Canada's hidden opioid crisis: the health care system's inability to manage high-dose opioid patients

Fallout from the 2017 Canadian opioid guidelines

Hance Clarke MD PhD FRCPC James Bao MD Aliza Weinrib PhD Ruth E. Dubin MD PhD FCFP DCAPM Meldon Kahan MD MHSc CCFP FRCPC

Opioid overprescribing, a plausible result of disingenuous marketing practices, has played a role in our current opioid crisis. The release and implementation of the 2017 "Guideline for opioid therapy and chronic noncancer pain" has created a shift in opioid prescribing for chronic noncancer pain, and patients in the years ahead will be protected by the lower-dose recommendations.[1] Physicians will shift their prescribing patterns and adhere to ceiling doses for new opioid initiations. They will potentially more often consider the use of alternative medications as first-line options for pain conditions, as opposed to opioids, which should be second- or third-line alternatives, if used at all for chronic noncancer pain. The evidence recommending nonopioid medications to be superior to opioid medications for chronic noncancer pain can (similarly to the evidence for opioid superiority) be criticized for not having adequate long-term follow-up, for small sample sizes, and for a lack of functional outcome data. However well meaning they are, the 2017 Canadian opioid prescribing guidelines were introduced to a health care system ill equipped to care for patients with chronic pain.

System factors potentiating the crisis

It appears that provincial medical regulators have adopted the Canadian guidelines as the standard of care by which medical pain and opioid prescribing practices will be judged. Provincial regulators have already investigated doctors who prescribe high doses.[2,3] An unintended consequence of this investigation is that some primary care physicians now practise in a climate of fear, concerned about complaints to their governing colleges, potential investigations, or practice restrictions owing to opioid mismanagement.[4] Some primary care physicians have dropped patients to whom they had prescribed opioids, while others have chosen to stop prescribing opioids altogether.[5] This affects pain patients and those suffering from opioid use disorder (OUD), leaving both with nowhere to turn.

Young physicians are rightfully cautious about prescribing opioids. When they acquire or take over a practice, many refuse to assume the care of these patients given the climate of fear that has been created around opioid prescribing. We are concerned that the 20% of Canadians living with chronic pain might not receive adequate care.[6] Refusing to provide care to these patients should be investigated with the same rigour applied to those who were prescribing excessive doses. We would even suggest that young physicians be granted an amnesty of sorts if they choose to assume care of or help abandoned patients.

The guideline might create unnecessary risk for patients already prescribed high-dose opioids. Recommendation 9 suggests tapering opioids to the lowest effective dose for patients who are taking more than 90-mg morphine equivalent doses.[1] However, it is becoming abundantly clear that 80% of opioid-related deaths result from inadvertent illicit fentanyl injection, co-ingestion of alcohol or benzodiazepines, or taking doses greater than those prescribed.[7] An otherwise healthy patient on a stable, carefully titrated dosage of 120-mg morphine equivalent doses is unlikely to overdose, given his or her tolerance. Although the guidelines note that tapering can be abandoned with any substantial increase in pain or decrease in function, by that point, patients will have already been exposed to a period of elevated risk of overdose. If such a patient has good pain relief, improved function, few side effects, and no aberrant behaviour, the clinical rationale for initiating tapering is unclear.

Ultimately, prescribing rates in Ontario tell a grim story. The Canadian opioid guidelines estimate the prevalence of OUD in patients with chronic noncancer pain who were prescribed an opioid to be 10%.[1] Even if most of the 1.9 million Ontarians prescribed an opioid in 2015 to 2016 received only a short-term prescription, thousands of patients must still be at risk of complications from being weaned inappropriately.[8] Discontinuation does not work for patients with OUD and is a very unsafe practice. Rapid or forced weaning or tapering can cause distressing withdrawal symptoms, leading some patients to seek opioids from other sources. This can cause fatal overdose, as tolerance is lost within days of abstinence and illicit sources commonly contain fentanyl. Withdrawal is also accompanied by severe anxiety, dysphoria, and a marked escalation in pain, and can trigger suicidal ideation in patients with underlying mood, anxiety, or substance use disorders. This trend has been foreshadowed in editorials,[9] and perhaps the stark increase in deaths caused by heroin and fentanyl use is related. We urge coroners' offices and individuals conducting health policy opioid research to use health

services data to look back at the prescription and dosing parameters surrounding an individual's death in which there was a known prescriber of opioids for chronic noncancer pain. Certainly, an inquiry into the deceased's prescription record before death (using PharmaNet in British Columbia, the Ontario Drug Benefits database in Ontario, etc), particularly the dispensing patterns, would be warranted. The story might not be as linear as was reported in the lay press.

Solutions to the opioid crisis

Regulatory colleges should require mandatory training in safe opioid prescribing and identification and management of OUD. Medical professionals already complete annual training to maintain privileges. Surely a mandated online course would not be undue?

Many opioid-related deaths occur in patients with OUD who are using high-potency illicit fentanyl. Several public strategies have already been implemented to deal with this development, including media campaigns on overdose prevention, distribution of take-home naloxone kits, safe injection sites,[10] and rapid-access addiction medicine clinics. One underused strategy is the prescription of buprenorphine, which has been shown to markedly reduce (illicit) opioid use and prevent overdose death in patients with OUD.[11] It should be available for dispensing on-site in all health care settings—emergency departments, hospitals, and primary care clinics.

Recommendation 10 of the 2017 Canadian opioid guidelines states that "for patients with chronic noncancer pain who are using opioids and experiencing serious challenges in tapering, we recommend a formal multidisciplinary program."[1] However, access to these multidisciplinary clinics is a considerable problem. Canada has an average of 1 multidisciplinary pain clinic per 258 000 people, with most of these existing in urban or tertiary care centres; for this reason, accessibility in rural centres is likely extremely difficult.[12] The guideline authors suggest the use of interprofessional teams; however, patients struggling with tapering often lack access to services not covered by provincial health plans. As long as prescription pads are more accessible than nonpharmacologic treatments, these recommendations will be difficult to implement. In reality, there will never be enough multidisciplinary clinics to overcome the current problems, and primary care providers must be part of the solution. Further, use of multidisciplinary opioid reduction programs is excellent in theory, but non–family physician specialists have yet to develop and demonstrate the effectiveness of specific behavioural protocols for opioid reduction.[1,13,14] Existing psychological treatment protocols were developed before the current crisis and require adaptation for opioid tapering.[13,14]

A multidisciplinary model of care that could be facilitated in any setting and could meet the needs of patients struggling with pain and OUD would involve pain physicians with OUD training, addiction medicine physicians, clinical psychologists, and other allied health professionals as needed by the community. Within this setting, primary care physicians could connect with this team and refer their patients with pain and OUD to the service. Primary care providers seek expertise from multidisciplinary pain clinics partly for temporary help to wean their patients taking high doses of opioids or switch them to buprenorphine (or methadone). Such clinics should not be allowed to refer to themselves as pain clinics without having the ability to manage opioid prescribing, at least in the short term. To ensure accessibility for more Canadians, primary care providers (providers include nurse practitioners and physician assistants as well as physicians) should accept the responsibility to resume care once patients are stable.

The Transitional Pain Service at Toronto General Hospital in Ontario is one such model.[15] High-risk postsurgical patients are followed by the multidisciplinary team for as long as 6 months until analgesics are at a safe level, pain is controlled, and daily function approaches presurgical levels. The experience of the program is that patients living with pain are concerned about their opioid use and are motivated to reduce their dose. However, they lack the knowledge and skills to do so independently without experiencing adverse consequences (increased pain, distress, reduced function). We believe that full-fledged behavioural programs should be created that consider educational content on opioids and their effect on sleep, reasonable weekly goals for opioid tapering, and introduction of psychological skills targeting barriers to weaning. Interventions should equip patients with pain self-management skills and better access to nonpharmacologic options to empower their pain management and improve quality of life.

Conclusion

We hope to stimulate discussion around balanced strategies to mitigate the current opioid overdose crisis and encourage an ongoing patient-oriented search for better solutions. Prescribing of controlled substances must continue to be appraised, and initiatives to curtail overprescribing are already under way. Recently, the creation of the Canadian Pain Task Force has been announced by the federal health minister, the goals of which will be to provide information on barriers that might prevent people experiencing persistent pain from receiving the treatment they need.[16] Without a clear and implementable patient-oriented strategy, combined with universal training in safe and effective chronic pain and addiction management for all health care providers, well-meaning documents like the 2017 Canadian guidelines might inadvertently harm the very people they hope to help.

Dr Clarke is a staff anesthesiologist and Director of Pain Services in the Department of Anesthesia and Pain Management in the Pain Research Unit at Toronto General Hospital in Ontario. **Dr Bao** is an anesthesiology resident in the Department of Anesthesia and Pain Management at Toronto General Hospital. **Dr Weinrib** is a clinical psychologist in

the Transitional Pain Service in the Department of Anesthesia and Pain Management at Toronto General Hospital. **Dr Dubin** is a family physician with a special interest in pain and addiction practising in Kingston, Ont, Associate Professor in the Department of Family Medicine at Queen's University, and Co-chair of ECHO Ontario Pain and Opioid Stewardship. **Dr Kahan** is Professor in the Department of Family and Community Medicine at the University of Toronto, and Medical Director of Substance Use Service/Addictions Medicine and Project Lead of META:PHI (Mentoring, Education and Clinical Tools for Addiction: Primary Care—Hospital Integration), both at Women's College Hospital.

Competing interests
None declared

Correspondence
Dr Hance Clarke; e-mail **hance.clarke@utoronto.ca**

References

1. Busse JW, Craigie S, Juurlink DN, Buckley DN, Wang L, Couban RJ, et al. Guideline for opioid therapy and chronic noncancer pain. *CMAJ* 2017;189(18):E659-66.
2. Grant K. Regulatory body investigates 86 Ontario doctors for prescribing high doses of opioids. *The Globe and Mail* 2016 Nov 2. Available from: **www.theglobeandmail.com/news/national/regulatory-body-investigates-ontario-doctors-for-prescribing-high-doses-of-opioids/article32655743**. Accessed 2019 Jul 12.
3. College of Physicians and Surgeons of Ontario. *Narcotics monitoring systems (NMS) opioid investigations—backgrounder*. Toronto, ON: College of Physicians and Surgeons of Ontario; 2018. Available from: **https://clinics.cpso.on.ca/CPSO/media/documents/Positions%20and%20Initiatives/Opioids/Opioid-Investigations-Backgrounder.pdf**. Accessed 2019 Jul 12.
4. Canadian Medical Protective Association. *The medical-legal risks of opioid therapy: questions from members.* Ottawa, ON: Canadian Medical Protective Association; 2018. Available from: **www.cmpa-acpm.ca/en/advice-publications/browse-articles/2018/the-medical-legal-risks-of-opioid-therapy-questions-from-members**. Accessed 2019 Jul 12.
5. Ireland N. Opioid crisis coupled with doctor shortage leaves chronic pain patients desperate. *CBC News* 2018 Oct 11. Available from: **www.cbc.ca/news/canada/thunder-bay/chronic-pain-opioid-crisis-doctor-shortage-1.4857382**. Accessed 2019 Jul 12.
6. Moulin DE, Clark AJ, Speechley M, Morley-Forster PK. Chronic pain in Canada—prevalence, treatment, impact and the role of opioid analgesia. *Pain Res Manag* 2002;7(4):179-84.
7. Egilson MB. *BC Coroners Service death review panel: a review of illicit drug overdoses. Report to the Chief Coroner of British Columbia.* Vancouver, BC: British Columbia Coroners Service; 2018. Available from: **www2.gov.bc.ca/assets/gov/birth-adoption-death-marriage-and-divorce/deaths/coroners-service/death-review-panel/bccs_illicit_drug_overdose_drp_report.pdf**. Accessed 2019 Jul 12.
8. Health Quality Ontario. *9 Million prescriptions: what we know about the growing use of prescription opioids in Ontario.* Toronto, ON: Health Quality Ontario; 2017. Available from: **http://opioidprescribing.hqontario.ca**. Accessed 2019 Jul 12.
9. Lynch ME, Katz J. "One size fits all" doesn't fit when it comes to long-term opioid use for people with chronic pain. *Can J Pain* 2017;1(1):2-7.
10. Canadian Pharmacists Association. *Environmental scan. Access to naloxone across Canada.* Ottawa, ON: Canadian Pharmacists Association; 2017. Available from: **www.pharmacists.ca/cpha-ca/assets/File/cpha-on-the-issues/Environmental%20Scan%20-%20Access%20to%20Naloxone%20Across%20Canada_Final.pdf**. Accessed 2019 Jul 12.
11. Sordo L, Barrio G, Bravo MJ, Indave BI, Degenhardt L, Wiessing L, et al. Mortality risk during and after opioid substitution treatment: systematic review and meta-analysis of cohort studies. *BMJ* 2017;357:j1550.
12. Peng P, Choiniere M, Dion D, Intrater H, Lefort S, Lynch M, et al. Challenges in accessing multidisciplinary pain treatment facilities in Canada. *Can J Anaesth* 2007;54(12):977-84.
13. Williams AC, Eccleston C, Morley S. Psychological therapies for the management of chronic pain (excluding headache) in adults. *Cochrane Database Syst Rev* 2012;(11):CD007407.
14. Eccleston C, Hearn L, Williams AC. Psychological therapies for the management of chronic neuropathic pain in adults. *Cochrane Database Syst Rev* 2015;(10):CD011259.
15. Katz J, Weinrib A, Fashler SR, Katznelzon R, Shah BR, Ladak SSJ, et al. The Toronto General Hospital Transitional Pain Service: development and implementation of a multidisciplinary program to prevent chronic postsurgical pain. *J Pain Res* 2015;8:695-702.
16. Learning Technologies Lab, Faculty of Health Sciences. *Canadian Pain Task Force.* Hamilton, ON: McMaster University; 2019. Available from: **https://healthsci.mcmaster.ca/learningtechlab/news/2019/06/11/canadian-pain-task-force**. Accessed 2019 Jul 26.

This article has been peer reviewed. *Can Fam Physician* 2019;65:612-4

La traduction en français de cet article se trouve à **www.cfp.ca** dans la table des matières du numéro **de septembre 2019** à la **page e376**.