



**BEST
BRAINS
EXCHANGE**
REPORT

Treatment of
Chronic Pain and
Complex Concurrent
Mental Health
and *Substance*
Use Conditions



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CIHR's Best Brains Exchange (BBE) Program
is a knowledge mobilization program dedicated
to creating synergies between senior policy
makers, researchers, implementation experts,
and key stakeholders.

EXECUTIVE SUMMARY

Background

IN MARCH 2019, the Government of Canada established the [Canadian Pain Task Force](#) (CPTF, or “the Task Force”), to provide advice and information to help better understand and address the needs of Canadians living with pain. In March 2021, the Task Force provided its final report to Health Canada—an [Action Plan for Pain in Canada](#)—which included over 150 recommendations for priority actions, including actions to support better integration of pain management services into mental health and substance use treatment services, and vice-versa.

Mental health and substance use are among the top health priorities for all levels of government: federal, provincial, and territorial. Persons living with chronic pain and concurrent mental health and substance use conditions represent a complex intersection between 2 significant health policy areas, particularly on the heels of responding to the Task Force’s recommendations and the ongoing overdose crisis.

Poorly managed pain takes a significant economic toll on both individuals and the country. It also results in poor outcomes for individuals: 36% report their pain prevents them from most or some activities of daily living, affecting their families and communities. Unmanaged pain can be a driver for other health and social issues, including mental health and substance use challenges.

From February 27 to February 28, 2023, Health Canada, in partnership with the [Canadian Institutes of Health Research](#) (CIHR), hosted a Best Brains Exchange (BBE) to enhance and share knowledge related to best practices and treatment options for people living with chronic pain and concurrent mental health or substance use-related conditions. This virtual event allowed participants to discuss opportunities and challenges for effective implementation of these best practices. Participants also discussed actions that could be undertaken to provide equitable access to services for populations disproportionately impacted by pain (see [BBE meeting agenda](#)). These include:

- Indigenous populations
- children and youth
- veterans and military personnel

Over the course of this event, more than 50 experts (see [List of Attendees](#)) from different sectors were brought together, including:

- subject matter experts, such as:
 - › researchers
 - › clinicians
 - › implementation experts

- people living with pain
- policy makers and professional organisations including:
 - › representatives from 7 provinces and territories
 - › representatives from 7 federal departments and agencies, such as:
 - Indigenous Services Canada
 - National Defence
 - Veterans Affairs Canada
 - Correctional Services Canada (CSC)
 - › representatives from the [Canadian Centre on Substance Use and Addiction](#)
 - › representatives from [Canada's Drug and Health Technology Agency](#)

Presenters and participants came together to enhance and share knowledge related to best practices regarding the treatment of chronic pain and co-morbid conditions. The BBE was also an opportunity to cut across the existing silos and in turn, discuss how to implement effective strategies to address the needs of those living with these complex health conditions.

Discussion summary

Overall, the aim of the BBE was to prioritize the most effective strategies and models of care to manage chronic pain and complex concurrent conditions. The emphasis was on innovation and ways to adapt or expand on some of these best practices. A further focus was to reflect on the experience of people living with chronic pain as well as the impact of chronic pain on populations disproportionately impacted by it.

Participants discussed the many and complex barriers to optimal care along with equally complex factors that can act as facilitators or solutions. As stated throughout the BBE, solutions for effective management of chronic pain and complex concurrent conditions require intersectoral and interdisciplinary leadership, particularly at a national level, with collaboration among all stakeholders.

Key recommendations

Reducing stigma and applying an equity lens

- The impact of stigma was a recurring theme across nearly all presentations, particularly those focused on populations disproportionately impacted by these concurrent conditions
- In education, the negative factors related to stigma, equity, and intersectionality can be reduced by involving people with lived and living experiences with pain and populations disproportionately impacted by pain in the development of:
 - › policies
 - › program
 - › research
 - › awareness efforts
- To prevent pain in adulthood, prioritize and treat pain early in the lifecycle and support the effective implementation of the pediatric pain management standard
- Remove barriers to care for populations disproportionately impacted by pain and ensure health priorities and funding commitments reflect the needs of these populations



Access to pain management services and effective models of pain care

- Integrate management of pain and concurrent mental health and substance use conditions into system reform and health in all policies
- Revise relevant standards and practice guidelines to help remove barriers to equitable and efficient care, including access to non-pharmacological services like physiotherapies and chiropractic services.
- Move away from the biomedical approach towards a more biopsychosocial one which supports an interdisciplinary model of care, involving people living with pain and their primary care providers
- Address barriers related to access to care by better supporting physicians and specialists
- To support access to virtual resources, including self-management and peer-to-peer programs, provide better internet access either by reducing costs or increasing availability
- Ensure access to pain medication, including avoiding rapid tapering, and address the underlying issues of unmanaged pain as a factor in the onset of substance use
- Enhance the connections between primary care and specialized care
- Adopt more efficient models of care that help improve wait times and access to specialized services

National leadership and coordination

- Enhance the connections between primary care and specialized care
- Foster national collaboration through ongoing partnerships across all levels of government to support efforts in making pain a health priority
- This includes the establishment of an empowered federal, provincial and territorial governance structure on chronic pain
- Provide resources that help providers and their patients acquire more wholistic and evidence-based knowledge of chronic pain and concurrent conditions
- To enable positive and lasting change, increase support from a range of other actors working inside and outside of the health system, such as:
 - › peer advocates
 - › non-governmental organizations
 - › academic institutions
 - › insurers
- Provide sufficient investment to evaluate and scale interventions across jurisdictions

Education, training and continuing professional development

- Educate stakeholders on how to recognize and reduce stigma, including internalized patient stigma and stigma within the medical community.
- Improve education on pain and complex concurrent conditions across the spectrum of clinicians, particularly among primary care physicians
- Ensure information is grounded in a biopsychosocial approach for interdisciplinary providers
- Create education resources and tools for use by both health care providers and patients

Research and data

- Support further research on the intersectional issues of chronic pain, mental health conditions, and substance use
- Build more evidence around pain itself and potential treatments, grounded in a biopsychosocial approach with an interdisciplinary team
- Rethink “evidence” to include the Indigenous community and their traditional medicine and practices
 - › Conduct more evaluations of best practices from within Canada and elsewhere
- Include people living with pain in all steps of the research process

Advocacy and awareness

- Develop and support advocacy at both the grassroots and national levels
- Draw on the expertise of people who are living with pain and to encourage and support the sharing of stories, knowledge, self-help networks, and peer support
- Bring further awareness around the impact of chronic pain on Canadians, building on stories and experiences of people living with pain
- Advocacy and awareness should also support efforts in reducing stigma and providing heightened awareness for priority setting with policy makers to increase funding for research and program implementation

Key takeaways

Investments and actions in pain prevention and management have the potential to reduce the social, economic and health impacts of chronic pain, and improve outcomes for Canadians and the healthcare system more generally. While there is a need for further evidence in this area, there is emerging consensus about what works and what actions are required to better support Canadians living with these complex concurrent conditions.

Overall, presenters and participants emphasized the need for all roles to take the following overarching approaches:

- Apply the lenses of equity and intersectionality and be aware of the multiple levels and impacts of stigma
 - › These are fundamental to understanding the complexity of the needs, barriers, and solutions for this patient population
- Aim for optimal national, provincial and territorial collaboration and coordination to efficiently align all available resources and creating the most effective and efficient solutions possible

Please note that the BBE used Chatham House Rules. As a result, the report does not attribute comments or information except for presenters who agreed to attribution.

1.0 BACKGROUND

1.1 Impact of chronic pain in Canada: Incidence, burden and co-morbidity

Chronic pain is a serious public health issue in Canada affecting approximately 1 in 5 Canadians, or 7.6 million people. Chronic pain is often an invisible condition that can affect people of all ages, including children and youth. It is defined as pain that lasts or recurs for more than 3 months. It is one of the most common reasons for seeking health care and there are significant intersections between chronic pain and other health and social priorities.

Substance use disorder

- Chronic pain is a significant driver
- In 2018, approximately 44% of individuals who died from an illicit drug overdose in British Columbia had sought assistance for pain-related issues in the year preceding death
- Over 50% of people living with moderate or severe chronic pain report using substances
- 31% to 55% of people who use drugs report having chronic pain

Mental health

- Chronic pain often results in anxiety and depression and can nearly double the risk of suicide
- 28% of people living with chronic pain have seriously considered suicide

Medical Assistance in Dying (MAID)

- Nearly 60% of Canadians who received MAID in 2021 cited inadequate control of pain (or concern about pain) as a reason that prompted their request

COVID-19

- Delayed medical procedures resulting from the COVID-19 pandemic have led some individuals' pain to transition from the acute stage to the chronic stage
- There is increasing evidence that chronic pain is a common symptom of post-COVID condition.

Aggravating factors

Complex issues and poor access to care

While effective treatment options and approaches are possible, there are challenges related to the availability and accessibility of multidisciplinary and interdisciplinary care services. These include:

- long wait times
 - › Average wait times are 5.5 months and can last up to 4 years
- limited access in rural, remote, and northern communities
- financial barriers for pain management services or other specialized treatments, such as:
 - › psychological support
- physiotherapy

Lack of knowledge

There is limited best practice guidance for the treatment of pain and concurrent mental health and substance use conditions.

Stigma

People living with chronic pain often face stigma from the general population, internalized stigma within the patient themselves, or stigma from the medical community, thus exacerbating challenges in accessing adequate services for managing their pain.

Burden

Untreated pain takes a significant toll on both individuals and the country. It results in poor outcomes for individuals: 36% report their pain prevents them from most or some activities of daily living. It also affects their families and communities. Populations disproportionately affected by social inequities and discrimination often face increased challenges in accessing adequate pain services.

In March 2019, the Government of Canada established the Canadian Pain Task Force to provide advice and information to help understand and address the needs of Canadians living with pain. In March 2021, the Task Force released an Action Plan for Pain in Canada, which included over 150 recommendations for priority actions so that people with pain are recognized and supported, and that pain is understood, prevented, and effectively treated. Several recommendations reflected the significant intersections between chronic pain, mental health, and substance use, as well as the importance of better integration of services particularly for those living with these complex concurrent conditions.

2.0 OBJECTIVES AND FORMAT OF THE BBE

CIHR's Best Brains Exchange (BBE) Program is a knowledge mobilization program dedicated to creating synergies between senior policy makers, researchers, implementation experts, and key stakeholders. The program also aims to address pressing health priorities with the goal of supporting the integration of research evidence into policy and practice.

In collaboration with CIHR, Health Canada's Chronic Pain Policy Team hosted a virtual BBE on February 27 and February 28, 2023. The purpose of this BBE was to enhance and share knowledge related to best practices and treatment options for people living with chronic pain and concurrent mental health or substance use-related conditions. It brought together representatives from different sectors and expertise, including:

- research experts
- pain specialists
- people living with pain
- representatives from 7 provinces and territories
- representatives from 7 federal departments and agencies
- representatives from the Canadian Centre on Substance Use and Addiction
- representatives from Canada's Drug and Health Technology Agency

As identified by the Task Force over the course of its 3 year mandate, there is limited centralized knowledge and resources regarding best practices for the treatment of persons living with chronic pain and complex concurrent mental health or substance use conditions. However, evidence generated by the Task Force suggests that research, researchers, and clinicians specializing in this area do exist, although barriers often prevent best practices from being implemented across jurisdictional or professional lines. As such, hosting a BBE involving experts in this area with federal, provincial, territorial, and professional representatives allowed the generation and sharing of relevant knowledge. This event was also a first step in responding to recommendations made by the Task Force related to providing equitable access to services for a group of Canadians disproportionately impacted by pain, namely people who are living with a concurrent mental health or substance-use related condition.

BBE participants were asked to consider the following questions:

1. Based on current evidence, what are the most effective strategies for the prevention and management of complex concurrent conditions of chronic pain and mental illnesses and/or substance use-related conditions?
2. To serve this complex population, what strategies could be put in place to support the implementation of effective programs and practices that may fall outside of those typically recommended for persons with only chronic pain, mental illnesses, or substance-use related conditions?

Additional details about the objectives of the BBE can be found in [Appendix A](#).

Day 1 of the BBE focused on the identification of best practices for the prevention and management of the complex concurrent conditions. Day 2 focused on challenges and opportunities to support implementation of these best practices, including a dedicated session to identify ways to better support populations disproportionately impacted by these complex intersections.

2.1 DAY 1: Prevention and management of complex concurrent conditions

The former Task Force co-chairs, Fiona Campbell and Maria Hudspith, began the BBE by providing a scene-setting presentation that situated the theme of the BBE in relation to the overall context of chronic pain in Canada and the activities and findings of the Task Force. They highlighted the issue of bifurcation (such as referral criteria that require substance issues to be managed before treating pain in a tertiary clinic) and the importance of supporting people with these complex health conditions in a holistic manner, as opposed to “treating conditions” separately. This is particularly important as they also noted that unmanaged pain can be a driver for substance use.

Panellist 1: Dr. Hance Clarke

The first panel of the day provided examples of effective programs, models of care, and best practices for treating chronic pain when and where it overlaps with complex concurrent conditions. Dr. Hance Clarke provided a brief overview of the [Transitional Pain Service](#), a multidisciplinary pain management program for patients who are at risk of chronic post-surgical pain and pain-related disability. This program was initially established at the Toronto General Hospital in 2014 as a pilot project, which kept mental health and substance use conditions at the core of treatment. It also moved away from curing or fixing chronic pain to focusing on coping and “living with pain” by helping patients increase their daily functioning and focusing on what is meaningful in their lives. In this setting, intervening early with transitional care is a way to prevent the path of post-surgical opioid use from evolving to higher risk use or overdose.

Today, several transitional pain services programs are being piloted and established across Canada. In addition to managing this transition post-surgery, Dr. Clarke emphasized that there are multiple transitional points within the healthcare system that need to be managed to avoid high-risk opioid use, such as post-emergency room (ER) or trauma.

Panellist 2: Dr. Rob Tanguay

Dr. Rob Tanguay, who presented on innovative and integrative approaches for the treatment of pain and substance use, added further nuance by emphasizing the importance of interdisciplinary care. He reflected on his experience that interdisciplinary team matters more than whether a patient receives care in an inpatient setting compared to an outpatient setting. While multidisciplinary care is an important step, interdisciplinary care requires a coordinated approach with different clinicians and support staff working together to develop a treatment plan (rather than multiple specialists under the same roof with little coordination). He highlighted specific initiatives in Alberta, including Alberta Health Services Alberta Virtual Pain Program, Canada’s first provincial pain program. This will include a provincial virtual transitional pain program that will be accessible to everyone going through surgery, with the goal of reducing or eliminating the need for opioid use for the management of post-surgical pain and avoiding the transition from acute to chronic pain. During his presentation, Dr. Tanguay emphasized that while there are effective models of care available, these evidence-based treatments will be of limited use until they are well-funded and easily accessed by those who need them.



Panellist 3: Dr. Patricia Poulin

Both Dr. Clark and Dr. Tanguay highlighted the integral role of virtual care options for patients, particularly for those living in rural areas. Patricia Poulin continued this theme by presenting on adapted stepped care 2.0 model and the recently launched [Power Over Pain](#) Portal. This program was created to address the issue of lengthy wait times of over 2 years to access multidisciplinary pain care at the pain clinic of the Ottawa Hospital. Their solution, stepped care 2.0, allowed patients to be streamlined based on their readiness, knowledge, and goals, reflecting that not all patients need to start at the same place in treatment. Under this new structure, the timelines to accessing specialized pain care in Ottawa were significantly reduced. She highlighted the launch of the Power Over Pain Portal as being an important component of the stepped care 2.0 model, providing patient with evidence-based, free, and less-intensive resources for patients. She reflected on the importance of this tool to enable people living with pain to be provided with immediate access to pain resources, and to help introduce these individuals to the concept of pain to help patients gain the understanding and help them take control of their pain through, for instance, self-management strategies.

Remarks

This panel was followed by remarks from Keith Meldrum, Member of Pain Canada's [National Advisory Committee](#). He highlighted his own experience to reflect the challenges faced by people living with pain in accessing appropriate services, and the nature and impact of accessing effective care. In addition to providing an overview of the cause and trajectory of his own chronic pain for the last few decades, he emphasized the harm that can come from a hyperfocus on the biomedical model. In his experience, once surgeries and time had "healed" the physical injuries, there was little support for his ongoing pain. Throughout his presentation, he suggested a person-first, rather than disease-first, approach to pain care, reflecting the importance to understand the needs of the person rather than the disease itself. He highlighted that until there is an understanding of what is going on in an individual's life, it will be challenging for health providers to understand the impact of pain on their patient's lives and as a result, they will continue to face challenges when treating the pain.

As a preview for day 2, the final session of the day was a facilitated discussion between all presenters and participants regarding the perceived barriers and solutions to the implementation of effective strategies and models of care. Details and outcomes of this discussion are found throughout [Section 3](#).

2.2 DAY 2: Implementation of effective strategies

As reflected in the CPTF reports, chronic pain does not affect the Canadian population equally. Some populations are disproportionately impacted by pain. As a result, implementation is not always the same across all populations. The first session of the day focused on the challenges, solutions, and implementation of programs for some of the populations disproportionately impacted by pain: children and youth, Indigenous, and veterans.

Panellist 1: Dr. Katie Birnie

Dr. Katie Birnie began the first panel with a focus on pain in children and youth, including specific challenges when addressing pain in pediatric populations. She highlighted that hospitalized children experience an average of 6 painful procedures every 24 hours and up to 14 procedures in the neonatal intensive care unit. Pain that starts in childhood has short and long-term impacts, including:

- changes to the brain
- pain sensitivity

- impairment across:
 - › emotional functioning
 - › physical functioning
 - › social functioning
 - › school functioning
 - › family functioning

In adulthood, chronic pain in childhood often leads to:

- chronic pain
- mental health concerns
- substance use
- socioeconomic disparities

Equity-seeking populations are disproportionately impacted due to racism, oppression, and adverse childhood experiences. Chronic pain is also an intergenerational issue; parents with chronic pain increases the risk of their children also having chronic pain. While Canada is a world leader in children's pain research, this knowledge is not always put into practice. To mitigate some of these trajectories, [Solutions for Kids in Pain](#) has recently published the first national health standard for pediatric pain management in the world, in partnership with the Health Standards Organization.

Panellist 2: Dr. Jaris Swidrovich

In addition to his background as a pharmacist and Assistant Professor at the University of Toronto, Dr. Jaris Swidrovich was a member of the CPTF. His presentation focused on specific challenges of treating chronic pain and concurrent conditions for Indigenous populations. Dr. Swidrovich described the role of past and ongoing impacts of colonization on the emotional, spiritual, mental, and physical health, as well as the importance of balance and wellness in each sphere. Stigma is a particularly potent barrier, as Indigenous persons are often seen as being dramatic or drug-seeking when attempting to access care for their pain, mental health, or substance use which compounds with other sources of stigma. As a result, stigma and social inequities can negatively impact their ability and willingness to seek and access care. Traditional practices and healing methods are seen as and understood to be very beneficial; however, the associated costs are not typically covered by the healthcare system. Evidence resulting from research into the use and effectiveness of these methods is often graded lower than other sources of evidence or not researched whatsoever.

Panellist 3: Dr. Ramesh Zacharias

Dr. Ramesh Zacharias ended the panel by providing an overview of the impact of chronic pain on Canadian veterans as well as best practices to manage it. Chronic pain prevalence is significantly higher among Canadian Veterans compared to the general population, with approximately 40% of veterans living with chronic pain compared to 20% in the general population. Chronic pain is even more prevalent in female Veterans, 50% of whom experience chronic pain. There is also a strong link between chronic pain and mental health conditions in the Veteran population: 63% of Veterans with chronic pain have diagnosed mental health conditions and 62% of Veterans with diagnosed mental health conditions have chronic pain.

Veterans Affairs Canada has funded 3 research centers, including the Chronic Pain Centre of Excellence for Canadian Veterans (CPCoE) that was recently established in 2020. The CPCoE provides national leadership for research that has been co-designed with Veterans and their families. It also supports the implementation of research within a national network of clinics to help Veterans and their families manage pain and increase their quality of life. Veterans face significant obstacles coping with pain and mental health conditions, particularly when these conditions impact their sense of identity, the military life, and the community they previously belonged to. However, Dr. Zacharias also emphasized that Veterans are truly resilient and, like many other populations, they have demonstrated real benefit from interdisciplinary care.

Panellist 4: Linda Wilhelm

The final session of the day was an armchair discussion focused on moving evidence into practice, which began with 3 presentations followed by a moderated discussion between the panelists, other presenters, and the BBE participants. Linda Wilhelm, who has lived with chronic pain for over 40 years since her diagnosis with rheumatoid arthritis, focused her presentation on both her experience living with chronic pain, the progress she has seen in treatment in recent years, as well as remaining challenges. Some of the most positive changes she has seen are the inclusion of people with lived and living experience in research and policy discussions, as well as the shift in attitude towards non-pharmaceutical methods like physiotherapy. Nevertheless, she noted that accessibility to alternative treatments remains a significant challenge, especially in terms of cost and insurance coverage.

Changes in opioid prescribing practices since the beginning of the overdose crisis have also been a challenge. She noted the lack of availability of certain doses, which led to rapid tapering instead of gradual tapering of her opioid medications. In closing, she emphasized the role that her knowledge and participation in the chronic pain community has had on her treatment trajectory. This foundation of knowledge and support has enabled her to be a strong advocate for herself and she acknowledged that many people living with pain do not have access to this support and knowledge, which can make seeking treatment and advocating for themselves very difficult.

Panellist 5: Dr. Daniel Buchman

When considering implementing different strategies for policy and clinical practice, Dr. Daniel Buchman encouraged participants and fellow presenters to keep in mind the ethics and stigma surrounding the issue of mental health, substance use, and chronic pain. Such considerations require asking, “what is the right thing to do?” and, in turn, identifying values and making them actionable in clinical practices and policy decisions. Stigma is multifaceted and there is no single type. Stigma is also an issue of justice—a fundamental cause of population health inequities—and a barrier to accessing care. When the stigmas of mental health, substance use, and chronic pain intersect, along with other patterns of social disadvantage, stigma is intensified. Stigma is largely structural, particularly within the medicalized context where we focus on objective indicators of illness or biological markers, as the pathology (if present) may not correlate with the level of pain. Pain is considered an “invisible” and subjective experience.

There is some research from mental health contexts which suggests that drawing upon biological understandings of mental illness can reduce some aspects of stigma, but it also may inadvertently increase other forms. He highlighted that evidence to reduce population-level stigma in the chronic pain and substance use context is limited, so we should not necessarily default to biological-based messaging. There are some lessons learned that we could take from the work done on HIV and mental health stigma and see if it is applicable to stigmas related to chronic pain.

Panellist 6: Dr. Abhimanyu Sud

Dr. Abhimanyu Sud continued the theme of broader structural issues by providing an overview of opportunities and challenges to translating evidence into practice. He suggested that adopting population health approaches to pain would be an important start. While there are some population health approaches for mental health and substance use, it is often not the case for chronic pain. Reflecting comments provided throughout other presentations, he indicated that the biopsychosocial model may be one lens for viewing population-level approaches to pain. Relatedly, Dr. Sud also asked participants to consider what a biopsychosocial model for health and all health conditions would look like and the implications this would have for clinical practice.

He also recommended that serious efforts should be given towards developing health economics evaluations, which would be particularly useful for policy makers for determining the effectiveness and efficiency of different treatment options. This would also include real investments to evaluate and scale interventions across the different health jurisdictions. On a more individual level and in the shorter-term, Dr. Sud reminded participants and fellow presenters that nearly 80% of pain care happens at the primary level and, as such, primary care providers should be included at specialist “tables” and discussions. He also noted the importance of better training and providing primary care providers with the resources and time required to treat patients living with chronic pain and complex concurrent mental health and substance use conditions.

Remarks

Like the previous panels, the armchair session was followed by an open discussion with participants where they could ask targeted questions to the presenters. Typically, these were follow-up questions regarding their advice for implementation as well as any outstanding challenges they had not previously addressed in their presentation. The following sections provide an overview of the key themes, challenges, and solutions raised over the course of this BBE.

3.0 OVERARCHING ISSUES

3.1 Stigma: Diverse sources, complex impacts

- Stigma plays a significant role in reducing and/or complicating access to appropriate care at the intersection of chronic pain, mental health, and substance use.
- Stigma can be minimized when it is okay to ask for help and help is available and accessible.
- Suggestions to alleviate issues surrounding stigma primarily revolved around education and awareness.

Factors related to stigma, equity and intersectionality regarding chronic pain and concurrent substance use and mental health conditions impact every aspect of creating solutions, from policy to implementation. The impact of stigma was a recurring theme across nearly all presentations, particularly those focused on populations disproportionately impacted by these concurrent conditions.

Stigma in its many forms plays a significant role in reducing or complicating access to appropriate care at the intersection of chronic pain, mental health, and substance use. The complexity of both the sources and impacts of stigma has implications for all aspects of pain care. Some participants expressed that it is easy to see why the trajectory from chronic pain to mental health and substance use would happen. At best, patients are undertreated. At worst, patients feel abandoned and as a result they develop coping mechanisms, like the use of substances, to get through the day.

Many patients deal with substantive intergenerational trauma that are often not sufficiently addressed in current approaches to pain, mental health, and substance use treatment across the lifespan. Participants and presenters noted that when stigma applies to one aspect of life it often applies to others, and that addressing stigma might reduce it in one way but increase it in another. For instance, adopting a biomedical approach to pain can lead to some types of pain being more accepted or “believable” by patients, clinicians, and the broader population. However, this biomedical approach may not be appropriate when pain has no medical explanation, exacerbating internalized stigma and social exclusion. Further, if there is no clear help available for pain treatment and the patient does not think they will be believed, there may be hesitancy to seek care, especially if the individual is already dealing with stigma.

Over the course of the BBE, presenters and participants highlighted and defined several different types, sources, and impacts of stigma.

Specific populations

Populations disproportionately impacted by pain are impacted by stigma more often than others. These include:

- Indigenous people
- racialized people
- people who use substances

Internalized stigma

Internalized stigma is a type of stigma that may come from a personal feeling of not deserving the care they need. Shame and stigma prevent people from speaking out and getting help.

Curtesy stigma

Being associated with a stigmatized person or population can result in incurring curtesy stigma. Clinicians or family members may be subject to this due to their professional or personal relationship with a person living with pain, substance use, or mental health conditions. Current policy and legal contexts for people living with pain may exacerbate this. Stigma around pain, substance use, and mental health may also prevent health care providers and policy makers from coming out about their own lived experience.

Structural stigma from a biomedical perspective

The following stigmas may lead to poor quality care.

Focus on biomedical indicators

Structural stigma stems from a medicalized context where providers focus on objective, biological indicators of illness, such as a fracture on an x-ray. Stigma results when pathology is missing or does not correlate to the level of pain. Too often, pain continues to be invisible to the health care system with some patients being told it is “all in their head.”

Bias against substance use

Given the bias regarding pain, patients who try to find relief with opioid medications or other substances may be seen as dramatic and drug-seeking. This type of stigma may be amplified when people are living with concurrent conditions such as mental health. It may be further exacerbated should the health care provider possess moral stands against the use of substances. This has led some individuals living with pain to seek substances from the illegal market to self-medicate.

The highest risk is when patients coping with pain along with mental health issues, such as anxiety, are using opioids. In interactions with health care professionals, these patients are more often assessed to determine if they have a substance use disorder and whether they are using substances for coping or for pain. When addressing these complex conditions, a determination on how the patient is feeling overall as result of the opioid use should take priority to ensure wholistic patient care and avoid stigma.

Bias against Indigenous traditional knowledge as evidence

Aiming to achieve health by seeking a life that balances mental, spiritual, emotional, and physical wellness is part of Indigenous peoples’ wellness. However, Indigenous populations’ traditional practices, healing methods, and advice from elders are often not recognized as best practices by health care professionals and insurers. Such practices are often seen to be of poor-quality evidence in many areas of the medical community, leading to a lack of coverage and traditional medicine services being offered for Indigenous populations.

Stigma among health care providers

With human resources issues compounded by high demand, many primary care providers feel overburdened and overworked. At times, this may lead to tough decisions on where they spend their time. Consequently, they may need to be selective about which patients to take on. For instance, they may not take on new patients with more complex health needs—like chronic pain, mental health, and substance use—given the difficulties in managing these complex conditions with their limited time and resources.

A lack of clear and distinct pain care treatment options, such as chronic pain wings in hospitals, were identified. Along with limited awareness and training on pain care being offered to physicians at this time, physicians who try to treat chronic pain may face barriers to offering appropriate treatment.

Some of the following issues were highlighted by participants:

- Physician's transitions
 - › Physicians may have patients who have been stable on high doses of opioids and can manage work and family life
 - If the physician needs to leave their practice—for example, for retirement—it can be difficult to refer these patients to another physician
- Bias from the medical community against opioid treatment
 - › Some physicians may have strong bias against the use of opioids as an effective treatment for pain
 - This may lead to additional barriers for individuals living with pain to access appropriate care
 - These challenges are also exacerbated when a person is taking a high opioid dose
 - › In recent years, some regulatory bodies have undertaken investigations against physicians' opioid prescribing practices
 - This has increased reluctance for some physicians to prescribe opioids to their patients
- Bias against alternative methods
 - › Many health care professionals have a strong bias against many forms of alternative medicine or non-pharmacological approaches, such as chiropractic services

Stigma within stigmatized communities

People living with pain may stigmatize those who use substances, including opioids, and blame them for changes to their opioid prescribing.

Proposed solutions to address stigma

The issue of stigma permeated all other issues raised throughout presentations and discussions at this BBE. Therefore, solutions described under other themes addressed in sections below will also contribute to minimizing the negative effects and impacts of stigma. Broadly speaking, stigma can be minimized when it is okay to ask for help and when help is available and accessible to all. Concrete suggestions raised by participants to alleviate issues surrounding stigma primarily revolved around education and awareness.

Overall, there is a need to ensure people living with pain and health professionals have the knowledge, skills, and educational support to appropriately assess and manage pain based on population needs. In education, there is a need to eliminate the negative factors related to stigma, equity and intersectionality. Expanding this knowledge can be done by involving people with lived and living experiences with pain and populations disproportionately impacted by pain in the development of the training and other tools. An equity lens and an inclusive approach should be incorporated into case writing and research papers, for instance, by referencing pronouns and reflecting ethnicities for all authors. Adequate representation from populations disproportionately impacted by pain, such as Indigenous people should also be ensured throughout the process. Similarly, in simulation labs, ensure that students have diverse groups to interact with, such as Indigenous actors.

For awareness and advocacy, there is a need to foster more support and encouragement for people with lived and living experiences with pain to share their stories. Raising awareness is a crucial element to addressing stigma: people with pain may be less hesitant to seek help and access to appropriate care may be more likely. Increasing awareness can also support policy makers in helping to increase funding for pain related treatments, programs, resources and education.

3.2 Equity, intersectionality, and people living with pain

Chronic pain disproportionately and differently impacts several sub-populations within Canada, including women, children and youth, Veterans, and Indigenous populations.

People who live with pain are often members of multiple and intersecting identities that can exacerbate their experience of pain as well as the barriers to accessing care.

Equity and access could be increased by removing barriers to services by:

- expanding health coverage to include a broader range of services, like physiotherapy and psychological therapies
- supporting virtual tools and virtual care
- implementing a universal pharmacare program

Like many other medical conditions, chronic pain is not equally distributed across all populations. As noted by the CPTF reports, chronic pain disproportionately and differently impacts several sub-populations within Canada. While the BBE was unable to include content specific to each one of the groups identified by the Task Force, it did include sessions focused on Veterans, children and youth, and Indigenous people. The recognition of tailored approaches for pain management that reflect the needs of these populations were also reflected as a cross-cutting theme throughout the BBE. Presenters and participants also emphasized that people who live with pain are often members of multiple and intersecting identities. This can exacerbate their experience of pain as well as the barriers to accessing care. Clinicians, researchers and policy makers should be aware of the ways that intersectionality may have a compounding effect on access to, willingness to access, and ability to access appropriate care.

First Nations, Inuit, and Métis Peoples

Many indigenous people have their pain outright dismissed by the public and by medical professionals. For example, some members of First Nations living on reserve have an “R” on their provincial health care card. This may trigger a biased response before the patient is even seen.

Indigenous peoples may also face the impact of moving locations—such as moving on or off a reserve or moving from rural to urban areas—and the physical barrier of rural and remote locations. For example, they may be transferred to care by an air ambulance, but on discharge they may not be offered transportation and must find the means themselves to get home.

“To achieve health, Indigenous people seek a life that balances mental, spiritual, emotional, and physical wellness, yet the scope of these 4 dimensions is not typically considered in the Western-based health system. Indigenous people experience ongoing pain and hurt in all these dimensions because of a colonial legacy that persists in current-day policy and care contexts.”

(Latimer, 2020)



Racialized peoples

Stigma, especially at the intersection of chronic pain, mental health, and substance use, is further exacerbated in this population. People of colour often have their pain outright dismissed by the public and by medical professionals.

People who use substances

Stigma, especially when it intersects with pain and mental health conditions, is further exacerbated in this population. There is harsher judgment for those who cannot cope without the use of medication or substances, whether legal or illegal. This, in turn, adds to the stigma and isolation, resulting in poorer care.

Children and youth

There is a lot of research on pain in children and youth. In fact, Canada is a leader in this research. However, evidence generated through this research is not always put into practice.

Burden of pain in children and its consequences

- Pain in childhood is common and has significant negative consequences on children and their families
- Hospitalized children experience an average of 6 painful procedures every 24 hours and up to 14 procedures in the neonatal intensive care unit
- Parents living with chronic pain and mental illness place children at risk for pain, as well as:
 - › poorer birth outcomes, such as lower birth weight
 - › psychological problems
 - › issues with physical functioning
 - › issues with family functioning
 - › issues with social competence
- Pain negatively impacts children's lives, including their sleep and their well-being:
 - › emotionally
 - › socially
 - › physically
 - › with family
 - › in school
- Poor pain management during infancy leads to:
 - › increased pain sensitivity
 - › neurodevelopmental problems
 - › socioemotional problems
- Poor pain management in childhood contributes to avoidance of medical care later in life and vaccine hesitancy
- In adulthood, children who have chronic pain are more likely to have:
 - › mental illness
 - › opioid use
 - › socioeconomic disparities

- Equity-seeking populations, such as First Nations children and Black youth, are disproportionately impacted due to:
 - › racism
 - › oppression
 - › adverse childhood experiences

Veterans

Veterans have unique challenges. Typically, they join the military at a young age and operate in a highly structured system. If they get mentally or physically injured, they may be medically discharged long before they are ready to change careers. They transition to a life with far less structure and support for ordinary things, and even less so for managing any chronic pain and co-morbid conditions. This leads to challenges with identity and loss of their sense of self.

Burden of pain in Canadian Veterans

- Over 240,000 Veterans have 1 or more disabilities
 - › 70% of these Veterans have a pain-related disability
- 40% of all Veterans live with chronic pain
 - › This is 2 times the rate of people experiencing chronic pain among Canadians in general
- 50% of female Veterans live with chronic pain
- 63% of Veterans with chronic pain also have diagnosed mental health conditions
- 62% of Veterans with diagnosed mental health conditions have chronic pain

Remarks

- Participants raised many additional challenges and limitations that greatly affect populations disproportionately impacted by pain, including:
 - › shortage of health care providers, such as:
 - › family physicians in general
 - › psychological services in rural and remote areas
- long wait times to access specialized pain care
- inadequate internet access to access virtual resources, such as the Power Over Pain Portal
 - › This is either because of affordability or lack of bandwidth in rural and remote areas
- the cost of medications and non-pharmacological therapies and their lack of coverage by insurance policies or the public health system
 - › This will often lead to costly out-of-pocket expenses, creating an additional barrier for those in need

It was also raised that many equity-seeking groups have dealt with substantive intergenerational trauma. Participants indicated that given our siloed approaches to pain, mental health and substance use treatments across patient's lifespans, the current health care system does not sufficiently address intergenerational trauma, particularly for children who experience pain.

Proposed solutions to better address equity and intersectionality in pain care

It is evident that ensuring timely access to appropriate care and treatment is a key element to improve equity in care. However, in doing so, participants noted the importance of taking on an inclusive and integrated approach to avoid inadvertently creating more siloes in the health care system. Participants noted the opportunity to build on the success of the recently-developed pediatric pain management standards. It could support the development and implementation of new national standards for equitable and quality pain management in other areas of pain management, like primary care or for adults. Participants also noted the importance to prioritize and treat pain early in the lifecycle as a way to further prevent pain in adulthood and improve the health of all Canadians over time.

Participants also noted the importance of removing barriers to services by expanding health coverage to include a broader range of pain management services, like physiotherapy and psychological therapies, as well as implementing a universal pharmacare program. They noted the importance of ensuring that Canadians have access to internet services, so that people disproportionately impacted by pain can access virtual resources available to help them manage. Above all, ensuring health priorities and funding commitments reflect the needs of these populations were also key points made by participants in considering equity and intersectionality issues in pain care.

3.3 Access to pain management services and effective models of pain care

Long wait times for specialized services and the shortage of primary care providers are significant barriers to accessing timely and adequate pain care in Canada.

A biopsychosocial model of care, as opposed to a biomedical approach, is most appropriate when addressing complex concurrent conditions of chronic pain, mental health, and substance use.

There are no one-size-fits-all approaches to addressing these complex health issues, hence the importance of providing a wholistic range of services and options to meet the patients where they are at in their journey.

Participants noted the importance of shifting away from the perspective of “trying to fix” patients as a final state of being to an approach that would focus on adaptation, where health providers accompany their patients in their lifelong journey.

People in Canada currently have inconsistent and limited access to pain services in primary care, with long wait times to access specialized pain management services in tertiary care. This is compounded by the shortage of primary care providers and pain specialists. While virtual tools are becoming more prevalent, many people still do not have or cannot afford internet. Even people living with pain who have been well connected with pain groups and resources have noted having problems accessing appropriate care.

As referenced by the CPTF reports and echoed during presentations and discussions at the BBE, evidence points to the need for access to pain care to be a broad spectrum of options matched to the unique needs of each individual, including:

- self-management
- primary care
- wellness-oriented programming

- community-based care
- specialized services
- interprofessional care

Presenters and participants made note of different barriers to provide access to consistent person-centred pain care models under the current health care system.

Emphasis on biomedical model over biopsychosocial approaches to care

Although there was a recognition by all participants that the health care system has evolved in recent years, the biomedical model is still predominantly adopted by health care providers. This model centres around the concept that illnesses and disease are attributable to a specific, physiological dysfunction. Moreover, that the mind and body are separate entities that do not interrelate. This approach does not look to address the social determinants of health.

As expressed by participants, there is still a need to move away from a focus on the biomedical model of care, searching for physiological explanations for health issues. Medical trauma in mental health, pain, and substance use care are also common, further justifying the need for a biopsychosocial approach to care.

People living with pain noted the detrimental impacts of having health care practitioners focus on objective indicators of illness or of seeking a biomedical explanation for pain. For instance, they expressed that it can be a very stigmatizing experience. If they cannot see it and the physiology has been fixed, the assumption is the pain must be in one's head: "can't see it, therefore can't treat it." The impact of social exclusion when pain does or does not have a medical explanation is difficult to process. People living with pain also noted the importance of acceptance in their journey of pain and the need to move away from fixing and curing chronic pain to shifting to a system that supports coping and learning to live with pain. They also noted the need to focus on what is helping them function and what is meaningful in their lives to improve quality of life. Further, when patients realize their pain may be long-term, they may grieve their old pain-free status and potentially loss of identity. Currently, the health system does not recognize or support this type of grief or processing.

Understanding models of care

Overall, participants recognized that there is a lack of understanding and awareness of chronic pain for both patients and physicians, as well as for effective models of care for pain management that are person-centered. Many people come to or are referred to specialized programs without a foundational knowledge of pain. Each unique perspective or conceptual models, like the biomedical model, may be too narrow.

It was raised that health systems do not consistently support consideration of pain from a comprehensive, intersectional lens. For example, health care providers are likely to treat substance use before treating pain. Participants noted that this approach can result in people being shut out of the system. There was consensus that the biopsychosocial model is a gold standard, yet it is still widely misunderstood or unused.

Limited Transitional care pathways and Tools

Participants indicated that there is currently a siloed approach to the management of pain. There is also a clinical gap in providing transitional pain services, as well as the stepped care 2.0 services model.

Interdisciplinary collaboration

There is a need to integrate the care of pain and co-morbid conditions into primary care. Treating patients with pain and co-morbid conditions often requires more intensive resources. However, having organizational silos within healthcare fosters a lack of integration of care. For instance, there are silos between those who prescribe medications and those who dispense them. Further, primary care providers make referrals, yet patients would greatly benefit from a transitional program as they wait to be admitted to a specialized pain clinic. Health care providers tend to be resistant to referring patients for other treatments, such as:

- physiotherapy
- acupuncture
- nutrition
- psychology

Care is not well coordinated: there is too little central-stepped care delivery. As well, some specialized programs need to deliver basic pain care. With the biomedical dominance in health care, payment models reinforce biomedical-based treatment. For instance, a person may have coverage for medications, but not for physiotherapy.

Lack of appropriate care guidelines

The lack of appropriate standards and guidelines on evidence-based approach to pain care often led to hesitancy, reticence, and lack of awareness in the system to address the needs of these individuals. Unwillingness may not be the issue but rather fear of the unknown in how to provide “alternative,” more wholistic levels of care, especially from an equity and diversity lens.

Pharmaceutical approaches to pain management

Existing prescribing rules and lack of knowledge about evidence-based guidelines for the use of opioids for pain management may lead to negative outcomes for patients. Some may have difficulties accessing their opioid medications to help manage their pain, while others may have had their opioid dose rapidly tapered or discontinued altogether. Others may have been forced to go back on opioids. Evidence suggest that cannabis may be beneficial to manage pain, but lack of evidence and pharmaceutical-grade cannabis products make it difficult for providers and patients to make informed decisions about appropriate use of cannabis for pain management.

Emotional impact on physicians

Current health human resource issues and lack of primary care providers, compounded by the high demand and need, is creating enormous pressure of health care providers. This is due to:

- diminished emotional reserve
- compassion fatigue
- burnout, particularly when looking to address the needs of patients with more complex health needs

These challenges were noted as potential contribution factors in some providers' inability to treat the person as a whole and not just their symptoms.

Solutions to implement effective models of pain care

Throughout the presentations and discussions at the BBE, it was apparent that providing equitable and consistent access to a continuum of timely, evidence-informed, and person-centred pain care and supports across jurisdictions would be the ideal model of care for all Canadians. Knowledge and benefits of the biopsychosocial model as an effective model of care for pain management and other health conditions more broadly needs to increase for both patients and health care providers. Coordinated and integrated implementation of pain management services is also necessary to prevent further silos and reduce duplication of efforts.

When addressing patients, especially those with co-morbidity issues of chronic pain, substance use and mental health, participants noted that biopsychosocial approach is crucial to support all 3 conditions. Participants emphasized the importance of looking at and treating a patient as a person more holistically, not just their symptoms. Participants living with pain emphasised that there is a need to help patients change their way of life to adjust to and accommodate living with pain and support the psychological side—such as the grief, stress, or other emotions they may experience—and social side. Changing their relationship to pain can help change their experience of pain. Care models for these complex conditions should be integrated. Alternative approaches and concurrent conditions should not be treated separately—for example, psychotherapy can be combined with physiotherapy. Participants acknowledged that care pathways are diverse and that providers should seek to help patients determine the best possible care that meets the unique needs of their patients. While evidence-based interventions were noted as ideal, participants emphasized that finding a way to include any type of care, even if there is less evidence—for example, peer support or meditation—should not be discounted.

The Stepped Care 2.0 model was referred to by participants as a promising approach to ensure that individuals with chronic pain receive more timely access to the right resources and care at the right time. This model provides immediate access to a variety of supports for different levels of need, promoting patient empowerment and choice, and enabling monitoring of outcomes to determine the right level of care. Stepped Care 2.0 uses a recovery-oriented approach to provide same day access to flexible wellness and mental health resources, like e-mental health apps and online and in-person services. It is an evidence-informed approach that structures care according to the least intensive and most effective options, giving service users the greatest likelihood of improvement. The intensity of treatment can be “stepped up” or “stepped down” based on a person’s preference.

Participants also emphasized the importance of identifying vulnerable populations at every step of the way to try and take them off the path of higher risk substance use. To this end, they highlighted the need to develop transitional care pathways, like strategies and educational tools, for the full spectrum of touch points with the health care system:

- post-surgery
- post-trauma
- post-emergency department visits
- during outpatient services

This triad of care and trauma informed treatment was noted as closing a major gap in clinical care.

Access to virtual evidence-based resources and ability for self-education options was also referenced by participants as essential for patients. Examples of virtual resources highlighted included the Power Over Pain Portal and an online psychology tool in support of the Transitional Pain Service. Participants also noted that offering peer support and meaningful engagement with people living with pain as part of

these virtual self-help tools would be very beneficial. Further, participants indicated that virtual networks could also be created to educate and provide support among health care providers. This approach could foster a team and community-based approach to building connections and support for care providers across sectors and jurisdictions. For example, project ECHO as an adaptive medical mentoring network was referenced as a best practice. The integration of online e-consultations and mobile technology into the clinical care pathways was also referenced as solutions to increasing access to care.

From a policy perspective, participants indicated the need to strategically look at how pain fits into other initiatives and ensure it is reflected and recognized as a priority for all levels of government. In doing so, participants also stated that there is a need to ensure stigma does not negatively affect the level of funding directed to pain services compared to other health conditions or priorities. Similarly, from a health care system perspective, there is a need to look at how to integrate pain into existing treatment models and not create further silos.

Participants suggested making changes to the Canada Health Act to enact the provision of appropriate and timely pain management services for Canadians, including services that may not currently be covered under provincial healthcare plans. This should reflect what is required for evidence-based care in its totality, including a bio-ethics perspective. There were also discussions about the need to create guidelines surrounding pain care management to support patients as well as primary health care providers.

Participants noted the complexities and time required for physicians to address the needs of their patients living with these complex health conditions. Recommendations were made to adjust the remuneration of the physicians when caring for these individuals. For instance, enact billing codes that support providers spending more time with patients to provide the wholistic care. Also, enable policy coverage and payment for non-pharmaceutical options to pain care and treatment of co-morbid conditions, following the biopsychosocial approach.

Moreover, there were suggestions made that interdisciplinary teams or referrals should include the full range of health providers at the right time and for the right duration, as well as a coordinated effort to create synergies and learn from each other. Primary care providers should ensure pain management care options are available from the first visit. Lower intensity programs should be available for the vast majority that need it and then referrals to specialists that can focus on the areas that need their specific knowledge and expertise.

The following were noted as components to person-centred care that can cover aspects of both mental and physical health:

- Counselling regarding exercise
- Mediation
- Diet
- Support groups
- Self-care apps
- Medications, including medical cannabis for:
 - › Sleep
 - › Integrating harm reduction into hospital care, to avoid rapid opioid tapering or discontinuation in the hospital setting

- Treatments or referrals for:
 - › Physiotherapy
 - › Psychologists
 - › Acupuncture
 - › Occupational therapy
 - › Dietitians
- Traditional healing
- Occupational therapists

Participants also noted a need to adopt evidence-based approaches on opioid prescribing and to revise policies regarding cannabis use for medical purposes. A polysubstance use approach is increasingly being adopted and patients and their providers need more information and guidance.

Additionally, participants emphasized that changes in perspective need to occur within the system to better support health care providers in adopting person-centred approaches to care. This includes a shift away from the perspective of “trying to fix” patients as a final state of being to an approach that would focus on adaptation, where health providers accompany their patients in their lifelong journey. As an example, a number of participants promoted resources such [Gabor Maté’s Compassionate Inquiry Master Class](#).

3.4 National leadership and coordination

Despite being a common condition that touches on nearly every domain of health care, chronic pain remains largely unrecognized as a public health priority.

This is further exacerbated by a lack of coordination, planning and implementation within and across federal, provincial, and territorial (FPT) jurisdictions, as well as providing sustainable and predictable funding so that pilot projects can mature and scale-up.

Addressing chronic pain requires multiple and diverse approaches to change, from policies and regulations to changes in programs, practices, and attitudes.

Broader engagement, perseverance, collaboration, commitment, leadership, and resources are also required.

Over the course of this BBE, there was wide consensus that chronic pain is a complex problem which currently exists everywhere, yet belongs nowhere. Considered as a condition that is highly prevalent, participants emphasized that pain touches nearly every domain of health care and, if unaddressed, it leads to significant detrimental impacts for people and the health care system more broadly. Despite this, it was noted that chronic pain remains an issue that is not recognized as a public health priority.

Lack of coordinated planning and implementation across federal, provincial, and territorial jurisdictions

Although participants agreed progress has been made in recent years, there was consensus that coordination of actions across jurisdictions to ensure a consistent approach to pain throughout Canada is still lacking. More specifically, they noted the lack of coordinated planning and implementation across federal, provincial and territorial jurisdictions for resources and funding dedicated to pain care. In some

cases, solutions may get started or funded by a national mechanism, but the provincial and territorial funding is not always available to fully implement them. Conversely, when funding is available, there is often duplication of efforts, creating silos and inefficiencies in the system.

Definition of chronic pain

Some participants noted that the current standard for defining chronic pain can create barriers in accessing timely care. Chronic pain is defined as pain that persists for 3 months or longer. However, participants further explained that patients and their health care providers should consider the unique needs and experiences of each individual living with pain and that treatment should be offered before the pain is officially considered as chronic. Otherwise, patients may miss out on guidance and support required in the interim.

Sustainability of funding

Participants also noted that there are several effective pilot programs to address the needs of people living with chronic pain and concurrent mental health and substance use related conditions. However, the lack of ongoing funding towards these programs often prevents them from becoming permanent. Short-term funding provided through programs such as Health Canada's Substance Use and Addictions Program (SUAP) means some projects yielding excellent outcomes may not be able to continue once funding ends. Therefore, participants emphasized there is a need for programs to obtain ongoing funding to continue level of care and resources and sustain progress in these fields to support patients.

Scope of Canada Health Act

As previously mentioned under the effective models for care, participants indicated that the scope of the Canada Health Act is too narrow as it focuses primarily on hospital care and less on a patient-centred approach to care. The health care needs of the Canadian population have evolved over the decades and the Canada Health Act should reflect this.

Solutions for national leadership and coordination

Participants concurred that addressing chronic pain requires multiple and diverse approaches to change, from policies and regulations to changes in programs, practices, and attitudes. It also requires broad engagement, and they further noted the importance of:

- perseverance
- collaboration
- commitment
- leadership
- resources

National leadership, supported by resources, is needed to continue to implement the recommendations outlined in the Action Plan for Pain in Canada, as well as other barriers discussed at this BBE. Participants expressed their desire for Health Canada and the Government of Canada to continue to lead the way in fostering the ongoing partnership with provinces and territories and with all levels of government to support efforts in making pain a health priority.

Participants noted that a more empowered FPT table on chronic pain could contribute to:

- more coordinated approaches
- sharing of resources
- identification of pain priorities
- identification of gaps that could be addressed through new health agreements

Efforts to treat pain must also include support from a range of other actors working inside and outside of the health system to enable positive and lasting change, including:

- peer advocates
- non-governmental organizations
- academic institutions
- insurers

BBE events and conferences were also noted as best practices to continue providing opportunities to create new synergies among partners, including policy makers.

Participants noted that policies should be created to support stable and long-term funding to ensure projects implemented are sustainable. Lessons learned can be leveraged from jurisdictions which have had some success in getting support and funding for pain services.

Participants also noted the importance to take stock on what is working and any remaining gaps to better support implementation of resources and effective programs. Further, population health approaches, such as early intervention and prevention focusing on intergenerational transmission, need to be integrated in the development and delivery of health system strategies. As a predominant theme discussed throughout the BBE, participants re-emphasized that approximately 80% of chronic pain is treated in primary care, necessitating more public health investments and pain education at this level.

It was also evident through discussions that there is a great need to continue to foster joint action between relevant communities of stigma, substance use, and chronic pain to better coordinate efforts and reduce silos in care. Participants indicated that councils or committees working on these issues should use the following approaches or lenses to help patients seek and receive optimal treatment: [stigma](#), [equity](#), and [intersectionality violence-informed](#) approach. As previously mentioned under the effective models of care, there was unanimous support amongst participants for the development of more national standards in pain management.

Overall, many organizations and stakeholders have a role to play. Coordination is required to foster collaboration and create synergies to learn from each other, reduce duplication of effort, and ensure results are achieved over time.

3.5 Pre- and post-licensure education, training and continuing professional development

Chronic pain and the biopsychosocial model of care remains misunderstood by the medical community.

People living with pain and health professionals require access to increased knowledge, skills, and educational supports to appropriately assess and manage pain based on population needs.

Although treating pain, especially with comorbid conditions, can be complex, participants agreed that there are options available. Yet, more work is required to ensure these options are taught and known amongst primary care and other interdisciplinary care providers.

Despite the wealth of knowledge on many aspects of chronic pain, participants and presenters noted that chronic pain and the biopsychosocial model of care remains misunderstood by the medical community. Participants noted the importance to act on the recommendations of the CPTF to ensure that people living with pain and health professionals have access to increased knowledge, skills and educational

supports to appropriately assess and manage pain based on population needs. As evidenced by the CPTF's report and in discussions at the BBE, there is concurrence that the medical community needs to better understand pain as a legitimate, biopsychosocial condition to reduce stigma and ensure more appropriate levels of care for people who live with pain. Although progress was acknowledged, BBE participants noted that significant gaps remain in terms of pain education and training, which often lead to barriers for people living with pain accessing adequate care.

Lack of time/focus specifically dedicated to pain

Currently, in Canadian medical schools, education on pain only ranges from 8 to 24 hours of total allotted time. Participants underscored how this was simply not enough time to cover the fundamental principles of a complex condition like pain, let alone its interactions with complex concurrent conditions.

Content of pain education

Participants also noted that pain education should cover and explain biopsychosocial aspects of pain and not solely focus on biomedical pathways to explain it. They also noted that patients need strategies to learn how to live with pain. Furthermore, participants emphasized that there is a lack of intersectoral collaborations and that many disciplines do not receive adequate education regarding pain and co-morbid conditions.

Knowledge regarding pain and the complexity of treatment

Participants noted that health care professionals may not have the knowledge and skills required at various and fundamental touch points in the health care system to adequately treat chronic pain in a holistic manner or offer the appropriate level of care required. This is especially crucial for primary care providers as they are likely to be the first touch point for most patients. These challenges are exacerbated when patients are living with co-morbid conditions such as mental illness or substance use. The complexity of treatment required may not be well understood by medical providers. If coupled with a lack of awareness of resources available for appropriate pain care treatments, participants noted the significant detrimental impacts this can have on patients.

Solutions for increasing pain education

Above all, participants indicated that more education and training is required regarding chronic pain diagnosis and management. Although treating pain, especially with comorbid conditions, can be complex, participants agreed that there are options available. More work is required to ensure these options are taught and known amongst primary care and other interdisciplinary care providers.

As previously mentioned under equity and diversity, people living with pain are being engaged more in the development of education curriculums. People living with pain have welcomed this change and appreciated being included in these discussions. Participants at the BBE concurred that this is an integral best practice that should continue to be adopted to improve education and training.

Participants also emphasized the need for pain education to be integrated into all healthcare domains and sectors. As previously mentioned under effective models of care, participants indicated the importance to shift to an increased understanding of a biopsychosocial model of care when addressing the source and treatment of pain. Therefore, participants highlighted the need for education models and training for health care professionals to include the biopsychosocial approach. People living with pain stressed how integral it is for healthcare providers to be educated and aware of how people's needs and their pathways for care can be very diverse, and that treatment approaches should be tailored accordingly.

Participants mentioned that health care professionals also need to be educated in less fractured approaches to care and need for early interventions. There is also the need for basic competencies to be increased in understanding and talking about pain, including for:

- healthcare providers
- patients
- family caregivers
- the public
- teachers

Participants emphasized that education is power and the development of resources nationally could help support all population groups impacted by pain.

3.6 Research and data

An increase in the generation, availability, and types of data and evidence would enable more effective monitoring and treatment of pain, as well as facilitate the improvement of the health system overall.

Data gaps are particularly significant in the areas of:

- non-conventional treatments, such as cannabis
- sources of evidence, such as Indigenous and youth populations
- health economic evaluation

A critical first step in addressing data gaps is making use of available data systems to understand and take stock of the current Canadian health system landscape. Opportunities also exist to build and leverage knowledge across jurisdictions. Throughout the BBE, participants noted that an increase in data and evidence would enable more effective monitoring and treatment of pain, as well as facilitate the improvement of the health system quality overall. Although participants agreed investments in research and knowledge mobilization have been made, they highlighted that many knowledge gaps persist and strategies to spark discovery, and foster innovation and knowledge mobilization continue to be needed.

Lack of data regarding safe use of opioids, cannabis, and psychedelics

Participants noted that the lack of evidence surrounding effective use of these substances and effective tapering practices is a major impediment to offer safe pain management treatment options for individuals living with complex concurrent chronic pain, mental health, and substance use conditions. Additionally, these gaps are contributing to increased stigma associated with the use of these medications for patients, as well as hesitancy by health care providers in prescribing them.

Acceptance of non-conventional sources of evidence and subject matter experts

Participants mentioned the importance in acknowledging and considering "traditional knowledge" as a legitimate source of evidence. Currently often being considered as grade D (poor quality), significant barriers remain for traditional knowledge to be reflected as legitimate services for people living with pain. For example, practices under traditional knowledge are currently not eligible expenses covered by insurer's health care plans. Similarly, participants emphasized on the importance for people living

with pain to be involved as subject matter experts throughout the research process. Their perspectives should be included and they should be recognized as experts in their own experiences. Their perspectives should be considered as evidence in the same way as those of other subject matter experts.

Health economic evaluation

Participants suggested that there remains an insufficient health economic evaluation for cost effectiveness of care across provinces and territories. Throughout the BBE, they often referred to the importance of pain research findings and outcomes stemming from evaluations of current health services as integral to the implementation of changes in practices and policies. This would help increase effectiveness and efficiencies in care across disciplines and jurisdictions.

Sustainable funding for research

Participants noted the lack of dedicated resources for pain research given the many competing agendas and priorities. With limited awareness of pain as a condition in its own right, it is often not prioritized in funding decisions for research development. Consequently, this impacts the scope of treatment options available and recognized by health care providers as effective pain management treatment options.

Practice-based evidence

It is difficult for peer review committees to review pain issues due to the interdisciplinary nature of pain. Given the current health human resource issues leading to a shortage of health care providers, there are also difficulties for researchers and healthcare providers to devote significant time to research review committees.

Solutions to increase evidence-based data

According to participants, there is a need to make use of available data systems to understand and take stock of the current Canadian health system landscape. Opportunities exist to build and leverage knowledge across jurisdictions to identify effective models of care that could be implemented and scaled-up. Participants raised the importance of exploring how to scale pain interventions and transfer them across other health care disciplines also addressing pain or co-morbid conditions. They also noted the importance of leveraging knowledge from our international peers.

Participants discussed how researchers—along with policy makers, insurers, and others—need to rethink how to characterize “evidence.” As previously mentioned, participants noted that effective traditional medicine and practices for the care and treatment of pain and co-morbid conditions should be considered good quality evidence. Further, the inclusion of people living with pain throughout the research process should be considered as the gold standard. Participants indicated that practiced-based evidence should be considered and viewed as solid evidence and be built into the framework of research for pain and co-morbid conditions. This would better support how the health care system and policy makers can adapt or scale treatment options.

Evidently, more pain research investments would be welcomed, yet participants emphasized the need for this research to include a bio-ethics perspective and be driven by the needs and the gaps identified by the pain community. Participants unanimously supported the idea for the Canadian Institutes of Health Research to consider the creation of a pain committee which could be dedicated to pain research planning and the coordination of research nationally to reduce duplication of efforts.

3.7 Advocacy and awareness: Public education

Participants noted the importance of increasing awareness as a first step for chronic pain to be reflected as a public health priority, similar to other health conditions or diseases.

Legitimizing pain in the health care system, in workplaces and education, and in society more broadly would make a significant contribution towards raising awareness and reducing stigma.

It is also crucial to draw on the expertise of people who are living with pain and to encourage and support the sharing of knowledge self-help networks, peer support, and stories from those living with pain and co-morbid conditions.

A prevailing barrier identified by participants, cross-cutting to all other issues raised, stems from the lack of awareness on chronic pain as a legitimate condition both in the health care system and the general public. Participants noted the importance of increasing awareness as a first step for chronic pain to be reflected as a public health priority, similar to other health conditions or diseases. For example, there is no “walk for the cure” or treatment wing specific to chronic pain, as there is for other conditions such as mental illness or cancer. Comparatively, co-morbid conditions related to pain such as substance use and mental health disorders have had significant success in advocacy efforts and gaining supportive allies at levels not yet seen in chronic pain.

Solutions to increase advocacy and awareness in the public education of pain

Above all, participants noted the importance of legitimizing pain in the health care system, in workplaces and education, and in society more broadly. They noted the importance for strong engagement of people living with pain to address stigma and improve quality of life for Canadians living with pain. Increased awareness of pain issues more generally was described by many participants as the catalyst required for policy and health care system changes needed. It was noted as crucial to draw on the expertise of people who are living with pain and to encourage and support the sharing of knowledge self-help networks, peer support, and stories from those living with pain and co-morbid conditions. These stories should be taken as a form of evidence to help guide health care providers.

Participants were cognizant that there remains a lot to learn on how advocacy applies to pain patients. Participants emphasized that the development of public health awareness campaigns would be an integral, concrete action which could contribute to increasing awareness. They noted the importance for these campaigns to highlight real stories from people living with pain, including success stories to ensure the messages on pain are being shared to help others and perhaps incite others to also share their own message. Campaigns also need to focus on pain education to help the public, health care providers, and policy makers understand that chronic pain is a legitimate biopsychosocial condition. Identifying pain as a disease is an important step, yet awareness could allow for further traction and support required to organize things such as walks for pain or Bell Let’s Talk day, as it is done for mental health. Raising awareness would also be beneficial to support efforts in reducing stigma, as well as provide the heightened awareness for priority setting with policy makers to increase funding for research and program implementations.

4.0 CONCLUSION

Chronic pain and its impacts can be reduced. As reflected over the course of the BBE, there is an emerging consensus about what works and what is needed for meaningful change. An improved approach for preventing and managing pain, particularly for people living with concurrent mental health and substance use conditions, has the potential to improve health outcomes for Canadians and Canada's healthcare system more generally.

Presenters and participants came together to enhance and share knowledge related to best practices regarding the treatment of chronic pain and co-morbid conditions. This BBE was also an opportunity to cut across existing silos and, in turn, discuss how to implement effective strategies to address the needs of those with chronic pain and concurrent mental health or substance-use related conditions.

While presenters and participants highlighted the many challenges faced by people living with these complex concurrent conditions, solutions were also proposed to address them.

Overall, presenters and participants emphasized the need for the following overarching approaches:

- National collaboration and coordination
 - › Need to coordinate efforts to use resources as well as possible and create the most effective and efficient solutions
- Application of three lenses: stigma, equity and intersectionality
 - › These are fundamental to understanding the complexity of both needs and solutions

Addressing the significant impacts of chronic pain on Canadians will require national collaboration. Evidence generated through this BBE provides a detailed overview of actions required to better address the needs of Canadians living with chronic pain and complex concurrent mental health and substance conditions. Health Canada is looking forward to continuing the efforts and collaborating with people living with pain, pain experts, and other stakeholders to support priority actions identified throughout this BBE.

APPENDIX A: OBJECTIVE BACKGROUNDER

Best Brains Exchange—Objectives Backgrounder

Treatment of Chronic Pain and Complex Concurrent Mental Health and Substance Use Conditions

Session A: Monday, February 27th, 2023 11:00am–2:00pm EST

Session B: Tuesday, February 28th, 2023 11:00am–2:00pm EST

The Canadian Institutes of Health Research in collaboration with Health Canada, Chronic Pain Policy Team

Objectives

The Best Brains Exchange (BBE) will bring federal, provincial and territorial partners together with researchers, clinicians, professional associations, implementation experts and those with lived experience to enhance and to share knowledge related to best practices and treatment options for people living with chronic pain and concurrent mental illnesses or substance use-related conditions.

More specifically, BBE participants will address the following questions:

1. Based on current evidence, what are the most effective strategies for the prevention and management of complex concurrent conditions of chronic pain and mental illnesses and/or substance use-related conditions?
2. To serve this complex population, what strategies could be put in place to support the implementation of effective programs and practices that may fall outside of those typically recommended for persons with only chronic pain, mental illnesses or substance-use related conditions?

Background and policy context

In March 2019, the Government of Canada established the Canadian Pain Task Force (CPTF, or “the Task Force”) to provide advice and information to help understand and address the needs of Canadians living with pain. In March 2021, the CPTF provided its final report to Health Canada, which included over 150 recommendations for priority actions, including better integration of pain management services into mental health and substance use treatment services, and vice-versa. Mental health and substance use are among the top health priorities for all levels of government: federal, provincial and territorial.

Persons living with chronic pain and concurrent conditions represent an intersection between 2 significant policy areas and populations, particularly on the heels of responding to the CPTF recommendations and the ongoing overdose crisis.

The proposed Best Brains Exchange represents an opportunity to enhance and share knowledge related to best practices and treatment options for people living with chronic pain and a concurrent mental illness or substance use-related conditions. It would also allow participants to discuss opportunities and challenges for effective implementation of these best practices. Finally, it responds to recommendations made by the Task Force related to providing equitable access to services for a group of Canadians disproportionately impacted by pain, namely people who are living with a mental illness or substance-use related condition.

Need for evidence

People living with chronic pain are at an increased risk of concurrent conditions, including those related to mental health and substance use.¹⁻³ Unmanaged chronic pain has been identified as an upstream factor in opioid and substance use: over 50% of people living with moderate or severe chronic pain report consuming substances, and 31% to 55% of people who use drugs report having chronic pain.⁴⁻⁸ Evidence suggests that people with chronic pain comprise 19% to 45% of drug/opioid overdose deaths in Canada.⁹⁻¹¹

A rapid review performed by Drug Safety and Effectiveness Network to inform the work of the CPTF found there were a limited number of high-quality guidelines with specific and consistent recommendations for managing chronic pain within the context of concurrent mental health or substance use.¹²⁻¹⁴ The report further recommended that “for the treatment of people with pain and concurrent mental illness and substance use disorders, future research priorities should ensure that studies do not exclude this complex population.”

As identified by the CPTF over its 3 year mandate, there is limited knowledge and resources regarding best practices for the treatment of persons living with chronic pain and complex concurrent conditions, such as mental illnesses and substance use-related conditions. However, we are aware that research, researchers, and clinicians specializing in this area do exist, though barriers often prevent best practices from being implemented across jurisdictional or professional lines. As such, hosting a BBE involving experts in this area with federal, provincial and territorial, and professional jurisdictions would allow the generation and sharing of relevant knowledge that would address the above-noted challenges.

Anticipated outcomes

This BBE will allow participants to:

- Identify effective strategies for the prevention and management of complex concurrent conditions of chronic pain and mental illnesses or substance use-related conditions
- Identify strategies to help implement effective programs and practices for the treatment of complex concurrent conditions of chronic pain, mental illness and substance use
- Make connections among researchers, health practitioners, as well as policy and decision makers to disseminate best practices for this group of individuals
- Identify areas for future research regarding the treatment of complex concurrent conditions of chronic pain, mental illness and substance use-related conditions.

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APPENDIX B: RESOURCES AND ARTICLES

The following resources may be useful to many of the actions covered in Section 3 of this report.

Articles and background information

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Resources: Relevant to solutions and facilitators

Adaptive Mentorship Networks for Pain, Mental Health and Substance Use (SUAP funded)—An example of supports for primary care. They are operating in [BC](#), Atlantic Canada, Alberta and are expanding in other provinces.

[AFMC Response to Opioid Crisis](#)—2 new curricula on opioids and pain and substance use for i) undergraduate medical students and ii) Faculty.

Alberta Health Services. Pain Society of Alberta. (Oct 2019). Alberta Pain Strategy 2019–2024: Achieving Excellence in Pain Management. www.albertahealthservices.ca/assets/about/scn/ahs-scn-alberta-pain-strategy-2019-24.pdf

[Atlantic Mentorship Network: Pain and Addiction](#)—An Innovative Approach to Delivering Health Care to People with Pain & Addiction—offers continuing education

[CAPSA](#) (Community Addictions Peer Support Association)—a charitable organization of people affected by substance use disorder based in Ottawa, ON; a national leader, does outreach, focus on stigma.

[Centre for Effective Practice](#)—new mentoring programs

[Chronic Pain Centre of Excellence for Canadian Veterans](#)—[Contact](#): For more information, view our contact information and use our form

[CRISM](#) (Canadian Research Initiative in Substance Misuse)—Translating Substance Use into Practice and Policy.

[Dr. Andrea Furlan YouTube channel](#)

Government of Canada. Health Canada. [Resources for Canadians living with pain during COVID-19](#)

[Manage My Pain App](#)

[Mental Health Benefits](#)—This program supports Veterans to access immediate care/services for mental health for up to 2 years while they wait for a diagnosis.

[NIHB](#) (Non-Insured Health Benefits) program—provides medically necessary coverage for eligible First Nations and Inuit in Canada

[Ont. Care.Connected](#), from the Ontario eConsult Centre of Excellence Remuneration for 40 min consult not always adequate

[Pain Canada](#)—will launch a multi-year ad campaign in spring 2023; helps change the public discourse and raise awareness/combat stigma.

[Peer Supporting Recovery from Substance Use Disorders](#)—program in AB with Recovery Coaches.

[Progress Over Pain](#)—Online Self-Management Program (ON, multiple funding sources)—May help reduce barriers for access in rural communities.

Samhsa's Working Definition of Recovery: 10 Guiding Principles of Recovery.

<https://store.samhsa.gov/sites/default/files/d7/priv/pep12-recdef.pdf>

[Sex- and Gender-Based Analysis Plus \(SGBA+\)](#)—Health Canada (2023). The Action Plan systematically integrates sex & gender considerations into all federal health initiatives.

Strategic Clinical Networks (see [AB](#))

[SUAP](#) (Substance Use and Addictions Program, Health Canada)—[Active Projects](#)

[Transitional Pain Service: Working together to relieve pain](#)

[Warrior Health](#) courses. [Introduction to Trauma Exposed Professionals](#)



APPENDIX C: BEST BRAINS EXCHANGE EVENT

Appendix C-1: Meeting agenda

Meeting purpose and objectives

The Best Brains Exchange (BBE) will bring federal, provincial, and territorial partners together with researchers, clinicians, professional associations, implementation experts and those with lived experience to enhance and to share knowledge related to best practices and treatment options for people living with chronic pain and concurrent mental illnesses or substance use-related conditions.

More specifically, BBE participants will address the following questions:

1. Based on current evidence, what are the **most effective strategies** for the prevention and management of complex concurrent conditions of chronic pain and mental illnesses and/or substance use-related conditions?
2. To serve this complex population, **what strategies could be put in place** to support the implementation of effective programs and practices **that may fall outside of those typically recommended** for persons with only chronic pain, mental illnesses or substance-use related conditions?

Time	Agenda Item / Discussion Questions	Speaker(s) / Facilitator(s)
DAY 1—Prevention and Management of Complex Concurrent Conditions		
10:45-11:00am	Registration	
11:00-11:20am	Opening Remarks: Welcome from the BBE Facilitator and hosts Land acknowledgement Format/technical guidance (housekeeping) Roundtable of introductions (in the chat) Overview of the BBE objectives	Facilitator—Christine Chambers
11:20-11:30am	Scene-Setting Presentation: Why are we here? 10-minute presentation Objective: Provide an overview of the work, findings and recommendations of the CPTF	Fiona Campbell, Former co-chair, CPTF Maria Hudspith, Former co-chair, CPTF Topic: Overview of Task Force mandate, findings and relevant recommendations.

Time	Agenda Item / Discussion Questions	Speaker(s) / Facilitator(s)
11:30-12:40pm	<p>Panel: Effective Strategies for Prevention & Management of Complex Concurrent Conditions</p> <p>10-minute snapshot presentations, followed by 30-minute facilitated question & answer period</p> <p>Objective: To learn effective strategies for addressing the needs of people living with chronic pain and concurrent mental illnesses and/or substance use-related conditions</p>	<p>Hance Clarke Topic: Transitional Pain Services Model</p> <p>Rob Tanguay Topic: Innovative and integrative approaches for the treatment of pain and substance use</p> <p>Patricia Poulin Topic: Adapted Stepped Care 2.0 model for Chronic Pain Care in Canada</p>
12:40-1:10pm	Lunch Break	
1:10-1:20pm	<p>Grounding Session- Spotlight</p> <p>A Lived Experience Perspective</p> <p>10-minute spotlight presentation followed by the facilitated discussion</p>	<p>Keith Meldrum Topic: Challenges faced by people living with pain in accessing appropriate services, and the nature and impact of accessing effective care</p>
1:20-1:50pm	Facilitated Discussion	<p>Facilitator—Christine Chambers Topic: Barriers and facilitators to the implementation of effective strategies and models of care for people living with chronic pain and concurrent mental health and substance use conditions</p>
1:50-2:00pm	Session 1 recap and stage setting for Session 2	Facilitator—Christine Chambers

Time	Agenda Item / Discussion Questions	Speaker(s) / Facilitator(s)
DAY 2—Implementation of Effective Strategies		
10:45-11:00am	Registration	
11:00-11:10am	Opening Remarks and Session 1 recap	Facilitator—Christine Chambers
11:10am-12:00pm	<p>Panel: Adapting Services to Populations disproportionately impacted by pain</p> <p>10-minute snapshot presentations, followed by 20-minute facilitated question & answer period</p>	<p>Katie Birnie Topic: SKIP, best practices for children and youth</p> <p>Jaris Swidrovich Topic: Specific challenges and targeted approaches for Indigenous populations</p> <p>Ramesh Zacharias Topic: Impact of chronic pain on Canadian Veterans and approaches to address pain needs of veterans</p>
12:00-12:30	Lunch Break	
12:30-1:40pm	<p>Moderated Armchair Discussion: Moving Evidence into Practice</p> <p>5-minute introductions followed by facilitated armchair Q&A/discussion</p>	<p>Facilitator—Christine Chambers</p> <p>Linda Wilhelm Topic: Progress in recent years and remaining challenges</p> <p>Daniel Buchman Topic: Ethical issues and stigma surrounding the issue of mental health, substance use and chronic pain</p> <p>Abhimanyu Sud Topic: Opportunities and challenges to translate evidence into practice</p>
1:40-1:45pm	BBE Evaluation (~5mins)	
1:45-1:55pm	<p>Closing Remarks & Adjournment</p> <p>Short summary/reflection and closing remarks</p>	<p>Facilitator: Christine Chambers</p> <p>Jennifer Novak</p>

Appendix C-2: Biographies of facilitator, presenters, and speakers



Fiona Campbell

Director, Chronic Pain Program, Anesthesia & Pain Medicine Co-director, Pain Centre, The Hospital for Sick Children Professor, University of Toronto

Former co-chair, Canadian Pain Task Force

Dr. Campbell is a Professor in the Department of Anesthesiology and Pain Medicine at the University of Toronto, Director of the Chronic Pain Program in the Department of Anesthesia & Pain Medicine, and Co-director of the SickKids Pain Centre at the Hospital for Sick Children. As inaugural Co-chair of the Ontario Chronic Pain Network (pediatric section), in partnership with the Ontario Ministry of Health, Dr. Campbell has helped shape a provincial strategy to enhance access to improved pediatric chronic pain services. Fiona is Past-President of the Canadian Pain Society and was Co-chair of Health Canada's Canadian Pain Task Force, which in 2021 published An Action Plan for Pain in Canada. Dr. Campbell received the 2022 Distinguished Alumni Award in Science from her alma mater, McMaster University for contributions to clinical practice, research, education, advocacy, and policy.



Maria Hudspith

Executive Director, Pain BC

Former co-chair, Canadian Pain Task Force

Maria is the Executive Director of Pain BC, a charitable organization working to enhance the lives of people who live with pain through empowerment, care, education, and innovation. She co-chaired the Canadian Pain Task Force, established by the federal Health Minister in 2019 to assess pain care, education, research and monitoring in Canada and provide recommendations on priority actions to ensure people with pain are recognized and supported and that pain is understood, prevented, and effectively treated across Canada. Maria is the Principal Knowledge User in the CIHR-funded Chronic Pain Network where she co-leads the Network's engagement of people with lived experience. She is also the Co-Director of the Partnership for the Engagement of Patients in Pain Research, a multi-year SSHRC-funded initiative. Maria's work has primarily been towards equity, systems change, and community engagement on a variety of health issues, including substance use, HIV and gender and health.



Hance Clarke

Director, Pain Services
Director, GoodHope Ehlers-Danlos Clinic Department of Anesthesia and Pain Management
Toronto General Hospital, University Health Network President-Elect
Canadian Pain Society
Associate Professor, Department of Anesthesiology and Pain Medicine, University of Toronto

Hance Clarke is the Director of Pain Services, the GoodHope Ehlers-Danlos Clinic and the Pain Research Unit at the Toronto General Hospital. He is the Knowledge Translation Chair for the University of Toronto Centre for the Study of Pain and an Associate Professor in the Department of Anesthesiology and Pain Medicine at the University of Toronto. He is the co-founder and Director of the world's first Transitional Pain Service designed to prevent chronic post-surgical pain. As a clinician-scientist, Dr. Clarke has played a leading role in educating the public about pain control and the need for further studies on the beneficial and adverse effects of cannabis. He is a champion of evidence-based solutions for the opioid crisis and an advocate for a national pain and addictions strategy. He has authored over 150 peer reviewed publications and has been invited to speak on pain control, cannabis and the opioid crisis to the House of Commons in Ottawa and elsewhere around the world. Currently, Dr. Clarke is one of the few Canadians honored to sit on the U.S. Science & Policy Advisor Council for the National Pain Advocacy Center and in 2022 became the president-elect of the Canadian Pain Society.



Rob Tanguay

Chief Medical Officer, The Newly Institute
Clinical Assistant Professor, University of Calgary Departments of Psychiatry and Surgery
Co-Lead, Alberta Pain Strategy, AHS
Founder and Co-Lead, Community RAAM, AHS
Hotchkiss Brain Institute & Mathison Centre for Mental Health

Dr. Tanguay is a Psychiatrist who completed two fellowships, one in Addiction Medicine and one in Pain Medicine. He is a clinical assistant professor with the departments of Psychiatry and Surgery at the Cumming School of Medicine, University of Calgary. Most recently Dr. Tanguay helped found and is the Chief Medical Officer and Vice President of The Newly Institute, a program dedicated to providing medical and psychological intervention for people living with complex and treatment resistant mental health disorders such as PTSD, depression, anxiety, addiction, and chronic pain with use of psychedelic-assisted psychotherapy. He was the Medical Lead for Addiction Education for Alberta Health Services (AHS) where he helped develop award winning programs. He is the Regional Director for Alberta and Northwest Territories for the Canadian Society of Addiction Medicine (CSAM) where he sits as a board member, the President of the Pain Society of Alberta, and the co-chair of the internationally recognized Alberta Pain Strategy. He is the founder of the Opioid Deprescribing Program with AHS, the Rapid Access Addiction Medicine (RAAM) Community Clinic with AHS, and the Transitional Outpatient Pain Program for Spine (TOPPS) clinic working with spinal surgeons to optimize spinal surgery outcomes. He also consults with the Carewest Operational Stress Injury Clinic treating veterans and RCMP for trauma related injuries. Academically, he is involved in research in trauma, addiction, chronic pain, opioids, cannabis, and psychedelics and is a member of the Hotchkiss Brain Institute and the Mathison Centre for Mental Health Research & Education at the University of Calgary.



Patricia Poulin

**Clinical, Health, and Rehabilitation Psychologist, The Ottawa Hospital Pain Clinic Associate Scientist, Ottawa Hospital Research Institute Assistant Professor, Department of Anesthesiology & Pain Medicine, University of Ottawa
Research Lead, St. Joseph Care Group Project ECHO Chronic Pain & Opioid Stewardship**

Dr. Patricia Poulin is a Clinical Health and Rehabilitation Psychologist at The Ottawa Hospital Pain Clinic, an Associate Scientist at the Ottawa Hospital Research Institute, and Assistant Professor in the Department of Anesthesiology and Pain Medicine at the University of Ottawa. Patricia is a member of the external advisory committee for the Canadian Pain Task Force. She is one of the principal applicants for the Chronic Pain.

Network (CIHR Strategy for Patient Oriented Research Network in Chronic Diseases) and is co-leading the development and implementation of the Power Over Pain portal. Patricia also comes from a place of lived experience and is committed to improving access to care for all Canadians living with chronic pain.



Keith Meldrum

Persistent Pain Advocate, A Path Forward

Keith has lived with persistent neuropathic pain since August of 1986, following a near-fatal motor vehicle accident. Following multiple surgeries, he still experienced pain and was told that it was “all in his head.” After 18 years of ineffective interventions, in 2005 he received an implanted spinal cord stimulator which was replaced in 2021 with dorsal root ganglion neuromodulation.

Due to the challenges Keith faced navigating a healthcare system ill-prepared to address the complexity of chronic pain, he focused his experiences on system change and helping others living with persistent pain. He was on the Board of Directors of Pain BC from 2011 to 2018 and following that, he has focused his efforts as a personal pain advocate. This led to an invitation to present at the International Association for the Study of Pain’s 2018 World Congress and was appointed to the Global Alliance of Partners for Pain Advocacy, an IASP Task Force.

Keith has presented locally, nationally, and internationally, has guest lectured at universities, and has co-authored two published articles. Keith is a civil engineer technologist living in Kelowna, British Columbia with his wife Barb and their Australian Labradoodle, Parker.



Kathryn Birnie

Assistant Professor, Department of Anesthesiology, Perioperative and Pain Medicine, and Department of Community Health Sciences, University of Calgary

**Associate Scientific Director, Solutions for Kids in Pain
Psychologist, Alberta Children's Hospital**

Dr. Kathryn (Katie) Birnie is a Clinical Psychologist and Assistant Professor in the Departments of Anesthesiology, Perioperative, and Pain Medicine, and Community Health Sciences at the University of Calgary where she leads the Partnering For Pain research program. She is the Associate Scientific Director of Solutions for Kids in Pain (SKIP), a national knowledge mobilization network on a mission to improve evidence-based children's pain management through coordination and collaboration. Dr. Birnie joined Alberta Children's Hospital as a medical psychologist in 2018, where she continues to provide clinical care through the Vi Riddell Children's Pain and Rehabilitation Program. Dr. Birnie has published more than 80 scientific articles and her work has been shared via CBC News, CTV News, Global News, the Washington Post, Radio Canada International, and The Globe and Mail, among others. She is a strong advocate for the partnership of patients and families in pain research, health care delivery, and health systems design.



Jaris Swidrovich

Assistant Professor, Teaching Stream Faculty of Pharmacy, University of Toronto

Dr. Jaris Swidrovich (he/him/they/them) is an Assistant Professor, Teaching Stream, in the Leslie Dan Faculty of Pharmacy at the University of Toronto. He is a queer, Two Spirit, Saulteaux and Ukrainian pharmacist from Yellow Quill First Nation. Dr. Swidrovich is the first and only self-identified Indigenous faculty member in pharmacy in Canada. Dr. Swidrovich was a member of the Canadian Pain Task Force and is currently a Director on the board of Solutions for Kids in Pain (SKIP), a member of the National Advisory Committee for Pain Canada, and is an inaugural board member for Pain Ontario, which is currently in development.

He received a Bachelor of Science in Pharmacy (BSP) from the University of Saskatchewan and a post-baccalaureate Doctor of Pharmacy (PharmD) from the University of Toronto. His areas of research and practice include pain, HIV/AIDS, substance use disorders, 2SLGBTQ+ health, Indigenous Peoples' health, and health professions education. Dr. Swidrovich is also a PhD Candidate in Education at the University of Saskatchewan, where he is studying Indigenous Peoples' experiences with pharmacy education in Canada.



Ramesh Zacharias

**Chief Executive Officer, Medical Director
Chronic Pain Centre of Excellence for Canadian Veterans Assistant
Clinical Professor, Department of Anesthesia
Faculty of Health Sciences, McMaster University Medical Centre**

Dr. Zacharias graduated with his Doctorate in Medicine in 1980 from the University of Western Ontario. From 1981–1985 he completed his Fellowship in General surgery at the University of Western Ontario. Subsequent to his surgical residency, he was the Senior Research Fellow at the University of Washington in the Department of Vascular Surgery from 1985–1987.

He founded Med-Emerg International Inc in 1983 and was the President and CEO from 1983–2009.

His clinical practice was Emergency Medicine from 1981–2005. Then from 2005–2012 he worked at a community- based clinic with a focus on Chronic Pain Management. In January 2012, he joined the Department of Anesthesia at McMaster University as an Assistant Clinical Professor and was appointed as the Medical Director of the Chronic Pain Management Unit at Hamilton Health Sciences. In April 2015 he became the Medical Director of the Michael G DeGroot Pain Clinic. It is currently the largest Interdisciplinary Pain clinic in Canada.

Dr. Zacharias became an Investigating Coroner in June 2012. During his tenure he has investigated over 650 cases as part of the Death Investigating System in the Province of Ontario.

Dr. Zacharias became the President, CEO and Medical Director of the Chronic Pain Centre of Excellence for Canadian Veterans in April 2020. The CPCoE is a Research Institute focused on improving the lives of Veterans and their families suffering from Chronic Pain. He continues to be involved in pain management of injured workers, Motor Vehicle Accidents and Veterans suffering from Chronic Pain. Over 60% of Dr. Zacharias' clinical practice is treating Veterans.



Linda Wilhelm

President, Canadian Arthritis Patient Alliance

Linda Wilhelm has been living with Rheumatoid Arthritis for over thirty five years, many of those years unresponsive to the medications used to treat the disease which resulted in significant and irreversible damage to most of the joints in her body leaving her to manage chronic pain on a daily basis and throughout her recovery from fourteen major joint reconstructive surgeries. Linda is a founding member of The Canadian Arthritis Patient Alliance, a national, volunteer, patient driven organization that has worked to improve the lives for people living with arthritis since 2002. She is a patient partner on a number of National research networks, research projects and a former member of The Canadian Pain Taskforce.



Daniel Buchman

Bioethicist and Independent Scientist Centre for Addiction and Mental Health

**Assistant Professor, Dalla Lana School of Public Health
Joint Centre for Bioethics, University of Toronto**

Dr. Daniel Buchman is a Bioethicist and Independent Scientist in the Campbell Family Mental Health Research Institute at the Centre for Addiction and Mental Health (CAMH). At CAMH, Dr. Buchman leads the Everyday Ethics Lab with a program of research focused on ethical issues related to mental health, substance use, and chronic pain. He is also an Assistant Professor in the Dalla Lana School of Public Health at the University of Toronto, a member of the University of Toronto Joint Centre for Bioethics, and an Affiliate Scientist in the Krembil Research Institute at the University Health Network. He is a Member of the Board of the Canadian Bioethics Society and is a Member of the Canadian Institutes of Health Research (CIHR) Standing Committee on Ethics.



Abhimanyu Sud

**Research Chair, Primary Care & Population Health Systems,
Humber River Hospital**

**Assistant Professor, Dept of Family and Community Medicine Temerty
Medicine, University of Toronto**

Dr. Abhimanyu Sud is a physician, medical educator, and health services researcher focused on the intersections of chronic pain, mental illness, and opioid use. He is an Assistant Professor at the Temerty Faculty of Medicine, University of Toronto, is the inaugural Research Chair in Primary Care and Population Health Systems at Humber River Hospital and is the Chief Scientific Officer for the Chronic Pain Centre of Excellence for Canadian Veterans. Dr. Sud has led the development, delivery, and evaluation of a number of medical education programs focused on chronic pain and opioid prescribing, with close consideration of the reciprocal impacts of mental illness. He is currently leading a first-of-its-kind national randomized controlled trial studying the efficacy and implementation of a virtually-delivered meditation intervention for improving depression in chronic pain. This trial aims to fill important gaps identified in a recent umbrella review assessing all intervention for improving depression in chronic pain led by Dr. Sud, particularly around the need to identify pathways for clinical and population health collaboration for addressing complex health problems and syndemics such as chronic pain and mental illness comorbidities.



Facilitator: Christine Chambers

**Scientific Director, Institute of Human Development,
Child and Youth Health, Canadian Institutes of Health Research**

Dr. Christine Chambers is the Scientific Director of the CIHR Institute of Human Development, Child and Youth Health (CIHR-IHDCYH). She is the Canada Research Chair (Tier 1) in Children's Pain, a Professor in the departments of Psychology & Neuroscience and Pediatrics at Dalhousie University in Halifax, Nova Scotia, and a clinical psychologist. She is a leader in children's health research and care who is passionate about patient engagement and research impact. She is also the Scientific Director of Solutions for Kids in Pain (SKIP), a national knowledge mobilization network whose mission is to improve children's pain management by mobilizing evidence-based solutions through coordination and collaboration. She is a member of the Royal Society of Canada's College of New Scholars, Artists and Scientists, and a fellow of the Canadian Academy of Health Sciences. She was also recently identified by the Women's Executive Network as one of Canada's Top 100 Most Powerful Women.

Appendix C-3: Participants and attendees

Participants other than the facilitator and presenters had no formal speaking role. Rather, we captured their input via chat and verbal questions and comments.

BBE Planning Team		
Batten, Sarah	Policy Analyst, Chronic Pain Policy Team	Health Canada (Project Authority)
Danish, Alya	Senior Advisor, Knowledge Mobilization Strategies, Science Policy Branch	CIHR (Collaborator)
Lalonde, Janet	Initiatives Officer, Knowledge Mobilization Strategies, Science Policy Branch	CIHR (Collaborator)
Leroux, Jean-Francois	Manager, Chronic Pain Policy Team	Health Canada (Project Authority)
Facilitator		
Chambers, Christine	Scientific Director, Institute of Human Development, Child and Youth Health	CIHR
Presenters		
Birnie, Katie	Associate Scientific Director	Solutions for Kids in Pain (SKIP)
Buchman, Daniel	Independent Scientist	CAMH
Campbell, Fiona	Former co-chair Professor at UofT and Pediatric pain physician at SickKids	CPTF
Clarke, Hance	Anesthesiologist & Director of Pain Services	Toronto General Hospital
Hudspith, Maria	Former co-chair	CPTF
Meldrum, Keith	Person living with pain representative.	Pain Canada's National Advisory Committee IASP Global Partners for Pain Advocacy (Rep)
Poulin, Patricia	Clinical Health and Rehabilitation Psychologist Associate Professor at UOttawa, co-lead Power Over Pain	The Ottawa Hospital Pain Clinic
Ramesh Zacharias	President, CEO & Medical Director	Chronic Pain Centre of Excellence for Canadian Veterans
Sud, Abhimanyu	Assistant Professor, Department of Family and Community Medicine	University of Toronto

Swidrovich, Jaris	Assistant Professor, Health Services Research	Leslie Dan Faculty of Pharmacy, University of Toronto
Tanguay, Rob	Chief Medical Officer	Newly Institute
Wilhelm, Linda	President	Canadian Arthritis Patient Alliance
Participants		
Beauregard, Lucie	Conseillère, Continuum Douleur chronique; Coordinator Chronic Pain Continuum	Ministère de la Santé et des services sociaux (Québec)
Beauvais, Carole	Director, Mental Health Division, Strategic Policy Branch	Health Canada
Beck, Ian	Director, Mental Health Directorate	Canadian Armed Forces/ DND
Belair, Eric	Associate Assistant Deputy Minister, Strategic Policy Branch	Health Canada
Besemann, Markus	Chief of Rehabilitation Medicine	Canadian Armed Forces/ DND
Boulanger, Aline	Directrice, Clinique antidouleur, Centre hospitalier de l'Université de Montréal	Ministère de la Santé et des services sociaux (Québec)
Carrese, Lina	Chief Psychologist, Mental Health and Strategic Planning	Veterans Affairs Canada
Cecchetto, Jo-Anne	Assistant Deputy Minister, Health Programs	Health and Social Services (Northwest Territories)
Denning, Bryany	Senior Advisor, Problematic Substance Use	Health and Social Services (Northwest Territories)
Di Renna, Tania	Medical Director, TAPMI, Ontario Chronic Pain Network Co-Chair	Toronto Academic Pain Medicine Institute (TAPMI)
Dib, Katherine	Senior Program Lead	Healthcare Excellence Canada
Drury, Julie	Director, Mental Health/Health Professionals Division	Veterans Affairs Canada
Dunkley, Rosamund	Director, Mental Health Promotion and Wellbeing	Public Health Agency of Canada
Freake, Teara	Vice-President, Clinical Patient Services (Western Health); Chair, Provincial Pain Advisory, NL	Department of Health and Community Services, NL
Furlan, Andrea	Research Team Lead	ECHO for Pain and Opioids Stewardship

Hadjistavropoulos, Thomas	Professor of Psychology, Research Chair in Aging and Health	University of Regina
Joiner, Meghan	Medical Officer, Directorate of Mental Health	Canadian Armed Forces/ DND
Khan, Karim	Scientific Director, Institute of Musculoskeletal Health and Arthritis	CIHR
Kirkconnell, Heather	Director, Workplace Mental Health, Substance Use Policy Division	Ministry of Mental Health and Addictions, BC
Kropp, Rhonda	Acting Vice-President, Research—Learning Health System	CIHR
Lane, Therese	Patient Partner	Chronic Pain Network
MacDonald-Billard, Denise	Project Executive, Primary Health Care Branch	Nova Scotia Health and Wellness
McIntyre, Virginia	Chief Executive Officer, People in Pain Network	People in Pain Network
Nix, Shannon	Associate Assistant Deputy Minister, Controlled Substances and Cannabis Branch	Health Canada
Novak, Jennifer	Executive Director, ORT	Health Canada
O’Keefe, Jonathan	Director, Strategic Planning and Development	Veterans Affairs Canada
Raymond, Vincent	Président, Comité Exécutif	l’Association Québécoise de la Douleur Chronique (AQDC)
Sharma, Supriya	Chief Medical Officer, Health Products and Food Branch	Health Canada
Shaw, Krista	ADM of Mental Health and Addictions	Health and Wellness, Ministry of Health, PEI
St-Aubin, Candice	Vice-President, Health Promotion and Chronic Disease Prevention	Public Health Agency of Canada
Taha, Sheena	Interim Associate Director, Knowledge Mobilization	Canadian Centre on Substance Use and Addiction
Tupper, Susan	Strategy Consultant for Pain Quality Improvement and Research	Saskatchewan Health Authority
Viveky, Navita	Senior Health Policy Analyst, Health Policy and Programs	Correctional Service Canada
Wasyllak, Tracy	Chief Program Officer	Alberta Health Services

Weeks, Laura	Director, Health Technology Assessment	Canada's Drug and Health Technology Agency (CADTH)
Wiebe, Patricia	Medical Specialist in Mental Health, Population Health & Wellness Division First Nations and Inuit Health Branch	Indigenous Services Canada
Williams, Desmond	Person living with pain representative	Pain Canada's National Advisory Committee
Wowk, Shannon	Associate Lead, Substance Use and Addiction, Institute of Neurosciences, Mental Health and Addictions	CIHR
Yarrow, Lindsay	Patient partner	Healthcare Excellence Canada
Observers		
Bourgon, Allison	Acting Associate Vice-President, Research Strategy	CIHR
Crupi, Amanda	Manager, Knowledge Mobilization Strategies	CIHR
Dastouri, Serenna	Senior Policy Advisor, Policy and Government Relations	CIHR
Downey, Maude	Consultant, Technical Writer, RN	Maude Downey Consulting
McKinnon, Lisa	Senior Policy Advisor, Chronic Pain Policy Team	Health Canada (Project Authority)
Mitchell, Steven	Acting Director General, Science Policy	CIHR
Twomey, Rosemary	Associate Scientific Director, Institute of Musculoskeletal Health and Arthritis	CIHR
Croxall, Lindsay	Indigenous Services Canada, Senior Policy Analyst	Indigenous Services Canada
Dana, Orgesa	Policy Analyst and Planner	Health and Wellness (Ministry of Health, Prince Edward Island)
Lopatina, Elena	Postdoctoral fellow	Alberta Pain Strategy
Weber, Kendal	Assistant Deputy Minister, CSCB	(HC/SC)
Willows, Tayte	Principal Advisor for Mental Health & Addictions	Health and Wellness (Ministry of Health, Prince Edward Island)
Kayla May	Knowledge Mobilization Coordinator	Chronic Pain Centre of Excellence for Canadian Veterans

Caudarella, Alexander	CEO	Canadian Centre on Substance Use and Addiction (CCSA)
Karine, Dorval	Member of l'Association Québécoise de la Douleur Chronique	C.A AQDC Québec City
Alessi, Grace	Analyst, Knowledge Mobilization Strategies Science Policy Branch	CIHR/IRSC
White, Chelsea	Manager, Research and Development	Chronic Pain Centre of Excellence for Canadian Veterans
Wincentak, Joanne	Lead, Partnerships & Knowledge Mobilization	CIHR/IRSC
Buckley, Norman	Professor Emeritus, Anesthesia	McMaster University
Hey, Brandon	Research and Policy Analyst	Mental Health Commission of Canada