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# Why Integrating Medications and Psychosocial *Interventions* is Important to Successfully Address the Opioid Crisis in Canada

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## The Opioid Crisis in Canada—The Need for More Robust Psychosocial Interventions

The opioid crisis continues unabated in Canada. In 2019, there were 3,923 reported deaths from opioid overdose, and 94% of these deaths were unintentional (Government of Canada, 2019; https://health-infobase.canada.ca/substance-related-harms/opioids). Moreover, it appears that opioid overdose death rates have increased since the beginning of the COVID-19 pandemic.[1] Clearly, there are multiple factors contributing to this crisis, and the limited accessibility to opioid agonist treatments (OATs), combined with a lack of utilization of psychosocial interventions (PSIs), further complicates this issue. Needless to say, the opioid crisis is a complex issue that will need nuanced solutions. We argue that while we have excellent evidence-based medication treatments for opioid use disorder (OUD), they are probably less effective when they are not appropriately combined with PSIs. As the death toll from Canada's opioid crisis continues to mount, it is thus imperative that empirically based solutions, which combine medications with PSIs, are widely implemented and are accessible to all patients with OUD.

## Opioid Medications

There are three Health Canada-approved medications used to treat OUD[2]: methadone, buprenorphine/naloxone (Suboxone) and oral naltrexone (ReVia). All three can be used for either opioid detoxification or maintenance treatment.[2] Moreover, in some parts of Canada such as British Columbia, there are evidence-based medication alternatives such as heroin-assisted treatment (HAT[3]), slow-release oral morphine, and oral or injectable hydromorphone,[4] which may be useful when patients do not respond to or refuse to take first-line OATs. In addition, buprenorphine is now available in injectable and implantable formulations (Sublocade). However, there are considerable gaps in our approach to OUD in Canada. First, there is a clear lack of trained medical prescribers of first-line medications to meet the current needs; most provinces train only a handful of physicians and other health providers in the prescribing of OATs. Moreover, Canadians also experience significant health disparities based on where they live, and those living in rural and remote areas face further barriers to accessing OAT. For example, methadone is not available in many communities, and thus individuals may have to travel significant distances each day to receive daily witnessed medication dispensed at a pharmacy. Indigenous Canadians are particularly disadvantaged in their ability to access OAT due to both geographical and cultural barriers, including a lack of cultural competency in prescribers. Thus, the ease of access and dispensing of a full range of evidence-based OAT is less than optimal in Canada, and these issue needs to be properly addressed.

## The Importance of Integrating PSIs into the Treatment of OUD

While this may not be widely known in the medical community, we have good evidence-based *PSIs* for OUD, including

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motivational interviewing (MI) and motivational enhancement therapy (MET), cognitive-behavioural therapies (CBTs), contingency management (CM), and mutual self-help (e.g., 12 steps; AA, alcohol anonymous; NA, narcotics anonymous).[5] *The evidence for* the efficacy of combining PSIs with OATs has been mixed,[6] and in fact there have been very few well-controlled studies of their integration, such as "dismantling" strategies that study combinations of OAT and PSIs, to OAT and PSIs alone. Notably, there is strong evidence that OAT alone (e.g., methadone without PSIs) can be very effective for detoxification of OUD, and in preventing OUD relapse.[5] Interestingly, while retention in OAT programs in Canada has historically been poor, it is known that providing evidence-based PSIs to OUD patients significantly increases treatment retention in OAT programs,[6], which can improve other treatment outcomes from both harm reduction and abstinence perspectives. Additionally, specifics of which individuals, which psychotherapies, and how they benefit OUD patients remain largely unanswered; it is likely that tailoring the type, intensity, and timing of PSIs with OAT to the individual with OUD may maximize treatment efficacy on the whole. Furthermore, the integration of OAT with psychosocial treatment is recommended in OUD guidelines worldwide.[6] Thus, this lack of consistent integration of PSIs with OATs falls below established standards of care for OUD patients. From a pragmatic stance, we underscore the value of this recommendation by highlighting OUD as a chronic, relapsing condition with significant social and psychological burden, including relational problems, unemployment, and the presence of concurrent major depressive disorder (MDD) and posttraumatic stress disorder (PTSD). *It is important to note that we simply do not have enough well-qualified PSI providers to support evidence-based OAT care in Canada, and that efforts to create more training programs and recruit more providers to acquire these skill sets are needed.* In addition to the availability of psychotherapies to target comorbid mental health conditions, there is evidence that social and employment supports for individuals with OUD improves addiction and mental health recovery outcomes.[5] The complexity of individuals with OUD therefore necessitates targeting of symptoms, skills, and social determinants of health, to ensure optimal outcomes. We argue this is only possible by taking a holistic approach, which combines pharmacotherapies, PSIs and social supports. The role of psychiatrists, or prescribing clinicians skilled in mental health and addictions care, in helping to achieve this integration is of paramount importance,[7] and such training should begin at the level of medical students and residents.

## Putting it All Together

It is increasingly clear that an integrated biopsychosocial approach to the management of OUD is needed to successfully address the opioid crisis in Canada. First, educating clinicians, patients, and families impacted by the opioid crisis about the availability of opioid medications to prevent overdose (e.g., naloxone) and treat *(naltrexone,* methadone, buprenorphine/naloxone, and other treatments) OUDs is needed. We must also address issues of access to OAT, recognizing that there are enormous disparities across the country. Toward the goal of optimizing OAT outcomes, the provision of evidence-based PSIs to complement OATs should be considered essential, but require further study. Second, we must invest in improving the lives of people with OUD, and those at high risk for overdose. Thus, it is critical that we improve access to integrated, culturally sensitive, trauma-informed mental health, addiction, and medical care for OUD.[8] Moreover, we need to provide basic needs such as safe and affordable housing, healthy food, adequate income support, and robust employment opportunities in order to allow individuals with OUD or at risk for it to exist in environments that promote healing, recovery, wellness, and stability.[9]

## Conclusions

Unfortunately, the opioid crisis is continuing, and in 2021, we can expect many more opioid overdose deaths in Canada. Accordingly, this is a clear and compelling public health emergency. While PSIs are often expensive and time consuming, they do make a difference in the lives of patients with OUD and those at risk for fatal opioid overdoses, especially when combined with broad psychosocial supports that address social determinants of health. Accordingly, PSIs should be viewed as an essential part of OUD treatment, and be fully integrated and funded in our models of care for OUD. Investing in standardized, comprehensive prevention and treatment approaches that integrate OAT with broad psychosocial supports which support basic and personalized needs may lead to better overall survival outcomes and quality of life for people whose lives are impacted by OUD and the opioid crisis.

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