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The role of psychology in mitigating Canada's opioid crisis

Le rôle de la psychologie dans l'atténuation de la crise des opioïdes du Canada

Kimberly Corace, PhD, C. Psych.
Guest Editor/Rédactrice en chef invitée

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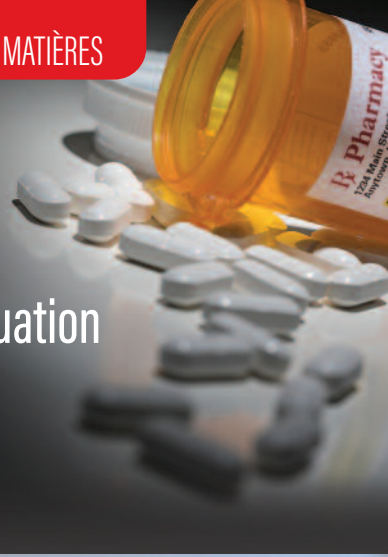

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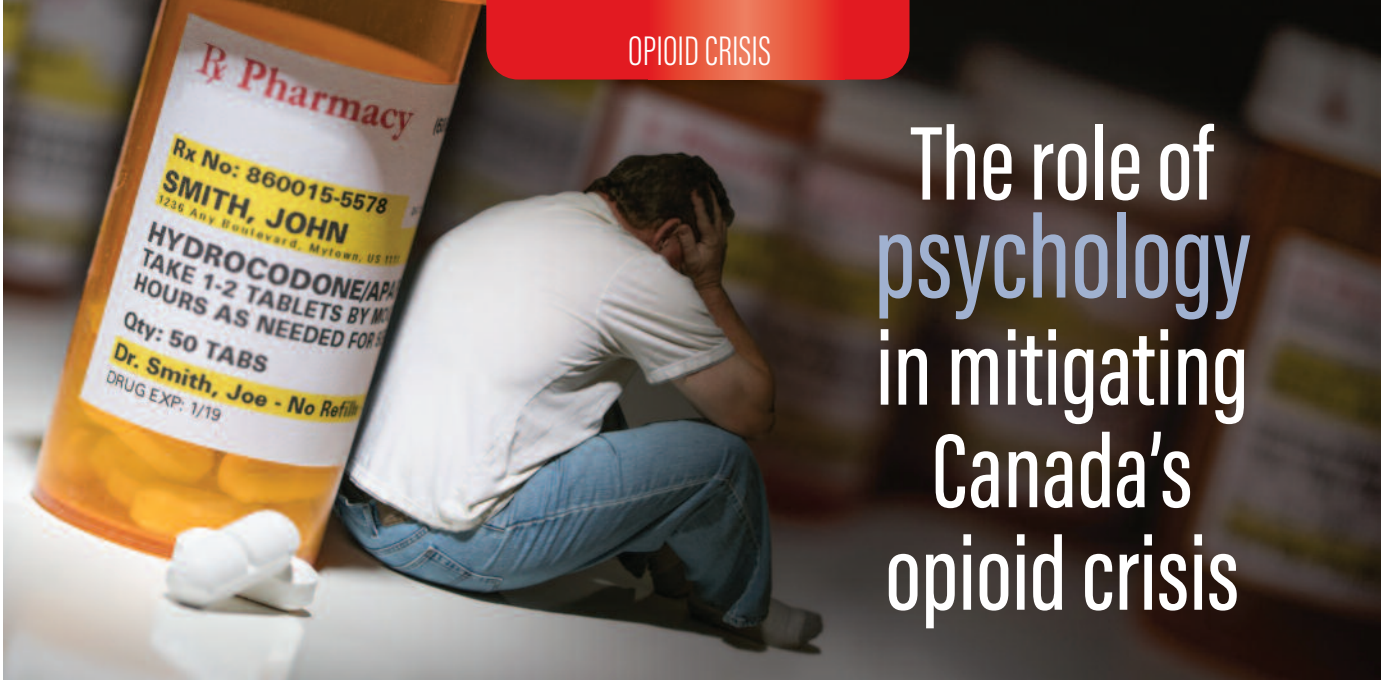

The role of psychology in mitigating Canada's opioid crisis

Kimberly Corace, PhD, C. Psych, The Royal Ottawa Mental Health Centre, University of Ottawa, Institute of Mental Health Research

Canada is in the midst of an opioid crisis, with devastating effects for individuals, families, and communities. There were nearly 4,000 apparent opioid-related deaths in Canada in 2017, which represented a 34% increase from 2016.[1] In 2016-17, there was an average of 16 hospitalizations every day in Canada due to opioid poisonings.[2] The crisis is continuing to grow at alarming rates, and most certainly, each and every one of us has been touched by it in some way.

How did we get here? There is no one reason; it is a complex interplay of multiple factors.[3,4,5] Most recently, the high rates of opioid-related poisonings and deaths are linked to an increase in illicitly manufactured fentanyl – a highly potent and toxic synthetic opioid – and fentanyl analogues available and sold on the streets. Fentanyl is being "cut" into other substances (i.e., heroin, cocaine) or sold as counterfeit pills that resemble other prescription opiod drugs. The consequences of the contaminated drug supply are dire as people are inadvertently taking fentanyl, unaware that it is in their drugs. In 2017, fentanyl or fentanyl analogues were involved in 72% of accidental apparent opioid-related deaths, which is an increase from 55% in 2016.[1]

Canada also has the unenviable distinction of being the second largest (or largest depending how it is defined) consumer of prescription opioids in the world.[6,7] The over-prescribing of opioids, including high doses of opioids, to manage chronic pain is a factor in the crisis. Previously, prescription opioids (i.e., oxycodone) were marketed as low risk and non-addictive.[8] Yet, there are significant risks associated with the use of opioids for chronic non-cancer pain, including nonmedical use and addiction.[7] Increased prescribing is also linked to an increase supply of opioids in the environment through diversion. Further, abrupt discontinuation or lack of access to prescription opioids can lead to illicit opioid use.[9] Lack of access to non-pharmacological treatments for pain (including psychological treatments) only compounds the issue. If opioids are easily accessible and publically funded, and non-pharmacological treatments are not (despite evidence of benefits), then where does this leave Canadians?

Finally, poor access to evidence-based treatment for opioid use disorder, including opioid agonist therapy (i.e., buprenorphine/naloxone), contributes to the crisis. Opioid use disorder is a "primary, chronic disease of brain reward, motivation, memory and related circuitry."[10] People with opioid use disorder deserve treatment with the same parity as those with other health disorders, including with compassion and dignity. Furthermore, there are the social determinants of health and social, psychological, and biological risk factors for opioid use disorders, including mental health problems, trauma, adverse childhood experiences, food and housing insecurity, and poverty.[4,5]
We need to address these root causes to make headway.

Complex problems require complex solutions – and just like no one thing caused this crisis, no one thing will fix it. Agencies, organizations, jurisdictions, and governments at all levels are working together to develop and implement a comprehensive response to mitigate this crisis, including a focus on prevention, treatment, harm reduction, and enforcement.[11] Canadian psychology also has an important role to play. From psychologists working on the front-lines, to psychology researchers developing and evaluating effective interventions, to psychology training programs preparing the next generation of psychologists – we can and must play a key role in addressing this crisis. In this issue of *Psynopsis*, clinicians and researchers from across Canada highlight what the role of psychology needs to be, including implications for practice, opportunities for advocacy, and directions for future research.

Fulton takes on "myth busting" as she de-bunks the misconceptions many may hold about opioid use. She aptly highlights that this is not a problem only in large cities or in Western Canada or in people who are homeless, but that

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anyone can die from opioids. Given the stigmatization that clients with opioid use problems experience, she emphasizes that language is important and that we must use person-first language.

Bell and colleagues make a call to action for psychologists to reconceptualise how we provide psychological services to meet the complex needs of individuals who use opioids. There is high comorbidity between mental health and opioid use disorders, and failure to recognize and address both substance use and mental health disorders in an integrated fashion results in poor outcomes. Our mental health and addiction systems are currently siloed, but we can help bridge this divide. Both Fulton and Bell et al. shed light on the effective treatments for concurrent opioid use and mental health disorders adjunctive to opioid agonist therapy, as well as the importance of incorporating harm reduction into practices. We need to move away from "just say no to drugs" and move towards meeting clients where they are at and helping them reduce the adverse consequences of substance use. Psychologists need to be prepared to assess, treat, and manage opioid use disorders, including alongside mental health disorders. It is imperative that psychologists seek out the appropriate training to develop the confidence and competence to do so, and that we train the next generation of psychologists accordingly.

Weinrib emphasizes the relationship between opioid use and psychological problems in medical patients, including those prescribed opioids for post-surgical pain relief. She describes the specific steps that psychologists can take to mitigate the risk of opioids in this population, including identification of vulnerable patients, brief behavioural interventions, and psychological treatments tailored to the needs of the individual. Given the strong evidence, Weinrib underscores the importance of offering psychological treatments for pain as part of standard of care in our hospitals and medical settings.

Garcia and colleagues echo Weinrib and stress the importance of non-pharmacological treatments for optimization of chronic pain outcomes. Cognitive behavioural therapy has similar effects on pain improvement as opioids, but with fewer side effects. Garcia et al review the role that prescriber behaviour plays in opioid-related morbidity and mortality. Clinical practice guidelines have been developed to assist providers with opioid prescribing, yet uptake of the recommendations is poor. Garcia et al. outline how psychology can help inform the development of interventions to assist prescribers with adopting these guidelines.

In Canada in 2017, the highest rates of apparent opioid-related deaths were among males aged 30-39.[1] Yet, as Agterberg and colleagues reveal, deaths related to opioid overdose are rising at a "drastically sharper rate" for women. Despite this, women are under-represented in treatment services, perhaps in part due to their unique barriers to care, including societal stigma. Sex and gender need to be taken into account when designing and delivering services. Agterberg et al. argue that collectively psychologists, providers, and communities must ensure that services are responsive and tailored to the needs of women.

Stewart and colleagues discuss the important role that personality plays in opioid use. They describe their novel research program that demonstrates that hopelessness is a risk factor for the onset of prescription opioid use and that self-medication for depression may be involved. This has important implications for prevention, as interventions targeting personality may help prevent and/or reduce opioid use. Evidence-based prevention strategies are crucial in addressing the crisis, and Canadian psychology can help move these efforts forward.

Finally, Rice and colleagues advocate for Canadian psychology to lend their "scientific hands" to help provide evidence-informed interventions to address the opioid problem. The optimal psychological treatments we should provide as an adjunct to opioid agonist therapy is not known due to shortcomings in research trials. They urge that it is imperative to conduct rigorous studies that are methodologically sound, clearly reported, and with agreed upon core outcomes. They describe a three-step plan on how to do this, which would ultimately inform clinical practice guidelines to optimize treatment delivery.

Together, we can work at multiple fronts to help combat the opioid crisis. Canadian psychology has a lot to offer by way of research, advocacy, practice, service delivery, training, and leadership. It is imperative that we work collaboratively across disciplines, sectors, and systems. The opioid crisis is too complex for one group to tackle alone. Whatever we do, we must ensure the meaningful engagement of people with lived experience because at the end of the day, this is who it is all about.

Dr. Kimberly Corace is the Director of Clinical Programming and Research in the Substance Use and Concurrent Disorders Program at The Royal Ottawa Mental Health Centre, an associate professor in the Department of Psychiatry at the University of Ottawa, a clinical investigator with the Institute of Mental Health Research, and a clinical health psychologist. Working at regional, provincial, and national levels, her work focuses on improving access to care and treatment outcomes for vulnerable populations struggling with substance use and mental health co-morbidities, with a particular focus on opioid use and concurrent mental health disorders. She is a member of the Canadian Psychological Association's board of directors and co-chair of the association's opioid crisis task force. In 2015, Dr. Corace was the recipient of The Royal Ottawa's 12th annual Inspiration Award in the young researcher category. In 2013, she and her colleague received the "Best Innovation in Mental Health Care Delivery" award from the Ontario Ministry of Health Innovation Fund for their Regional Opioid Intervention Service.

For a complete list of references, visit www.cpa.ca/psynopsis

Le rôle de la psychologie dans l'atténuation de la crise des opioïdes du Canada

Kimberly Corace, Ph. D., psychologue agréée, Centre de santé mentale Royal Ottawa, Université d'Ottawa, Institut de recherche en santé mentale

Le Canada connaît en ce moment une crise des opioïdes qui a des effets dévastateurs sur les individus, les familles et les collectivités. Près de 4 000 décès apparemment liés à la consommation d'opioïdes ont été dénombrés au Canada en 2017, ce qui représente une augmentation de 34 % comparativement à 2016[1]. En 2016-2017, les intoxications aux opioïdes ont entraîné en moyenne 16 hospitalisations par jour au Canada[2]. La crise continue de s'accentuer à un taux alarmant, et sans aucun doute, chacun de nous a été touché d'une certaine façon.

Comment en sommes-nous arrivés là? Il n'y a pas qu'une seule raison qui explique cela; il s'agit plutôt de l'interaction complexe de plusieurs facteurs[3,4,5]. Récemment, le taux élevé d'intoxications et de décès rattachés aux opioïdes est relié à l'augmentation de fentanyl – un puissant opiacé synthétique et toxique – fabriqué illicitement et d'analogues du fentanyl disponibles et vendus dans la rue. Le fentanyl est « coupé » avec d'autres substances (p. ex., héroïne, cocaïne) ou vendu sous forme de comprimés de contrefaçon qui ressemblent à d'autres médicaments opiacés sur ordonnance. Les conséquences de la présence sur le marché de drogues contaminées sont terribles, car les gens prennent par inadvertance du fentanyl, ignorant ce que la drogue contient. En 2017, le fentanyl ou les analogues du fentanyl étaient impliqués dans 72 % des décès accidentels apparemment liés à la consommation d'opioïdes comparativement à 55 % en 2016[1].

Le Canada occupe également la position peu enviable de deuxième plus grand (ou plus grand, selon la définition qu'on en donne) consommateur d'opiacés sur ordonnance du monde entier[6,7]. La prescription excessive d'opioïdes, y compris de fortes doses d'opioïdes pour gérer la douleur chronique, est un facteur qui contribue à la crise. Auparavant, les opioïdes sur ordonnance (c.-à-d., l'oxycodone) étaient commercialisés comme des médicaments à faible risque, qui ne créent pas de dépendance[8]. Pourtant, des risques importants sont associés à l'utilisation d'opioïdes pour la douleur chronique non reliée au cancer, notamment l'usage non médical et la dépendance[7]. La prescription accrue est également associée à l'accroissement de l'offre d'opioïdes dans l'environnement par le détournement de médicaments. En outre, l'arrêt brutal du traitement ou l'accès insuffisant aux opioïdes sur ordonnance peuvent conduire à la consommation d'opiacés illicites[9]. Le manque d'accès aux traitements non pharmacologiques pour soulager la douleur (y compris les traitements psychologiques) ne fait qu'aggraver le problème. Si les opiacés sont facilement accessibles et financés par l'État, et que les traitements non pharmacologiques ne le sont pas (même si leurs bienfaits sont démontrés), que reste-t-il comme solution aux Canadiens?

Enfin, le manque d'accès au traitement fondé sur des données probantes pour le trouble lié à la consommation d'opiacés, y compris le traitement par agonistes opioïdes (c.-à-d., buprénorphine/naloxone), contribue à la crise. Le trouble lié à la consommation d'opiacés est « une maladie primaire et chronique qui affecte les circuits de récompense, de motivation et de mémoire du cerveau »[10] [traduction]. Les personnes qui ont un trouble lié à la consommation d'opiacés ont droit à un traitement équivalent à celui que reçoivent celles qui ont d'autres problèmes de santé, y compris des soins prodigués avec compassion et respect. Par ailleurs, les déterminants sociaux de la santé et les facteurs de risque sociaux, psychologiques et biologiques contribuent au trouble lié à l'usage d'opiacés, notamment les problèmes de santé mentale, les traumatismes, les expériences vécues au cours de la petite enfance, l'insécurité alimentaire et l'insécurité sur le plan du logement, ainsi que la pauvreté[4,5]. Pour progresser, nous devons nous attaquer aux causes profondes.

Qui dit problème complexe, dit solution complexe – et tout comme la crise ne s'explique pas par une seule cause, plusieurs choses seront nécessaires pour la résoudre. Les organismes, les organisations et les différents ordres de gouvernement travaillent ensemble pour élaborer et mettre en œuvre une réponse globale afin d'atténuer cette crise, notamment en mettant l'accent sur la prévention, le traitement,

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la réduction des méfaits et l'application de la loi[11]. La psychologie au Canada a aussi un rôle important à jouer. Quel que soit notre champ d'activités – psychologues en première ligne, chercheurs en psychologie qui élaborent et évaluent des interventions efficaces et programmes de formation en psychologie qui préparent la prochaine génération de psychologues – nous pouvons et nous devons tous jouer un rôle clé pour régler cette crise. Dans le présent numéro de *Psynopsis*, cliniciens et chercheurs de partout au Canada mettent en évidence le rôle que doit jouer la psychologie, dont les incidences sur la pratique, les possibilités de défense des intérêts et l'orientation de la recherche future.

Fulton entreprend de démolir les mythes en contestant les idées fausses qui circulent au sujet de la consommation d'opioïdes. Elle souligne avec justesse que ce problème n'est pas exclusif aux grandes villes ou à l'ouest du Canada, ni aux sans-abri, mais que n'importe qui peut mourir du fait de la consommation d'opiacés. Considérant la stigmatisation que vivent les clients qui ont un problème de consommation d'opiacés, elle souligne que la terminologie est importante et qu'il faut utiliser des désignations qui mettent d'abord l'accent sur la personne en tant que sujet humain (*person-first language*).

Bell et ses collègues invitent les psychologues à agir afin de reconceptualiser la façon dont nous fournissons les services psychologiques pour répondre aux besoins complexes des personnes qui font l'usage d'opioïdes. Il existe une forte comorbidité entre la santé mentale et les troubles liés à la consommation d'opiacés, et si nous omettons de reconnaître et de traiter la toxicomanie et les troubles de santé mentale d'une manière intégrée, nous ne pouvons espérer de bons résultats. Actuellement, nos systèmes de santé mentale et de traitement de la toxicomanie sont cloisonnés, mais nous pouvons contribuer à briser le mur qui les sépare. Fulton et Bell et ses collaborateurs font la lumière sur les traitements efficaces des troubles concomitants de la consommation d'opioïdes et des troubles de santé mentale complémentaires au traitement par agonistes opioïdes, et insistent sur l'importance d'intégrer la réduction des méfaits aux pratiques. Clamer qu'il faut « Dire non à la drogue » ne suffit pas; nous devons aller à la rencontre des clients là où ils se trouvent et aider ceux-ci à réduire les conséquences néfastes de l'usage de drogue. Les psychologues doivent être préparés à évaluer, traiter et prendre en charge le trouble lié à la consommation d'opiacés, en même temps que les troubles de santé mentale. Il est impératif que les psychologues aillent chercher la formation appropriée pour acquérir la confiance et les compétences qu'il leur faut pour accomplir ce travail, et que nous formions la prochaine génération de psychologues en conséquence.

Dans son article, Weinrib met l'accent sur la relation entre l'usage d'opioïdes et les problèmes psychologiques chez les patients, y compris ceux qui utilisent des opioïdes sur ordonnance pour le soulagement de la douleur post-chirurgicale. Elle décrit les mesures particulières que peuvent prendre les psychologues pour atténuer les risques liés aux opioïdes dans cette population, y compris l'identification des patients vulnérables, les interventions comportementales brèves et les traitements psychologiques adaptés aux besoins de la personne. À la lumière des abondantes données probantes à ce sujet, Weinrib souligne l'importance d'intégrer les traitements psychologiques aux normes de soins, dans nos hôpitaux et nos établissements de santé, pour soigner la douleur.

Garcia et ses collègues abondent dans le même et insistent sur l'importance des traitements non pharmacologiques pour optimiser les résultats de la prise en charge de la douleur chronique. La thérapie cognitivo-comportementale pour soulager la douleur a des effets semblables à ceux des opioïdes, mais comporte moins d'effets secondaires. Dans leur article, Garcia et ses collaborateurs examinent le rôle que joue le comportement du prescripteur dans la morbidité et la mortalité liées aux opiacés. Des lignes directrices de pratique clinique ont été élaborées pour guider les fournisseurs qui prescrivent des opiacés, mais à ce jour, peu de fournisseurs suivent les recommandations. Garcia et ses collaborateurs décrivent comment la psychologie peut aider à orienter l'élaboration d'interventions qui amèneraient les prescripteurs à adopter ces lignes directrices.

Au Canada, en 2017, la plupart des décès accidentels apparemment liés à la consommation d'opioïdes sont survenus chez les hommes de 30 à 39 ans[1]. Pourtant, comme le révèlent Agterberg et ses collègues, le taux de décès liés au surdosage d'opiacés augmente de manière spectaculaire chez les femmes. Malgré cela, les femmes sont sous-représentées dans les services de traitement, ce qui est peut-être attribuable en partie aux obstacles propres aux femmes, qui nuisent à l'obtention de soins, y compris la stigmatisation sociale. Le sexe et le genre doivent être pris en compte lorsque vient le temps de concevoir et de dispenser les services. Agterberg et ses collaborateurs soutiennent que les psychologues, les fournisseurs de services et les collectivités devraient collectivement s'assurer que les services sont adaptés et conçus pour répondre aux besoins des femmes.

Dans leur article, Stewart et ses collègues parlent du rôle important que joue la personnalité dans l'usage d'opioïdes. Ils décrivent le programme de recherche novateur qu'ils ont conçu et qui montre que le désespoir est un facteur de risque du début de la consommation d'opioïdes sur ordonnance et que l'automédication pour atténuer les symptômes de dépression est peut-être en cause. Cela a des répercussions importantes sur la prévention, considérant que les interventions portant sur la personnalité pourraient contribuer à prévenir ou à réduire l'usage d'opioïdes. Les stratégies de prévention fondées sur des données probantes sont essentielles pour faire face à la crise, et la psychologie au Canada est à même de soutenir ces efforts.

Enfin, Rice et ses collègues encouragent le milieu de la psychologie au Canada à donner un « coup de pouce scientifique » pour aider à concevoir des interventions validées scientifiquement pour surmonter le problème de la consommation d'opiacés. Les traitements psychologiques optimaux que nous devrions fournir en complément des traitements par agonistes opioïdes ne sont pas connus, car ils ne sont pas pris en compte dans les essais cliniques. Selon eux,

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Opioid crisis MYTH busting

Heather G Fulton, PhD, R. Psych., Psychologist,
British Columbia Provincial Health Services Authority

As with any highly stigmatized and politicized issue, there are many popular myths and mistaken beliefs regarding opioid use, the opioid crisis, and substance use disorders in general. As the opioid crisis continues to evolve, it is important for psychologists to have the facts to help them in their practice and to be informed consumers of media regarding the crisis...

MYTH: The opioid crisis does not affect the practice of most Canadian psychologists.

FACT: Substance use, related problems, and issues associated with opioid medications are relevant to almost every clinical setting and population. While estimates and definitions vary, approximately 5-8% of adults and 5-20% of adolescents/young adults report non-medical, prescription opioid use in the past year,[1] and approximately 18.5% of clients in mental health settings have concurrent substance use disorders.[2] With increased scrutiny on opioid prescribing, treatment of pain (both chronic and acute) is also affected.

MYTH: The opioid crisis is only about opioid use.

FACT: 71% of opioid-related deaths in Canada in 2017 involved substances other than opioids.[3] This means that these deaths involved either intentional or unintentional polysubstance use. Mixing substances (e.g., alcohol, benzodiazepines) with opioids is risky because side effects like respiratory depression can be amplified. Illicit stimulant drugs (e.g., crystal methamphetamine, cocaine) can also be tainted with opioids (e.g., fentanyl),[4,5] so people who think they're at low risk because they don't use opioids may actually be at risk for poisoning.

MYTH: This is a Western Canada or urban city centre problem.

FACT: Some areas of Canada, including BC and larger urban centres, do appear to be more affected. However, the opioid crisis is affecting communities from coast-to-coast-to-coast in cities both big and small.[5,6,7]

MYTH: It is only people who are homeless, inject drugs and/or have serious substance use disorders who are dying from opioids.

FACT: Anyone can be poisoned or die from opioids, whether it is their first use, 1000th use, or, as mentioned above, they don't even know they are using an opioid substance. Use of any substance bought on the street is potentially risky, even from a known and trusted dealer, because the concentration of a substance or the presence of other substances/toxins is never certain. Resources to share with clients about safer use are available at: http://towardtheheart.com/safer-use.

MYTH: Naloxone kits and training are only for people who use drugs.

FACT: Naloxone is a substance that can reverse the effects of an opioid overdose. If someone begins to overdose, they are unlikely to be able to use naloxone on themselves. In addition to discussing the risks of using alone with clients, psychologists should consider being trained in using naloxone and should encourage the friends and family members of clients to do the same. Videos on how to administer naloxone are available at www.naloxonetraining.com. Naloxone kits are available in most jurisdictions, typically free of charge for people who are considered high risk of overdose and for those likely to witness an overdose, such as friends or family. Kits are also available for purchase for a small fee from many pharmacies or similar health service locations.

MYTH: We should talk to clients about the high potency of opioids on the street.

FACT: Yes, people should absolutely be informed about the risks of use, particularly when such education is combined with techniques such as motivational interviewing. However, using terms like "strength" or "potent" to describe these substances and the related risks can make these substances sound more attractive. That is, it can suggest the substances are especially good quality or the desired effect will be really strong. Instead, it is recommended to use terms such as "toxic" or "lethal" when describing risks related to use.[8]

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MYTH: The terms "addict" and "abuse" are acceptable to use.

FACT: Most psychologists are well aware of the importance of using person-first language and that using certain terms contributes to stigma around a disorder. Yet in the area of substance use disorders, it can be confusing given that the DSM-IV previously used the term "substance abuse," the term "abuse" remains in the title of many organizations working to assist those with substance use disorders (e.g., National Institute of Drug Abuse), and there are important arguments for those within the recovery community to use terms such as "addict" to describe themselves. For those who may not be well versed in the area of recovery communities (e.g., 12-step groups, other peer support groups), people who identify as members of these communities typically identify or introduce themselves as "addicts." Often, use of these terms are considered to be sources of empowerment and reminders of the potential fragility of one's own recovery;[9] however, use of terms like "addict" or "abuse" by people outside of these recovery communities is associated with both implicit and explicit bias against individuals with substance use disorders.[10] Further, when reading clinical vignettes where terms such as "substance abuser" were used to describe a person, healthcare providers viewed the person as more responsible for their illness and recommended more punitive treatments.[11] *The Addictionary* website from the Recovery Research Institute[12] is a great place to start to learn more about language considerations. In general, it is best to use medical terms (e.g., "recurrence of use" rather than "relapse") and person-first language, while avoiding stigmatizing terms (e.g., clean/dirty, abuse).[13]

MYTH: Treatment for substance use disorders doesn't work.

FACT: There are many effective medications and psychosocial treatments (e.g., contingency management, cognitive behaviour therapy) for treating substance use disorders, including opioid use disorders.[14,15] Unfortunately, not all treatments and programs are evidence based. Treatment is also sometimes delayed based on the mistaken notion that a person has not hit "rock bottom" or isn't completely committed to stopping use. Just like treatment for other mental health disorders, early intervention is best and ambivalence regarding treatment is to be expected. Medications for treatment of opioid use disorder, such as methadone and buprenorphine, have been found to reduce mortality but are underutilized.[16]

Poisonings and deaths related to opioids are on the rise across Canada, and many Canadians are at risk. Regardless of the setting or location where a psychologist works, the opioid crisis is likely to affect their clients in some way. Psychologists need to be informed regarding the realities of the opioid crisis in order to effectively work with affected clients. Given psychologists' strong scientific training, as well as their expertise in assessment and treatment of a variety of different disorders and conditions, members of the profession are in an excellent position to provide evidence-based therapies, referrals to further resources, and/or general education to reduce stigma and improve the health of affected individuals, their friends, and family members.

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il est impératif de mener des études rigoureuses, fondées sur une méthodologie solide, communiquées clairement, et accompagnées de résultats convenus. Ils décrivent une démarche en trois étapes pour structurer ces études, qui, à terme, orienterait les directives de pratique clinique de manière à optimiser l'administration du traitement.

Ensemble, nous pouvons travailler sur plusieurs fronts pour aider à lutter contre la crise des opioïdes. Les psychologues canadiens ont beaucoup à offrir au moyen de la recherche, de la représentation, de la pratique, de la prestation des services, de la formation et du leadership. Il est impératif de travailler en collaboration dans l'ensemble des disciplines, des secteurs et des systèmes. Un groupe seul ne peut s'attaquer à la crise des opioïdes, qui est d'une extrême complexité. Peu importe ce que nous faisons, nous devons donner une place importante aux personnes qui ont souffert ou qui souffrent d'un trouble lié à la consommation d'opiacés, car, en fin de compte, ce sont elles que nous voulons aider.

La D^re^ Kimberly Corace est directrice des programmes cliniques et de la recherche dans le cadre du Programme de traitement de la toxicomanie et des troubles concomitants au Centre de santé mentale Royal Ottawa, professeure agrégée au département de psychiatrie de l'Université d'Ottawa, chercheure clinique à l'Institut de recherche en santé mentale, psychologue clinicienne et psychologue de la santé. Active à l'échelle régionale, provinciale et nationale, elle concentre son travail sur l'amélioration de l'accès aux soins de santé et de la prise en charge de populations vulnérables chez qui coexistent toxicomanie et problèmes de santé mentale, en mettant un accent particulier sur l'usage d'opioïdes et les troubles de santé mentale concomitants. Elle est membre du conseil d'administration de la Société canadienne de psychologie et coprésidente du groupe de travail sur la crise des opioïdes mis sur pied par la Société. En 2015, la D^re^ Corace a reçu le 12^e^ prix annuel Inspiration du Royal dans la catégorie Jeunes chercheurs. En 2013, elle et sa collègue ont reçu le « Best Innovation in Mental Health Care Delivery Award » du ministère de la Santé de l'Ontario, pour le service de traitement de la dépendance aux opioïdes qu'elles ont mis sur pied.

For a complete list of references, visit www.cpa.ca/psynopsis

Psychology in the opioid crisis:

Breaking out of the 50-minute hour

Suzanne Bell, PhD, C. Psych., Psychologist, The Royal Ottawa Mental Health Centre; Louise Overington, PhD, C. Psych., Psychologist, The Royal Ottawa Mental Health Centre; and Isabelle Arès, PhD, C. Psych., Psychologist, The Royal Ottawa Mental Health Centre

"I'm sorry Doug, we only have about five minutes left this session, how about we put that on the agenda to speak about next week?"

From fainting couches to the 50-minute hour, stereotypes of the practice of psychology have pervaded for centuries, and in some cases, justifiably so. With the growing, multifaceted difficulties that individuals and society face within the context of the opioid crisis, psychologists are called to expand their roles and reconceptualise their provision of psychological services. In 2017, there were 3,987 apparent opioid-related deaths.[1] It is time psychologists adapt their practice to better serve the complex needs of individuals who use opioids.

"You can come back and see me to work on your trauma symptoms Doug, after you stop stealing the Oxys from your mother."

The endorsement of mutually exclusionary perspectives of mental illness and substance use treatment places clients in a disparaging game of table tennis they are rarely set up to win. A significant portion of individuals who use opioids have concurrent mental health disorders.[2,3,4] Regardless of how these concurrent difficulties developed, the important consideration is addressing the ways in which mental health and substance use problems reinforce each other, both negatively and positively. Just as in couples' therapy, psychologists must also treat *the relationship* rather than simply the individual entities in separation. As is evident from the literature, integrated mental health and substance use treatment has the best outcomes.[5,6] For psychologists, one component of treatment is attending to the function substances serve for clients (e.g., to numb trauma-related symptoms, to cope with social anxiety) and working with the client to build skills and find alternative coping strategies.

"Doug, you seem tired today, how has your sleep been? Have you used any substances recently?"

Drowsiness, increased anxiety, or elation in a session can be due to a variety of reasons, including substance use. The effects of intoxication or withdrawal from various substances can mimic mental health concerns (e.g., depressed or irritable mood during opioid withdrawal).[7] As such, psychologists must know about the physical effects of substances, withdrawal symptoms, signs of overdose, and their clients' substance use patterns (e.g., which substances clients are using, quantity, frequency, and methods of use). This knowledge base as well as skills in how to ask clients about their substance use should be cultivated from the beginning of clinical training. Graduate students need this knowledge in their future roles as psychologists; it is necessary for gaining an accurate mental health picture, enhancing clients' safety, and providing effective treatment.

"Do you mind, Doug, if we talk a bit about how you are using opioids?"

Effective interventions include the principles of harm reduction. Individuals with opioid use difficulties coming to see psychologists may have a variety of goals, ranging from complete abstinence from substance use to simply getting their parents to stop yelling at them (without any interest in changing their use). Harm reduction aims to reduce the adverse health, social, and economic consequences of

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Using prescribed opioids wisely:

How psychologists can help

Aliza Weinrib, PhD, C. Psych., Lead Pain Psychologist, Toronto General Hospital & Toronto Western Hospital, University Health Network

Robert* had beaten an addiction to heroin in his youth and went on to have a family and a richly rewarding career. In his 50s, after surgery to remove a tumour in his lung, he developed an opioid use disorder, lying on his couch all day in a fog, numb to his physical and emotional pain. In his own words, "When I took my pain killer, it was like a vacation from having cancer. The drugs took that weight off my mind." Robert came to our interdisciplinary in-hospital pain clinic, staffed by pain-specialized physicians and psychologists, and was successfully transitioned to buprenorphine-naloxone, the first line treatment for opioid use disorder, returning to his business and his busy and full life.

Kathleen had knee replacement surgery several months before coming to our clinic and, though she wasn't addicted to opioids, she was struggling to wean off her opioids. She told me, "I feel stuck. I am scared of staying on this medication but I can't get off on my own... Every time I cut back, I get so anxious that I can't breathe." She told me she had struggled with anxiety and panic in the past and recovered with the help of cognitive behavioural therapy. The elevated anxiety that came with opioid withdrawal was overwhelming her. Drawing on mindfulness and cognitive-behavioural techniques, a few sessions of psychological support were all that was needed for Kathleen to wean off her opioids completely.

**Names and identifying details have been changed.*

Thousands of cutting-edge, life-saving surgeries are performed in Canadian hospitals each year. Opioid medications are an expected and medically appropriate strategy for post-surgical pain relief. For a minority of patients, a routine post-surgical opioid prescription opens a Pandora's box of problems, including long-term, high-dose, high-risk opioid use.[1] A recent study of people with opioid use disorder shows that – whether they first obtained opioids from a prescription for pain relief or via the street to get "high"– the vast majority stated that they used opioids to self-medicate psychological problems and to escape the stresses of everyday life.[2] Given that the reasons for problematic opioid use are often psychological in nature, psychologists are uniquely positioned to help address the root causes of problematic opioid use among medical patients.

Here are some specific and powerful steps psychologists in hospitals and medical settings can take to address the opioid crisis.

Identify vulnerable patients. Psychologists can guide psychometrically valid screening procedures in hospitals and medical clinics to identify patients at high risk of problematic opioid use. Research has shown that surgical patients are more likely to develop new persistent opioid use if they have a history of substance use (including alcohol use disorder and tobacco use preoperatively) or mental health disorders (e.g., mood and anxiety disorders).[3]

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substance use, without necessarily reducing drug consumption, and is the recommended practice with individuals struggling with opioid use disorder.[8,9] Examples of harm reduction strategies in the context of opioids may include speaking with clients about places to access safe supplies (e.g., needle exchange), not using alone, not mixing opioids with other substances, carrying a naloxone kit, and making sure family and friends are trained in using naloxone kits.[8,9] Although psychologists may want to hammer home the message that "drugs are bad, just stop using them" with their clients, a focus on harm reduction instead facilitates the relationship between psychologist and client and allows the pursuance of clients' valued goals, while also increasing their safety and wellbeing.

"I know you are worried about getting to all of your appointments next week Doug, how about we schedule our next session for 30 minutes, and then we can touch base with your social worker about your difficulties with housing?"

Individuals with concurrent mental health and substance use difficulties often have complex psychological, social, and physical needs that a psychologist's 50-minute hour will not sufficiently address. There are numerous evidence-based psychosocial treatments for concurrent mental health and substance use disorders that psychologists are likely already using in their practices, including motivational interviewing and cognitive behaviour therapy.[10] It is important to note that in treating moderate to severe opioid use disorders, psychosocial-based treatments are adjunctive to opioid agonist therapy (e.g., buprenorphine -naloxone); opioid agonist therapy is the gold standard of care.[9] Consequently, it is integral for psychologists to build partnerships with other professionals and community resources to increase clients' contact with care providers and meet their multifaceted needs.

The lethality of the opioid crisis is ever-present; it has claimed thousands of Canadian lives just in the past year.[1] It is, therefore, essential for psychologists to ask clients about substance use, offer integrated treatment, use harm reduction strategies, increase knowledge about signs and symptoms of withdrawal and overdose, and develop collaborations and enhanced flexibility as part of their practice. It behoves us, as health care providers with diverse skill sets and areas of expertise, to become educated in these life-saving interventions and take an active role in assisting individuals and society to help prevent the opioid crisis from causing further devastation.

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Using prescribed opioids wisely: How psychologists can help

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Offer brief behavioural interventions to medical patients at high risk. Patients flagged as higher risk for problematic opioid use can benefit from low-cost psychological interventions. For example, there is early evidence that brief acceptance and commitment therapy (a form of cognitive-behavioural therapy) before or after surgery can reduce opioid use following major surgery interventions.[4,5]

Provide mind-body relief. Given our renewed appreciation for the risks of opioid medication, even when prescribed appropriately, psychological treatments that reduce pain perception should be available as part of standard care in our hospitals. Mind-body therapies that promote pain relief include progressive relaxation, mindfulness meditation, guided imagery, and clinical hypnosis.[6,7,8] Preliminary research suggests these interventions are acceptable to patients and are, importantly, cost effective.[9]

Treat problematic opioid use in medical settings without judgement. When patients who have been prescribed opioids develop problematic use or addiction, we need to intervene in a timely manner and offer effective treatment, including opioid agonist treatment such as buprenorphine-naloxone, without judgment and with appropriate psychological support, tailored to the needs of each individual. As one of our patients explained after transition to buprenorphine-naloxone, paired with psychological intervention, "What has been given back to me is the opportunity to be engaged in my life, to participate with my friends and family, to pursue my career, to simply be connecting with a life that is a good life. I thought it was too late... but it's not too late."

The current opioid crisis is an opportunity to bring the transformative tools of pain psychology into the medical system in a new way. Pain is always a mind-body problem, and psychological interventions may allow opioid medication to work more effectively, while mitigating its risks.

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Prescription opioid analgesics for chronic pain management and the opioid epidemic:

Challenges and opportunities

David Garcia, MD, Graduate student, Clinical Epidemiology, Memorial University of Newfoundland; Michael Asamoah-Boaheng, M.Phil., Graduate student, Clinical Epidemiology, Memorial University of Newfoundland; and Joshua A. Rash, PhD, Assistant Professor, Department of Psychology, Memorial University of Newfoundland

It has been argued that over-prescription of opioid analgesics to manage chronic pain has led to an increase in opioid addiction, which in-turn has been associated with a rise in opioid-related morbidity and mortality.[1] Given the current opioid crisis in North America, it is important to understand clinical decision making surrounding the prescription of opioid analgesics and how chronic pain can be managed in a safe and effective manner.

A systematic review of data from the United States and Canada identified three interacting factors associated with opioid-related mortality – prescriber behaviour, patient characteristics, and systemic determinants.[2] The authors of the review identified several ways in which the prescribing behaviour of healthcare providers contributed to an increase in opioid-related morbidity and mortality, including prescribing high doses at high volumes and prescribing opioids with a narrow window between a therapeutic and harmful dose, such as methadone. Supporting these findings, a linear increase in the prescription of opioid analgesics was observed in the U.S. until 2013 (from 47 million prescriptions per quarter in 2006 to 67 million per quarter in 2011) when it began to plateau.[3] Similarly, when measured as defined daily doses (DDD) the prescription of opioid analgesics in Canada tripled between 2000 and 2012 (from 10,209 DDD per 1 million population to 30, 504) when it also began to plateau.[4,5] On average, 12.5% of the Canadian population was prescribed opioids in 2016, of which 25% (~4.1% of the population) were prescribed a high dose (i.e., a DDD exceeding 200mg morphine equivalents).[6] In fact, Canada has the second highest rate of opioid prescription in the world when measured using DDD, and the highest rate overall when considering morphine equivalents dispensed.[7] This is particularly concerning given the robust association between opioid dose and mortality observed in a sample of 607,156 patients in Ontario who were prescribed opioids.[8]

The prescription of opioid analgesics represents a double-edged sword. On the one hand, opioid analgesics result in modest improvement in pain and function when prescribed appropriately for the management of chronic non-cancer pain.[9] On the other hand, opioid analgesics have a potential for harm, including non-medical use, and are associated with serious and increasing public health problems. Clinical practice guidelines (CPGs) have been developed in the United States[10] and Canada[7] to assist providers with the judicious prescription of opioid analgesics to manage chronic non-cancer pain. However, not unlike other areas of medicine,[11] there appears to be poor uptake of recommendations made by CPGs. For example, surveys of primary care physicians in Canada indicated that: 1) only 40% of physicians correctly answered two out of nine questions pertaining to knowledge of opioid prescribing; 2) only 20% of physicians often required patients at risk for addiction to sign a treatment agreement; 3) urine drug screens were performed by only 20% of physicians; 4) 43% of physicians mistakenly believed that there was no minimum dose that should be considered before switching to the use of a fentanyl patch; and 5) the minimum

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Addressing the opioid crisis: Incorporating sex and gender in the discussion

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In recent years there has been an alarming increase in opioid-related morbidity and mortality, evoking an ongoing and rapidly evolving public health crisis across Canada.[1] While the majority of Canadians are aware of the crisis, it is not commonly known that the prevalence and severity of these opioid-related problems tend to differ based on gender and may have a particularly significant impact on the health of women.[2]

In 2013, the National Advisory Committee on Prescription Drug Use[3] revealed that the consumption of all psychopharmaceutic drugs is higher among women (27%) than men (21%). Similarly, results of the 2015 Canadian Tobacco Alcohol and Drugs Survey[1] indicated that women (25%) more frequently use psychoactive pharmaceutical drugs than men (18%), with women (14%) and men (12%) displaying similar rates of past year prescription opioid use.

While men are currently more likely to die from opioid overdose, deaths related to opioid overdose continue to rise at a drastically sharper rate among women.[4] For instance, between 1999 and 2015, fatalities attributed to prescription opioid overdose rose by over 471% among women and by 218% among men. In addition, prescription opioid-related deaths among women rose from 8.2 per 100,000 in 1999 to 11.8 per 100,000 in 2015.[5] Together, these figures indicate that women represent a large and growing population of individuals who use prescription opioids and who, as a result, experience alarmingly high rates of life-threatening, opioid-related health concerns.

Research shows that men and women may differ in terms of the pathways to substance use, disease progression, consequences of use, treatment access, and treatment outcomes.[6] Sex differences in body fat percentage, hormones, and the metabolic processing of substances can predispose females to a faster progression from the onset of substance use to developing a substance use disorder (i.e., "telescoping").[7] Hernandez-Avila and colleagues[7] demonstrated that women have shorter periods of regular substance use prior to entering treatment, and the onset of regular use occurs at the same age for women as it does for men. Despite shorter periods of pre-treatment substance use, women's levels of substance use and severity are similar to those of men, and women have more severe mental health-, physical health-, and employment-related problems due to their substance use.

Women are more likely than men to report chronic pain, be prescribed opioids to manage the pain, and be prescribed higher doses over a longer period of time.[8] They also disproportionately encounter traumatic experiences and co-occurring mental health concerns, which may increase their vulnerability to the onset and continuation of opioid use,[9] and

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"watchful dose" of 200mg of morphine equivalent was underestimated by 45% of physicians.[12,13] Further, more than 70% of physicians surveyed did not feel confident to safely prescribe opioid analgesics despite 75% of the sample having received continuing education on the topic.[13]

Novel interventions to assist providers with the prescription of opioid analgesics to manage chronic pain are being met with some success. Liebschutz and colleagues[14] conducted a cluster-randomized controlled trial and assigned primary care clinics in the U.S. to a control condition that received an electronic decision tool (n = 28 clinics; 399 patients) or a multicomponent intervention that involved nurse care management, electronic registry, academic detailing and an electronic decision tools (n = 25 clinics; 586 patients). After one year, patients attending intervention clinics were more likely than controls to have received care that coincided with recommendations made by CPGs (65.9% vs. 37.8%), including a treatment agreement (53.8% vs. 6.0%), urine drug testing (74.6% vs. 57.9%), and a 10% reduction in dose or discontinuation of opioid therapy. Similarly, Quanbeck et al.[15] conducted a randomized matched-clinics trial with eight primary care clinics in the United States. Clinics were assigned to a no-contact control or a multicomponent intervention that consisted of a checklist depicting CPGs, system engineering tools, and consultation between external physician experts and in-clinic "change teams" composed of six to eight staff members. Intervention clinics were more likely than control clinics to perform mental health screens, and initiate treatment agreements and urine drug tests at six months.

Clearly, the prescription of opioid analgesics for the management of chronic pain represents an important, though challenging area of clinical decision making. In addition to endorsing CPGs, psychologists can help respond to this challenge by: 1) informing the development of interventions that are grounded in behaviour change theory to assist providers with the adoption of CPGs;[11] 2) providing assessments of patient risk for non-medical opioid use; 3) helping to manage pre-existing psychopathology; and 4) optimizing of non-pharmacological treatments for chronic pain rather than initiating opioid therapy.[7] Randomized controlled trials indicate that psychological therapies, such as cognitive behavioural therapy, improve pain relative to usual care (standardized mean difference = 0.54) or active control conditions (standardized mean difference = 0.29) with effects that are similar to those for opioid medication (standardized mean difference = 0.41) but with fewer side effects and less attrition.[9] Rising to this challenge will likely require building an increased capacity in an area plagued by high wait times,[16] but together we stand to make a difference in the opioid crisis and the many lives affected by it.

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Addressing the Opioid Crisis: Incorporating sex and gender in the discussion

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are more likely to receive long-term prescriptions of sedatives to manage depression, anxiety and other psychological disorders.[10] Collectively, these factors contribute to women's increased risk of prescription opioid-related harms.

Given the above, it is imperative that women with problematic opioid use have access to support and psychological services, tailored to their unique needs, aimed at providing treatment and minimizing opioid-related harms. In order to understand and respond to the treatment needs of women with opioid-related problems, we must acknowledge the sex and gender differences that make women more vulnerable than men to some of the consequences associated with opioid use. Although women represent a growing population struggling with opioid-related problems, they remain underrepresented in substance use treatment services across Canada.[11] This may be because women experience multiple obstacles and barriers to accessing appropriate treatment services, including fear of losing their children, social stigma, a lack of reliable and financially accessible child care, and a lack of flexible and woman-centred services.[12]

Communities, psychologists, and other health care providers must recognize and respond to these barriers to ensure that available services both reflect the realities of women and are receptive to their needs. Further research into gender-specific care, as well as research aimed at identifying and mitigating barriers to care among women who use opioids, is essential given the rising rates of opioid use, harms, and overdose among women across Canada and elsewhere.

For a complete list of references, visit www.cpa.ca/psynopsis

What is the role of personality in problematic opioid use?

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A four-factor model of addiction

vulnerability[1-3] posits that four traits increase risk for problematic substance use: hopelessness (pessimism about the self and future), anxiety sensitivity (fear of arousal-related sensations), impulsivity (action without forethought), and sensation seeking (preference for novel/intense experiences). Each trait is said to confer susceptibility to problematic use of certain psychoactive substances due to neuro-psychopharmacological sensitivities to their rewarding drug effects. These traits are also thought to confer vulnerability for specific forms of psychopathology.

We first tested this model in a sample of women who used alcohol and prescription drugs.[2] We identified distinct subtypes of women who used substances problematically where each subtype corresponded to a specific four-factor trait. We found that personality subtype predicted dependence on specific, theoretically-relevant drugs. For example, the high hopelessness subtype was significantly more likely than the other subtypes to be dependent on opioids (which can numb painful experiences and memories and can reinstate previously-extinguished reward behaviours). Personality also predicted comorbid psychopathology; for example, the high hopelessness subtype showed increased odds of depression. Overall, traits were related to the probability of being dependent on specific drugs that meet personality-specific needs. Importantly, our results suggested that individuals high in hopelessness might be particularly drawn to prescription opioids to self-medicate depression.

We next examined whether these four traits predicted problematic prescription drug use at earlier stages in the substance use trajectory. In a study with undergraduate students,[4] we explored whether personality was associated with concurrent use of prescription depressants (i.e., sedatives, anxiolytics, and opioids). As predicted, both anxiety sensitivity and hopelessness were associated with use of this broad category of prescription drugs. Moreover, hopelessness was associated with greater self-reported substance use to cope with depression.[4] In a more recent study with undergraduates, we demonstrated concurrent relationships between each of the four-factor traits and the use/problematic use of either prescription opioids, sedatives/anxiolytics, and/or stimulants. As predicted, those higher in hopelessness endorsed elevated rates of prescription opioid use.[5] In our most recent study, high school students were followed from Grade 9 to Grade 10. Again, as predicted, each trait was related to escalations in problematic use of a theoretically-relevant type of prescription drug, as mediated through escalations in specific psychopathology symptoms. For example, hopelessness in Grade 9 predicted Grade 10 escalations in misuse of opioid medications via escalations in depressive symptoms.[6] Across these studies, our results consistently showed that hopelessness was a risk factor for the onset of problematic prescription opioid use and may involve self-medication of depression (i.e., prescription opioid use to numb psychic pain).

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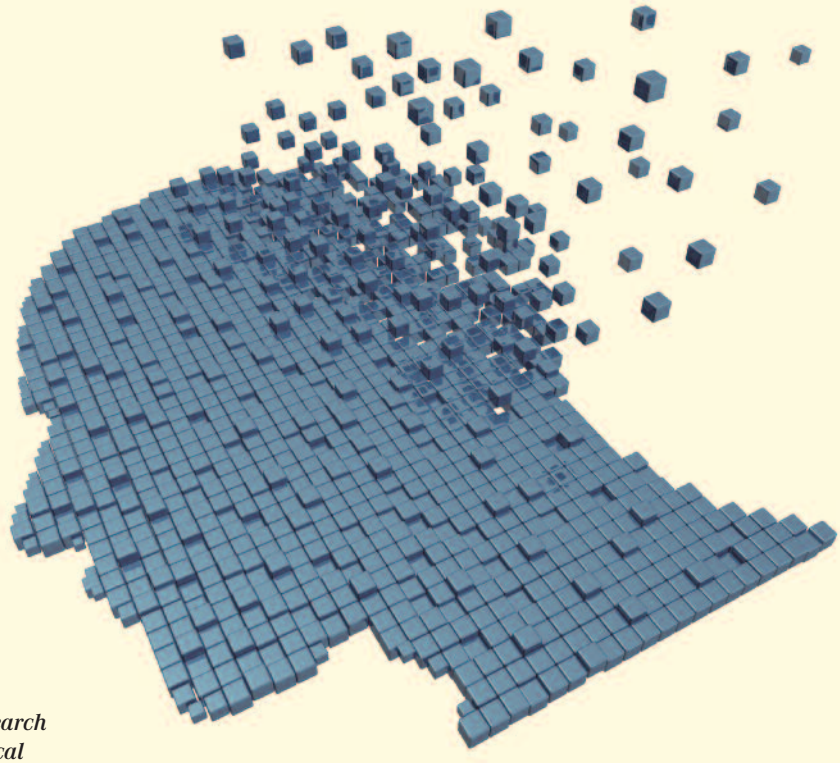
Directions for future psychological research in addressing the opioid crisis:

Moving the field forward



Danielle B. Rice, MSc, Doctoral Student, McGill University; Brian Hutton, PhD, Director and Scientist, Ottawa Hospital Research Institute; and Kimberly Corace, PhD, C. Psych., Director of Clinical Programming and Research, Royal Ottawa Mental Health Centre

"All scientific hands on deck."[1] This was the message from directors of the National Institute on Drug Abuse and the National Institutes of Health in the U.S. over a year ago. This call for help has been echoed in Canada by the Minister of Health and leading substance use centres in Canadian provinces.[2,3] And yet, there is still much work to be done.

The role of psychologists in a healthcare team is imperative in addressing the opioid crisis. Psychologists often embody two roles simultaneously – the scientist and the practitioner.[4] They acquire a unique set of skills that can allow for both the delivery of psychological interventions for treating opioid use disorder and the rigorous study of these interventions in the context of clinical trials.

Armed with these abilities, psychologists can mitigate the opioid crisis within Canada by providing psychological services as an adjunct to first-line pharmacological treatment (opioid agonist therapy; OAT) for opioid use disorder, but determining the optimal psychological service to provide is challenging due to limitations in clinical trials that are relied upon to inform guidelines and policy. Clinical guidelines currently recommend that individuals with opioid use disorder receive concurrent pharmacological and psychological therapy; however, we have yet to determine the optimal psychological intervention to use for people with opioid use disorder.[5,6] Quite likely, inconsistent results between trials comparing psychological services can be attributed, in part, to research methods, poor reporting, and varying outcomes that limit the ability to integrate results between studies.

Informed and evidence-based guidelines and policies rely on clearly reported and methodologically sound studies. Given that psychology has long been a leader in research methods, in addition to providing services, we can provide scientific support for the opioid crisis by improving the dependability of research findings. Specifically, psychologists can increase their involvement in trials of psychological services and can prioritize a set of research recommendations to be considered in clinical decision making related to opioid use disorder.

First, to appropriately deliver a psychological intervention as an adjunct to pharmacological (or OAT) management for opioid use disorder, we must have a clear understanding of the interventions being tested. Currently, the vast majority of clinical trials testing psychological interventions for opioid use disorder lack adequate and consistent information about the interventions delivered. For example, a treatment manual is absent from most studies, as is the number and length of

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sessions, details of who delivered the intervention, and how it was delivered (e.g., online, individually). Without these crucial pieces of information, it is not only difficult to replicate the studies and amalgamate results between studies, but importantly, clinicians are not able to implement the interventions in practice. To increase the usability of research, reporting guidelines have been created that describe a minimum set of information to include in an article. Adherence to the Template for Intervention Description and Replication (TIDier) 12-item checklist[7] can help clinicians to reliably implement psychological interventions that have been tested and deemed effective for people with opioid use disorder.

Second, combating the opioid crisis requires an understanding of the outcomes that are a priority to those most affected by opioid use disorder and its consequences. Existing trials use varied outcomes to measure treatment effectiveness (e.g., urine analyses, psychological treatment retention, opioid agonist adherence),[8] which further complicates the usability of research findings and the potential to combine study results to formulate evidence-based guidelines. An understanding of priority outcomes for people with opioid use disorder and their families, clinicians, policy-makers, and researchers would facilitate attentiveness to issues most central to the crisis and could result in adjusting the focus of psychological interventions. Developing a set of core outcomes can be achieved through use of the Delphi consensus process.[9] In the immediate future, researchers can start by incorporating measures into their trials that have been previously used to allow for comparisons between trials.

Third, once a foundation of transparently reported research with more consistent outcomes is available, comparing the usefulness of interventions delivered to people with opioid use disorder can allow for refined guidelines, with increased specificity. To date, guidelines understandably lack clear recommendations for the type of psychological service to provide. Conducting high-quality reviews and meta-analyses can offer answers to these unknowns when original studies are clearly reported. Synthesizing evidence also offers an important advantage by having larger sample sizes to allow for subgroup analyses to consider if certain psychological interventions differ in their effectiveness among populations (e.g., pregnant people, youth).

Psychologists have an opportunity and an interest in lending their "scientific hands" to providing evidence-supported solutions for Canada's opioid crisis. In addition to informing and advocating on behalf of patients, psychologists are well equipped to shape future research and refine clinical approaches that are being used as an adjunct to pharmacological treatment. Through high-quality and transparently reported clinical trials that collect priority outcomes, more explicit and strengthened guidelines can be formulated to mitigate the harms of the opioid crisis, including the drastic rates of deaths caused by opioid overdose.

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What is the role of personality in problematic opioid use?

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Our recent work has also addressed whether personality is related to specific choices of substances at later stages of addiction. In a study with opioid-dependent clients in methadone clinics across two provinces, each of the four traits was associated with a unique, theoretically-relevant pattern of recent substance use.[7] For example, those with higher hopelessness were more likely to report "topping up" their methadone with opioids, suggesting that hopelessness is positively associated with opioid approach motivation[8] and that personality may play a role in the maintenance of problematic substance use. Overall, our studies indicate that personality plays an important role in opioid use, both at earlier and later stages of the problematic substance use trajectory.

These results suggest that personality might be a useful intervention target for addressing the growing North American opioid crisis. We have developed a set of personality-matched interventions for individuals with elevations on any of the traits in the four-factor model. These interventions use motivational techniques, psychoeducation, and cognitive-behavioural skills-building to address the unique needs of each personality type and to prevent or reduce their likelihood of problematic use of the substances to which they are most sensitive. While there is considerable evidence for the utility of these interventions in preventing/reducing alcohol, cannabis, and illicit drug use,[9] we do not yet know whether they are specifically effective in preventing/reducing problematic opioid use.

In an early study, we showed that prescription drug-dependent women who received personality-matched interventions reduced their prescription drug use more than those in a motivational control group.[10] The target population was not, however, specific to women problematically using opioids. Future studies could test whether targeting hopelessness in opioid-dependent clients might help them reduce their tendency to "top up" with opioids while undergoing opioid-agonist treatment. Future studies should also focus on young people to determine whether the hopelessness-targeted intervention might reduce the uptake of opioids as a preventative strategy. Finally, interventions targeting the other three traits have resulted in reductions in other forms of substance use.[9] Given that many street drugs are now being cut with powerful opioids like fentanyl, using these personality-targeted interventions to reduce any form of substance use could have potentially important preventative effects with respect to opioid overdose and mortality. We have ongoing work addressing each of these important questions,[11-13] illustrating how Canadian psychology has much to offer in addressing the opioid crisis.

For a complete list of references, visit www.cpa.ca/psynopsis

CPA HIGHLIGHTS

Karen R. Cohen, PhD, C. Psych, Chief Executive Officer and
Lisa Votta-Bleeker, PhD, Deputy Chief Executive Officer and Director, Science Directorate

Below is a list of our top activities since the last issue of *Psynopsis*. Be sure to contact membership@cpa.ca to sign up for our monthly CPA News e-newsletter to stay abreast of all the things we are doing for you!

1 New board members

We offer our congratulations to Dr. Samuel F. Mikail, who assumed the role of President 2018/19, having been elected as President-Elect in 2017, and to Dr. Ian R. Nicholson, who was elected President-Elect at our June 2018 Annual General Meeting (AGM). We also welcome Dr. Judi Malone, who joined the board as representative of CPAP. We are grateful to Dr. David J. A. Dozois (former Past-President) and Dr. Andrea Piotrowski (former CPAP representative) for their service; they ended their board terms at the June 2018 AGM.

2 Pre-budget submission

We made a submission as part of the federal government's consultations in advance of the 2019 budget. Our submission recommends fixing unequal access to the psychological services offered by the federal government; improving access to psychological services for all Canadians; and investing in students, early career researchers, and research infrastructure. The full report can be found on our website.

3 Senate Committee report on the Disability Tax Credit (DTC)

On June 27, the Standing Senate Committee on Social Affairs, Science and Technology released its report: "Breaking Down Barriers: A critical analysis of the Disability Tax Credit and the Registered Disability Savings Plan." Among the recommendations of the report are calls to broaden the mandate of the Disability Advisory Committee, to limit the fees disability service providers can charge to complete the DTC application, and to revise the DTC eligibility criteria. We presented to the Standing Committee in February as part of its study, and one of our recommendations for change to the eligibility criteria for the DTC, as applies to mental functions, appeared among the Senate Committee's own recommendations.

4 Science advocacy toolkit

Earlier this year, we released our new grassroots advocacy kit for psychological science. Members who are interested in advocacy are encouraged to consult the kit for an overview of the current top science and research priority issues for the CPA, instructions for contacting their local MP, sample letters, and key messaging. The kit can be found on our website.

5 2019 National Convention

Planning is well underway for our 2019 Annual National Convention, which will be held in Halifax, NS from May 31 through June 2. As always, we will also be offering pre-convention workshops on May 30. Our 2019 convention will take place in conjunction with the 4th North American Correctional and Criminal Justice Psychology Conference and will mark the CPA's 80th anniversary. The call for abstracts will be launched in the fall.

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6 CSEPM webinar

Earlier this year, we joined our fellow members of the Coalition for Safe and Effective Pain Management in a public webinar to promote the launch of the group's report. It makes several important recommendations that, if implemented, would improve access to a range of interventions for the management of pain which may include, but is not limited to medication. CSEPM believes that with better access to an inter-disciplinary range of pain interventions, prescribing and reliance on opioids can be reduced. We would like to thank Dr. Rose Robbins who presented on our behalf at this event.

7 Public consultation – Accreditation standards

Our Accreditation Panel has officially launched its public consultation survey for the revision of the Accreditation Standards and Procedures for Doctoral Programmes and Internships in Professional Psychology. The survey is part of a multi-step revision process, and your feedback is important. These standards are community standards set by the Canadian psychology community.

8 Health and well-being needs of LGBTQI+ people

We endorsed a statement of the International Psychology Network for Lesbian, Gay, Bisexual, Transgender and Intersex Issues (IPsyNet) advocating for greater awareness of the health and well-being needs of LGBTQI+ people in care, research, the media and public policy. The statement was the product of more than five years of work sponsored by IPsyNet to develop an empirically grounded affirmation of LGBTQI+ human rights and a commitment from psychology organizations to advance and support affirmative and inclusive research and service methods focused on the LGBTQI+ population. The statement, available on our website, was released at the 29th International Congress of Applied Psychology at a reception co-hosted by IPsyNet and our Section on Sexual Orientation and Gender Identity.

9 New fact sheets

We recently published four new "Psychology Works" fact sheets on our website. These new resources provide relevant facts and information about perinatal anxiety, seasonal affective disorder, social anxiety, and caregiver stress. Members interested in writing new fact sheets can email factsheets@cpa.ca.

10 Membership renewals

We will be launching our membership renewal process in November. Keep an eye on your inbox for further information and your renewal details.

Want to learn more about what the CPA is doing for you?

Check out our newly redesigned 2017/2018 annual report!

Find it online at https://cpa.ca/aboutcpa/.

FAITS SAILLANTS des activités de la SCP

Karen Cohen, Ph. D., C. Psych., chef de la direction, et
Dre Lisa Votta-Bleeker, Ph. D., directrice générale associée et directrice de la Direction générale de la science

Voici la liste des principales activités menées depuis la publication du dernier numéro de *Psynopsis*. Écrivez à membership@cpa.ca pour vous abonner à notre bulletin électronique semestriel, *Nouvelles de la SCP*, pour vous tenir au courant de toutes les choses que nous accomplissons pour vous!

1 Nouveaux membres du conseil d'administration

Nous offrons nos félicitations au Dr Samuel F. Mikail, qui devient le président de la SCP en 2018-2019, après avoir été président désigné en 2017, et au Dr Ian R. Nicholson, qui a été élu président désigné lors de notre assemblée générale annuelle (AGA). Nous souhaitons également la bienvenue à la Dre Judi Malone, qui a rejoint le conseil d'administration à titre de représentante du Conseil des sociétés professionnelles de psychologues (CSPP). Nous tenons à exprimer notre reconnaissance au Dr David J. A. Dozois (président sortant) et à la Dre Andrea Piotrowski (représentante du CSPP) pour leur dévouement au conseil d'administration; leur mandat a pris fin en juin, à l'AGA de 2018.

2 Mémoire prébudgétaire

Nous avons soumis un mémoire pour les consultations du gouvernement fédéral en vue du budget de 2019. Notre mémoire recommande régler l'accès inégal aux services psychologiques offert par le gouvernement fédéral, améliorer l'accès aux services psychologiques pour tous les canadiens et investir dans les étudiants, les chercheurs en début de carrière et l'infrastructure de recherche. Le mémoire se trouve sur notre site Web.

3 Rapport du comité sénatorial sur l'application du crédit d'impôt pour personnes handicapées (CIPH)

Le 27 juin, le Comité sénatorial permanent des affaires sociales, des sciences et de la technologie a publié son rapport, « Éliminer les obstacles : Analyse critique du Crédit d'impôt pour personnes handicapées et du Régime enregistré d'épargne-invalidité ». Les auteurs du rapport recommandent, entre autres, que le gouvernement élargisse le mandat du Comité consultatif des personnes handicapées, limite les frais que peuvent imposer les fournisseurs de services pour remplir la demande de crédit d'impôt pour personnes handicapées et revoit les critères d'admissibilité au CIPH. Nous avons fait une présentation au Comité permanent en février dans le cadre de son étude, et l'une de nos recommandations préconisant de modifier les critères d'admissibilité au CIPH lorsqu'il s'agit des fonctions mentales se retrouve parmi les recommandations du Comité sénatorial.

4 Trousse de représentation au nom de la science

Cette année, nous avons publié notre nouvelle trousse de représentation à l'échelle locale au nom de la recherche en psychologie. Les membres qui s'intéressent à la défense des intérêts sont encouragés à consulter la trousse afin d'avoir un aperçu des principales questions prioritaires en ce moment pour la SCP en matière de science et de recherche; ils y trouveront également des instructions pour communiquer avec leur député local, des modèles de lettres et les messages clés à communiquer. La trousse se trouve sur notre site Web.

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5 Congrès national de 2019

La planification de notre congrès national annuel de 2019, qui se tiendra à Halifax, en Nouvelle-Écosse, du 31 mai au 2 juin, a déjà commencé. Comme toujours, nous allons offrir des ateliers précongrès le 30 mai. Le congrès de 2019 aura lieu conjointement avec la quatrième Conférence nord-américaine de psychologie de la justice pénale et criminelle et marquera le 80e anniversaire de la SCP. L'appel de communications sera lancé à l'automne.

6 Webinaire de la CSEPM

Nous avions rejoint nos collègues de la Coalition pour la gestion sûre et efficace de la douleur (CSEPM) plus tôt cette année à l'occasion d'un webinaire public visant à promouvoir le lancement du rapport du groupe. Le rapport fait plusieurs recommandations importantes qui, si elles sont mises en œuvre, amélioreront l'accès à la gestion de la douleur, y compris, mais sans s'y limiter, les médicaments. CSEPM croit qu'un meilleur accès à une gamme d'interventions de douleur interdisciplinaire réduira le nombre de patients à qui l'on prescrit des opioïdes au Canada. Nous tenons à remercier la Dre Rose Robbins qui a fait une présentation en notre nom dans le cadre du webinaire.

7 Consultation publique – Normes d'agrément

Notre Jury d'agrément a lancé un sondage de consultation publique dans le but de mettre à jour les *Normes et procédures d'agrément des programmes de doctorat et d'internat en psychologie professionnelle*. Le sondage constitue l'un des volets de la consultation publique, qui se fera en plusieurs étapes. Vos commentaires nous sont importants - les Normes sont des normes communautaires définies par le milieu de la psychologie au Canada.

8 Les besoins en matière de santé et de bien-être des personnes LGBTQI +

Nous avons approuvé la déclaration de l'International Psychology Network for Lesbian, Gay, Bisexual, Transgender and Intersex Issues (IPsyNet) réclamant une plus grande sensibilisation aux besoins en matière de santé et de bien-être des personnes LGBTQI + dans les soins, la recherche, les médias et les politiques publiques. La déclaration est le fruit de plus de cinq années de travail dirigé par l'IPsyNet dans le but d'élaborer une déclaration, basée sur des données empiriques, des droits des personnes LGBTQI + et d'amener les organisations de psychologie à s'engager à promouvoir et à appuyer des approches de recherche et des méthodes de prestation de service inclusives et en faveur de la population LGBTQI +. La déclaration, disponible sur notre site Web, a été rendue publique au 29e International Congress of Applied Psychology lors d'une réception organisée par l'IPsyNet et notre Section sur l'orientation sexuelle et l'identité sexuelle.

9 Nouvelles fiches d'information

Nous avons récemment publié sur notre site Web quatre nouvelles fiches d'information « la psychologie peut vous aider ». Ces nouvelles ressources contiennent des faits et de l'information au sujet de l'anxiété périnatale, le trouble affectif saisonnier, l'anxiété sociale et le stress de l'aidant. Les membres désireux d'écrire de nouvelles fiches d'information peuvent envoyer un courriel à factsheets@psynopsis.ca.

10 Renouvellement de l'adhésion

Nous lancerons la période de renouvellement de l'adhésion des membres en novembre. Veuillez surveiller vos courriels pour plus d'informations et vos détails de renouvellement.

Vous voulez en savoir plus sur tous ce que la SCP fait pour vous?

Parcourez notre nouveau rapport annuel 2017-2018!

Trouvez le au https://cpa.ca/aproposdelascp/.

University of Calgary program celebrates a first-of-its-kind partnership with Manitoba First Nations

Jac J.W. Andrews, PhD, Professor and Chair, School and Applied Child Psychology Program, University of Calgary; Erica Makarenko, MA, PsyD, Director, Integrated Services in Education, Instructor, and MEd SACP Academic Coordinator, School and Applied Child Psychology Program, University of Calgary; and Meadow Schroeder, M.Sc., PhD, Assistant Professor, Director of Practicum, and M.Ed. Academic Coordinator, MFNERC cohort, School and Applied Child Psychology, University of Calgary

The School and Applied Child Psychology (SACP) Program within the Werklund School of Education at the University of Calgary has three graduate programs: a doctoral program, a Master of Science, and a Master of Education. Our M.Sc. and PhD programs are delivered on-campus, and our M.Ed. is a blended learning program that combines face-to-face learning experiences with online course work and class delivery to provide maximum flexibility for individuals who choose to pursue higher education.

Through research, academic, and clinical activities, the SACP Program emphasizes the inherent strengths of all learners and strives to develop optimal outcomes for children, youth, families, educators, communities, and society. The mission of the program is to prepare school psychologists to be contributors and effective collaborators in enhancing learning and mental health outcomes for all individuals within a wide variety of settings. As part of our mission, we support students with diverse backgrounds, ideas, languages, cultures, and experiences and we aim to be understanding of the culture, language, and ethnic diversity of the children and families with whom we work.

In this spirit, our M.Ed. SACP program has created a customized delivery and design program for a cohort of 14 First Nations students in partnership with the Manitoba First Nations Education Resource Centre (MFNERC). We recognize the need for First Nations communities to access

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professionals and clinicians who are First Nations peoples themselves, and we believe providing this unique opportunity for First Nations students to participate in the M.Ed. SACP program will ultimately provide a stronger and more diverse community of Canadian school psychologists. Students started the M.Ed. program in the summer of 2018. As far as we are aware, this is the first program of its kind in Canada. The Werklund School of Education was selected because of the reputation and flexibility in delivery of our program. The MFNERC /SACP partnership signing celebration was held in Calgary on March 28, 2018.

There is arguably no more important or timely need within the educational scene in Canada than to address the educational and developmental needs of First Nations children and youth across the country. Psychologists can play a very important role in addressing social, cultural, academic, and mental health needs of First Nations communities. They can do this most effectively when they build positive relationships with children and youth, teachers, and parents and create expectations for success that are shared, contagious, and realized.

We will be blending on-campus and online instruction for this cohort, making education accessible for working professionals who want to obtain higher education but for many reasons cannot complete an on-campus program (i.e. financial, family, and work commitments). It also allows individuals living in rural areas to access education that they probably would not obtain elsewhere. Manitoba faces a shortage of Indigenous school psychologists in their schools and communities. We expect that our M.Ed. cohort model will work well for First Nations people because it will allow students within the cohort to share and develop similar goals as well as support one another throughout this educational journey. We want to ensure that we are doing justice to Indigenous knowledge, including consultations with Indigenous scholars and those of Indigenous backgrounds. To that end, an advisory committee has been formed to provide consultation and support in the ongoing development of this program throughout our three-year partnership. It is really about greater authenticity, so that it is not us prescribing aspects of the program, but rather bringing Indigenous knowledge into the course design process.

The University of Calgary is pleased to partner with the Manitoba First Nations Education Resource Centre to deliver this program for students and hopes to continue efforts to train and support First Nations students in school psychology service delivery in years to come. We believe this is the first step in broadening the diversity of the school psychology profession in Canada and beyond.

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Award nominations are due October 15, 2018 and Fellow nominations are due November 30, 2018.

Learn more at https://cpa.ca/aboutcpa/cpaawards/.

CPA•SCP 2019 Halifax

MAY 31 TO JUNE 2

Halifax, Nova Scotia

The Canadian Psychological Association (CPA) invites you to join us in Halifax, Nova Scotia from May 31st to June 2nd, 2019 for our 80th Annual National Convention taking place in conjunction with the 4th North American Correctional and Criminal Justice Psychology Conference (NACCJPC).

ABSTRACT SUBMISSIONS DUE NOVEMBER 15

For sponsorship and exhibitor inquiries, please contact
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www.convention.cpa.ca
convention@cpa.ca

CANADIAN PSYCHOLOGICAL ASSOCIATION

SOCIÉTÉ CANADIENNE DE PSYCHOLOGIE

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"Do you mind, Doug, if we talk a bit about how you are using opioids?" Effective interventions include the principles of harm reduction. Individuals with opioid use difficulties coming to see psychologists may have a variety of goals, ranging from complete abstinence from substance use to simply getting their parents to stop yelling at them (without any interest in changing their use). Harm reduction aims to reduce the adverse health, social, and economic consequences of substance use, without necessarily reducing drug consumption, and is the recommended practice with individuals struggling with opioid use disorder.[8,9] Examples of harm reduction strategies in the context of opioids may include speaking with clients about places to access safe supplies (e.g., needle exchange), not using alone, not mixing opioids with other substances, carrying a naloxone kit, and making sure family and friends are trained in using naloxone kits.[8,9] Although psychologists may want to hammer home the message that "drugs are bad, just stop using them" with their clients, a focus on harm reduction instead facilitates the relationship between psychologist and client and allows the pursuance of clients' valued goals, while also increasing their safety and wellbeing.

"I know you are worried about getting to all of your appointments next week Doug, how about we schedule our next session for 30 minutes, and then we can touch base with your social worker about your difficulties with housing?"

Individuals with concurrent mental health and substance use difficulties often have complex psychological, social, and physical needs that a psychologist's 50-minute hour will not sufficiently address. There are numerous evidence-based psychosocial treatments for concurrent mental health and substance use disorders that psychologists are likely already using in their practices, including motivational interviewing and cognitive behaviour therapy.[10] It is important to note that in treating moderate to severe opioid use disorders, psychosocial-based treatments are adjunctive to opioid agonist therapy (e.g., buprenorphine -naloxone); opioid agonist therapy is the gold standard of care.[9] Consequently, it is integral for psychologists to build partnerships with other professionals and community resources to increase clients' contact with care providers and meet their multifaceted needs.

The lethality of the opioid crisis is ever-present; it has claimed thousands of Canadian lives just in the past year.[1] It is, therefore, essential for psychologists to ask clients about substance use, offer integrated treatment, use harm reduction strategies, increase knowledge about signs and symptoms of withdrawal and overdose, and develop collaborations and enhanced flexibility as part of their practice. It behoves us, as health care providers with diverse skill sets and areas of expertise, to become educated in these life-saving interventions and take an active role in assisting individuals and society to help prevent the opioid crisis from causing further devastation.

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