



Recommendations for Addressing the Opioid Crisis in Canada

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The Canadian Psychological Association (CPA) is the national association for the science, practice, and education of psychology in Canada. CPA's chief mandate is to improve the health and welfare of all Canadians, which we accomplish by supporting and promoting the development, dissemination and application of psychological knowledge. CPA is committed to working with government and other health and science stakeholders in advocating for public policy that is evidence-informed and best meets the needs of the public it serves. It is the science and practice of psychology, particularly in the areas of mental health and addictions, that CPA brings to the following set of recommendations to address the opioid crisis in Canada.

Canada is in the midst of an opioid crisis that has resulted in increasing morbidity and mortality, with devastating effects for people, families, and communities. There were more than 10,300 apparent opioid-related deaths in Canada between January 2016 and September 2018. Critically, there was nearly a 40% increase in apparent opioid-related deaths in Canada between 2016 and 2017, and the number of opioid-related deaths in the first 9 months of 2018 exceeded the total in 2016. In 2016-17, there was an average of 17 hospitalizations every day in Canada due to opioid poisonings. Opioid-related harms continue to grow at alarming rates.

Understanding the Opioid Crisis

Between January and September 2018, most opioid-related deaths were accidental (93%) and occurred among males (75%), with distribution by sex varying by province or territory. Most deaths occurred amongst individuals between the ages of 30 and 39 years (27%), 20% of deaths occurred amongst individuals between 20-29 years, 21% were between 40-49 years, and 21% were between 50-59 years. In addition, 75% of accidental apparent opioid-related deaths involved one or more types of non-opioid substances (e.g., alcohol, benzodiazepines, cocaine, methamphetamine).

As described in the 2018 summer edition of *Psynopsis*, there is a complex interplay of **multiple factors** that have resulted in this opioid crisis. Currently, the high rates of apparent opioid-related deaths are linked to an increase in illicitly manufactured **fentanyl and fentanyl analogues** available and sold on the streets. There is a contaminated drug supply, with fentanyl being “cut” into other substances (i.e., heroin, cocaine) or sold as counterfeit pills that resemble other prescription opioid drugs. This leads to dire consequences as people are inadvertently taking fentanyl, unaware that it has been added to other drugs. Between January and September 2018, fentanyl or fentanyl analogues were involved in 73% of accidental apparent opioid-related deaths, which is an increase from 55% in 2016.

There is also legitimate public health concern about **opioids prescribed for pain relief**. One in five Canadians report living with chronic pain, and one-third of these describe their pain as severe. In 2016, 1 in 8 people in Ontario were prescribed an opioid medication. Canada is also the second largest consumer of prescription opioids in the world. The overprescribing of opioids, including high-dose opioids, to manage chronic pain is a factor in the crisis. Increased opioid prescribing can be linked to an increase supply of opioids in the environment.. With more drugs in circulation, there is greater likelihood they will also be more available to those for whom they were not prescribed. Initiatives to reduce opioid

¹ References appear at the end.

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prescribing have at times led to abrupt discontinuation or lack of access to prescription opioids, which can lead to illicit opioid use and exposure to fentanyl and its analogues.

Prescription opioids, such as oxycontin, were historically marketed in a way that minimized risk, including the risk of addiction. Opioid consumption carries a 5.5% risk of developing addiction, and is associated with an increased likelihood of overdosing at higher doses. However, even low levels of opioids [<20 Morphine Equivalent Dosing (MED)/day] produce a risk of both fatal (0.1%) and non-fatal overdose (0.2%). There is growing evidence that many people living with persistent, non-cancer pain have improved pain, function, and quality of life when opioid use is reduced. Among individuals taking prescribed opioids, people with serious mental illness and/or active substance use disorder are at elevated risk of opioid use disorder and overdose. For example, for people diagnosed with serious mental illness, the risk of opioid addiction from prescribed opioids is 8%, and even low-level opioid intake (<20 MED/day) produces elevated risk of fatal (0.15%) and non-fatal overdose (0.3%) in such individuals. Furthermore, people with chronic non-cancer pain and active substance use disorder who consume less than 20 MED per day had increased risk of opioid addiction (5.5% to 8.9%), non-fatal overdose (0.2% to 0.9%), and fatal overdose (0.1% to 0.5%). We are particularly concerned about the risks of prescribed opioids to these vulnerable Canadians. Notably, regardless of whether opioids are initially taken for pain relief or for psychoactive effect, once opioid use disorder develops, individuals report that opioids primarily serve to relieve psychological distress (often due to serious pre-existing psychological disorders), including the distress associated with opioid withdrawal.

Lack of access to non-pharmacological treatments for pain (including psychological treatments) exacerbates the issue. **Lack of access to evidence-based treatment for opioid use disorder**, including opioid agonist therapy (i.e., buprenorphine/naloxone), contributes to the crisis, as do **silos between substance use and mental health systems** (despite high comorbidity levels).

Stigma, including stigma towards people living with substance use, mental health or chronic pain problems, contributes to this crisis. People with opioid use disorder deserve treatment with the same parity as those with other health disorders, and it should be delivered compassionately and with respect for the dignity of the individuals struggling. Finally, we must address **the social determinants of health** and social, psychological, and biological risk factors (including adverse childhood experiences) for opioid use disorders and chronic pain disorders to make headway.

Psychological Approaches for the Prevention of Problematic Opioid Use

While much of the attention on the opioid crisis is downstream, focusing on upstream efforts (i.e., prevention) is crucial to addressing the crisis. Adverse childhood experiences (including abuse, neglect, and household challenges) are associated in a graded dose-response relationship to numerous negative health, behavioural, and social problems across the lifespan, including - chronic pain, problematic opioid use, and injection drug use. Evidence-based preventative interventions are critical because they can delay early use and stop the progression from use to problematic use or even addiction. However, there is very little opioid-specific prevention data due to a dearth of programs designed to specifically prevent opioid use, and a general failure to assess opioid outcomes in programs designed to prevent or intervene early with substance use in youth.

Studies have examined the longer-term efficacy of established universal prevention programs as a public health strategy for reducing risk for non-medical prescription opioid use. For example, the Strengthening Families Program for Parents and Youth (10-14 years), which -- either alone or in combination with a school-based universal skills program for youth (i.e., the Life Skills Program) -- shows significant reduction

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in risk for non-medical prescription opioid use from Grade 12 to age 25 (relative risk reduction of 21% to 65%). There is evidence that Strengthening Families Program plus Life Skills Training works better for reducing risk of non-medical prescription opioid use in higher risk adolescents than lower risk adolescents. These types of programs show promise, but this area is under-developed and under-researched as yet. Thus, **a range of preventive interventions targeting opioid use needs to be developed, tested, and broadly implemented.**

In addition to universal programs that target all young people, targeted prevention programs (e.g., Preventure) that selectively intervene with young people at high risk should be considered. Risk factors for problematic opioid use that could be targeted include personality (depression-proneness; impulsivity), mental health disorders (e.g., anxiety, depression), genetics (including family history of addiction), age (15-24 year olds), pain conditions, other substance use, adverse childhood experiences, trauma history, and poverty, each of which could be targeted in prevention. Prevention programs can also target the building of protective factors such as resiliency. The developmental timing is important -- deliver preventative interventions when students are beginning to experiment with substance use but before students move on to more frequent or serious use.

Evidence-Based Treatment of Opioid Use Disorder

Addiction is often equated with 'bad choices', 'bad behaviour', personality flaws, and/or moral or ethical failings, rather than being conceptualized as a health care concern needing treatment. Stigma prevents Canadians from seeking help and engaging in ongoing care. Stigma must be addressed in order to reduce barriers to care. Compassionate, accessible, and evidence-based treatment of opioid use disorder is imperative.

The first-line treatment for opioid use disorder (OUD) is opioid agonist treatment, particularly buprenorphine-naloxone, due to its safety profile. Combining opioid agonist treatment with psychological interventions has been shown in some studies to lead to improved outcomes, including improved treatment retention and reduced opioid use. Cognitive-behavioural therapy, contingency management, and web-based behavioural interventions, when provided in addition to methadone maintenance therapy, have been shown to be effective at reducing opioid use. Other psychosocial interventions such as use of a telephone support system and community reinforcement and family training, when offered in combination with buprenorphine treatment, have been shown to be associated with reductions in opioid use and increases in treatment adherence, relative to treatment as usual.

It is critical to integrate harm reduction strategies and interventions (i.e., education, naloxone kits, access to safe supplies, supervised consumption services) across all services and treatments for individuals with problematic opioid use, OUD, as well as those receiving prescribed opioids, as this is critical to reduce infections, overdoses, and deaths.

Psychological Interventions for Pain Management

Opioids have long played a central role in pain management in acute care (e.g., after surgery) and in treatment of cancer pain. More recently, the use of opioids for chronic non-cancer pain became extensive.

When pain becomes chronic (lasting for more than three months), focusing narrowly on reducing pain intensity through the use of opioid medications has limited long-term effectiveness and confers risks of

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side effects, overdose, and opioid misuse. Contrary to expectations, long-term opioid use may lead to poorer functioning and even higher pain levels, due to opioid-induced hyperalgesia. Recommended psychological interventions for people living with chronic pain, with an evidence-based track record of efficacy, include:

- Cognitive Behavioral Therapy
- Acceptance and Commitment Therapy
- Mindfulness Meditation
- Clinical Hypnosis
- Biofeedback
- Self-Management
- Motivational Interviewing

Psychological interventions can lead to biologically mediated changes in pain perception, leading to reduced pain intensity, as well as reductions in pain-related distress and disability that improve quality of life. Opioids have been accessible despite risk of harm and concerns about long-term effectiveness, while psychological treatments with less risk of harm have not been publicly funded and accessible.

For legacy patients who have been prescribed high dose opioids under older pain treatment guidelines, the 2017 *Canadian Opioid Guideline for Chronic Non-Cancer Pain* recommends referral to multidisciplinary pain programs if they are “experiencing serious challenges in tapering.” While we agree with the recommendation for multidisciplinary care, there is not yet scientific evidence as to what specific psychological treatment protocols should be followed to facilitate opioid tapering. More psychological research is needed – and, indeed, is underway.

Considering the Needs of Women

Sex and gender must be considered when addressing the opioid crisis. There are key differences between men and women regarding opioid use. It is important to consider the specific needs of women, which may result from biological factors, socio-economic status, family roles, reproduction, child care responsibilities, and vulnerability to sexual and intimate partner violence.

Important gender differences relevant to the opioid crisis include:

- Higher rates of prescription opioid use among women (64% of people who use opioid pain relievers are women)
- Higher prevalence of many pain disorders
- Higher prevalence of depression and anxiety disorders
- Women are also more likely to be prescribed drugs that confer added risk when combined with opioids, such as anxiolytics
- Women are more likely to misuse opioids after being prescribed them
- Women are more likely than men to be admitted to hospital for intentional opioid overdose
- Women progress from use of opioids to dependence more quickly than men
- Women suffer more severe emotional and physical consequences of drug use than men

Data show that a majority of women living with addictions have suffered severe trauma, such as childhood sexual abuse. Biological effects of trauma over time contribute to mental health disorders, chronic pain, and increased vulnerability to substance use disorders. In addition, women living with opioid use disorder

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are more likely to meet criteria for Borderline Personality Disorder, which is often associated with a trauma history, is hypothesized to be associated with dysregulation of the endogenous opioid system, and can be effectively treated with behavioral methods that are at this time seriously underfunded in relation to population need. The needs of women suffering from the sequelae of trauma, including the mental health sequelae, are important considerations in planning treatment programs. That the particular needs of women have not been adequately addressed is demonstrated in the fact that women are under-represented in treatment settings. Lack of access to childcare, fear about their children being removed if they disclose a substance use problem, and lack of trauma-informed services create barriers to women accessing and engaging in care.

Considering the Needs of Youth

Youth are a particularly vulnerable group affected by the opioid crisis. In Canada, young people, aged 15 to 24, had the fastest-growing rates of hospitalizations due to opioid poisoning between 2007 and 2015. The onset of mental health and substance use problems often occur during this age cohort as well. Concurrent mental health and substance use disorders are the norm amongst youth, with higher rates than other age groups in the Canadian population. Youth with opioid use problems have unique needs compared to adults. Some evidence suggests more complex substance use and mental health problems than adults. Treating OUD in youth should be developmentally and culturally appropriate, safe, low barrier, youth-centred, collaborative, flexible, evidence-based, trauma-informed, and integrate harm reduction and treatment for concurrent mental health disorders. Families (as defined by the youth) should be involved as appropriate. Existing evidence strongly supports buprenorphine/naloxone as first line treatment for youth with moderate to severe OUD. Guidelines recommend psychosocial and psychological treatments should be offered to youth struggling with opioid use problems. Similar to adults, detoxification and withdrawal management alone should be avoided due to associated risks of relapse, overdose, and mortality. Interventions should be tailored to the unique needs of youth, and not presume a “one-size fits all” approach.

Understanding the Needs of Indigenous Peoples

Opioid use problems are a serious concern for Indigenous communities living in Canada (i.e., First Nations, Metis, and Inuit). Indigenous individuals have a higher rate of opioid use problems and overdose events – for example, recent statistics from British Columbia indicate that Indigenous women in BC are experiencing eight times more overdose events and five times more deaths from overdose than non-Indigenous women, and Indigenous men are experiencing three times more overdose events and deaths than non-Indigenous men. The problem of opioid use is not evenly distributed across Canada’s Indigenous populations, with communities more linked to the rest of Canada struggling more with opioid use than communities in rural and remote locations.

Trauma, loss, poverty, and family separation resulting from colonization are widely understood to have had far-reaching and multi-generational impacts on the mental wellness of Indigenous Peoples, which has contributed to opioid use problems. In addition, Indigenous Nations and individuals continue to face structural racism across many fronts, including access to healthcare. It is essential for opioid problems within Indigenous communities to be contextualized within this historical and ongoing socioeconomic context.

Traditional Indigenous perspectives and values about wellness are different from those of Western biomedicine. Traditional approaches to healing, including traditional medicines, are sophisticated and

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have benefited Indigenous Peoples for thousands of years. At the same time, Western interventions for addressing opioid use disorder and overdose are increasingly implemented by Indigenous communities and desired by Indigenous individuals seeking treatment (including buprenorphine or methadone, as well as the emergency use of naloxone to treat opioid overdose; however, no published research of which we are aware has examined the use of these interventions with Indigenous individuals). Interventions informed by “two-eyed seeing” (the practice of creating wellness plans with the best evidence available from both Western and Indigenous wellness methodologies) should be available to Indigenous individuals, in order to determine what aspects of each are best suited for healing.

Reducing Criminality Associated with Opioid Use

The legalization of cannabis in October of 2018 leads to the question of whether the laws prohibiting the non-medical use of opioids should also be revisited. The main argument in favour of a more permissive drug policy is that current laws push the non-medical use of opioids underground into a culture of criminality, leading to criminal records, incarceration, stigma, and avoidance of treatment. Decriminalization for possession (i.e., replacing criminal penalties with fines or warnings) or outright legalization are approaches that shift the emphasis from criminal justice enforcement to health and welfare considerations.

In Canada, the beginnings of such a shift are already evident in several ways: (1) prescription injectable opioid agonist programs that provide supervised access to controlled drugs; (2) good Samaritan laws that protect individuals from prosecution if they report the occurrence of a suspected overdose, and (3) supervised consumption sites which allow drug use to occur in a safe, monitored environment without the risk of arrest.

Other jurisdictions around the world have gone further with respect to decriminalization. For example, Portugal and the Czech Republic have made possession of illicit drugs for personal use an administrative offense, rather than a criminal one. Uruguay has introduced full legalization. These options have been reviewed recently for the Canadian Centre on Substance Use and Addiction. Although there are few rigorous evaluations, the Portuguese experience includes reductions in costs associated with transmission of HIV/AIDS, productivity improvements among the drug-using population, and reduced demand on law enforcement resources, prisons, and the courts, without any marked increase in use.

Recommendations for Addressing the Opioid Crisis

The opioid crisis is a complex issue, which requires a complex solution. Through advocacy, research, practice, education, and leadership, Canadian psychology can help address the crisis through multiple means. We need to break down system silos, including those between the mental health and substance use systems, as these silos are harming Canadians. We need to work collaboratively with our partners across disciplines, systems and sectors—there is power in the collective. We must ensure meaningful engagement with people with lived and living experience in all of our efforts. Based on the above findings about the nature of the current opioid crisis, and the needs of Canadians, the CPA makes the following recommendations, including recommendations for research priorities to address important gaps in our knowledge base:

STIGMA

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- Combating stigma, including stigma related to substance use, mental health, and chronic pain problems, is key to combating the opioid crisis. Funding is needed to address stigma at multiple levels, including at the individual, healthcare, educational, criminal justice, structural, organizational, and societal levels. It is important to meaningfully engage people with lived and living experience (including families) in this work.
- Funding is needed to develop and evaluate the effectiveness of current and novel strategies to reduce stigma, including those targeted to reduce stigma amongst health care providers. While education is important, it is not sufficient to end stigma.
- Substance use disorders need to be treated as a mental health issue not as a criminal matter.

PREVENTION

Prevention of opioid use disorders.

- Investment in evidence-based and accessible prevention programs for young people to prevent problematic opioid use, including school-based programs, is needed. Targeted prevention programs that selectively intervene with high-risk individuals (e.g., Preventure) are a priority.
- Prevention programs can target risk factors (i.e., personality, mental health disorders, adverse childhood experiences, trauma) for problematic opioid use and OUD. Prevention programs can also target the building of protective factors such as resiliency.

Prevention of persistent pain and high dose opioid use.

- Interdisciplinary pain programs are being developed that aim to help people suffering from acute pain who are at high risk of developing chronic pain after injury and surgery. Risk can be stratified based on medical variables (e.g., type of surgery) as well as psychological variables (e.g., history of depression/ trauma). Accessible consultation on opioid-sparing medications, as well as psychological interventions and physiotherapy, can be provided to reduce pain chronicity and reduce long-term opioid use.
- Opioid prescribing guidelines can help limit the in-flow of extra, unneeded prescribed opioids into Canadian homes following critical events such as surgery, while ensuring that adequate opioids are prescribed for expected pain, thus reducing the risk of diversion and use by family and friends.

HARM REDUCTION

Harm reduction is key in the context of the opioid crisis.

- Equitable, easy, and rapid access (i.e., same day access) to full range of harm reduction services (e.g., education, safe supplies, vaccination, infectious disease testing, supervised consumption services, naloxone kits) save lives and can reduce the impact of the opioid crisis.
- Harm reduction services should be offered to all people who use opioids (including prescribed opioids) and integrated across the care continuum, including within substance use treatment services (i.e., residential treatment services).

Harm reduction can also be applied in terms of pain management.

- Important initiatives in harm reduction for people living with persistent pain include ensuring that patients with a history of taking pain medication are not seeking drugs through illicit channels, with the risk of obtaining contaminated and dangerous drugs. With that in mind, prescribing opioid medication so that people do not have to buy contaminated drugs on the street is a harm reduction approach that should be followed by appropriate pain care.

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- Patients taking opioids should not be abruptly weaned or tapered. When an opioid taper is recommended, it must be undertaken with the awareness that opioid tapering is a time of increased risk. Tapering too quickly can trigger withdrawal symptoms that are difficult to bear, thus leading to people living with pain to seek opioids through other channels, including pain medication from the street which may be contaminated with fentanyl, or street drugs like heroin which may not have been used before, thus leading to additional risk of overdose and death. Tapering must always be done gradually under physician or nurse practitioner supervision, with the patient's consent, and with ongoing support and monitoring of pain and functioning, as well as management of withdrawal symptoms. Another option is rotation to buprenorphine/naloxone or methadone, then gradual tapering. Tapering can reduce the risks of opioid use even if doses are reduced, rather than completely weaned.
- People living with pain can be offered the option of transitioning to buprenorphine-naloxone (or other opioid agonist therapy) as appropriate. Surprisingly, some patients report markedly less pain after this transition as they are no longer suffering from opioid-induced hyperalgesia, which is when opioids paradoxically increase pain levels.

TREATMENT

It is a priority to build the capacity of the primary care system to assess and treat opioid-related concerns.

- We strongly recommend better integration of the mental health, addiction, primary care, public health and pain systems of care.
- Canadians are most likely to seek care from their primary care team. As such, it is imperative that we build capacity for assessment and treatment of opioid use disorders, pain disorders, and co-morbid mental health problems within primary care settings.
- Psychologists can contribute their expertise in identifying, assessing, and treating substance use and pain disorders in primary care through family health teams.

Building capacity among psychologists is additionally important.

- Psychologists have considerable expertise in both pain and substance use; however, we are not building capacity at this time at the rate that is needed to address this crisis. Training and continuing education programs for psychologists should build competence in the treatment of opioid use disorders and pain disorders.

Treatment for opioid use disorder should be empirically supported, accessible, and offered within a context that reduces stigma. All treatment systems and services should meaningfully engage people with lived and living experience (including families) in their design, implementation and evaluation.

- As people with mental health problems are at increased risk of opioid use problems, psychologists should routinely screen for problematic opioid use using validated tools. Based on screening, psychologists should further assess for opioid use disorders and readiness to change opioid use as part of a comprehensive assessment.
- Opioid agonist treatment (OAT) should be the first-line treatment for OUD and should be accessible to all, including eligible individuals with a pain disorder. Psychological treatment approaches to OUD are used in conjunction with OAT. Opioid detoxification and withdrawal management alone should be avoided, due to the increased risk of relapse, overdose, morbidity, and mortality.
- Psychological therapy -- offered by well-trained service providers grounded in empirically supported approaches -- can be paired with opioid agonist treatment to improve treatment

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retention and opioid use outcomes. Treatment should be targeted to help individuals' achieve their recovery goals (including abstinence and harm reduction).

- Funding is needed for healthcare professional training on opioid use disorders, other substance use disorders, pain, and co-morbid mental health disorders to build provider capacity and competence to identify, assess, and treat opioid use problems and pain. Psychologist training and continuing professional education programs should build competence in the treatment of opioid use, substance use, and pain disorders, and related problems.
- Comorbidities of OUD and mental health disorders are high. Thus, concurrent and integrated treatment should be provided for concurrent OUD and mental health disorders. Integrated care is the gold standard. Concurrent disorders care (including psychological treatments for mental health and substance use disorders) should be part of the publicly funded health care system and not solely part of the private sector. Failure to provide accessible treatment within the publicly funded system creates barriers, contributes to stigma, and will interfere with addressing the opioid crisis.
- Psychological treatment of mental health vulnerabilities that can lead to concurrent opioid use (including depression, anxiety, post-traumatic stress disorder, and personality disorders) should be publicly funded and accessible.
- Reducing stigma is essential to reduce barriers to care, and will entail intervention at multiple levels, including the individual, educational, and societal level.
- Treatment should be tailored to the unique needs of youth, and should be developmentally appropriate, low barrier, youth-centred, and integrate harm reduction and concurrent disorders treatment (mental health and substance use).
- There are significant gaps in the research on treatment of OUD, and even the most successful interventions show highly variable outcomes. We need to better understand the type, format and duration of psychological interventions that work best in combination with opioid agonist therapy. Research is needed to identify strategies to implement existing evidence-based interventions into services and care given the challenges that exist with widespread adoption of evidence based practice (i.e., concurrent disorders treatment; buprenorphine/naloxone treatment).
- Further research is needed to examine the relationship between opioid use disorder and mental health disorders. Research is also needed to examine the efficacy of psychological and pharmacological treatments for those with OUD and common comorbidities, including depression, anxiety, PTSD, other substance use, sleep disorders, and chronic pain.
- Research is needed to examine effective treatments (pharmacological and psychological) specifically for youth with OUD, including those with OUD and mental health disorders, given the dearth of research in this area.

Treatments priorities for people living with persistent pain include publicly funded psychological therapies for pain coping, co-morbid mental health issues, and opioid tapering.

- We need increased funding for multi-disciplinary pain management and opioid weaning clinics. These clinics were recommended as part of standard care in the 2017 opioid guidelines for Canada; however, with one multi-disciplinary pain management clinic for every 50,000 Canadians living with pain, few of us can access behavioral support for pain management or opioid weaning.
- Equitable, rapid access to behavioral treatments for pain is needed. In addition, the psychological vulnerabilities (e.g., depression, anxiety, trauma history) that can exacerbate pain and increase vulnerability to problematic opioid use in people struggling with pain needs to be addressed with publicly funded and accessible programs.

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- Behavioral pain treatments need to be adapted to explicitly address opioid tapering goals. Psychological treatments can support people living with pain so to identify personally meaningful and motivating opioid tapering goals, address psychological barriers to reducing use (e.g., increased anxiety upon withdrawal), and utilize empowering psychological strategies to cope with pain while moving forward in their lives based on their own goals and priorities.
- There is ample evidence that people with pain that is not accompanied by obvious tissue damage are rated by health care providers as having lower pain intensity and are viewed less sympathetically and more suspiciously. Educating health care workers broadly on the often-invisible suffering of our fellow Canadians who are living with pain will help to reduce stigma and unhelpful interactions with health care providers. Psychologists can be leaders in providing education on the science of pain, including central sensitization, and how pain can persist after tissues have healed.
- Rigorous, controlled clinical trials are needed in which psychological interventions are deployed for acute and chronic pain, and the outcomes measured include those both historically assessed (e.g., pain intensity, pain-related distress, and physical function) and opioid use (e.g., self-report diaries, prescriptions filled, urine tests, etc.).

Treatment priorities for women who use opioids include reducing barriers to care and understanding the special considerations that come with pregnancy. Systems and services should be co-designed along with women and people with lived/living experience.

- **Prevention.**
 - Prevention strategies for pregnant women should not use fear-based interventions. Shaming language or graphics aimed at women as these have been shown to be ineffective, but instead, focus on education in normalizing and respectful ways.
 - Prevention materials should incorporate a gendered lens and promote equitable relationships and responsibility for families, for example, campaigns that encourage both parents to support each other's use of harm reduction techniques or to seek support for their addictions, rather than positioning the mother as the gatekeeper of the family's health.
- **Treatment.**
 - When providing treatment for women, a multimodal approach should be standard and incorporate medical, psychological and support for activities of daily living, including evidence-based psychological interventions, such as Dialectical Behaviour Therapy and Seeking Safety.
 - Trauma-informed care, which utilizes a strength-based approach, offers choice, voice and control to clients, and works to provide a welcoming and safe space is essential to effective work with women, as well as all individuals who struggle with opioid use.
- **Special Considerations for Pregnancy and Motherhood.**
 - Reducing the stigma of opioid use so that pregnant people can access services and care is essential. Routine, non-judgmental screening for substance use should be undertaken at the first prenatal assessment and throughout the pregnancy.
 - Opioid Agonist Therapy (OAT) should be a priority for pregnant people with OUD, as it has been associated with improved neonatal outcomes, such as fewer preterm births, higher birth weights, and increased likelihood of babies being discharged from hospitals with their mothers following birth. In addition, access to wrap-around care and integrated services is effective, including: education and outreach, low barrier services (including trauma-informed therapy), food vouchers and prenatal vitamins, collaboration between

child welfare services and wellness services, and assistance with transportation and childcare to attend appointments.

- Rooming-in, where parents and their babies who are recovering from Neonatal Abstinence Syndrome (NAS) stay together in the same room, has been found to offer both health benefits for babies and promotes family-centered care.
- Lack of family support or reluctance to be separated from their children can be a major barrier to women accessing treatment for addiction. Integrated treatment centres allow women to attend with their children and can offer parenting skills coaching as well. Programs such as Sheway in Vancouver integrate many or all of these services and have played a role in stopping a multigenerational cycle of addiction, poverty and child removal.
- **Sex and gender should be routinely incorporated into research and include the meaningful involvement of stakeholders (e.g., women with lived/living experience)**
 - There is a paucity of research that considers sex and gender in its design, methods, analysis and findings. All research that addresses the opioid crisis, including prevention, harm reduction, and treatment, should integrate sex and gender.
 - More research is needed to understand the barriers to care experienced by women, and strategies to mitigate these barriers.

Treatment of Indigenous Peoples must be offered with local consultation so it can be designed in a culturally-centered manner, thus improving engagement and effectiveness.

- Indigenous Peoples generally have reduced access to mental health and addiction treatment, including opioid agonist therapy, compared to the general population. Ensuring equitable access to adequate treatment for Indigenous Peoples across Canada should be a federal priority.
- Investigating facilitators and barriers for treatment access and implementation among Indigenous communities should be a priority. Opioid agonist treatment should be integrated with holistic and culturally-centered care, while addressing underlying vulnerabilities to substance use problems.
- Given the history of colonization, it is imperative that interventions into Indigenous communities from outside practitioners be carefully planned in order to be culturally and emotionally safe. Treatment facilitators and service providers should invest time in finding local cultural resources, including Elders, knowledge keepers, and partnerships with Indigenous organizations in order to understand community goals and perspectives in regards to opioid addiction. In addition, non-Indigenous practitioners working with Indigenous populations on opioid addiction should receive mandatory cultural safety training relevant to the specific First Nations, Inuit or Metis communities they are working with.

Reducing Criminality Associated with Opioid Use

- Considering that substance use disorder is considered a medical condition, and the grave problems with the illicit drug supply, it behooves us to re-examine our laws and policies that criminalize substance use. A public health approach, rather than a criminal justice approach, is needed. This work can be informed by other countries that have decriminalized substance use, with promising results.

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