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Been There, Done That: Lessons from Vancouver's Efforts to Stem the Tide of Overdose Deaths

Michael R. Krausz, MD, PhD, FRCPC[1], James S. H. Wong, BSc[1], Ehsan Moazen-Zadeh, MD[1,2], and Kerry L. Jang, PhD[1]

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The alarming statistics (as cited in Babu et al.[1]) of the number of opioid-related deaths is not just a tragedy in the United States but one that is growing throughout North America.[1] According to the 2019 reports by the Government of Canada and the British Columbia Coroners Service, Canada has recorded 4,460 deaths in the past year, and Vancouver, British Columbia, with a population of 630,000, recorded 1,136 deaths for the past 4 years or about 5.5 per week. Babu et al.'s[1] recommendations to combat the crisis have been part of the city of Vancouver's strategy to tackle the crisis for several years. Harm reduction and prevention measures such as supervised injection sites and opioid substitution treatment trials have long been in existence for over 20 years. In response to the current crisis, the widespread public distribution and training of naloxone kits was implemented. People who use drugs (PWUD) are trained to revive an overdosing peer and are told not to use alone. To support this, the Parliament of Canada passed a national "Good Samaritan Law" which protects a person, who is in possession of illicit drugs from prosecution when law enforcement arrives at the scene. Moreover, local health authorities have established additional supervised drug-use sites throughout the city and provide PWUD with a testing program to detect if fentanyl is present, which has been effective in reducing self-administered dosage if detected.

Despite these successes, the death rate has barely declined. Harm reduction measures have simply established a revolving door of overdose and revival. The success of naloxone has led to a false sense of security that overshadows its side effects as cravings are increased in the revived individual making relapse almost always assured. It is tempting to think that naloxone is effective because the numbers of deaths could be even higher, but this fallacy is underscored when the number of overdoses in Germany with a population of 84 million is lower than the entire Province of British Columbia with a population of 4.5 million.

The general public believes the overdose crisis can be solved by increasing access to substance use disorder treatment and pressure lawmakers to pour resources into treatment. However, what is lost on the general public is that only increasing available care is insufficient if the treatment system is unable to keep patients in care. This is demonstrated by a report by the Chief Provincial Health Officer for British Columbia who reported an increase in the number of patients entering methadone treatment with only 32% staying in care after 1 year.[2] The key is to provide patients with a range of options that they are satisfied with and suit their needs. It is critical not only to address withdrawal symptoms but also to address the multiple challenges our patients are coming with, in dealing with an unbelievable burden of early and ongoing trauma, suicidal ideation, and mortality. The role of psychiatry is crucial in improving the quality of care and the lack of leadership, expertise and engagement of psychiatrists is part of the problem. In North America, addiction specialist means 2 very distinct medical subdisciplines—addiction psychiatry versus addiction medicine—that approach addiction very differently and rarely work together on a clinical or administrative level with the patient becoming the collateral damage from their turf war.[3] Following are some issues that have impeded collaboration between addiction medicine and psychiatry. Medications and routine counseling are still

[1] Department of Psychiatry, University of British Columbia, Vancouver, British Columbia, Canada
[2] Department of Psychiatry, Icahn School of Medicine at Mount Sinai, New York, NY, USA

Corresponding Author:
Michael R. Krausz, MD, PhD, FRCPC, Department of Psychiatry, Institute of Mental Health, University of British Columbia, David Strangway Building Room 430, 5950 University Boulevard, Vancouver, British Columbia, V6T 1Z3 Canada.
Email: m.krausz@me.com

regarded as the only necessary treatments for opioid use disorder from the point of view of many primary care providers, with much less attention to mental comorbidities. There has been no systemic effort of initiative to bridge this gap and provide opportunities for collaboration between these 2 parties. Also, very scarce are treatment settings where psychiatrists and primary care physicians work together as a clinical team providing integrated care. Long waiting times for psychiatry visits should also be considered as a contributing factor especially that many psychiatrists are not comfortable with office-based management of opioid agonist therapy. Differences in historical, economic, and professional interests also play an important role.[3]

The importance of addiction psychiatry in addressing the opioid overdose crisis is strongly implied from the available evidence at least in (1) training primary care physicians for mental health screening and administration of treatment medications either as substitution treatment or detoxification and (2) treatment of psychiatry comorbidities associated with opioid use disorder. In fact, while there has been an increasing demand on the primary care system to expand on its capacity for treatment of patients with opioid use disorder, insufficient training of medical graduates has been a major concern to the extent that a national training initiative led by American Academy of Addiction Psychiatry in the United States is dedicating to this issue.[4] On the other hand, on average approximately 60% of patients with opioid use disorder suffer from concurrent mental illness, while only one-third of them receive treatment for both conditions.[5] Many of these patients struggle with schizophrenia, depression and suicide, anxiety disorders, in particular posttraumatic stress disorder (PTSD), and misuse of psychotropic medications related to their concurrent mental disorders like sedative hypnotics.[6] While available evidence for the impact of common psychosocial interventions on decreasing illicit drug use in patients with dual diagnosis is inconclusive,[7] there are few lines of empirical evidence in support of the importance of patient-specific psychiatric care in this population, which of course requires expertise in diagnosis and treatment management. For example, according to a Cochrane review, trauma-focused psychosocial therapy was superior to control therapy/treatment as usual in decreasing alcohol and substance use 5 to 7 months posttreatment completion in patients with dual diagnosis of PTSD and substance use disorder,[8] while nontrauma-focused therapy did not. Finally, beyond the empirical evidence, other experts in the field have reflected on the importance of addiction psychiatry with similar arguments.[9,10]

Switzerland is a great example of how quality care and interdisciplinary collaboration can change the whole situation, with a coverage of substitution treatment between 70% and 75% and a retention in care for the first year in the same range because of a number of medication options including heroin-assisted treatment and excellent psychosocial care.[11] There are just no waiting times to see a psychiatrist or counselor in Basel or Zurich. The overdose numbers there are low, so low that the government is not announcing them any longer in press releases. The crisis related to the open drug scenes in the 1980s and 1990s is definitively over and the incidence of intravenous use is declining.[3] The whole approach including the model of substitution and mental health care seems to be different and based on an integrated instead of a siloed model. If you are a high-risk substance user in Zurich and request care, for example, in the Arud Centers for Addiction Medicine (https://arud.ch), you have immediate access to mental health and counseling, social supports, and specialized physical health care, for example, in treating infectious disease or pain.

Why can't we learn from that blueprint? Why don't we as a clinical community crave to resolve the mystery of these stunning differences?

In British Columbia, in an effort to increase patient choice, buprenorphine is offered along with methadone, which ironically is what less than 10% of patients would choose if there were other options.[11] In Basel, you can personally choose your preferred substitution medication and the preferred route of administration from methadone to buprenorphine in its different combinations, from heroin orally to intravenous to slow-release morphine, and so on. And you may switch too as a user, if you wish to. That is critical for retention in treatment.

The limited treatment range here is attributable to ideologies such as prohibitionism and to the fact that many other issues a patient is suffering, such as psychiatric issues, go unaddressed while undergoing addiction treatment. It is a real step forward that under the growing pressure of the crisis, the federal government regulated the use of hydromorphone for addiction treatment and made it available in Canada. The introduction of heroin-assisted treatment is also considered from Health Canada based on the positive experiences in Europe.

One of the great tragedies is the divide between the disciplines of primary care medicine and addiction psychiatry that often fail to collaborate leaving the patient with no means but to relapse and leave a treatment program to return to the street to find the solace and relief that treatment could not provide.[3] General problems of access to immediate care contribute to the failure to prevent tragedies. In British Columbia, 79% of individuals who have died of overdose have been in contact with social and health services multiple times to no avail.[2] That is a dramatic number proving the limitations in the Canadian system.

Keeping patients in treatment to decrease the number of deaths will require that a full suite of substitution treatment is on offer to suit the patients' needs and psychiatric and psychological supports to resolve long-standing issues with an aim to increase patient satisfaction rates over 60%. Getting there will require a shift in thinking. One of the barriers is to shift the current focus on prescription opioids. The morphine consumption per capita in North America to treat pain has risen to record levels over the past decade making it an easy conclude that the use of opiates in pain treatment is

squarely behind the overdose crisis.[12] Is this conclusion justified by the evidence? Canada and Germany have similar prescription levels of medical opiates from 2017 according to the World Drug Report 2018, using comparable therapeutic guidelines. However, Canadian overdose deaths increase while the numbers in Germany decline to very low levels suggesting that there are other reasons beside increases of medical opiate prescription for pain fueling the overdose crisis. Another important challenge is asking for closer collaboration between pain specialists, primary care colleagues, and addiction psychiatrists. Access to specialized pain treatment especially for marginalized populations is difficult and comes with long waiting times, which is a system problem.

As a result, a great deal of current discussion focuses on how to create a safe street drug supply and the merits of legalization. This debate has included proposals that would supply patients with heroin via vending machines or compassion clubs so the user can bypass tainted street drugs. These proposals have overshadowed investment and reform to the treatment paradigms to have their use medically supervised.

Refocusing: The Legend of the 3 Arrows

In addressing the overdose death crisis, one is reminded of the old Japanese legend of the 3 arrows. Lord Mōri Motonari wanted his 3 sons who handed each an arrow and explained that 1 arrow could be broken easily, but 3 arrows held together could not. In the context of the overdose crisis, the first arrow is the patient who makes the choice to enter or stay in treatment. The second arrow is addiction medicine, and the challenge to expand the *range* of pharmacological treatment is paramount because any patient who has a range of suitable treatments is more likely to stay engaged in treatment.[3] It is difficult to fathom why the range of available substitution medications remains so steadfastly limited. In 2019, heroin-assisted, hydromorphone-assisted, and slow-release morphine treatments are still not accessible in most parts of the United States and Canada despite being the primary substitution treatments in many countries.[12] Substitution treatments do not deal with the underlying causes of addiction. The third arrow and the challenge is for addiction psychiatry to step up and play an integral part of addiction treatments. To achieve this important mission, more capacity is required for addiction psychiatry fellowship training programs, as well as comprehensive training for opioid use treatment during the general psychiatry training with more attention to the management of concurrent mental disorders and pain. Also, it is crucial that primary care physicians and psychiatrists collaborate as a team where the physicians at primary care are the frontline of clinical encounter with the opioid use patients in majority of cases, supported and consulted by the psychiatrists who provide expert assessment and care for referrals. More psychiatry tertiary care treatment facilities are also required to accommodate patients with concurrent severe opioid use problem and serious mental illness.

Finally, a word about enforcement. To the general public, news reports and television programs showing the seizure of illicit drugs as evidence that the war on drugs is working. It is unlikely that China's reclassification of fentanyl as a controlled substance will have much impact because given the potency of fentanyl, only small, hard to intercept amounts need to be imported to turn a sizeable profit. The Canadian government recently made the sale of pill presses to the public illegal, but drugs are widely used in many other forms. This is all really a political stunt borne out of North America's prohibitionist past.[2]

The Chinese word for crisis is including 2 signs, one standing for risk and the other for chance. The risk is certainly that we fail to stop the dying. The chance for psychiatry is that it is revisiting its role in addressing this public health emergency and makes a quality addiction psychiatry a priority from an educational, a clinical, and an academic perspective. Our patients deserve a functioning system and a patient-focused approach, there are few significant learnings from other countries we should consider.

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ORCID iDs

Michael R. Krausz, MD, PhD, FRCPC https://orcid.org/0000-0002-6208-4364

Ehsan Moazen-Zadeh, MD https://orcid.org/0000-0003-0846-1402

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