSNL) Methadone Maintenance Therapy (MMT) guidelines recommend that physicians periodically screen and assess their MMT patients for mood and anxiety disorders and collaborate with that patient's primary care team for appropriate management [7]. CPSNL also recommends decreasing long term benzodiazepine use in MMT patients, especially if they show signs of misuse.

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Northwest Territories

No information found.

Nova Scotia

Mental health

In April 2012, the government of Nova Scotia released its five-year mental health and addictions strategy, *Together We Can: The Plan to Improve Mental Health and Addictions Care for Nova Scotians*. In 2012/13, $5.2 million dollars from the provincial budget was invested into implementing this strategy in its first year. Of the five key priority areas included in the five-year plan, four included at least one key action that explicitly addresses mental health in the context of addictions. These actions include: 1. Collaborative care among primary health, mental health and addictions providers; 2. Expanding opioid replacement treatment to areas of the province with the greatest need; 3. Reviewing location of mental health and addictions bed; 4. Expanding the toll-free crisis line across the province to make sure that people with mental health and addictions concerns are able to talk to someone immediately; 5. Undertaking work to increase diversity in addictions, mental health workforce; and 6. Addressing mental health and addictions care for incarcerated adults [1, 2]

Some of the highlights from the January 2016 progress report of *Together We Can* include the successful expansion of the toll-free crisis line across the province, available to anyone, any age, anywhere, anytime. In addition, clinicians answering these calls are able to access a variety of services to support callers (e.g., mental health programs, EHS, police, local emergency departments). Another highlight is the introduction of nine peer support specialists in four areas of the province. Peer support specialists are people who have experienced mental illness and have been trained to support others who are returning to the community from hospital or are being followed in a community mental health clinic. A third highlight is the increase in the number of opioid dependence treatment spots from 75 to 145 in the Nova Scotia Health Authority's Central Zone. Lastly, nearly 250 professionals have completed training on concurrent mental illness and addiction, and hundreds more have started the training, as a result of the provincial strategy (this includes social workers, psychologists, nurses, etc.). Lastly, since the release of the strategy in 2012, the government has worked with the Health Association of African Canadians (HAAC) to develop training for clinicians about the mental health and addictions needs of African Nova Scotians. The HAAC has also held two conferences since 2012 on the unique mental health and addictions needs of African Nova Scotians [3].

Chronic pain

In May of this year, the College of Physicians & Surgeons of Nova Scotia (CPSNS) endorsed the US Centres for Disease Control and Prevention's (CDC) Guidelines for Prescribing Opioids for Chronic Pain as best practice. One of the biggest changes that this introduced for Nova Scotian physicians was its reduction of the acceptable upper limit of daily dosage for prescribed morphine for non-cancer pain (from 200 mg to 90 mg). One of the other noteworthy components of these guidelines is the recommendation regarding promotion of non-pharmacological and non-opioid therapies as preferred treatments of chronic pain [4].

Past efforts by the CPSNS to increase multidisciplinary/non-pharmacological pain management include an awareness campaign that took place in late 2014, and was aimed at encouraging patients and physicians to explore pain management alternatives. This campaign, titled Right Tool for the Job, was based on the acknowledgement that misuse of prescription drugs is a complex problem that causes significant social harm. Although its intention was to highlight cases where alternative pain treatment may have been just as, if not even more, effective than pharmacotherapy, with a lower level of risk, it was clear in stating that it did not intend to demonize prescription pain medication, since in many cases these drugs are appropriate [5].

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Nunavut

Illicit fentanyl use has not been seen yet by authorities and there have not been recorded fentanyl overdoses in Nunavut, but RCMP have received naloxone kits in preparation for the potential risk [1]. However, in September 2016 the Nunavut health department issued a public health advisory warning the community that fentanyl was stolen from the local health centre in Kugluktuk [2, 3].

Inuit living in Nunavut may receive health coverage under the federal Non-Insured Health Benefits (NIHB) plan, in addition to the Nunavut territorial health care plan and extended benefits [4]. As of 2012, the NIHB program implementing a prescription drug abuse strategy which includes a maximum 30 day supply of opioids to be dispensed by pharmacists at a time. As of 2013, the NIHB program also limited the daily dose of opioids given to patients [5]. The

NIHB has a prescription monitoring program, expanded to all regions including Nunavut in 2011. The program sends warning messages to pharmacists and places specific clients under a restriction requiring that they find a single prescriber. NIHB also includes methadone and suboxone as a limited use benefit [6].

Chronic pain

There is no specific pain management clinic for chronic pain treatment in Nunavut. The 24 health centres scattered across the territory offer a variety of general basic health services. Iqaluit has a hospital as well as specialised mental health and rehabilitation services [7].

Mental health and opioid use

Existing resources and services for mental health and addictions in Nunavut do not seem to explicitly address the link between the use of opioid drugs and mental illness [8, 9, 10].

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Ontario

Chronic pain

According to the Canadian Pain Coalition Pain Clinic Listing, Ontario has about 68 multidisciplinary pain treatment facilities. Twenty-nine of these are located in Toronto and 7 in Hamilton [1]. The ECHO Ontario Chronic Pain and Opioid Stewardship is an initiative that uses telemedicine to increase the capacity of primary care providers to manage patients with chronic pain that reside in underserviced areas [2].

Mental health

In June 2011, Ontario's comprehensive mental health and addictions strategy (aka *Open Minds, Healthy Minds*) was released [3]. The four guiding goals of *Open Minds, Healthy Minds* are: 1. Improve mental health and well-being for all Ontarians; 2. Create healthy, resilient, inclusive communities; 3. Identify mental health and addictions problems early and intervene; and 4. Provide timely, high quality, integrated, person-directed health and other human services. With this strategy, Ontario aimed to build on its developments in treatments for mental illnesses and addictions between 2003 and 2011, such as the 80% increase in funding for mental health programs, the 49% increase for addictions programs, and the provision of the only two base funding increases to child and youth mental health in over a decade, resulting in an additional $64 million dollars for these services.

In order to achieve guiding goal #1, *Open Minds, Healthy Minds* proposes a few key strategies. One of these strategies is developing workplace programs, which is based on the fact that mental health disability claims have overtaken cardiovascular disease as the fastest growing category of disability costs in Canada. In addition, a prime example from Ontario that has been able to meet this guiding goal is the Thunder Bay Walk-In Counselling Clinic, which provides immediate access to professional counselling. As for guiding goal #2, the main strategies that are proposed include: a. reducing stigma and discrimination; b. harmonizing policies to improve housing and employment supports; and c. creating community hubs for activities and services. Guiding goal #4 will hopefully make it so that patients with mental illness and addiction do not need to visit separate service programs or service providers for their mental health needs and their addiction needs, the same way someone with high blood pressure does not to visit several health care providers to address their needs. Furthermore, this guiding goal seeks to eliminate instances of people being discharged from emergency without appropriate community supports, as well as instances of people ending up in the justice system when they should be in the health system.

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Prince Edward Island

Prince Edward Island had four opioid-related deaths in 2014, the last year for which data is available [1]. PEI's Narcotics Safety and Awareness Act, passed in 2013, requires professionals to keep records of narcotics prescriptions and further gives the provincial government authority to monitor prescribing practices [2]. The act has been criticized for having minimal consultation with physicians [3]. A provincial Drug Information System provides an electronic record of all medications dispensed to residents; however, less than half of PEI's physicians have elected to subscribe. PEI has government-run methadone clinics in three towns as well as a private clinic in Charlottetown. RCMP in PEI are now required to carry nasal spray naloxone [4]. Pharmacists who wish to provide methadone or buprenorphine/naloxone must apply for an Extended Practice Certification from the college [5].

Chronic pain

Prince Edward Island has only one dedicated pain clinic, located in the capital city [6]. The College of Physicians and Surgeons of PEI approved a set of guidelines on prescribing opioids in chronic non-cancer pain in 2005 which outlined problems related to opioid use as well as steps to evaluate and review patients' need for opioids [7].

Mental health

In 2016, Prince Edward Island released a 10-year mental health and addictions strategy, focusing on mental health promotion at all ages as well as timely access to recovery-oriented services. The plan does not make specific recommendations about harm reduction or addiction services for opioid use [8].

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Quebec

Compared to other provinces, Quebec has relatively few regulations on opioid use and monitoring of prescribing practices. There is no prescription monitoring program, although there is a single-pharmacy designation policy designed to prevent 'double-doctoring'. "When a patient visits multiple pharmacies and multiple physicians and habit-forming drug therapy overlaps are found Quebec's system sends out a warning (by a designated Ordre des pharmaciens du Québec [OPQ] staff member) to the pharmacist and neighbouring pharmacies about that patient" [1]. Recently, the provincial associations of doctors and pharmacists of Quebec have demanded that the provincial government share prescription and dispensing data collected by the public drug insurance plan and by private insurers [2]. Rather than follow Ontario's lead in discontinuing public coverage of opioid pain medications, the Quebec health minister has indicated favouring the educational approach to prevent physicians from inappropriately prescribing opioids. The Quebec college of physicians has also engaged in consultation in fall 2016 and may recommend measures to the minister in the coming months [3]. In addition, relating to harm reduction, the Quebec government has promised $12 million over three years to open safe injection sites in Montreal, and a mobile unit, which could be open by winter or spring 2017 [4].

Chronic pain

As of the 2014 Canadian Pain Coalition Report Card, Quebec has 50 chronic pain treatment clinics as of a report published in 2005 [5]. As of 2005-2006, there were 26 multidisciplinary pain management centres in Quebec, second only to Ontario at 35, and ahead of Saskatchewan at 13, Alberta at 12, and BC at 7 [6]. This implies relatively good coverage compared to other provinces, with approximately half of the pain clinics in Quebec as multidisciplinary pain clinics with specialised and integrated services for patients suffering from chronic pain. There are also multiple stakeholders advocating for patients with chronic pain, including the Association Québécoise de la Douleur Chronique, a patient advocacy group with over 8000 members [7], the Quebec Pain Portal developed in collaboration with the Quebec Pain Research Network which provides resources for patients and professionals [8], and La Société Québécoise de la douleur, a group of professionals which advocates for education, multidisciplinarity and continuity in chronic pain management. [9]

Mental health

In October 2015, the Quebec government announced a five year plan to improve mental health services to be implemented from 2015-2020. It includes public education campaigns to reduce stigma associated with mental health problems, more mental health services for youth, more subsidised housing for those with chronic mental illness, and the accountability of health care establishments for ensuring access to services [10]. However, the government's policy has been criticised by the psychologists' association for focusing on medication-based therapies and not including psychotherapy as part of family medicine group clinics [11] . That said, Quebec has lower rates of hospitalizations for opioid poisonings than other provinces, at 9.7 per 100 000 people, and it has been suggested that lower rates of opioid prescribing in Quebec may be related to greater access to services such as psychological counselling, physiotherapy, and other non-drug treatments for pain, but it is impossible to know for sure [12].

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See also:
http://www.cmq.org/publications-pdf/p-1-2009-05-01-fr-douleur-chronique-et-opioides.pdf

Saskatchewan

Chronic pain

Saskatchewan has a Pharmaceutical Information Program (PIP), which helps prescribers select optimal medications to avoid adverse drug interactions, duplications of therapy, and potential drug abuse. This system also facilitates multidisciplinary care of patients with chronic pain as it allows pharmacists to view prescriptions from multiple prescribers [1].

Mental health

The College of Physicians and Surgeons of Saskatchewan released the Saskatchewan Methadone Guidelines and Standards for the Treatment of Opioid Addiction/Dependence in 2014. This document is a guide for physicians and other health care practitioners who are using methadone to treat patients diagnosed with 'Opioid Use Disorder.' This includes those suffering from pain and those suffering from opioid dependence, as per the four policies recently adapted

by the college. It is acknowledged in these guidelines that it may be impossible to differentiate between an addiction and chronic pain, and in cases where the two cannot be clearly differentiated, it is strongly recommended that there is consultation with a physician experienced in managing patients with both an addiction and chronic pain. These standards and guidelines are meant to enhance patient care by improving the consistency of and access to methadone maintenance treatment (MMT), as well as support patient and community health and safety.

Among the standards for initiating physicians who provide MMT (i.e., experienced MMT physicians with a focussed MMT practice, in either a private or a Health Region-supported methadone clinic), is that these physicians have certain training and experience (i.e., MMT workshop/course recognized by the CPSS; period of direct training, supervision and mentorship; documentation of clinical competence; mentorship and support from an established Methadone prescriber during first 2 years of practice). It is also included as a standard that initiating physicians will pursue ongoing education relevant to MMT; that if the initiating physician is going to be away or is suspending their practice, that they ensure that another physician with the appropriate training will support their patients; and that they should make reasonable efforts to provide non-pharmacological support to their patients (i.e., pharmacy, addiction services, counseling, etc.). There are similarities between the requirements for an initiating and a maintaining physician, the latter being physicians who provide MMT to a limited number of stabilized patients as a part of their practice. However, the training, experience and mentorship standards are either not as rigorous or are non-existent for maintaining physicians [2].

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Yukon

In April 2016, Yukon Health and Social Services released *Forward Together: Yukon Mental Wellness Strategy*, a 10-year strategy addressing mental wellness in Yukon. *Forward Together* has the primary objective of increasing seamless mental health, trauma and substance use services with equitable access, and can be separated into four strategic priorities (i.e., 1. Promotion and prevention; 2. Service delivery; 3. System performance and access; and 4. Innovation and Research). The rationale for the four strategic priorities of Forward Together is the recognition that a substantial reduction in the impact of mental health and substance

misuse/abuse issues will not be feasible through treatment alone. Furthermore, Forward Together aims to reach accessibility to culturally competent service through any entry point or provider in the Yukon system.

Although there is no specific mention made of narcotics or opioids in the strategy, three out of the four strategic priorities of *Forward Together* include explicit goals for improvement and integration of mental health and substance abuse services. For example, for one of the objectives of strategic priority #1 (i.e., raising awareness and compassion for those individuals, families and caregivers experiencing mental health disorders, substance abuse issues and mental health problems), one suggested strategy to accomplish this is to "implement a harm reduction approach to prevention, engaging individuals and providing support to individuals making changes", a strategy which may concurrently bridge individuals from prevention and support into treatment services. In addition, for one of the objectives of strategic priority #3 (i.e., increasing access to ensure that individuals with mental health and/or addictions receive timely and appropriate service), one of the main strategies suggested is to "Integrate Mental Health Services, Child and Adolescent Therapeutic Services, and Alcohol and Drug Services within the Department of Health and Social Services" [1].

Sources

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