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PSYNOPSIS

CANADA'S PSYCHOLOGY MAGAZINE

SUBSTANCE USE HEALTH AND ADDICTIONS

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CANADA'S PSYCHOLOGY MAGAZINE

THE OFFICIAL MAGAZINE OF THE CANADIAN PSYCHOLOGICAL ASSOCIATION

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MESSAGE FROM THE GUEST EDITOR

DR. KIMBERLY CORACE,
Ph.D., C.Psych., Vice-President, Innovation & Transformation, The Royal Ottawa Mental Health Centre

Substance use and related harms have been increasing at alarming rates, particularly since the onset of COVID-19. Each and every day, 10 people living in Canada die in hospital from substance use-related harms, with three in four of these deaths due to alcohol use.[1] There were over 36,000 apparent opioid toxicity deaths between January 2016 and December 2022.[2] In 2022 alone, there were on average 20 apparent opioid toxicity deaths per day. In 2019, prior to the pandemic, there were on average 10 apparent opioid toxicity deaths per day. The devastating effect of this escalation is staggering. Substance use cost the Canadian economy $49.1 billion in 2020.[3] That's a jump of more than $11 billion between 2007 and 2020 or nearly 12% in per-person costs. The majority of costs associated with substance use are not health-related, but rather are related to lost productivity. Seventy-eight per cent of people over age 15 living in Canada use substances (including alcohol and tobacco).[4] Clearly, we're all impacted by substance use health.

It is important to understand substance use on a spectrum or continuum, similar to our understanding of physical health and mental health. National thought leaders at the Community Addictions Peer Support Association (CAPSA) have developed the term "substance use health" to help us understand this continuum.[5] As noted by CAPSA, "substance use" is incorrectly used as a "synonym" for addiction or a substance use disorder, which contributes to stereotypes, discrimination, and stigma. The same way we all have "mental health", we all have "substance use health", where on one end of the spectrum people may not use at all, to some individuals experiencing beneficial effects of substance use, to lower risk use, to problematic use, or a substance use disorder. We all fit somewhere on this continuum. And at any point, supports and services are helpful to support our wellness. Just as we have mechanisms and discussions about well-being within mental health and physical health, we need to have such discussions about well-being within substance use health. Health promotion activities as well as supports to maintain substance use health are needed. We can't only focus on illness when it comes to substance use health. We need to support the wellness of people and communities across the spectrum.

For those people in need of care and treatment for their substance use health concerns, the majority do not receive it. People with concurrent mental health problems are even less likely to get care. Unfortunately, during the COVID-19 pandemic, while substance use and related harms were increasing and when people needed care supports and services more than ever, access to care was interrupted and barriers to care increased, in part, due to the COVID-19-related restrictions. COVID-19 compounded the already significant barriers that individuals face to get access to care, with structural and systemic stigma often at the root of these barriers.

With these great challenges, came opportunities to overcome them. Canadian Psychology stepped up, given the important role it plays in practice, science, and education in the field of substance use health and addictions. This special issue highlights the key role psychologist clinicians, psychology researchers, and psychology educators across Canada have played to address these needs and gaps. A common thread that knits together these various approaches and initiatives is the need for meaningful partnership and leadership of clients, families, and persons with lived and living expertise in all that we do. We will get nowhere unless we do it together – across sectors, systems, and disciplines. Through digital health innovations, novel approaches to address the unmet needs of children and youth, safer and healthy gambling practices, measurement-based care to enhance treatment, improvement in health systems, approaches to the decriminalization of illegal substances, and mitigating stigma, we can see how Psychology has helped answer, and continues to answer, the "call to action" before all of us.

FROM THE PRESIDENT'S DESK

DR. ELEANOR GITTENS, Ph.D., CPA President

Substance use health and addiction issues are multifaceted, encompassing a wide array of challenges, from addiction to illicit drugs, alcohol, other harmful substances, and possibly disruptive behaviours, e.g., internet use, gambling, gaming, etc. These concerns impact and are not limited to various groups including children, youth, women, and immigrants. The consequences of these issues extend far beyond the individual, impacting families, communities, and society as a whole. As professionals in psychology working in practice, science, and education, it is incumbent upon us to take a leading role in understanding, preventing, and treating substance use health and addiction concerns to foster a healthier and more resilient society.

First, we must recognize the myriad of factors that contribute to and reinforce substance use health and addiction issues. We must emphasize the importance of early intervention and comprehensive mental health care to address the root causes effectively. Research and evidence-based practice lie at the core of our efforts. With the increase in virtual care and digital interventions, research to advance our understanding of the complexities surrounding substance use health and addiction is critical. This research must extend beyond the individual level to examine familial impact and influence, societal factors, and systemic influences, including access to health care, education, and socioeconomic disparities, which play pivotal roles in shaping substance use and addiction patterns.

Moreover, we must strive for greater collaboration and integration across disciplines to develop comprehensive approaches to prevention, treatment, and harm reduction that tackle the social determinants of substance use health and addiction, including poverty, homelessness, and social inequality.

Interdisciplinary cooperation between professionals in psychology, medical professionals, public health experts, policy makers, and community organizations is essential to address substance use health and addiction issues holistically. By sharing knowledge, expertise, and resources, we can forge a more robust response to this crisis. We must emphasize evidence-based interventions, best practices, and quality standards in the field as well as advocate for increased funding and support for substance use health and addiction training programs to bolster the expertise of professionals in this vital area.

Beyond our professional responsibilities, we must also challenge the stigma and misconceptions surrounding substance use health and addiction issues. By promoting a compassionate and non-judgmental approach, we can create an environment that encourages individuals to seek help and support without fear of shame or discrimination. Public awareness campaigns and educational initiatives are essential in disseminating accurate information and fostering understanding. Additionally, as community members, we must recognize our collective responsibility to support individuals and families impacted by substance use health and addiction issues. Together, we can create a network of empathy, compassion, and assistance, fostering a society that stands together to combat addiction and promote mental well-being.

In conclusion, the challenges of substance use health and addiction issues impact us all. I encourage you to pick up a naloxone kit free from almost any pharmacy and take a free online module on administering naloxone. This one intervention is a simple way to save someone's life. We each can do our part to build a brighter and healthier future for generations to come.

PSYNOPSIS

CANADA'S PSYCHOLOGY MAGAZINE

Psynopsis is the official magazine of the Canadian Psychological Association. Its purpose is to bring the practice, study and science of psychology to bear upon topics of concern and interest to the Canadian public. Each issue is themed and most often guest edited by a psychologist member of CPA with expertise in the issue's theme. The magazine's goal isn't so much the transfer of knowledge from one psychologist to another, but the mobilization of psychological knowledge to partners, stakeholders, funders, decision-makers and the public at large, all of whom have interest in the topical focus of the issue. Psychology is the study, practice and science of how people think, feel and behave. Be it human rights, healthcare innovation, climate change, or medical assistance in dying, how people think, feel and behave is directly relevant to almost any issue, policy, funding decision, or regulation facing individuals, families, workplaces and society. Through *Psynopsis*, our hope is to inform discussion, decisions and policies that affect the people of Canada. Each issue is shared openly with the public and specifically with government departments, funders, partners and decision-makers whose work and interests, in a particular issue's focus, might be informed by psychologists' work. CPA's organizational vision is a society where understanding of diverse human needs, behaviours and aspirations drive legislation, policies and programs for individuals, organizations and communities. *Psynopsis* is one important way that the CPA endeavours to realize this vision.

CANADIAN PSYCHOLOGICAL ASSOCIATION

SOCIÉTÉ CANADIENNE DE PSYCHOLOGIE

DR. LISA VOTTA-BLEEKER, PH.D., NEW CEO OF CPA

AN UNCONVENTIONAL CAREER PATH LEADS HOME – THE CPA WELCOMES NEW CEO DR. LISA VOTTA-BLEEKER

ERIC BOLLMAN, CPA Communications Specialist

"Choose a job you love, and you'll never work a day in your life."

In Confucius' time, not a lot of people had shopping mall retail jobs.

When I was very young, I worked at a music store where customers would come in looking for something specific, or something general, or sometimes something new. It was one of the great pleasures of my workday to spend time with those customers, talking music, and suggesting new bands and experiences. My boss at the time was not a fan of this approach. The more time we spent with customers, the less time we were spending…doing whatever else she thought our work was supposed to be. Mostly cleaning. When customers came in looking for me specifically to discuss Glenn Gould vs. Angela Hewitt or to ask whether Regis Philbin's new crooner album was worth a campy listen, I would get reprimanded. The idea, I soon figured out, was that you are never truly working so long as you are having fun. And that by the transitive property of this notion, it stands to reason that if you are having fun, you are not working. And I was being paid to *work*!

Since that time, I have discovered that while this attitude toward work is not the norm, a small vestige of it remains in the minds of many leaders. This kind of workplace can affect employees even many years later. The CPA is not one of those workplaces. Camaraderie, workplace friendships, and interpersonal connections are not just tolerated with a side-eye but actively encouraged. Of course, our jobs are not always fun. There are reports and spreadsheets and put-your-head-down work that must be completed, and few of us enjoy that (although surprisingly, a few in our office do indeed love spreadsheets).

This attitude starts from the top. Our previous CEO, Dr. Karen Cohen was, and is, a friend to all of us in the office, and conversations with her were entertaining, and moments to which we all looked forward. It is for this reason that we feel, collectively, that the transition to a new CEO will be fairly seamless – especially in regard to our workplace culture.

The CPA's new CEO, Dr. Lisa Votta-Bleeker, is well-known to us all. Lisa served as the CPA's Deputy CEO for a time that predates most of us. Maybe the most cheerful and quick to laugh person in the entire office, we are all quite certain that Lisa is a leader who embraces fun. It just so happens that for her, talking about, and advocating for, psychological science or the process of applying for and receiving a research grant appear to be amongst the many things she finds fun.

When I first started at the CPA, I dreaded those conversations partly because I worried that they would demonstrate how little I knew about academia and science. I must know how journal submissions work, but will I be able to stay awake through, and remember, the entire answer?

After one of my earliest conversations with Lisa ("what is the difference between C.Psych. and R.Psych. and what do they mean??") all that trepidation was gone, and it has not returned. Not only did I get a lengthy, comprehensive, and extremely helpful answer, I actually enjoyed hearing it. I stayed awake through the entire conversation! I left Lisa's office that day feeling, against my expectations, a little excited that I knew more about credentials and the processes that go into becoming the different kinds of psychologist. Since then, I have never hesitated to visit Lisa with questions about all kinds of psychology and science – from the definition of 'pathology' to the challenges facing researchers and granting agencies with the advent of COVID-19. Not only will Lisa have the answer to my question, I will remember the answer from that point on.

Lisa gets excited about knowledge. That enthusiasm permeates the office, leading the rest of us to become just a little bit more excited (and confident) about learning new things, expanding our horizons, and taking leaps of faith with our new ventures and ideas. Among her many roles at the CPA, Lisa has been the 'science person' – a wealth of knowledge on a variety of high-level subjects, and a human rolodex for the folks on all subjects where she herself is not the expert. She will remain that, but now her role is something more.

She looks forward to forging new relationships, collaborations, and partner-

ships with organizations outside the CPA; exploring opportunities within the CPA; and nurturing the various activities initiated by her predecessor – all with the goal of making the CPA stronger, unified, and more diverse. It's a good thing Lisa can also get excited about financial and risk management, strategic planning, working with committees and boards, and talking to decision-makers! At the same time, she gets to leave behind some of the duties she had as Deputy CEO – operational things that must get done by someone. She readily admits she will not miss constant calls to building operations about the office temperature.

In addition to her knowledge, and an easy and friendly cheerfulness, the other thing we all know we will get with Lisa is commitment. Lisa demonstrates a determined commitment to psychology and psychological science through all she does at work, but this attitude is not confined to the office. She remains a diehard Backstreet Boys fan, despite a decade separating the group from their last notable hit (she would not have been one of my preferred customers at the music store). She and her husband Tim are two of the few hardcore Ottawa Senators fans who have remained season ticket holders through thick and thin. They remain optimistic about our local team's prospects in 2023–24 despite six consecutive years without a playoff game and 15 years since our lone Stanley Cup Finals appearance.

She says, "the most recent run, where they lost in double overtime to Pittsburgh, I'm not sure I've completely gotten over that." That loss to the Penguins was in the 2017 Eastern Conference finals. Almost seven years ago. Lisa remembers. Her kids go to Senators camps and participate in all kinds of team programs, making their fandom a truly family affair. Says Lisa, "it's a source of fun for us."

Her commitment to psychology began long before her move to Ottawa and natural metamorphosis into a Senators fan. Lisa knew this was the path she wanted to take since a psychologist came to talk to her high school in London, Ontario on Career Day. From there it was a fairly straight path through school, with a B.A. (Honours) at Western University in her hometown, an M.Sc. at Memorial University of Newfoundland, and a Ph.D. at Carleton University in Ottawa, where she has lived ever since.

Her career path, on the other hand, has not been so straightforward. Lisa is a big advocate for creating a space at the CPA for people with psychology Ph.D.s who are working outside of health services delivery and academia. She is also the primary force behind a renewed emphasis at the Association on job fairs and career sessions for students, hoping to illustrate to them the options that are available to them outside the traditional, or more travelled, routes. A lot of this is because she herself had to forge a unique career path.

One of her first jobs, while completing her Ph.D., was at a shelter for homeless youth in Ottawa. While there, she recruited participants for a research study, achieving a stunning 97% response rate, a truly remarkable number when working with an unhoused population. Part of this success can be attributed to the fact that participants got a small McDonald's gift certificate for participating. Part of it was because Lisa was so identifiable, wearing a distinctive hat that resulted in her being given the street name "Paddington". But it seems likely that the main reason so many volunteered for the study was that knowing Lisa was running it, participation was likely to be *fun*.

"I loved working at the shelter…I loved the kids. But that's when I learned about the post-doc world. One of the disadvantages in me having had to work so much, and not having a teaching assistantship, was that I wasn't graduating with the presentations, the publications, and the grants that other students had on their CVs. When I started to look at career options, I realized I was kind of behind the 8-ball."

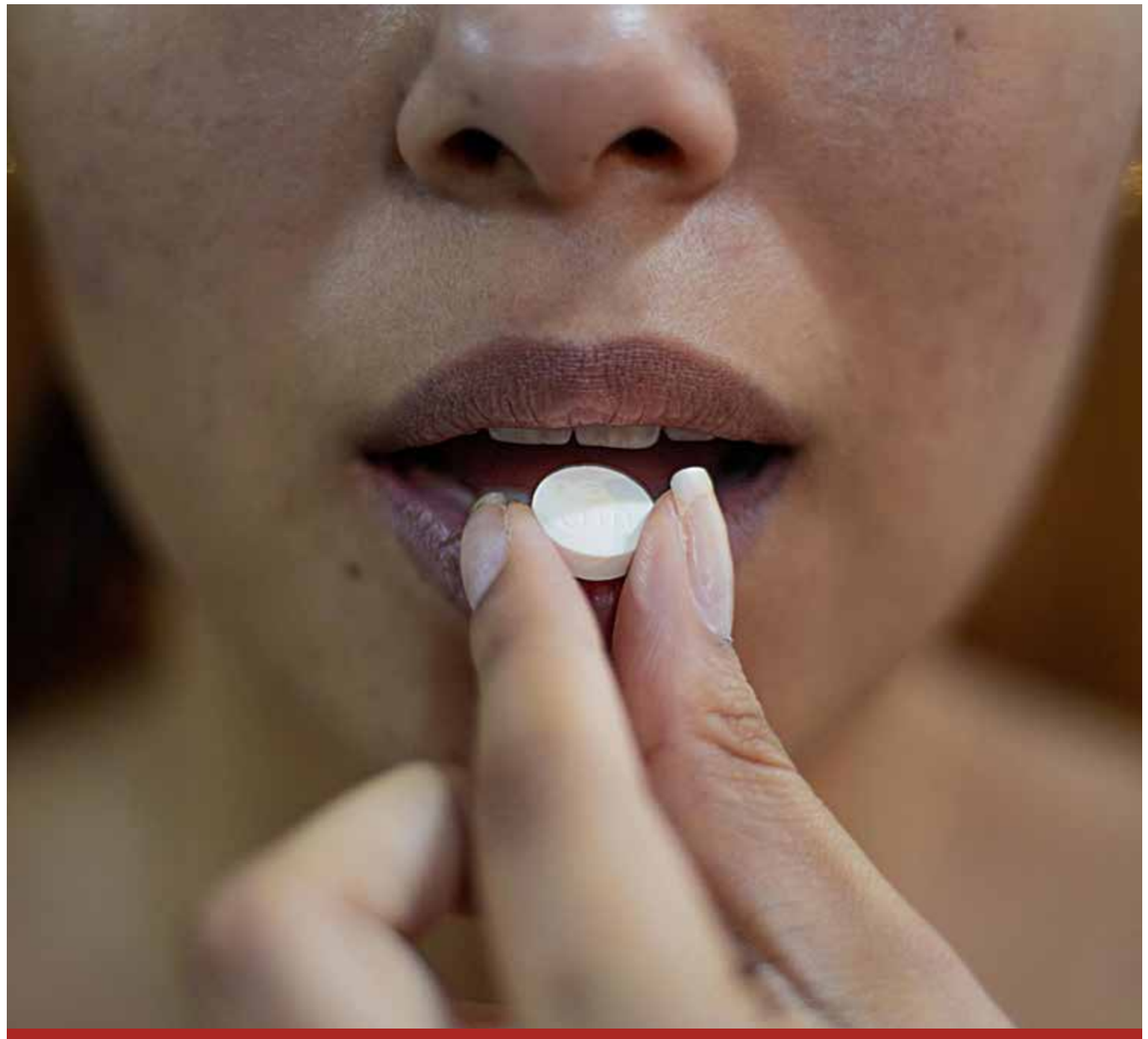
A post-doctoral fellowship, aka post-doc, is a time-limited position where you get funding to do work in a particular field under a particular supervisor. An employer doesn't pay you; you take the funding you've received to, say, a researcher and you say, 'can I do this research with you?' After completing a grant-funded research coordinator position at CHEO's Injury Prevention Centre, Lisa says she was very fortunate to be accepted into some post-doc positions. The first was with Dr. Nancy Edwards at the University of Ottawa's Institute of Population Health. "She was integral to my career" having provided opportunities to publish and receive grant funding. The second was a CIHR Fellowship as part of the TUTOR-PHC program (Transdisciplinary Understanding and Training of Research – Primary Health Care).

She turned down a third post-doc with the Canadian Health Services Research Foundation (CHSRF) to take a job as Program Lead at the Canadian Institute of Health Information (CIHI). Eventually, her career journey landed her at the CPA. Lisa had been a member once, for one year. She had joined as a student affiliate some years ago to present her research on homelessness at the CPA's annual national convention in Sainte Foy, Québec. She remembers driving all the way there to present her research in a room with four other people – three of whom had also come from Ottawa. Lisa looks back on that convention with gratitude for the opportunities and relationships it would create. Of the four people in that room that day, one is now the chair of a CPA Section and a CPA committee member, and another has become a lifelong best friend with Lisa and her family. For a student who hadn't had the chance to conduct or publish a lot of research, it turned out to be a pretty great outcome.

Lisa recalls being interviewed for the position of Associate Executive Director at the CPA, giving Karen (the Executive Director at the time) the laundry list of reasons she was not a member of the Association. There just didn't seem to be a place for people outside of academic institutions and clinical practice. "That's what helped me get the job…. I was part of the demographic they needed to reach."

Since then, Lisa has worked very hard to ensure the CPA reaches out to that very demographic. People doing incredible work and fantastic research outside of academic institutions. Psychologists optimizing workplaces for peak mental health. Researchers designing roads to be safer, conducting assessments in a prison setting, or examining how children learn language. In addition to the career fairs and information sessions, Lisa led the charge to make these kinds of jobs the focus of Psychology Month in 2020, and in 2022 helped create the new CPA Section, Psychology Careers and Professionals, giving a whole new group of psychology graduates resources, opportunities for collaboration, and a home at the CPA.

One day, Lisa will retire as did Karen before her. Or…the Ottawa Senators will look to hire a new team Psychologist. Or the Backstreet Boys will go back out on tour and require a road manager, and Lisa will check off the final box in Career Bingo and we will lose her. Until then, however, we at the CPA and those of us involved in psychology in Canada will benefit greatly from her enthusiasm and dedication. We're excited for the years to come with Lisa at the helm, and we know one thing for certain… it's going to be fun.



COMMENTARY ON THE DECRIMINALIZATION OF ILLEGAL SUBSTANCES IN CANADA

RENEE ST. JEAN, M.A. Student, Carleton University
ANDREW (HYOUNSOO) KIM, Ph.D., C. Psych., Assistant Professor, Department of Psychology, Toronto Metropolitan University; University of Ottawa Institute of Mental Health Research at The Royal

Canada is currently facing an overdose crisis. From January 2016 to September 2022, over 34,400 people died due to apparent drug toxicity.[1] This alarming situation has highlighted the ineffectiveness of the current punitive and criminal justice approach to illegal substances. Additionally, a criminal justice approach has led to a range of detrimental consequences, such as social harm, violence, financial burdens on society, physical health issues (including infectious diseases), delays in seeking treatment and health care, reluctance to seek emergency services for fear of arrest, and heightened stigmatization.[2] These negative consequences are even more pronounced among individuals who face structural inequities and racism.[3] As a result, there is a growing movement among various stakeholders, including those with lived and living experience, policymakers, healthcare professionals, and law enforcement, to decriminalize currently illegal substances in Canada.

Decriminalization involves eliminating criminal penalties for the simple possession and personal use of currently illegal substances, such as opioids (e.g., heroin), stimulants (e.g., methamphetamine), psychedelics (e.g., MDMA), among others.[4] In simple terms, decriminalization involves addressing substance use as a public health concern rather than a criminal justice matter, with the aim of reducing harm. It is essential to understand that decriminalization does not equate to legalization or safer supply. Under decriminalization, simple possession and personal use could still be subject to non-criminal interventions, such as warnings, civil fines, drug treatment, or drug education. Moreover, the non-medical and non-scientific production and sale of illicit substances would remain illegal and subject to prosecution under the law.[4]

Examining countries that have already implemented decriminalization provides insight into several benefits associated with this approach. Portugal, for instance, took the lead in 2001 by decriminalizing the possession of small quantities of illicit drugs due to a surge in overdose deaths.[5] Instead of enforcing severe penalties, Portugal's strategy focused on education and harm reduction. Contrary to concerns, decriminalization did not lead to an expansion of the drug market. On the contrary, it resulted in a reduction of various social harms.[6] Notably, there was a significant decrease in overdose deaths and problematic substance use,[7] and the rate of new HIV/AIDS cases have plummeted since 2001.[5] Consequently, the strain on both the healthcare system and the criminal justice system diminished. In just five years after decriminalization, the societal cost associated with illegal substances in Portugal decreased by 12%, reaching 18% by 2012.[2] Portugal's emphasis on harm reduction in their approach to substance use health serves as a compelling demonstration of the positive societal impact that decriminalization can incur.

Here in Canada, the decriminalization of illegal substances has emerged as a significant issue, with implications for both public health and public policy. Efforts to address the drug crisis are underway in various Canadian provinces. For instance, the Canadian Association of Chiefs of Police has not only endorsed alternatives to criminal sanctions for simple possession,[2] but many police departments have adopted an unofficial small-scale decriminalization approach, whereby individuals found in possession of small quantities of illegal substances for personal use are not typically charged.[8] Moreover, cities like Toronto, Edmonton, and Vancouver have also taken proactive steps towards decriminalizing the possession of small amounts of illegal substances for personal use.[9-11] Furthermore, in May 2022, the Federal Minister of Mental Health and Addictions, along with the Associate Minister of Health, granted British Columbia's request for a planned exemption under subsection 56(1) of the Controlled Drugs and Substances Act (CDSA) for five years.[12] This exemption permits adults over the age of 18 in the province to possess up to 2.5 grams of certain illegal substances for personal use, making British Columbia the first province in Canada to decriminalize small amounts of drugs. The implementation of this policy change came into effect on January 1st, 2023.

While progress has been made in the direction of decriminalization, there are important considerations to be addressed as we move forward. Firstly, it is crucial to involve all relevant stakeholders, including individuals with lived experience with substance use, in determining the threshold for "personal use" quantities. Their input can provide valuable insights into realistic and effective measures for reducing harm. Secondly, it is essential to prioritize the expansion of treatment and harm reduction options and improve access to treatment for those with problematic substance use and/or substance use disorders. The current availability of treatment falls short of meeting the needs of individuals facing substance use-related harms in Canada,[13] hence decriminalization must be conjoined with increased access and availability of treatment if we are to see a meaningful reduction in harm.

These considerations, along with other recommendations, are outlined in the Position Paper prepared by the Canadian Psychological Association's (CPA) Working Group on the Decriminalization of Illegal Substances in Canada. This working group, composed of experts (and trainees) in substance use health, public policy, and law enforcement from various regions of Canada, aimed to develop an official position for the CPA on the decriminalization of currently illegal substances. The recommended position was informed by a systematic review of recent evidence from 2018 to 2022, assessing the harms associated with a criminal justice approach to illegal substances and the potential impacts of decriminalization. The position paper was approved by the CPA Board of Governors at the 2023 CPA Convention and and is available on the CPA website.

FOR A COMPLETE LIST OF REFERENCES, PLEASE GO TO CPA.CA/PSYNOPSIS

BIAS-FREE LANGUAGE: THINGS TO KEEP IN MIND WHEN TALKING ABOUT SUBSTANCE USE

MALCOLM DISBROWE, B.A., Honours Psychology Student, University of Manitoba

There is ample evidence that language matters and that stigma-free language is essential when addressing substance use.[1] Language is powerful and can have a negative and harmful impact on how people think about themselves and their actions. It could convey that the person using substances is actively choosing to suffer harms. It can communicate that the person using 'is' the problem, rather than 'has' a problem.

HERE ARE THREE REASONS TO USE BIAS-FREE LANGUAGE:

1. STIGMATIZED LANGUAGE ABOUT SUBSTANCE USE CAN SEED NEGATIVE THOUGHTS AND FEELINGS.

When discussing substance use, we must remember that everyone who uses substances is human and there are biological, social, and psychological factors that impact use. For substance use, like any other human behaviour, some combination of all these factors can determine whether someone develops a substance use problem or disorder.

2. STIGMATIZED LANGUAGE COULD IMPLY THAT THE PERSON WITH A SUBSTANCE USE DISORDER IS MAKING AN ACTIVE CHOICE TO HAVE A HEALTH CONDITION.

Language that blames and shames creates stigma which in turn makes it hard to relate to, or empathize with, people using substances. It leads to a misunderstanding that substance use disorders are what people with substance use disorders want.[2] In fact, people with substance use disorders are not using substances to inflict pain on themselves or others but may use them to cope with past or current pain and problems. It is also important to keep in mind that any health condition has biological, social, and psychological components to varying degrees. This is as true for cancer and heart disease as it is for substance use disorders and mental illnesses.

3. STIGMATIZING LANGUAGE SUGGESTS THE PERSON WITH A SUBSTANCE USE DISORDER 'IS' THE PROBLEM AND DOES NOT 'HAVE' A PROBLEM.

A lack of understanding and information can cause people to view those with substance use disorders as the problem. People see the impact of the substance use disorder and do not see the biological, social, and psychological journey that led to the disorder. Sadly, this lack of understanding does not engage people in wellness or health.[2]

For these reasons and more, everyone should use stigma-free language when working with people with substance use problems or any disorder. This reminder is as important for members of the public as it is for health professionals.[3] Stigma-free language helps health and psychology professionals to develop the empathy and understanding necessary to engaging their clients and families in their wellness.[4] Dr. Heather Fulton's article on "Language Essentials" in this issue of *Psynopsis* presents a table of terms to avoid and their alternatives. Using stigma-free language in professional and daily life is a great place to start in supporting people in their wellness.

FOR A COMPLETE LIST OF REFERENCES, PLEASE GO TO CPA.CA/PSYNOPSIS

SUBSTANCE USE: LANGUAGE ESSENTIALS

HEATHER FULTON, Ph.D., R.Psych., Wayfinder Wellness Centre and University of British Columbia

In the field of mental health, including substance use health, using person-first language is essential. Language that puts the person before their diagnosis emphasizes a person's value as a human being first. It conveys their illness or disorder is just one aspect of a whole person. It can also decrease stigma associated with certain conditions – and substance use disorders are among the most stigmatized conditions in the world.[1] Additionally, language is an important safety cue for people to engage with health services: What we say and how we say it influences whether people will engage. Often people do not seek help for fear of being labelled "an addict" and/or due to previous negative, stigmatizing experiences with health professionals related to their substance use.[2,3]

Language is always changing. It can be helpful to check in and review our practice to ensure that we are not unintentionally using terms that can be harmful and stigmatizing. Further, when we are talking about mental health, including substance use health, the language we use can shape our understanding not only of the challenge, but also possible solutions.[4] For example, in one study, when terms such as "substance abuser" were used, clinicians not only viewed a person as more responsible for their problem, but more punitive treatment approaches were recommended compared to more neutral terms such as "having a substance use disorder".[5]

Below is a table of terms to avoid, as well as those that may be more helpful.

TERMS TO AVOID	RATIONALE	BETTER TERMS
Abuse, abuser, addict, alcoholic, misuse, misuser, former addict	"Abuse" implies intentional, controllable conduct that is victimizing someone. Misuse is vague, implies judgment (e.g., is a medication used for different reasons than prescribed, different amounts, routes of administration?), and can minimize important contextual factors (e.g., inadequate dosing). Not all use, even use of illegal substances, constitutes a substance use disorder. Use of these terms is associated with increased stigma and reduced help seeking. People are more than their substance use or diagnosis. Using person-first language and terms that are medically accurate and objective are recommended to avoid labelling and dehumanizing people.	• Person who uses… • Use of … • Person with a substance use disorder • Experiencing challenges with their substance use health/concerned about their use • Using medications more often/in higher doses/in ways not prescribed • Using medications for reasons not prescribed such as… • Person with living/lived experience
Born addicted/ addicted baby	Substance use disorder is a behavioural disorder characterized by continuing to engage in a behaviour despite negative consequences; thus an infant cannot qualify for such a diagnosis. However, an infant can demonstrate a withdrawal syndrome due to prenatal substance exposure. These terms also contribute to blame and shame of the person who gave birth to the baby.	• Baby born to person who used substances while pregnant • Baby with signs of neonatal opioid withdrawal • Newborn exposed to substances
Clean/dirty	These terms imply negative and moral judgments about use. They can imply that any steps towards recovery may not "count" (i.e., you're not really "clean"), and thus contribute to "all or nothing" thinking and shame regarding use.	• The toxicology screen was negative/positive for use • Used substances • Not currently using substances/ drinking • On their healing/wellness journey
Habit	This term can erroneously imply a substance use disorder is a choice and/or a person's use is controllable.	• Substance use • Substance use disorder *(if warranted through diagnostic assessment; use of substances, even those that are illicit, does not necessarily constitute a use disorder)*
Lapse/relapse	Relapse can imply a moral failing (e.g., lapse in grace). Some also believe that these terms imply judgment or blame towards someone who uses substances.	• Experienced a recurrence of symptoms • Recurrence of substance use • Resumed use
Opioid substitution/ replacement therapy Medication-assisted therapy	These terms can lead to people thinking medications are "substituting" one substance or for another. They can also imply medications have a temporary or adjunct-only role rather than a critical part of some treatment plans.	• Opioid agonist therapy • Pharmacotherapy • Medication for substance use disorder • Medication for opioid use disorder
Vulnerable populations High-risk group	These terms focus on weaknesses rather than points of action or empowerment.	• Priority population • Key populations

This resource is adapted from Canadian Public Health Association,[6] Canadian Centre for Substance Use and Addiction,[7] National Institute on Drug Abuse,[8] and Recovery Research Institute.[9]

FOR A COMPLETE LIST OF REFERENCES, PLEASE GO TO CPA.CA/PSYNOPSIS

WHEN ONE DOOR CLOSES, ANOTHER OPENS: VIRTUAL CARE FOR CONCURRENT DISORDERS WORKS AND CLIENTS LIKE IT

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COVID-19 came in 2020 and the doors that used to welcome folks with concurrent disorders became more difficult to access because the way that services were delivered changed. The Substance Use and Concurrent Disorders Unit (SUCD) at The Royal Ottawa Mental Health Centre quickly pivoted and constructed novel pathways to care, also welcoming people who were previously unable to access services. As we have seen through history, great hardship is often paired with great innovation. The challenges brought to us by the pandemic-related public health restrictions were an opportunity for our SUCD team to expand and grow.

The Virtual Concurrent Disorders Unit Day Program (V-CDU) was developed to be a comprehensive, virtually-delivered program staffed by an interdisciplinary team of professionals across multiple sites. The program philosophy is one of integrated concurrent disorders treatment, harm reduction, and trauma- and gender-informed care. Services offered include stabilization, assessment, diagnostic clarification, evidence-based group and individual treatment, and transition planning.

Instead of clients coming "in person" to our program, we took services to the clients. Partnerships were further integrated into the framework of the program such that region-wide access to concurrent disorders care was made possible, from wherever the client was located – home, a friend's place, a park, a shelter, or a community centre. To date, hundreds of clients have received services through the V-CDU. The regional reach of the program has also increased by 30%, as individuals outside Ottawa and across the province of Ontario have been able to connect to care. Access to specialty services is limited in many areas of the province, so without V-CDU, these clients would not have been able to get the care they required.

At the end of each client's time in the V-CDU, they are asked to complete a questionnaire to express their level of satisfaction with the program (among many other questionnaires to measure client characteristics and program effectiveness). Every single client who completed the questionnaires was satisfied with services received and would recommend the V-CDU to family and friends in need.

Open-ended client responses to the questionnaire captured the following themes:

- Gratitude for services received
- Appreciation for being in a supportive environment
- Being provided with many useful skills and resources
- Having greater access to care

BELOW ARE A FEW SPECIFIC QUOTES TO BETTER ILLUSTRATE THE CLIENT EXPERIENCE IN THE V-CDU:

- *"It was a life-changing experience."*
- *"The staff is great, very compassionate, friendly, efficient, and knowledgeable."*
- *"I really learned a lot and gained new skills from the program."*
- *"The amount of resources offered to me was incredible."*
- *"The [virtual] groups worked out very well. I didn't need to drive anywhere or have the social anxiety about meeting and being around other people and was able to focus on the program."*

This picture of client care contrasts starkly with traditional views purporting in-person services as the only option for people with more complex mental health and substance use health challenges. Virtual services are essential for increasing access to care, particularly in rural communities. Building community partnerships can reduce barriers to care by offering clients services closer to home. This is just the beginning, with much more work needed to gain an in-depth understanding of the outcomes across larger client samples. Future research can also help establish long-term outcomes. If there was one silver lining of COVID, it was the rapid responses of innovative programs. Let's keep opening more doors.

FOR A COMPLETE LIST OF REFERENCES, PLEASE GO TO CPA.CA/PSYNOPSIS

DIGITAL INTERVENTIONS FOR SUBSTANCE USE CONCERNS IN WOMEN: MOVING KNOWLEDGE TO ACTION

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Rates of alcohol and drug use have been increasing in adults who identify as women in recent decades. This substance use is not without impact, and in line with this, rates of substance use have also been increasing in women.[1] Yet, specialized services for substance use concerns continue to primarily serve men. To some degree the prevalence of men in treatment settings reflects the higher frequency of substance use disorder in men as compared to other gender groups; however, it may also reflect gender-specific barriers to care. Examples of barriers include caregiving duties, lack of financial or family support, and stigma.[2]

Despite these long-standing trends, recent studies of digital interventions for substance use disorder have shown higher proportions of women than previous in-person investigations.[3] Indeed, the success of online and mobile intervention studies to recruit and engage women has suggested that this mode of treatment may address some of the barriers experienced by women. In a recent meta-analysis conducted by this team,[1] there was support for digital interventions for substance use concerns that included samples with a meaningful number of women. Yet, these studies rarely assessed gender identity specifically, or incorporated sex or gender into the analyses conducted. These gaps resulted in little direct evidence for the specific impact of these digital interventions for women with substance use concerns. Moreover, very few investigations were conducted in Canada and only one evaluated an intervention in the French language – suggesting that there is considerable room for growth in digital interventions for women with substance use concerns within the Canadian healthcare system.

WHAT DO DIGITAL INTERVENTIONS LOOK LIKE?

Digital interventions vary widely. They can be delivered via online websites or mobile applications, over a single point in time or multiple weeks or months. Features of these interventions may include monitoring substance use, providing psychoeducation, teaching cognitive and behavioural strategies, setting goals for use, and connecting users to other resources.[1] For example, digital interventions often include an initial series of questions about current substance use and goals, to provide a useful 'reference point' for users. Psychoeducation and skills building exercises may then support progress towards those goals, with tracking of wellness to monitor progress. Digital interventions may include features that are more sensitive to the unique experiences and needs of women as well. For example, resources may portray a range of gender roles and expressions, promote gender-specific resources such as peer support and community programming, and discuss the connection between trauma, violence, and substance use. All of these features can help to provide gender-informed care.

HOW CAN DIGITAL INTERVENTIONS MAKE AN IMPACT?

It is critical that continuing research and evaluation in digital health include knowledge users to help move knowledge to action in the most meaningful way. Knowledge users include women who have used or use substances, as well as representatives from health, social services, education, policy, and other sectors who support those who use substances. Our team recently conducted a needs assessment with a broad range of 75 knowledge users to advance this important work, including allied health professionals, clinical leaders, researchers, policy makers, lived expertise advisors, and more.[4,5] This assessment showed that these knowledge users were primarily using digital resources for psychoeducation and awareness, screening and monitoring, and peer support. A wide range of opportunities for growth were flagged, however, from supporting patients throughout their care journey (e.g., while waiting for services, after completing programming), to supporting those with barriers to accessing care, to improving engagement with care. Knowledge users also flagged important barriers to these digital interventions, including user access to equipment and internet, as well as meaningful support and integration with other care. The need for funds and for personnel support to help access and facilitate engagement with the digital interventions was emphasized, as well as the need for treatment approaches sensitive to gender, trauma, and culture.

MOVING KNOWLEDGE TO ACTION

In short, there is a critical need to develop and evaluate digital interventions for women who use substances, particularly in the Canadian healthcare system. The valuable information provided by knowledge users suggest areas for future research to improve delivery of digital resources and to provide effective care for women. While the current research evidence is promising, more work is necessary to improve digital health supports for women and health equity for Canadians of all genders.

FOR A COMPLETE LIST OF REFERENCES, PLEASE GO TO CPA.CA/PSYNOPSIS

MEASUREMENT-BASED CARE FOR SUBSTANCE USE DISORDERS

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Measurement-based care (MBC), also referred to as progress and outcome monitoring or routine outcome monitoring, uses standardized measurement to guide and monitor progress and outcomes of treatment over time. Specifically, MBC is supported by an information system that collects, stores, analyzes, and reports on client-reported symptoms, functioning, and treatment response, along with clinical workflows that facilitate the use of these data. Despite a number of benefits, MBC remains underutilized in substance use disorder (SUD) treatment. In this article, we outline some key aspects of MBC and considerations for its implementation within SUD treatment.

MBC AND SUD TREATMENT

MBC can enhance many aspects of SUD treatment including:

- Initial assessment – MBC typically begins with a comprehensive assessment of clients' substance use health, including type and frequency of substances used, severity of use, as well as measures of co-occurring disorders (e.g., major depressive disorder, post-traumatic stress disorder), global functioning, and quality of life. Many brief validated tools (e.g., Alcohol Use Disorders Identification Test; AUDIT) and recommendations exist (e.g., ICHOM Patient Centred-Outcome Measures for Addiction) to collect this information. Importantly, the initial assessment provides a baseline from which to track progress throughout the course of treatment, as well as information that can help clinicians tailor treatment approaches for each person.
- Progress monitoring, treatment adjustment, and reconnection – Regular progress monitoring can provide both clinicians and clients with valuable insights into how clients are responding to treatment. It also provides an opportunity to make treatment adjustments (e.g., changes to medication, therapy approaches) and/or reconnect clients to additional services should that be necessary. For inpatient or live-in programs, repeated measurement is recommended during treatment (e.g., at two-week intervals), upon discharge, and at multiple timepoints post-discharge (e.g., at three-month intervals). For outpatient services, intermittent measurement is recommended at a frequency that is responsive to clients' needs and the treatment environment.
- Shared decision-making – MBC supports collaborative decision-making between clinicians and clients. The data collected are shared with clients to help them understand their progress and engage in treatment planning discussions. Involving clients in decision-making empowers them to take an active role in their treatment, leading to increased engagement and better treatment outcomes.
- Quality improvement, program evaluation, and clinical research – By systematically collecting and analyzing these data, SUD programs can identify areas for improvement and make evidence-based decisions about service delivery. In addition, MBC provides valuable data to address important research and evaluation questions, providing unique insights into SUD and the recovery process, as well as evidence of treatment effectiveness. Thus, MBC can be a cornerstone for creating a learning health system in which these data can be integrated with existing evidence and used to drive improvements to care and, in turn, client outcomes benefiting the program and health system at large.

IMPLEMENTATION CHALLENGES

Implementing MBC in SUD treatment can present several challenges; however, they may be addressed with special consideration of the following:

- Staff training and skill competency – MBC requires clinical competency in the administration of validated tools and interpretation of their results, as well as clinical workflows that support the use of these results. Training staff to ensure they are equipped with the knowledge and skills is necessary but can be a challenge, especially in settings with limited resources or high staff turnover.
- Time and resource constraints – Administering assessments, reviewing and interpreting results, and integrating with treatment plans can be time-consuming. Clinicians may face challenges in allocating sufficient time to MBC procedures and coordinating tasks among the treatment team. Additionally, limited resources to purchase and/or support data collection technologies can pose barriers to implementation.
- Assessment completion – Engaging and motivating clients to participate in MBC can be challenging, especially if the perceived value in doing so is low. Efforts to communicate and demonstrate how these data provide value can encourage assessment completion. Repeated assessment, particularly following treatment completion, may require extra effort to contact clients once they leave treatment. Use of brief assessment tools can reduce the time required for clients to complete.
- Measurement validity and reliability – Using valid and reliable assessment tools is necessary to ensure accurate measurement of symptoms, substance use, and treatment outcomes. Although many brief validated tools exist, selecting those that may be most appropriate for the treatment context may be a challenge.
- Information systems and resources – MBC is supported by an information system that collects, stores, analyzes, and reports on standardized data. However, not all treatment settings have such information systems in place, nor do they have access to the resources that support them (i.e., hardware, software, staff). In addition, lack of compatibility between different information systems can also hinder integration of MBC into existing workflows and should be carefully considered.
- The benefits of implementing MBC in SUD treatment outweigh their challenges. Efforts to proactively address these challenges can facilitate implementation, including carefully thought-out change management and sustainability plans.

MOVING FORWARD

Collectively, MBC shows great promise for enhancing SUD treatment quality and its outcomes. Not only are there direct benefits to clients and clinicians, but the same data can be used at the program and system levels to identify and guide quality improvement efforts and resource allocation, as well as answer important research and evaluation questions. At present, few SUD treatment settings systematically monitor treatment outcomes and there is no coordinated approach to do so within or across provincial and territorial health systems. Efforts to promote, align, and support MBC are necessary to optimize SUD treatment and, in turn, client outcomes.

FOR A COMPLETE LIST OF REFERENCES, PLEASE GO TO CPA.CA/PSYNOPSIS

YOU CAN DO IT: TREATING CLIENTS WITH SUBSTANCE USE IN PRIVATE PRACTICE

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Integrated care is the gold standard for treating concurrent mental health (MH) and substance use (SU) disorders.[1] *The Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (DSM5) dedicates 104 pages to SU disorders, the largest section in the DSM5. Nonetheless, psychologists are often reluctant to treat individuals who are using alcohol or other drugs due to lack of training, experience, or confidence with their assessment and treatment.[2]

In Canada, only two CPA-accredited adult clinical Ph.D./Psy.D. programs have a dedicated addictions course. Only 11 of 40 (28%) CPA-accredited residency programs offer a rotation in SU or concurrent disorders. Of 195 CPA-accredited residency spots, only 11 (5.64%) provide training in concurrent disorders, assuming these positions are available every year.[3]

"Are you suggesting psychologists are ill-equipped to assess and treat individuals with substance use difficulties and concurrent disorders?"

No, we are proposing the opposite. Psychologists have the highest level of education and extensive training in developmental psychology, biological and cognitive-affective bases of behaviour, psychopathology, assessment, and evidence-based psychotherapies to treat various psychological problems. Psychologists conduct comprehensive psychological assessments, provide diagnostic clarity for complex co-occurring MH difficulties, and conceptualize problems from a bio-psycho-social perspective. With knowledge of research and program development/evaluation, psychologists are in a strong position to transfer many of these aforementioned skills to the area of concurrent disorders.

"I'm a psychologist in private practice. I don't have access to a multidisciplinary team in my clinic to help these individuals with concurrent substance use and mental health problems."

Realistically, 20–50% of individuals will experience a concurrent disorder in their lifetime.[4] At least 20% of people with a psychological disorder have a co-occurring SU disorder.[5] This number is significantly higher for severe and persistent mental illness (e.g., bipolar disorder, schizophrenia). Therefore, individuals with substance use across the spectrum of severity are showing up in private practice waiting rooms. Psychologists are responsible to understand the implications of SU for not only assessment and treatment, but also as advocates for client care.

Private practitioners can play an important role in early identification of problematic SU, provide person-centred and integrated treatment, and help clients prepare and connect with specialized community services.

HERE ARE FIVE STRATEGIES TO INCREASE THE COMFORT AND ABILITY OF PRIVATE PRACTITIONERS TO WORK WITH INDIVIDUALS WHO USE SUBSTANCES.

#1 – Self-reflection and education: It is incumbent on psychologists to consider their assumptions about treatment of people who use alcohol and other drugs, and to determine when and under what circumstances (e.g., substance type, severity, perceived competence) they refer to other clinicians. Intoxication and withdrawal symptoms can mimic MH symptoms. It is essential that psychologists have knowledge of the physical effects of substances, withdrawal symptoms, and signs of overdose. Multiple resources are readily accessible: consulting with psychology colleagues; CPA's Addiction Section and listserve; the Canadian Centre on Substance Use and Addiction (CCSA) for Canada's Guidance on Alcohol and Health; peer support community services (e.g., Community Addictions Peer Support Association – CAPSA); and virtual or in-person conferences/workshops (e.g., CCSA's Issues of Substance conference).

#2 – Screening and assessment: All initial assessments should include screening for SU. Psychometric measures can include the Alcohol Use Disorders Identification Test (AUDIT), CAGE and CAGE-AID, and Drug Use Disorder Identification Test (DUDIT). Ask clients directly if they use alcohol or other substances. If yes, in a curious and non-judgmental manner, ask follow-up questions: quantities, methods and frequency, current and historical patterns, motives and consequences, past treatment, motivation for change, and SU goals. These answers will help you understand your client's readiness for change, inform treatment conceptualization and planning, match symptom severity to appropriate level of treatment, and bring awareness to the interplay between SU health, MH, and other psychosocial factors.

#3 – Intervention: The Life in Recovery in Canada Survey[6] revealed that long-term wellness is attainable and sustainable, even where SU is marked by high severity, complexity, and chronicity. Evidence-based interventions for SU disorders have been shown to improve treatment outcomes (i.e., abstinence, treatment retention, functioning, and relapse prevention).[7] Psychologists have many transferable skills, including extensive training in modalities that are evidence-based for concurrent disorders (e.g., motivational interviewing, cognitive-behavioural). Motivational interviewing helps clients explore and strengthen reasons for making changes to their SU. Weekly client SU monitoring increases awareness of links between antecedents, thoughts, emotions, behaviours, and consequences of SU. Cognitive behaviour therapy (CBT) can assist with evaluating thoughts about the effects of SU, often a maladaptive coping skill, and address relevant core beliefs. Dialectical behaviour therapy (DBT) can help clients learn skills to regulate emotions or more effectively tolerate distress.

#4 - Consultation: It is important that private practice psychologists connect with primary care providers (e.g., family physicians, nurse practitioners) or other health professionals (e.g., psychiatrists). Collaborative care can include advocating for additional appointments, requesting blood work for urine screening, medication management, and promoting referral to specialist programs addressing SU or concurrent disorders.

#5 – Building bridges with community services: Psychologists should be aware of specialized services in their area offering withdrawal management services, inpatient and outpatient programs, and self-help groups (e.g., Alcoholics Anonymous, Self-Management and Recovery Training [SMART]). Discuss different treatment options with clients. There may be an opportunity for shared care with other service providers, where psychologists focus treatment on the MH needs of the client and take a supportive role (e.g., reinforcing homework) in coordination with another clinician assuming the main role for SU treatment. Liaising with community providers will help psychologists make informed decisions about the appropriate level of care required for their client, while increasing their comfort working in a private practice setting.

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PLAYING IT SAFE: UNDERSTANDING THE IMPORTANCE OF RESPONSIBLE GAMBLING

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Gambling is a popular activity in many parts of the world. In Canada, approximately 64% of Canadians reported gambling in some form during the past year.[1] This includes activities such as playing lottery games, going to a casino, or participating in online gambling. For many people, gambling can provide entertainment, socialization, and financial opportunities. However, for some individuals, gambling can become a serious issue leading to financial problems, relationship difficulties, and mental health issues.

The concept of responsible gambling (RG) involves principles and practices aimed at promoting safe and healthy gambling behaviours (for a review, see Tabri, et al.[2]). These principles include setting limits on the amount of time and money spent on gambling, being aware of the risks and consequences of gambling, and seeking help when necessary. RG is crucial because it can help prevent the negative consequences of problem gambling while also promoting healthy and enjoyable gambling experiences. RG can also be seen as a form of social responsibility. According to the Reno Model,[3] although the player retains the ultimate responsibility over their gambling choices, gambling stakeholders, including governments, gambling providers, and health services, have a responsibility to promote safe and healthy gambling practices and to protect vulnerable individuals from the negative consequences of problem gambling.

Overall, gambling stakeholders have adopted the Reno Model and the associated duty of care for players.[4] In addition to providing contact information for treatment services and programs that allow players to take a break from gambling (e.g., by limiting access to a gambling venue for a specified period of time), resources have also been developed to help minimize gambling-related harms for all players. For example, when people visit a gaming venue, educational materials are readily available that, among other things, help explain how games work and the odds of winning. Budgeting tools have also been developed that allow players to predetermine the amount of money they are willing to lose. When that predetermined amount is reached, they are notified. For instance, when players who set a budget with an operator-provided tool on an electronic gaming machine (EGM; e.g., a slot machine), a message will appear on the screen when their budgeted limit has been reached. Players may also be provided with personalized feedback messages about their play (e.g., they are informed that they are engaged in risky play) or normative feedback messages (e.g., they are informed about how their play compares to most other players).

RG tools are important because although players tend to set a limit of their own accord, they tend to either set a vague limit or fail to recognize when their limit has been reached due to losing track of time and space when gambling.[5] By promoting RG practices and tool use, stakeholders can help fulfill their social responsibility obligations while also helping to protect individuals and communities from the negative impacts of problem gambling. Indeed, research has shown that people who use RG resources and tools experience less gambling-related harms than those who do not.[6-9]

Unfortunately, only 1–10% of players use the RG resources and tools made available to them.[10,11] Thus, it is crucial to find means of increasing the uptake of RG tools and resources.[12] One way to increase uptake may be to integrate informational messages about RG programs into the gambling experience (e.g., via messages on EGMs). Such messaging may also serve to normalize RG and make RG tool use as natural for all players as using a seatbelt is for everyone who enters a vehicle. Finding what messages resonate with players is a potentially fruitful avenue for psychological research. By finding ways to promote safe and healthy gambling practices, psychologists can help reduce the negative consequences of gambling while also promoting enjoyable and sustainable gambling experiences.

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SUBSTANCE USE AND ADDICTIONS: NEEDS AND PRIORITIES FOR SUPPORTING CHILDREN AND YOUNG PEOPLE

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For different reasons and to varying extents, young people use substances and engage in behaviours such as internet use, video gaming, and gambling. These activities can be enjoyable and, in some unique cases, even beneficial. However, some substance use can be immediately problematic, while certain activities and substance use can become problematic over time, when young people become reliant on them and start experiencing negative consequences in their lives. This is known as the spectrum or continuum of use.[1]

Young people, particularly those aged 15 to 24, are especially vulnerable to the addictive nature of substances and certain activities. They tend to have higher rates of substance use disorders and problematic gambling compared to adults over the age of 25, and frequently engage in excessive technology use and gaming.[2,3,4] Substance use and addictions can have negative effects on a young person's physical health, cognitive development, and relationships, and are closely linked to mental health challenges.[5,6,7] Despite the prevalence and harms, the healthcare system, and many interrelated sectors, currently lack the necessary resources to effectively address the complex and unique needs of children and young people experiencing problematic substance use or behavioural addictions.[8,9] The COVID-19 pandemic amplified many of these challenges and emphasized the need for timely and high-quality substance use and addiction care for children and young people.[10]

The Knowledge Institute on Child and Youth Mental Health and Addictions (the Knowledge Institute) is an intermediary organization focused on improving the quality of child and youth mental health and addictions services, and mobilizing knowledge and evidence-based practice in more than 170 community-based agencies across Ontario.[11] Given the important relationship between mental health conditions and problematic substance use, we recently added substance use and addictions as a new focus area in our strategic plan. To inform our work and understand the current state of the sector, we engaged in a series of consultations (113 individuals) with agencies and organizations across the province, including leaders and service providers in child and youth mental health, family members, and young people. We also spoke with individuals across a variety of allied sectors including primary care, education, and social services.

In these consultations, we heard about a range of challenges, barriers, and needs related to supporting children, young people, and families experiencing substance use and addictions concerns. We heard that there are many opportunities to integrate and strengthen the mental health and substance use health system for young people, including continued efforts toward implementing a unified, provincial strategy. Many individuals described current mental health and substance use health services as fragmented, and the system as largely overlooking the integrated nature of mental health and substance use health and addictions. Concerns around long wait times were shared, as well as inconsistent service quality among different providers and regions. Government and systems-level leaders have previously identified many of these same challenges.[9,12,13] As a result, children and young people often find themselves moving between mental health and substance use health and addictions services without receiving the appropriate and comprehensive care they need.

Several leaders and service providers expressed feeling ill-equipped to address the growing concurrent mental health and substance use health needs among children and young people due to a lack of funding specific to these areas, policies and mandates that speak to either mental health or substance use health rather than supporting concurrent care, and lack of time and resources to provide front-line staff with continued education. In addition, we heard about the need for identity-affirming, youth-centred substance use health and addictions care that acknowledges and respects the unique experiences and backgrounds of young people and their families. Those we spoke with underscored the absence of addiction and concurrent services specifically tailored for young people, particularly those under the age of 12 and those in the transition years of 18–25.[9]

Families face their own set of challenges while navigating the mental health and substance use health and addictions system. Privacy and confidentiality restrictions make it difficult for them to be involved in treatment, and caregivers and siblings lack resources to support young people dealing with substance use health or addictions concerns.

Stigma, negative beliefs, and stereotypes around substance use and addictions were identified as additional barriers to accessing care, making it difficult to recognize a problem or seek help without fear of judgment. Leaders and service providers expressed that there is lingering discomfort around harm reduction in certain contexts, emphasizing the need for psychoeducation on concurrent disorders and harm reduction approaches to help dismantle misinformation and stigma.

Despite these challenges, we also heard about innovative initiatives and programs that are making positive impacts throughout the province and beyond. Collaborations and partnerships within and between sectors lie at the core of these success stories, and were the main needs expressed by those we consulted. Substance use health and addictions care thrives when service providers, agencies, and sectors establish meaningful relationships, innovate on collaborative care pathways, and engage in mutual capacity building.[14]

The Knowledge Institute is committed to driving high-quality, evidence-based child and youth mental health and addictions services for Ontario's children, young people, and families. We look forward to continuing to support the child and youth mental health and addictions sector by addressing the knowledge and capacity building needs that were identified throughout our consultations. We are excited to build on the successes and contribute to ongoing efforts for improvement by fostering partnerships and collaboration, creating new knowledge products, and sharing high-quality resources and initiatives throughout the province and beyond.

FOR A COMPLETE LIST OF REFERENCES, PLEASE GO TO CPA.CA/PSYNOPSIS

INNOVATION IN YOUTH SERVICES: YOUTH-INFORMED SUBSTANCE USE HEALTH SERVICES OFFERED THROUGH THE INTEGRATED YOUTH SERVICES MODEL

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For many young Canadians, trying to navigate and access substance use health, mental health, or primary care health services is challenging, confusing, and frustrating. In Canada, it is estimated that one in five youth experience mental health and substance use disorders.[1,2] Fragmentation and siloing of services interferes with timely access to care. Youth Wellness Hubs Ontario (YWHO, youthhubs.ca), a collective of youth-serving organizations integrated, networked, and operating as a learning health system, is transforming the service system with and for young people across Ontario. Currently in Canada, YWHO is just one of several Integrated Youth Services (IYS) system transformation initiatives (e.g., Foundrybc.ca; Aire Ouverte [www.quebec.ca], Accessopenminds.ca) with accompanying research within a learning health system (IYS-Net, www.cihr.ca).

WHAT ARE INTEGRATED YOUTH SERVICES?

Integrated Youth Services (IYS) are innovative multicomponent service models that have been developed worldwide (e.g., Australia, Ireland, Canada) in response to shortfalls in youth substance use health and mental health services and outcomes. YWHO[3] is a youth codesigned model of IYS to address the substance use health, mental health, and other health and social needs of youth (12 to 25 years). Through meaningful engagement with local and provincial youth and family advisory committees, as well as other engagement activities, YWHO Networks are delivering services that reflect the needs, priorities, and service preferences of young people with substance use health and mental health challenges. As Ontario's IYS Network, YWHO is focused on improved service access and equitable substance use health and mental health outcomes for youth.

More than 1000 youth, family members, service providers, clinicians, and researchers have contributed to the creation of the YWHO model and values. The values that underpin YWHO are (1) meaningful engagement; (2) access, equity, and inclusion for diverse youth; (3) high visibility and stigma-free services; (4) integration across sectors; (5) continuous learning and quality improvement; and (6) service approaches that are youth-centred, developmentally-appropriate, and wholistic. YWHO services, guided by these values, are currently delivered in 30 community-based youth hubs throughout Ontario.

HOW DOES YWHO ADDRESS THE UNMET SUBSTANCE USE HEALTH NEEDS OF YOUTH?

Substance use prevention and intervention is an important but underdeveloped service area within youth and young adult mental health services in Canada. Based on data from 14 YWHO sites within the first two years of service provision, 50% of youth indicated substance use-related problems in the past year (as measured by the Global Appraisal of Individual Needs – Short Screener [GAIN-SS] Problematic Substance Use Scale). Significantly fewer youth (3%), however, identified substance use support as their primary service goal. Rather, youth sought services to improve their mental health (41%). This highlights the importance of service providers being equipped to deliver integrated mental health and substance use health services.

YWHO enhances substance use health services through both direct service provision, and partnerships with existing system initiatives. A continuum of substance use health services, integrated with mental health services, is offered across YWHO sites, including screening, psychoeducation, prevention, early intervention, cognitive behaviour therapy (CBT), dialectical behaviour therapy (DBT), harm reduction, peer support, primary care (including withdrawal management and pharmacological interventions), and navigation to Rapid Access Addiction Medicine (RAAM) clinics (www.metaphi.ca). The federal government, through their Health Canada Substance Use and Addictions Program, has supported service providers – including peer support workers, mental health clinicians, and other relevant community partners – to work closely with youth with substance use concerns to codesign meaningful services and share learnings across the country.

YWHO, in addition, has developed substance use training materials in collaboration with clinicians and diverse youth who use substances. These materials supply service providers with foundational substance use and related knowledge to deliver treatments based on available evidence. YWHO is also addressing substance use health by supporting the implementation of the PreVenture program (www.preventureprogram.com) in community and school settings, in collaboration with other system partners (e.g., School Mental Health Ontario). PreVenture[4] is an evidence-based approach to delaying and preventing substance use among youth using personality-focused interventions. YWHO-affiliated community organizations and partner schools are supported to implement PreVenture, with no costs to the community organizations or schools. Finally, in the coming year, YWHO is strengthening its province-wide substance use health service model, particularly around youth-friendly practices, with corresponding implementation of a fidelity tool for the delivery of substance use services within IYS, and related policy recommendations.

Appropriate supports and services to address substance use challenges among youth, integrated with mental health and other health and community supports, are urgently needed. YWHO Networks across the province are responding to this need by providing youth-informed, developmentally appropriate, and evidence-based substance use services to young people within an integrated youth health services setting.

Youth Wellness Hubs Ontario is supported and funded by the Government of Ontario and CAMH Foundation.

FOR A COMPLETE LIST OF REFERENCES, PLEASE GO TO CPA.CA/PSYNOPSIS

QUALITY STANDARDS: IMPROVING MENTAL HEALTH AND SUBSTANCE USE HEALTH SERVICES FOR CHILDREN AND YOUTH

MADISON ERBACH, B.Sc., Research Coordinator, Children's Hospital of Eastern Ontario Research Institute
POPPY DESCLOUDS, Ph.D., Senior Researcher, Knowledge Institute on Child and Youth Mental Health and Addictions; Investigator, Children's Hospital of Eastern Ontario Research Institute
AMY PORATH, Ph.D., Director of Research and Knowledge Mobilization, Knowledge Institute on Child and Youth Mental Health and Addictions; Investigator, Children's Hospital of Eastern Ontario Research Institute

SUBSTANCE USE HEALTH AND ADDICTIONS

Before we can offer consistent, high-quality mental health and substance use health services for children, young people, and families, we must first determine what high-quality care looks like. That's where quality standards come in.

Quality standards are developed by combining the best available evidence with expert consultation and feedback from service users.[1] By outlining the principles of high-quality care, quality standards play an important role in improving mental health and substance use health services. After a quality standard is developed, however, an important challenge remains: implementing the standard. It is not enough to merely define what high-quality care looks like; we must also make meaningful and sustainable changes to practice.

In Ontario, the community-based child and youth mental health and substance use health sector is under the jurisdiction of the Ministry of Health. There are over 170 agencies that provide community-based mental health and/or substance use health services for children, young people, and their families. The Knowledge Institute on Child and Youth Mental Health and Addictions (the Knowledge Institute) supports these agencies by guiding quality improvement efforts and mobilizing evidence to strengthen services.

One quality improvement initiative in the mental health and substance use health sector is the development of quality standards. Different organizations have developed quality standards on a variety of topics; however, there is a lack of mental health and addictions standards specific to children and youth. There is also a shortage of comprehensive, flexible, and accessible implementation resources to accompany standards.

Another important evidence-based practice happening within the sector is the engagement of service users. Engagement allows young people and family members to play an active role in their care, and meaningful engagement has positive impacts on both service experience and treatment outcomes. For example, engagement can lead to better relationships with healthcare professionals,[2] higher satisfaction with care,[2,3] improved psychological well-being,[3] and higher quality of life.[3]

Recently, the Knowledge Institute developed two quality standards on the topic of engagement, one for youth engagement[1] and one for family engagement.[4] These standards were codeveloped with young people and families. They present core principles that describe what optimal, high-quality engagement looks like, as well as practical examples to help community-based agencies strive toward the principles through ongoing improvement of meaningful engagement practices.

However, implementation of these engagement standards varies across the province of Ontario, as does meaningful engagement of young people and families in mental health and substance use health care throughout the country. To increase the uptake of these and other standards, the Knowledge Institute is carrying out a study, funded by the Canadian Institutes of Health Research (CIHR), to examine the barriers and facilitators that agencies face when trying to implement quality standards. Our project focuses on barriers and facilitators to implementing quality standards for youth and family engagement that are rooted in principles for ongoing, continuous improvement. Our goal is to use this information to help inform what strong engagement and implementation look like across any quality standards in child and youth mental health and substance use health.

In the first phase of our study, we are collecting surveys from leaders and service providers at community-based child and youth mental health and substance use health agencies in Ontario to get a sense of their familiarity, comfort, and interactions with the youth and family engagement standards. In the second phase, we are conducting interviews, and in some cases document reviews, with participants to take a deeper look at the barriers and facilitators they face when trying to implement and sustain these standards. After synthesizing the findings, we will host knowledge mobilization workshops to share what we have learned about implementing quality standards, practicing meaningful engagement, and the importance of this work in the mental health and substance use health sector. Based on the findings, we will develop implementation resources that will help scale and spread the quality standards for youth and family engagement across Canada. The recommendations from this research will also inform the development of implementation strategies for pan-Canadian standards for mental health and substance use health services, which will ultimately lead to better outcomes for children, youth, and families.

If you are a leader or service provider interested or involved in quality standard implementation or improving engagement practices in the child and youth mental health and substance use health sector, we want to hear from you. Please reach out to Poppy DesClouds at pdesclouds@cymha.ca if you would like to learn more, or if you are interested in being involved in this research.

FOR A COMPLETE LIST OF REFERENCES, PLEASE GO TO CPA.CA/PSYNOPSIS

BUT WHAT ABOUT THE FAMILY? REASONS FOR INCLUSION AND OPTIONS FOR CARE

HEATHER FULTON, Ph.D., R.Psych., Wayfinder Wellness Centre and University of British Columbia
FRANCES KENNY, Founder and Facilitator of Parents Forever – A Support Group for Parents and Family Members of Loved Ones Struggling with Substance Use
ISABELLA MORI, M.Ed., MPCC, Vancouver Coastal Health Mental Health & Substance Use Services

While not all clinical and counselling psychologists in Canada work in dedicated substance use disorder treatment services, many clinical and counselling psychologists will encounter clients who have loved ones struggling with substance use. Approximately one in five Canadians will develop a substance use disorder in their lifetime,[1] and while no similar Canadian data exist, US data from the Pew Research Centre (2017)[2] suggest that 46% of Americans have a close family member or friend who has a substance use disorder.

Families play a unique and important role, and should be considered part of the circle of care. For the purposes of this article, we define family as not restricted to biologically-related people but also "found family", partners, siblings, grandparents, any concerned and involved significant others. Unlike professional services, families have no waitlists or defined "session limits". They are often witness to transitions through different intensities or types of treatment services and wellness. However, supporting a person with a substance use health challenge is stressful. Family members frequently report heightened levels of stress, anxiety, depression, and physical health problems.[3,4] They can feel perplexed and exasperated by continued substance use despite negative effects on their loved one's lives. They may use ineffective communication styles in an effort to help. All these are issues that psychologists are ideally placed to assist with.

Research shows that engagement of concerned family members in care helps people with substance use disorders. Family is one of the most frequently reported motivators for entering treatment and for continued wellness.[5] Unfortunately, families often feel excluded and ignored by the mental health (including addiction) treatment system in Canada.[6] They can even be pathologized by some providers as sources of the problem (e.g., negatively labelled as "codependent", "enablers"). Another challenge is that even treatment providers who have the best of intentions and who want to provide more family-centred services can find it challenging to navigate privacy and consent legislation, ethics (e.g., who is the client?), as well as practical and logistical concerns.

As helping professionals, there are several options we can provide to not only help family members to address the major stressor of having a loved one experiencing substance use challenges in their life, but also to foster resiliency and wellness for themselves:

1. Provide education about myths and facts of substance use and substance use disorders.
   - The Canadian Centre on Substance Use and Addiction (CCSA) has several resources for healthcare providers: https://www.ccsa.ca/
   - The US-based Recovery Research Institute has many excellent resources: www.recoveryanswers.org
2. Encourage training and carrying of naloxone kits. The toxic drug supply means that even people who do not use opioids can unintentionally take substances that result in serious adverse consequences. Education about this and having naloxone on hand can help. Naloxone is free, over-the-counter from pharmacies and other sources in some jurisdictions. Free online training is available: https://towardtheheart.com/naloxone-training
3. Learn about and share tools to help support a loved one with substance use concerns. These may include Community Reinforcement and Family Training (CRAFT) and/or the Invitation to Change approaches. These approaches are based on contingency management, Motivational Interviewing, and Acceptance and Commitment Therapy. Another tool is the 5-Step Method, based on a stress-strain-coping-support model.
   - CCSA's summary of CRAFT: https://www.ccsa.ca/sites/default/files/2019-04/CCSA-Community-Reinforcement-Family-Training-Summary-2017-en.pdf
   - Helping Families Help website for resources and locating providers: https://helpingfamilieshelp.com/
   - Centre for Motivation and Change for books, trainings, and free guides: https://motivationandchange.com/
   - 5-step Method: A psychosocial intervention that supports families in their own right rather than viewing them as primarily supporters for their loved one's treatment: https://www.afinet-work.info/5-step-method-resources-in-troduction
   - From Grief to Action Toolkit: A toolkit developed in combination with parents and professionals: https://www.hereto-help.bc.ca/workbook/from-grief-to-action-coping-kit
4. Encourage the family member to consider joining a support group. Having a loved one experiencing substance use challenges can be incredibly isolating and comes with its own stigma. Connecting with others who have gone through similar challenges can help combat this. Online, telephone, and in-person resources exist. A good approach is to encourage families to try out a variety of groups where possible – one size does not fit all.
   - Families for Addiction Recovery Canada has free phone coaching and support groups: https://www.farcanada.org/
   - SMART Family and Friends have in-person and virtual groups: https://www.smartrecovery.org/family/
   - Al-Anon or Nar-Anon can be useful for those who find a spirituality-based 12-step approach helpful.

The authors of this paper have an aggregate of 35 years experience working with families affected by the substance use of loved ones and can be contacted at drheatherfulton@gmail.com and fkenny@telus.net for further consultation.

FOR A COMPLETE LIST OF REFERENCES, PLEASE GO TO CPA.CA/PSYNOPSIS

CPA HIGHLIGHTS

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!

CPA HIRES A NEW CEO

The Board of Directors of the Canadian Psychological Association is thrilled to announce the appointment of Dr. Lisa Votta-Bleeker to the role of Chief Executive Officer. Dr. Votta-Bleeker was previously the CPA's Deputy CEO, and will build on the exceptional work of her predecessor, Dr. Karen Cohen, who served as CPA's Executive Director and CEO for 15 years. The Board of Directors thanks Mr. Glenn Brimacombe for his knowledge and expertise in acting as Interim CEO during this transition period.

EMPLOYEES, EMPLOYERS & THE EVIDENCE...THE CASE FOR EXPANDING COVERAGE FOR PSYCHOLOGICAL SERVICES IN CANADA

To better understand the value employees place on accessing psychological services and how employers perceived the value of their employee health benefit plans, the CPA released Employees, Employers & the Evidence…The Case for Expanding Coverage for Psychological Services in Canada. The report summarizes the available clinical evidence in support of psychological services, the business case/return-on-investment for employers, and a number of leading practices by employers.

NEW POSITION STATEMENT: PROMOTION OF GENDER DIVERSITY AND EXPRESSION AND PREVENTION OF GENDER-RELATED HATE AND HARM

Gender-based stereotypes, prejudice, and discrimination continue to persist across social systems and services (e.g., education, health, justice). With the rise of gender minority hate and violence worldwide, this policy statement outlines the discrimination that people of gender minority face, as well as the changes that need to be made to redress it. The CPA commits to helping to bring about these changes and calls on legislators, policy makers, and agencies and individuals who deliver health and social services to assert their commitments to join us.

CPA HIGHLIGHTS

WELCOME TO THE NEW CPA BOARD MEMBERS

At the CPA's 84th annual convention in Toronto in June, elections were held for four board positions. Congratulations to the CPA's new Director Representing Science, Dr. Adam Sandford, Director Representing Education, Dr. Meghan Norris, Director Representing Practice, Dr. Mitch Colp, and Director-at-Large, Dr. Claire Sira.

ACCREDITATION STANDARDS RELEASE

The Sixth Revision of the CPA's *Accreditation Standards for Doctoral and Residency Programs in Professional Psychology* (the Standards) has been approved by the CPA Board of Directors and the completed document was presented at the CPA's 84th annual convention in June. This revision is the result of a six-year process led by the CPA's Accreditation Panel and Standards Review Committee, including surveys, public consultation, and focused consultations with CPA sections and groups external to the CPA.

2023 CPA AWARD WINNERS

Congratulations go to the winners of the CPA's 2023 awards!

CPA Gold Medal Award for Distinguished Lifetime Contributions to Canadian Psychology: Robert Vallerand, Ph.D.

CPA Donald O. Hebb Award for Distinguished Contributions to Psychology as a Science: Sherry Stewart, Ph.D.

CPA Award for Distinguished Contributions to Education and Training in Psychology in Canada: Meghan Norris, Ph.D.

CPA Award for Distinguished Contributions to Psychology as a Profession: Randi McCabe, Ph.D.

CPA Award for Public, Community Service, and Human Rights and Social Justice in Psychology: Ben Chung-Hsing Kuo, Ph.D.

CPA Humanitarian Award: BlackNorth Initiative

CPA President's New Researcher Award: Samantha Dawson, Ph.D.

NEW CPA FELLOWS

Congratulations to the newly-elected CPA Fellows for 2023!

Judith Wiener, Ph.D.
Laurie Ford, Ph.D.
Judi Malone, Ph.D.
Kate Harkness, Ph.D.
Caroline Pukall, Ph.D.
Karen Rowa, Ph.D.
Lia Daniels, Ph.D.
Robinder Bedi, Ph.D.
Kang Lee, Ph.D.
Marc Nesca, Ph.D.
Sophie Bergeron, Ph.D.

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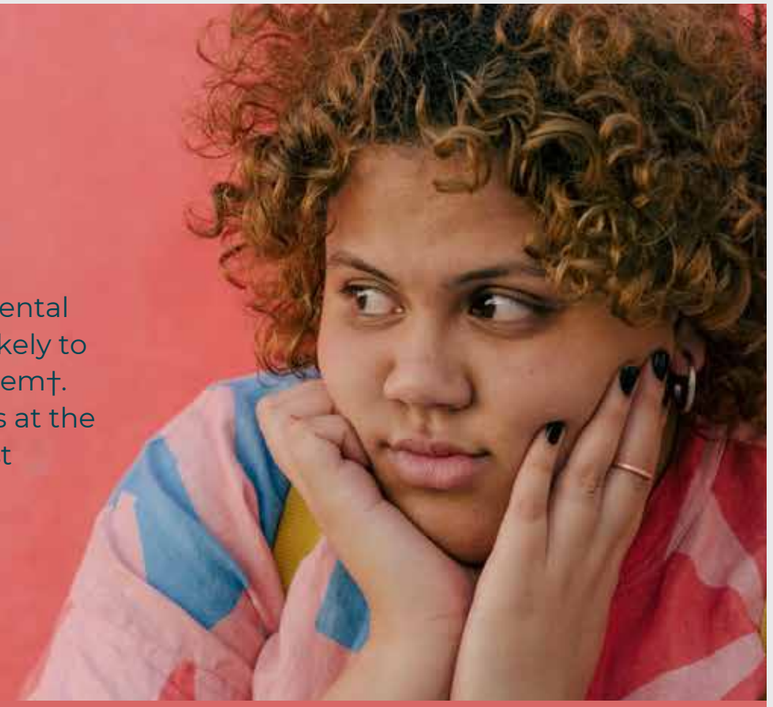

†The Canadian Journal of Psychiatry

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WHO WE ARE

ABOUT US

The Canadian Psychological Association (CPA) was founded in 1939 as the national association for the science, education and practice of psychology in Canada. We were incorporated under the Canada Corporations Act, Part II, in May 1950 and received our Certificate of Continuance under the Canada Not-for-Profit Corporations Act (NFP Act) in August 2013. With over 7,000 members and affiliates, we are Canada's largest national association for psychology.

VISION

A society where understanding of diverse human needs, behaviours and aspirations drive legislation, policies and programs for individuals, organizations and communities.

MISSION

Advancing research, knowledge and the application of psychology in the service of society through advocacy, support and collaboration.

OUR STRATEGIC GOALS

1. As an association, we are guided by the vision that the science, practice and education of psychology has broad and deep relevance to public policy and the public good. We aim to realize this vision by being an association that:
2. Supports and promotes psychological science to advance knowledge and to address the concerns of people and the society in which we live and work.
3. Meets the needs, supports the growth and enhances the impact of the discipline and profession.
4. Advocates for access, resources and funding for psychological services and research, in parity with physical health, for the people in Canada.
5. Addresses the education, training and career development needs of students, educators, scientists and/or practitioners of psychology across their lifespan.
6. Promotes and models equity, diversity and inclusion in all we do.
7. Is accountable to Indigenous people through the recommendations of the CPA's response to the Truth and Reconciliation Commission (TRC) of Canada's report.

CPA GUIDING PRINCIPLES

- Evidence-based practice, policy and decision-making.
- Respect our organizational mission in all things: support and promote the development of the discipline and profession and its contributions to the people and society in which we live and work.
- Deliver value to members and affiliates.
- Respect, integrity, diversity and inclusion guides all our activity.
- Model the principles of the CPA Canadian Code of Ethics in all we do.
- Collaborate meaningfully and constructively with the CPA's and psychology's partners and stakeholders.

CPA OPERATING PRINCIPLES

- A commitment to best practice in the governance and management of the association.
- Organizational effectiveness. Our strategic goals reflect and respond to the needs and views of our membership and stakeholders. We align operations to strategic goals. We balance the need for continuity of policy and programming with the need to respond to changes in the organization's climate and context. We walk the talk of respect and collaboration among Board, management, staff, members, affiliates, partners and stakeholders.
- Provide psychology across Canada a professional home. We can do this by being a convenor and by supporting networks and communication among scientists, practitioners and educators in psychology.
- Have an opinion, lend a voice, make change for the good. We engage members and their expertise in making contributions to public policy.
- See, hear and consider a diversity of perspectives from among members, affiliates, partners and stakeholders when addressing issues, problems, policies and initiatives facing psychology or the organization.

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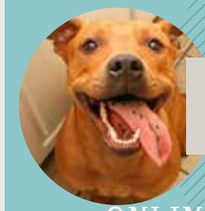

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