

The

INSIDE STORY[®]

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THE SPOTLIGHT IS ON TREATING DEPRESSION



...BUT WHAT ABOUT
PREVENTING IT
IN THE FIRST PLACE?

Given the serious burden of depression on every aspect of life—including the workplace where it drives up absenteeism, presenteeism, and disability—there is now a large body of evidence about treatment. But why not also decrease its impact through prevention? Fortunately, the evidence is building regarding preventing depression, so finally some encouraging news on this topic...

Adding prevention to the mix

Thankfully, effective therapies are available for treating depression, but imagine if we could actually decrease its incidence. Of course, this would be ideal, but Canada's approach to health care—or should we say "sick care"—is often anything but ideal. It typically focuses on reacting to sickness by diagnosing and treating illness, rather than preventing disease onset in the first place.

DEPRESSION TOPS LIST OF CAUSES OF ILL HEALTH

According to the latest estimates from the World Health Organization, depression is the leading cause of ill health and disability worldwide with more than 300 million people with depression in 2015; an increase of more than 18% between 2005 and 2015.¹

The high level of illness and disability is mirrored in how depression impacts workplaces. The Conference Board of Canada estimated that in 2010 only 17% of those with depression and/or anxiety were working full time and fully functioning at work, 40% were working full time but at a reduced level of functioning, 20% were working part time because they are unable to work full time, and the remaining 23% were unable to work at all.²

In addition, as you may recall in the June 2016 issue of *The Inside Story*, we reported that if depression is not the leading cause of your disability claims and costs, it is probably number two. And GSC's Health Study has consistently shown that over GSC's book of business, we pay more claims for antidepressants—both in terms of number of claims and cost—than any other class of medication.

It's clear that plan sponsors are investing a lot of dollars in treating depression. Hopefully, adding prevention to the mix will not only improve plan member health, but also help curb costs.

WHAT IS DEPRESSION?

Major depression—referred to as major depressive episode or disorder, clinical depression, or simply, depression—is a mood disorder with symptoms of sadness and/or loss of interest and pleasure in usual activities that persists beyond two weeks, negatively affecting day-to-day functioning at work, school, or regarding social relationships. There are various types of depression like postpartum depression, seasonal affective disorder, and depression with psychosis.

What causes depression?

There is no simple answer because anyone can become depressed and typically the combination of several interrelated factors—referred to as risk factors—increases the likelihood of getting depression.

Risk factors⁵

Although it is possible to develop depression without any risk factors, usually the more of the following risk factors someone has, the more likely they will develop depression:

- Genetics or family history of depression
- Female gender
- Biological factors (e.g., imbalances in brain chemistry and in the endocrine/immune systems—could be genetic or due to lifestyle behaviours like inactivity and unhealthy diet)
- Chronic physical or mental issues
- Life events
- Social risk factors (like child abuse or neglect)
- Environmental stresses
- Little or no social support
- Personality style (e.g., low self-esteem, pessimistic worrier, perfectionistic)
- Low socioeconomic status
- Sleep disorders
- Certain drugs (e.g., some beta blockers and calcium antagonists used to treat high blood pressure)
- Substance abuse (in addition to a risk factor, it can be secondary to depression as a type of self-medication)

Historically this reactive approach made sense given that Canada's health care system was designed in the post-Second World War era to address acute care needs. However, it no longer makes sense today with just over half of Canadian adults having one or more chronic disease.³ A focus on prevention has never been more important. So why not apply to depression a preventive approach like the ones identified for chronic conditions for decades?

Adding prevention to the mix may also be especially beneficial regarding depression because of its many variations and treatment challenges. As you may recall from the June 2016 and the January 2017 editions of *The Inside Story*, a range of issues have led to today's trends, including prescribing antidepressants at subtherapeutic doses and overprescribing them. And we're sure you will remember (since we keep talking about it) that medication adherence is a significant issue regarding antidepressants where we see a lot of "dropouts"—those who never start their prescription—and "one and done's"—those who don't continue their prescription past the first fill.

Clearly, just like with chronic conditions, there is value in incorporating prevention to tackle the impact of depression. But how?

Identify key risk factors to depression

A main aspect of proactive care is to categorize individuals based on key risk factors. For example, research indicates that four risk factors—tobacco use, alcohol consumption, physical inactivity, and unhealthy eating—lead to 90% of chronic disease.⁴

And here's the kicker... all four are modifiable, which means that proactive interventions have the potential to help people change their behaviour to reduce the risk factors and in turn, reduce their risk of developing a chronic condition.

So in theory, to help plan members from becoming depressed, all we have to do is figure out the risk factors of depression and then offer interventions to help them address risk. Easy peasy, right? Wrong—there is nothing simple about depression. Part of what makes depression difficult to diagnose is its myriad of risk factors. Compared to physical health conditions like cardiovascular disease, a lot less is known about the risk factors of depression, but fortunately evidence continues to emerge. And it's showing that some of the main risk factors are modifiable.



IF PLAN MEMBERS CAN MODIFY LIFESTYLE BEHAVIOURS, THEY MAY BE ABLE TO DECREASE RISK FACTORS, AND POSSIBLY DECREASE THE RISK OF DEVELOPING DEPRESSION.



Not just any risk factors... *modifiable* risk factors

Most existing research surrounding prevention of depression focuses on specific age groups—like adolescents or seniors—and a lot of attention is placed on preventing relapse. However, an Australian study is especially insightful because it used participants ranging from 20 to 64 years old. The researchers developed profiles of the participants that included demographic and lifestyle characteristics, then followed up with the participants over four years to check their health status.

They discovered that participants who had developed full-blown major depressive disorder had initially reported some depression-type symptoms, possibly foreshadowing depression on the horizon. In addition, depression was significantly higher for those who were “younger, smoked, used alcohol at a harmful or hazardous level, used marijuana, did not participate in moderate physical activity, rated their health more poorly, had less education, were in less secure employment or under financial pressure, or had experienced more life events.”⁶

Findings like these highlight the role of *modifiable* factors driving the risk of depression. This provides hope that if plan members can modify lifestyle behaviours, they may be able to decrease risk factors, and possibly decrease the risk of developing depression. In addition, perhaps intervening early can help curb initial depression symptoms from further developing. Here are highlights of several studies contributing to the growing body of evidence around some main modifiable risk factors...

EVEN SMALL AMOUNTS AT LOW INTENSITY

In a study that spanned 11 years, researchers followed 33,908 healthy adults who had no symptoms of mental or physical health issues. The researchers found that regular leisure-time exercise was associated with reduced incidence of future depression. And here comes the really good news: the majority of this protective effect occurred at *low levels* of exercise and was observed *regardless of intensity*. Ditching the research-speak, this means, to get the prevention benefits, it didn't matter how much exercise as long as there was some deliberate physical activity for at least an hour each week—that's it, just a one-hour total!⁸

Physical inactivity

To examine the role of physical activity in preventing depression, researchers recently collected data from 49 studies to create a sample of more than 266,000 people on four continents. Those who followed the guideline of 150 minutes each week of moderate aerobic activity—like cycling or brisk walking—were less likely to develop depression during nearly eight years of follow-up compared with those who didn't meet the guideline.

The researchers theorize that this may be the case because exercise can impact biological risk factors through brain chemistry and the endocrine/immune systems. In addition, exercise may impact environmental risk factors by, for example, providing opportunities for social interaction. Overall, the researchers conclude that exercise helps protect against depression regardless of age or location anywhere in the world—you can't get much better than that. Or maybe you can; another recent, large study found that even small amounts of exercise at low intensity are beneficial.⁷ Sweet! Check out the sidebar.



Unhealthy diet

Turns out comfort food may not be that comforting and in fact, may be doing more harm than good for preventing depression. Researchers analyzed data of more than 5,500 adults, looking at the association between depression and five previously identified factors associated with depression: demographics, lifestyle, diet, biomarkers, and somatic symptoms (bodily sensations that a depressed person may perceive as unpleasant or worrisome, like changes in sleep, appetite, or digestion, as well as fatigue and pain). Not only did results indicate that unhealthy eating heightens the risk of depression, but also that diet had the highest association with developing depression. The researchers think this finding will be key in raising awareness of the association between depression and diet, which is in sync with the growing body of evidence around how gut health affects brain health and behaviour.⁹

Although it is well documented that what happens in your brain can affect your gut, researchers are discovering that the reverse may also be the case. In fact, the gut is now being referred to as a “second brain” or technically, as the enteric nervous system (ENS). The ENS appears to communicate back and forth with the central nervous system and our other brain (the one in the head). And research is building that shows irritation in the ENS may result in signals to the brain that trigger mood changes like depression and anxiety.¹⁰

Poor sleep

Evidence is building that things really do look brighter in the morning, in that a good night’s sleep can help improve mood. Various studies show an association between poor sleep—like sleep disturbances and short sleep duration—and an elevated risk of depression in a range of populations known for sleep issues, such as university students, new mothers, and physician trainees (or think of yourself during the Stanley Cup playoffs).¹¹ In addition, a number of longitudinal studies—where participants are observed and data collected over a period of time, anywhere from several months to several years—support that insomnia is a risk factor for developing both first-onset and recurrent depression.

For example, a study followed 1,244 middle-aged adults for 12 years where a third of women and quarter of men had insomnia. At follow-up, three-quarters of participants still reported insomnia. However, the women who initially reported insomnia were significantly more likely to report feeling depressed. This was not the case with men (interestingly, this jibes with the sidebar about the causes of depression: just being a woman is a risk factor).¹²

Although sleep problems are common in people with a range of mental health issues including depression, the reverse may also be the case—lack of sleep may contribute to mental health issues. In fact, researchers believe that sleep and mood are so closely linked that clinically it is often difficult to tell which came first—the poor sleep or the low mood.

Sustained or chronic stress

When relaxed, the body's chemicals and hormones regulate processes like sleep, hunger, and energy, as well as moods and emotions. Enter stress—particularly stress that lasts a long time or becomes chronic—and you can say goodbye to normal regulation of body processes. Hormones like cortisol rise while others like serotonin and dopamine decrease. When this stress response doesn't shut off, it can lead to depression. In fact, research indicates that stressful life events have been consistently associated with an increase in depressive symptoms in adults and adolescents.¹³ And not surprisingly, the more stressful life events a person experiences, the more likely it is they will develop depression.¹⁴

Although the scientific research continues to show an association between chronic stress and depression, it also provides hope regarding prevention. For example, a recent scientific review examined existing studies of brain areas impacted by chronic stress, anxiety, and fear in humans and animals. The review warns that people need to reduce chronic stress and anxiety, or they may be at increased risk for developing stress-induced damage to the brain that could contribute to depression and even dementia. However, the researchers also provide hope suggesting that stress-induced brain damage may not be completely irreversible. They feel that interventions—like exercise, mindfulness, and cognitive behavioural therapy—warrant further investigation.¹⁵

Let's put all the prevention pieces together... ... eat healthy... exercise (even a little)... sleep well... de-stress

Seem familiar? The modifiable risk factors for depression are in many cases the same as those for various chronic conditions. In turn, many of the preventive measures are also similar. And just like with chronic conditions, there is no magic bullet; it's the *combination* of lifestyle changes that will make the difference in terms of preventing depression. Accordingly, by encouraging plan members to adopt healthier lifestyles, you help them decrease their risk of not just depression, but other health issues.

... And of course, a big part of developing a healthy lifestyle is figuring out how to keep stress at bay in the workplace. As you may recall from the November 2017 edition of *The Inside Story*, the benefits of psychotherapy—like mindfulness and cognitive behavioural therapy—are growing as a way to not just treat depression by de-stressing, but also to prevent it. However, more research is needed, especially on the role of psychotherapy in preventing the initial onset of depression, not just relapse, and on how to implement psychotherapy techniques specifically in the workplace setting. We're on it! To be continued—the results of our new depression prevention pilot project are coming later in 2018 and 2019.



DEPRESSION PREVENTION PILOT PROJECT

GSC is embarking on a pilot project with the University of Ottawa's Institute of Mental Health Research. The project will assess the usability and effectiveness of a web-based program that aims to prevent the onset of depression among employees who are at high risk of developing it.

Here's the plan:

- We'll recruit 200 study participants via the Change4Life® portal by way of a self-assessment.
- Then we'll randomly assign those who meet eligibility criteria—like that they are at high risk of having major depression—into a control group or an intervention group.
- Next, we'll provide both the control group and intervention group with the link to a mental health self-help website filled with information about common mental health problems, self-help resources, and personal stories.
- Then, only the intervention group will have access to the web-based mental health program that is the focus of the pilot project. It includes eight weekly 30-minute online sessions that focus on two therapeutic strategies: cognitive behavioural therapy (CBT) and problem solving therapy (PST).
- Each session includes a homework assignment that participants complete and submit online.
- The program is guided by trained coaches via telephone/text messaging who, for example, provide comments on homework assignments and explain CBT and PST principles and techniques. By the way, you can find out more about CBT here: <https://www.camh.ca/en/health-info/mental-illness-and-addiction-index/cognitive-behavioural-therapy>, and about PST here: <http://www.div12.org/sites/default/files/WhatsProblemSolvingTherapy.pdf>.

Finally, based on follow-up by the coaches with all participants at three- and six- months—as well as responses to online questionnaires—we'll analyze the data. The results will reveal any differences between the intervention and control groups regarding depression and anxiety symptoms, as well as regarding workplace outcomes like presenteeism and absenteeism.

Keep an eye out this summer as we launch the program on Change4Life. And participants will even earn Change4Life points!



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REPORT PROPOSES EXPANDING PUBLIC DENTAL COVERAGE

To ensure all Canadians have access to dental coverage, a new report by the C.D. Howe Institute—called *Filling the Cavities: Improving the Efficiency and Equity of Canada's Dental Care System*—proposes that provincial governments expand public dental programs and move toward universal dental insurance.

Although the report suggests that provincial governments could gradually expand and merge existing public plans until there is universal coverage for all Canadians, it also suggests that private plans could still exist. The approach for the future could be a “mixed model” of public and private coverage that the report suggests would create healthy competition; healthy in that competition could help make the dentistry sector more efficient and help reduce costs.

The report indicates that most of the working poor and many retired people do not have access to dental coverage. This is due to a combination of ineligibility for government dental programs and no coverage by private plans. Also, the report predicts that over the next decade, the lack of dental coverage will likely worsen as the baby boomer generation retires, losing their employee coverage. In addition, the gig economy of contract and freelance workers is expected to continue to grow, which doesn't typically include group benefits.

Benefits of ensuring access to dental care identified in the report include enhanced quality of life and possibly the ability to prevent health issues like heart disease, stroke, and certain forms of cancer; all of which have been linked to lack of access to dental care. Increased access to dental care would also help decrease costly visits to primary-care physicians and emergency rooms.

Although the report presents possibilities for expanding dental coverage to all Canadians, it also recognizes numerous challenges in doing so. For instance, deciding which services to cover, payment models, and regulation would all have to be ironed out to ensure expansion resulted in efficient service delivery.

For more information and to download the report, visit <https://www.cdhowe.org/public-policy-research/filling-cavities-improving-efficiency-and-equity-canada's-dental-care-system>.

DISRUPTED BODY CLOCK LINKED TO MENTAL HEALTH ISSUES

Our body clock—technically known as our circadian rhythms—are the natural variations in our behaviour and activity throughout a 24-hour period where, for example, we experience a sleep-wake cycle and daily hormone release patterns. A new study called *Association of disrupted circadian rhythmicity with mood disorders, subjective wellbeing, and cognitive function* has found a strong association between a disrupted body clock and an increased risk of developing mood disorders, including depression and bipolar disorder, as well as lower subjective well-being, higher neuroticism, and greater mood instability.

The researchers accessed data from 91,105 adult participants in the United Kingdom's Biobank cohort (baseline data and samples from 500,000 adults collected to act as a health research resource to help improve prevention, diagnosis, and treatment of a wide range of illnesses). Data analysis focused on identifying the participants' daily rhythms of activity versus rest. Participants who had less of a distinction between active periods and rest periods—a disrupted body clock—were at greater risk of depression and bipolar disorder. In addition, they had low subjective ratings of happiness and health satisfaction, as well as higher risk of reporting loneliness.

The researchers feel that these results are especially important because this study is the largest of its kind, and because people are increasingly living in urban environments. City living is known to increase the risk of circadian disruption and based on these results, in turn, could increase the risk of developing mental health issues.

For more information and to download the report, visit [https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366\(18\)30139-1/fulltext](https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(18)30139-1/fulltext).

OPIOIDS UPDATE

Opioids warning sticker and patient information now mandatory

To ensure patients receive consistent, relevant information about the safe use of prescription opioids and their potential risks, Health Canada has published regulations that will make it mandatory as of October 2018 for all Canadian pharmacies and doctors' offices to include warning stickers and patient information handouts with any opioids they dispense. The regulations also require pharmaceutical companies to implement risk management plans; this means activities like developing educational materials aimed at reducing the potential harms associated with using their opioid products.

The warning sticker states that opioids can cause dependence, addiction, and overdose. The patient handout includes potential side-effects and the signs of opioid overdose, as well as warnings such as not to share the medication and to always store it safely out of reach of children.

For more information, visit <https://www.canada.ca/en/health-canada/news/2018/05/new-regulations-to-provide-better-information-for-patients-on-the-safe-use-of-opioid-medications.html>.

MAIN REASONS FOR STARTING OPIOIDS

The researchers grouped the reasons for starting opioids into six categories based on the percentage of prescriptions:

- Dental pain: 23.2%
- Postsurgical pain: 17.4%
- Musculoskeletal pain: 12%
- Trauma-related pain: 11.2%
- Cancer or palliative care: 6.5%
- Other types of pain: 17.7%

The remaining 12% of prescriptions was not linked to any of the above categories.

Ontario opioid prescribing exceeding guidelines

A new study—*Clinical indications associated with opioid initiation for pain management in Ontario, Canada: a population-based cohort study*—reports that nearly a quarter of first-time opioid prescriptions in Ontario exceed recommended dose limits. The threshold recommended last year for North American physicians treating non-cancer pain with opioids is that opioids be restricted to less than the equivalent of 90 milligrams of morphine per day, and ideally to less than 50 milligrams. However, when researchers at the Institute for Clinical Evaluative Sciences and St. Michael's Hospital examined initial opioid prescriptions for more than 650,000 Ontarians between April 2015 and March 2016, they discovered that 23.9% of initial opioid prescriptions in Ontario had a daily dose of more than 50 milligram morphine equivalents.

Across all clinical indications, a high percentage of people received daily doses of more than 50 milligram morphine equivalents and prescription lengths exceeding seven days. This combination of prescription dosage and duration has been associated with opioid-related adverse events and long-term opioid use.

The researchers think that the findings should raise awareness of the importance of developing a better understanding of alternative pain management options that might be appropriate for some patients to help avoid reliance on opioids—alternatives like cognitive behavioural therapy and physiotherapy.

For more information, visit <https://www.ices.on.ca/Publications/Journal-Articles/2018/May/Clinical-indications-associated-with-opioid-initiation-for-pain-management-in-Ontario>.

High use of opioids in long-term care facilities

A new report by the Canadian Institute for Health Information—called *Drug Use Among Seniors in Canada, 2016*—conveys that, according to 2016 data, seniors in long-term care facilities in five provinces were twice as likely to be prescribed opioids compared to other people their age, and three times as likely to be taking antidepressants.

Regarding opioids, almost 40% of long-term care residents in British Columbia, Manitoba, New Brunswick, Ontario, and Prince Edward Island were prescribed opioids, compared to 20.4% of seniors in the community. And in terms of antidepressants, about 60% of the long-term care residents were on antidepressants, compared to 19.1% of seniors in the community.

For more information and to download the report, visit <https://www.cihi.ca/sites/default/files/document/drug-use-among-seniors-2016-en-web.pdf>.

OUT & ABOUT... *Events not to miss*

HR Tech Summit

June 26 & 27 – Toronto Congress Centre

<http://hrtechsummit.com/toronto/>

Peter Gove, GSC's innovation leader – health management, will be speaking about the opportunities and limitations to consider when introducing online health portals to employees.

June
Haiku

Move the discussion
To preventing depression
It's the next level

FITBIT WINNER

Congratulations to **M. BRILLANTES**, of **SCARBOROUGH, ON**, the winner of our monthly draw for a Fitbit. Through this contest, one name will be drawn each month from plan members who have registered for Plan Member Online Services for that month.

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