Plénière 10 - Réduction des Risques & des Dommages

RdRD à l'ère des psychostimulants

June 11, 2026

Didier Jutras-Aswad
Professor – Université de Montréal
Principal scientist – CHUM research centre
Chief of staff, Department of psychiatry – CHUM

Université de Montréal

CRCHUM
CENTRE DE RECHERCHE
Centre hospitalier de l'Université de Montréal

COI/Funding

Research supported by the Canadian Institutes of Health Research, Fonds de Recherche du Québec, Health Canada, the Quebec Ministry of Health and Social Services, and the CHUM Foundation.

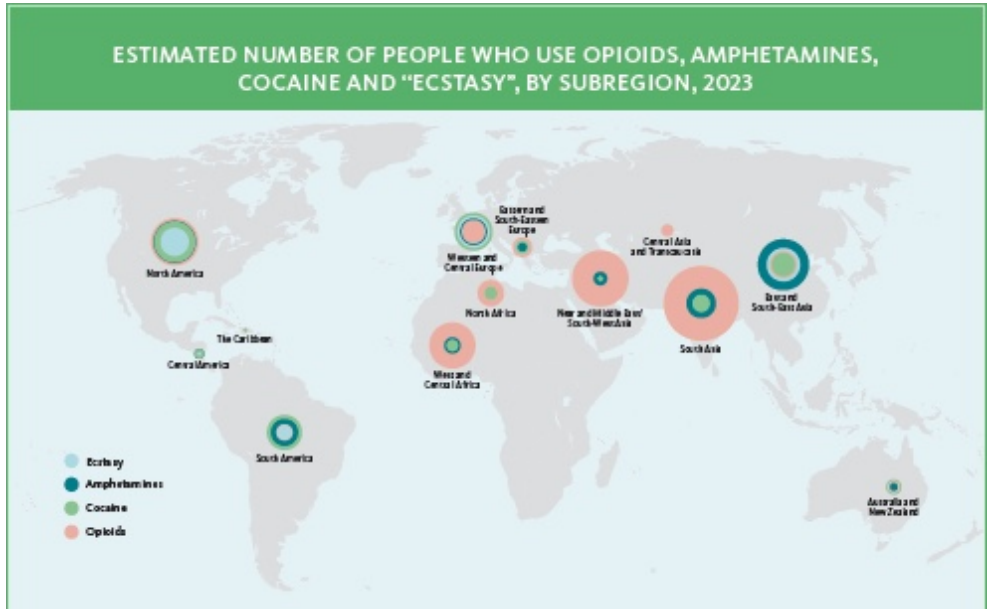
Acknowledgement

I am grateful to live and work in Tiohtià:ke/Montreal, on the unceded territory of the Kanien'kehá:ka Nation.

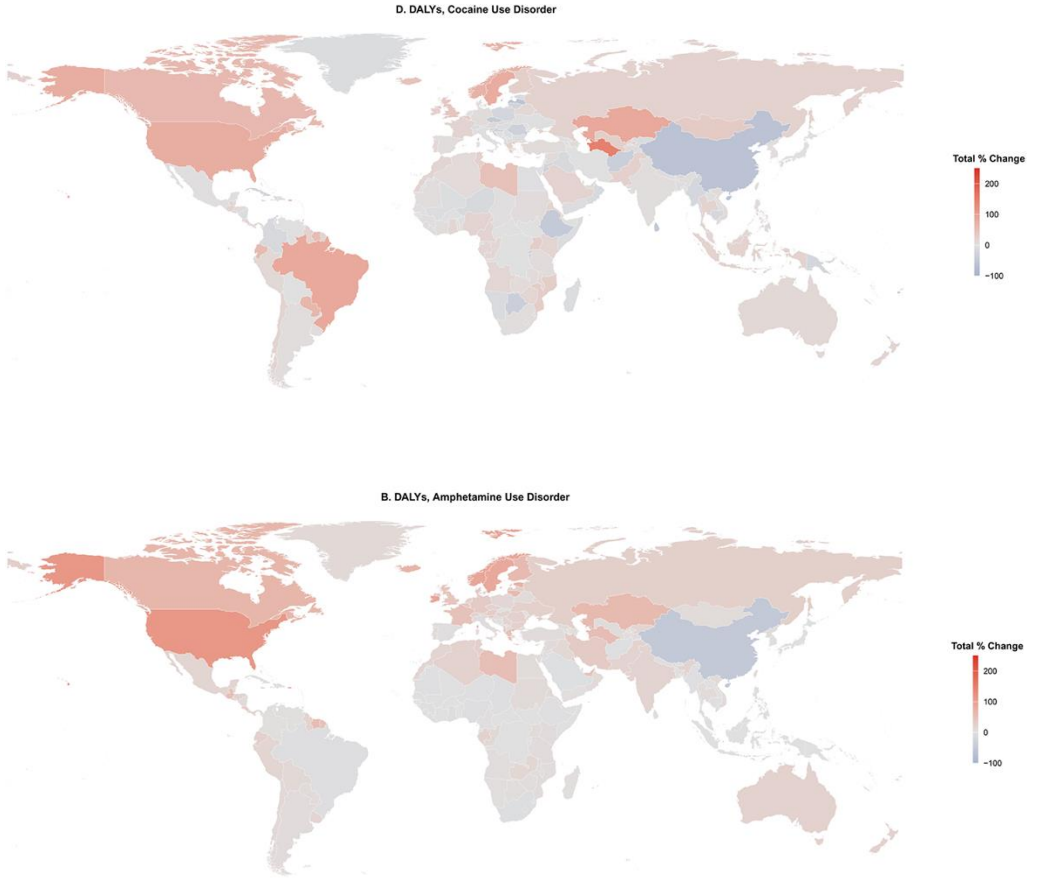
My research also takes place on the unceded traditional lands of many First Nations across the territory now known as Canada.

I acknowledge that the reasons people use substances are diverse, and that substances can have benefits as well as harms. Many individuals use them without experiencing problems. Today, my focus will be on responses to substance use that leads to problems and unwanted consequences.

Drug use prevalence and global burden of disease due to stimulants



2023



1990-2011

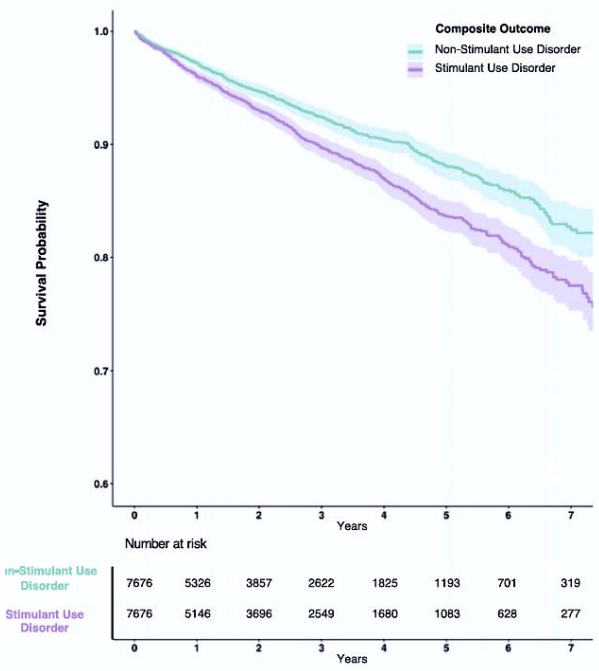
Zhu DT et al., PLoS One. 2025; World Drug Report 2025, UNODC

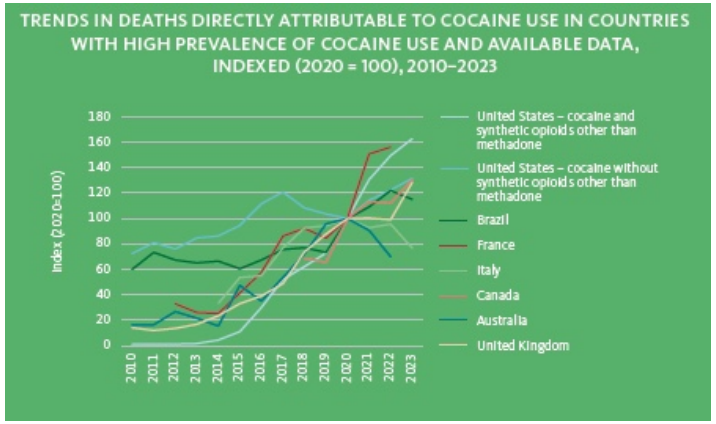
Université de Montréal

CRCHUM
CENTRE DE RECHERCHE
Centre hospitalier de l'Université de Montréal

Stimulant use disorder: the perfect storm

- High addictive potential that can manifest within days of initial exposure
- Associated with acute and long term behavioral, cognitive, psychiatric and physical morbidity
- Involved in a large proportion of overdose-related deaths
- No treatments for stimulant use disorder currently approved by most regulatory bodies



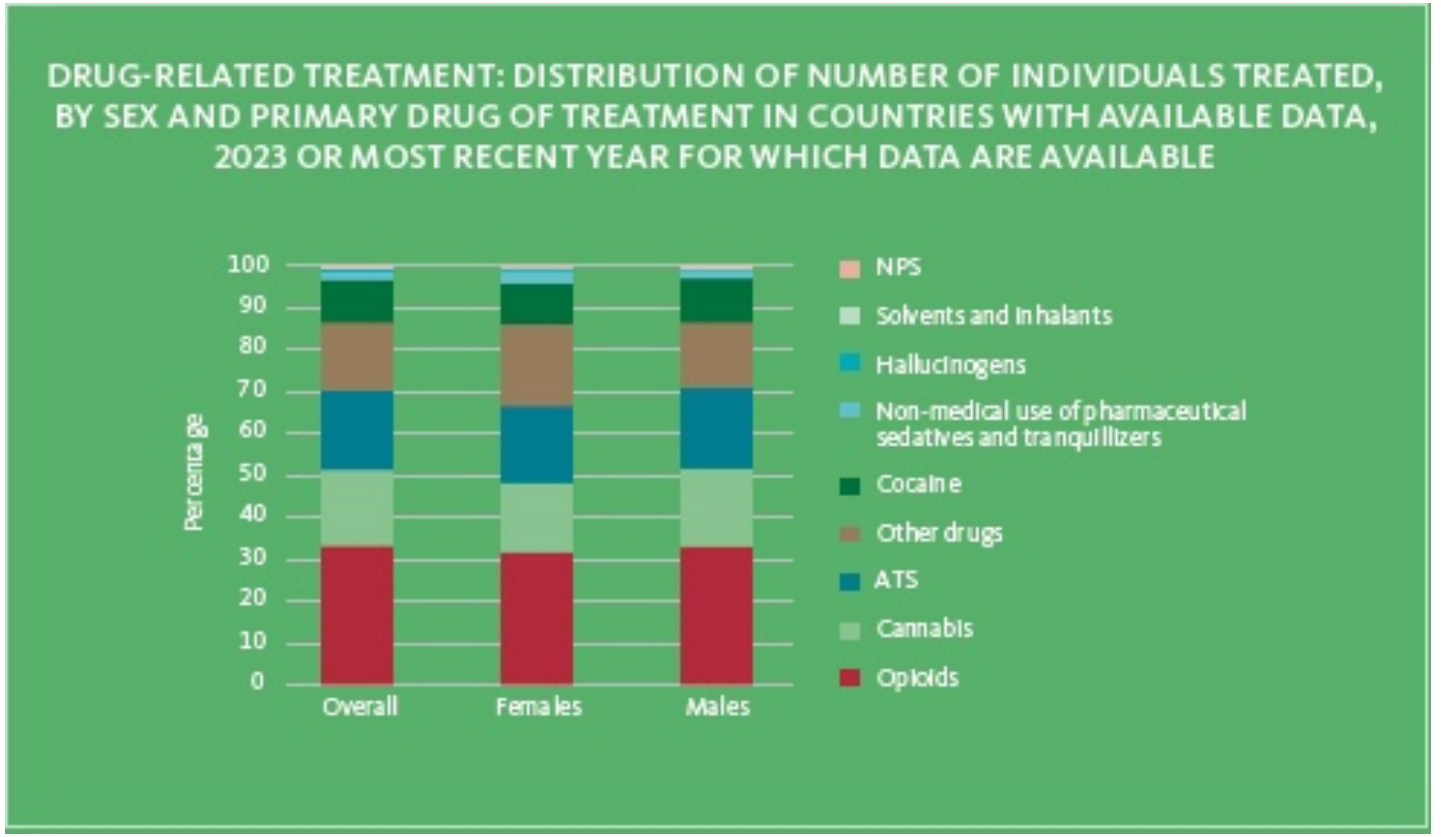


Fischer et al, Subst Abuse Treat Prev Policy (2021); Siefried et al, CNS Drugs (2020); Government of Canada (2024); Garel et al, J Addict Med (2025); World Drug Report 2025, UNODC

Université de Montréal

CRCHUM
CENTRE DE RECHERCHE
Centre hospitalier de l'Université de Montréal

Treatment of stimulant use disorder



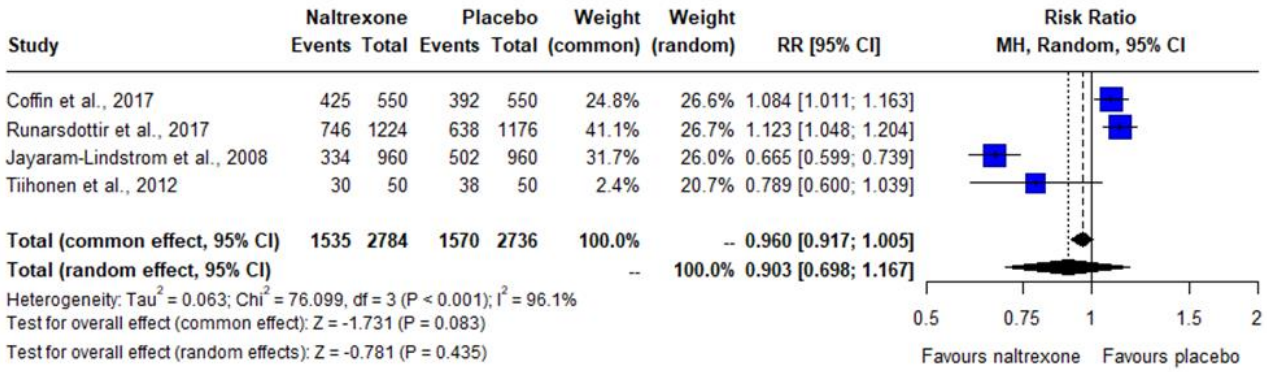
World Drug Report 2025, UNODC

Université de Montréal

CRCHUM CENTRE DE RECHERCHE Centre hospitalier de l'Université de Montréal

Treatment of stimulant use disorder (amphetamine-type)

Naltrexone

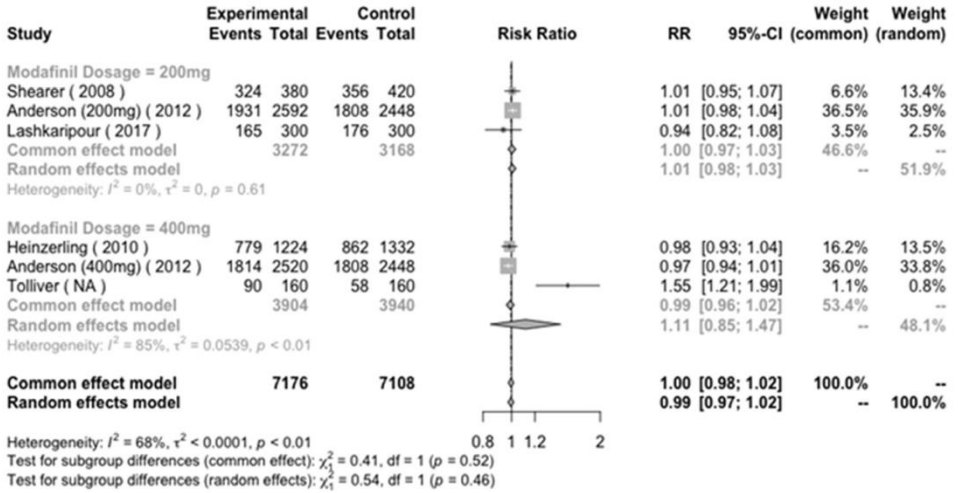


Study	Naltrexone Events	Total	Placebo Events	Total	Weight (common)	Weight (random)	RR [95% CI]
Coffin et al., 2017	425	550	392	550	24.8%	26.6%	1.084 [1.011; 1.163]
Runarsdottir et al., 2017	746	1224	638	1176	41.1%	26.7%	1.123 [1.048; 1.204]
Jayaram-Lindstrom et al., 2008	334	960	502	960	31.7%	26.0%	0.665 [0.599; 0.739]
Tiihonen et al., 2012	30	50	38	50	2.4%	20.7%	0.789 [0.600; 1.039]
Total (common effect, 95% CI)	**1535**	**2784**	**1570**	**2736**	**100.0%**	--	**0.960 [0.917; 1.005]**
Total (random effect, 95% CI)					--	**100.0%**	**0.903 [0.698; 1.167]**

Risk Ratio MH, Random, 95% CI

Heterogeneity: $Tau^2 = 0.063$; $Chi^2 = 76.099$, df = 3 ($P < 0.001$); $I^2 = 96.1\%$
Test for overall effect (common effect): Z = -1.731 (P = 0.083)
Test for overall effect (random effects): Z = -0.781 (P = 0.435)

Modafinil

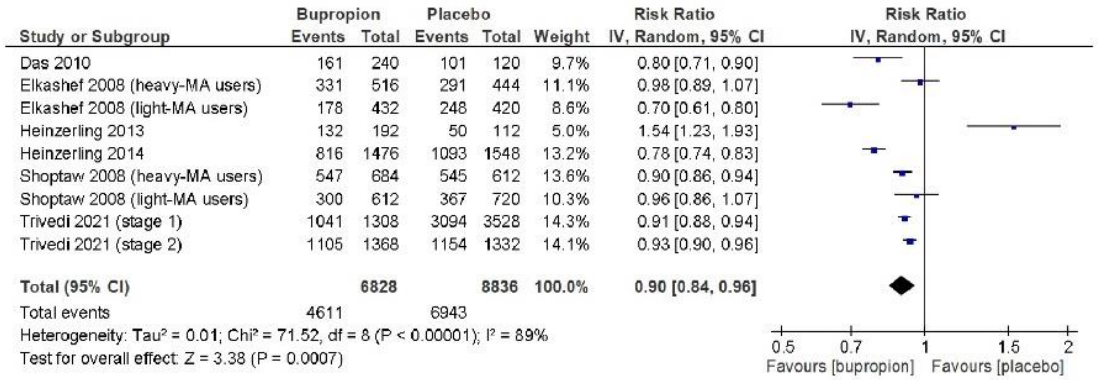


Study	Experimental Events	Total	Control Events	Total	RR	95%-CI	Weight (common)	Weight (random)
Modafinil Dosage = 200mg								
Shearer (2008)	324	380	356	420	1.01	[0.95; 1.07]	6.6%	13.4%
Anderson (200mg) (2012)	1931	2592	1808	2448	1.01	[0.98; 1.04]	36.5%	35.9%
Lashkaripour (2017)	165	300	176	300	0.94	[0.82; 1.08]	3.5%	2.5%
Common effect model		3272		3168	1.00	[0.97; 1.03]	46.6%	--
Random effects model					1.01	[0.98; 1.03]	--	51.9%
Heterogeneity: $I^2 = 0\%$, $\tau^2 = 0$, $p = 0.61$								
Modafinil Dosage = 400mg								
Heinzerling (2010)	779	1224	862	1332	0.98	[0.93; 1.04]	16.2%	13.5%
Anderson (400mg) (2012)	1814	2520	1808	2448	0.97	[0.94; 1.01]	36.0%	33.8%
Tolliver (NA)	90	160	58	160	1.55	[1.21; 1.99]	1.1%	0.8%
Common effect model		3904		3940	0.99	[0.96; 1.02]	53.4%	--
Random effects model					1.11	[0.85; 1.47]	--	48.1%
Heterogeneity: $I^2 = 85\%$, $\tau^2 = 0.0539$, $p < 0.01$								
Common effect model		**7176**		**7108**	**1.00**	**[0.98; 1.02]**	**100.0%**	--
Random effects model					**0.99**	**[0.97; 1.02]**	--	**100.0%**

Risk Ratio

Heterogeneity: $I^2 = 68\%$, $\tau^2 < 0.0001$, $p < 0.01$
Test for subgroup differences (common effect): $\chi^2_1 = 0.41$, df = 1 ($p = 0.52$)
Test for subgroup differences (random effects): $\chi^2_1 = 0.54$, df = 1 ($p = 0.46$)

Bupropion



Study or Subgroup	Bupropion Events	Total	Placebo Events	Total	Weight	Risk Ratio IV, Random, 95% CI
Das 2010	161	240	101	120	9.7%	0.80 [0.71, 0.90]
Elkashef 2008 (heavy-MA users)	331	516	291	444	11.1%	0.98 [0.89, 1.07]
Elkashef 2008 (light-MA users)	178	432	248	420	8.6%	0.70 [0.61, 0.80]
Heinzerling 2013	132	192	50	112	5.0%	1.54 [1.23, 1.93]
Heinzerling 2014	816	1476	1093	1548	13.2%	0.78 [0.74, 0.83]
Shoptaw 2008 (heavy-MA users)	547	684	545	612	13.6%	0.90 [0.86, 0.94]
Shoptaw 2008 (light-MA users)	300	612	367	720	10.3%	0.96 [0.86, 1.07]
Trivedi 2021 (stage 1)	1041	1308	3094	3528	14.3%	0.91 [0.88, 0.94]
Trivedi 2021 (stage 2)	1105	1368	1154	1332	14.1%	0.93 [0.90, 0.96]
Total (95% CI)		**6828**		**8836**	**100.0%**	**0.90 [0.84, 0.96]**
Total events	4611		6943			

Risk Ratio IV, Random, 95% CI

Heterogeneity: $Tau^2 = 0.01$; $Chi^2 = 71.52$, df = 8 ($P < 0.00001$); $I^2 = 89\%$
Test for overall effect: Z = 3.38 (P = 0.0007)

Prescription psychostimulants

Number of studies/effect estimates		ATS use by UA n	ATS use by UA RR (95% CI)	Self-reported ATS use n	Self-reported ATS use SMD (95% CI)	Retention in treatment n	Retention in treatment RR (95% CI)	Dropout following AEs n	Dropout following AEs RD (95% CI)
Medication	Methylphenidate	7	**0.91 (0.83, 1.00)***	3	−0.15 (−0.52, 0.21)	7	1.10 (0.85, 1.42)	7	−0.01 (−0.03, 0.02)
	Dextroamphetamine	1	**1.04 (0.96, 1.11)**	2	−0.06 (−0.44, 0.31)	3	1.20 (0.84, 1.69)	3	−0.01 (−0.06, 0.04)
Maximum daily dose with low-level cut-off[b]	Low dose	6	0.97 (0.93, 1.01)	3	−0.15 (−0.52, 0.21)	6	1.04 (0.83, 1.29)	6	−0.00 (−0.03, 0.02)
	High dose	2	0.86 (0.60, 1.24)	2	−0.06 (−0.44, 0.31)	4	1.34 (0.89, 2.02)	4	−0.02 (−0.07, 0.02)
Maximum daily dose with high-level cut-off[c]	Low dose	7	**0.98 (0.94, 1.02)**	4	−0.10 (−0.39, 0.20)	8	**1.04 (0.90, 1.20)**	8	−0.00 (−0.03, 0.02)
	High dose	1	**0.71 (0.68, 0.76)***	1	−0.17 (−0.73, 0.40)	2	**2.31 (1.24, 4.30)***	2	−0.08 (−0.16, 0.01)
Duration of treatment	< 20 weeks	5	0.97 (0.86, 1.08)	5	−0.11 (−0.37, 0.15)	7	**1.04 (0.89, 1.21)**	7	−0.00 (−0.03, 0.02)
	≥ 20 weeks	3	0.88 (0.78, 1.00)	0	–	3	**1.83 (1.11, 3.02)***	3	−0.03 (−0.08, 0.02)
ADHD in study population	All ADHD population	2	0.93 (0.55, 1.59)	1	0.07 (−0.73, 0.87)	2	1.31 (0.32, 5.38)	2	−0.05 (−0.14, 0.05)
	Mixed population/not described	6	0.97 (0.94, 1.00)	4	−0.13 (−0.41, 0.14)	8	1.10 (0.95, 1.27)	8	−0.01 (−0.03, 0.02)

Bastien G, et al. 2024; Elkrief L, et al. 2024; Bakouni H, et al. 2023; Sharafi H, et al. 2024

Université de Montréal

CRCHUM
CENTRE DE RECHERCHE
Centre hospitalier de l'Université de Montréal

Clinical Practice Guideline on the Management of Stimulant Use Disorder American Society of Addiction Medicine (2024)

Pharmacotherapy Recommendations (Amphetamine-type)

Recommendation	Certainty	Strength
1. **Bupropion** for ATSUD with low- to moderate frequency use ($\leq$ 18 days/month) - special consideration if nicotine dependence or depression	Low	Conditional
2. **Bupropion/Naltrexone** - special consideration if alcohol use disorder, nicotine dependence or depression	Moderate	Conditional
3. **Topiramate** - special consideration if alcohol use disorder	Low	Conditional
4. **Mirtazapine** - special consideration if depression	Low	Conditional
5. **Methylphenidate*** (reduce use of ATS, or moderate- to high frequency use ($\geq$ 10 days/month) - special consideration if ADHD; consider maximum dose or above)	Low	Conditional

- Physician should be board certified in addiction medicine or adequately trained
  Adequate monitoring should be implemented (clinical visit, medication dispensing, etc.)

ASAM/AAAP Clinical Practice Guideline on the Management of Stimulant Use Disorder.
Journal of Addiction Medicine 18(1S):p 1-56. 2024

Clinical Practice Guideline on the Management of Stimulant Use Disorder American Society of Addiction Medicine (2024)

Behavioral Treatment Recommendations

Recommendation	Certainty	Strength
1. Contingency Management (primary component)	High	Strong
2. The following interventions are preferred alongside CM:		
• Community Reinforcement Approach Behavioral skills training, increase positive reinforcers, relapse prevention	Low	Conditional
• Cognitive Behavioral Therapy	Moderate	Strong
• Matrix Model Individual counseling; CBT, family education, and social support groups; and mutual support group (16 weeks)	Moderate	Conditional
3. Behavioral interventions delivered via digital therapeutics or web-based platforms as add-on components	Low	Strong
4. Telemedicine to deliver behavioral treatment to patients who may face challenges accessing in-person care	Moderate	Strong

ASAM/AAAP Clinical Practice Guideline on the Management of Stimulant Use Disorder.
Journal of Addiction Medicine 18(1S):p 1-56. 2024

Université de Montréal

CRCHUM
CENTRE DE RECHERCHE
Centre hospitalier de l'Université de Montréal

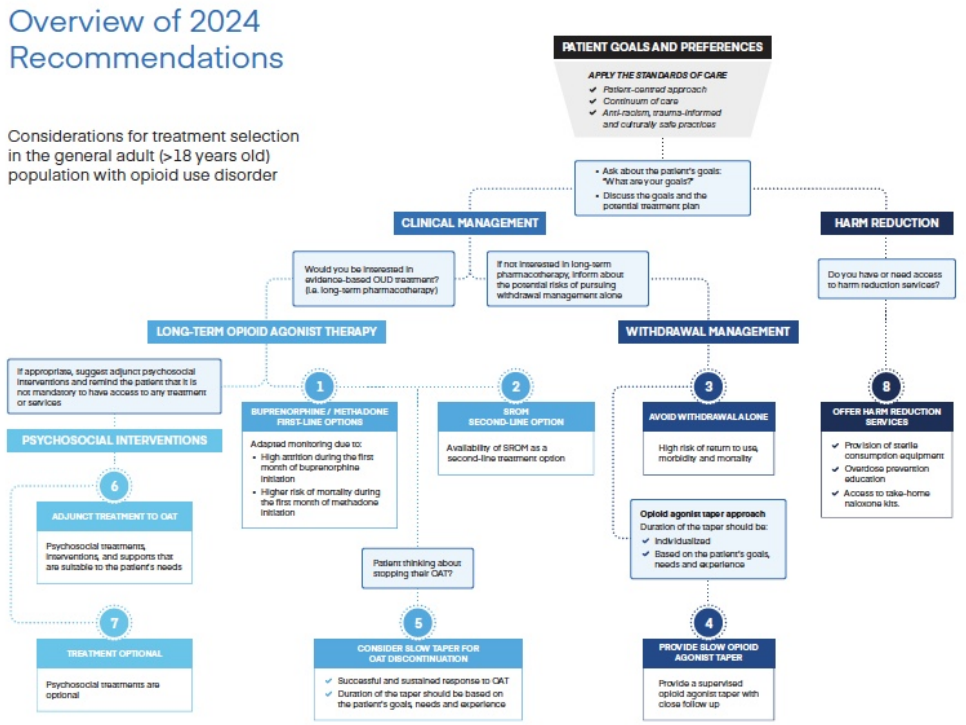
Stimulant Use Disorder: Key Recommendations British Association for Psychopharmacology (2026)

- **No pharmacotherapy currently has broad regulatory approval**
- Amphetamine
  - Current evidence does not support the use of prescription stimulants; for adults with ADHD, prescription stimulants may both improve ADHD symptoms and reduce amphetamine use
  - Preliminary evidence for depot naltrexone + extended-release bupropion
  - Preliminary evidence for atomoxetine among people receiving opioid agonist therapy
  - Antipsychotic agents can be used to treat psychosis
- Cocaine
  - No conclusive evidence to support prescription stimulants, antidepressant, dopamine agonists, anticonvulsants or antipsychotics
  - Limited preliminary evidence for bupropion for some cocaine use outcomes
- **Evidence remains limited or mixed** for most medications; additional large pragmatic trials are needed

Sinclair JM et al., 2026

Interventions for the management of stimulant use disorder: towards more refined treatment algorithms

Recommendation	Certainty	Strength
1. **Bupropion** for ATSUD with low- to moderate frequency use (≤ 18 days/month) * special consideration if nicotine dependence or depression	Low	Conditional
2. **Bupropion/Naltrexone** * special consideration if alcohol use disorder, nicotine dependence or depression	Moderate	Conditional
3. **Topiramate** * special consideration if alcohol use disorder	Low	Conditional
4. **Mirtazapine** * special consideration if depression	Low	Conditional
5. **Methylphenidate** (reduce use of ATS, or moderate- to high frequency use (≥ 10 days/ month) * special consideration if ADHD; consider maximum dose or above)	Low	Conditional



https://crism.ca/opioid-guideline/; The ASAM/AAAP Clinical Practice Guideline on the Management of Stimulant Use Disorder. Journal of Addiction Medicine 18(1S):p 1-56. 2024

Université de Montréal

CRCHUM CENTRE DE RECHERCHE Centre hospitalier de l'Université de Montréal

Enhancing treatment outcomes through a diversified treatment pipeline

- Expert review of promising pharmacological and neuromodulation strategies for stimulant use disorder
- Most promising medications: Suvorexant and GLP-1 receptor agonists
- Other candidate medications: Cariprazine, Guanfacine, and Clavulanic Acid
- Promising neuromodulation approaches: LIFU and Photobiomodulation (tPBM)
- Toward personalized treatment based on heterogeneous phenotypes, stage of recovery, and co-occurring conditions

ELSEVIER

Journal of Substance Use and Addiction Treatment

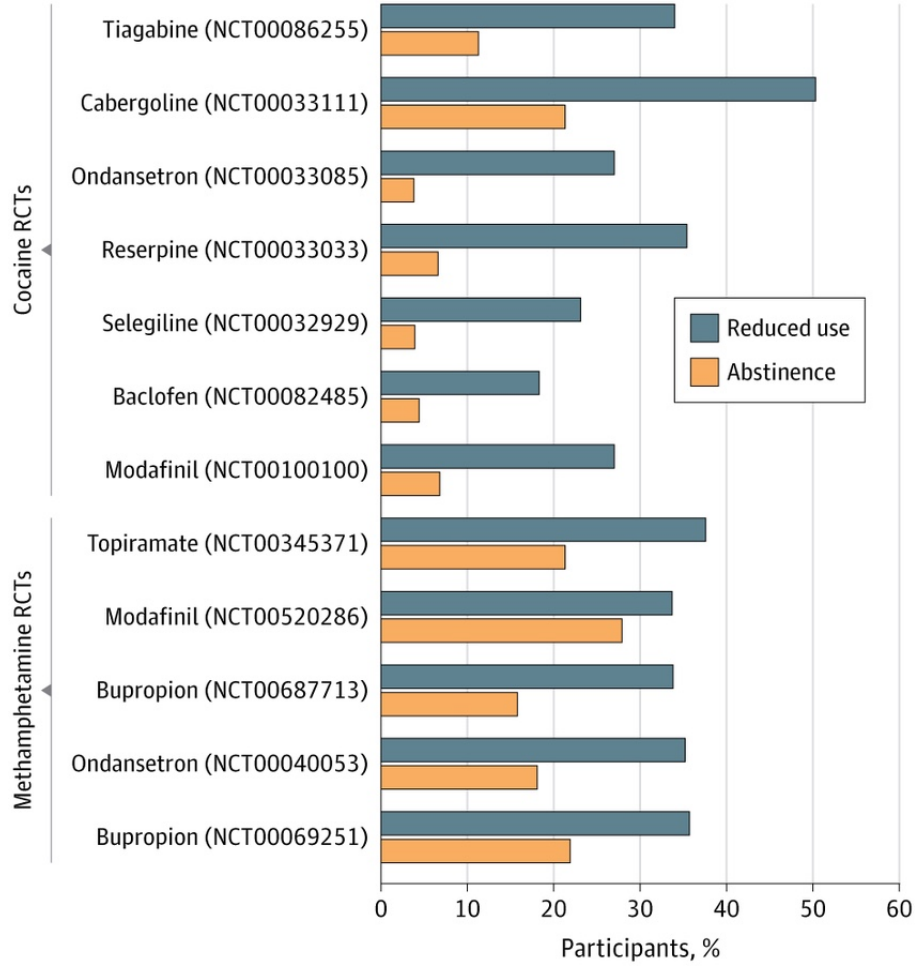
Available online 24 April 2026, 209994

In Press, Corrected Proof What's this?

National Institute on Drug Abuse (NIDA) clinical trials network (CTN) stimulant use disorder (StUD) task force results: 2024 update ☆

Chatnapha Kittirattanapaiboon [a b 1], Steven Shoptaw [a 1], Taryn L. Mayes [c d], Manish K. Jha [c], Udi E. Ghitza [e], Madhukar H. Trivedi [c]

Expanding Outcome Measures for Stimulant Use Disorder Clinical Trials



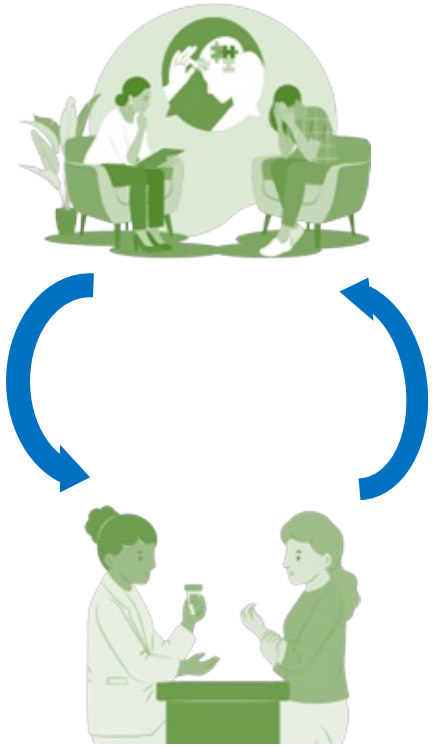
- Abstinence is an important outcome - but it should not be the only one
- Clinical trials should also capture meaningful reductions in use, improved functioning, mental health, and quality of life

Amin-Esmaeili M et al. JAMA Psychiatry. 2026 Jun 3:e261092

Enhancing treatment outcomes by combining psychosocial and pharmacological approaches

Opportunities

- Potential for additive and synergistic effects when interventions are well designed and integrated
- Improved retention and engagement in treatment
- Ability to address a broader range of needs and preferences
- Implementation of a tailored, stepped-care approach for more precise and effective care



Challenges

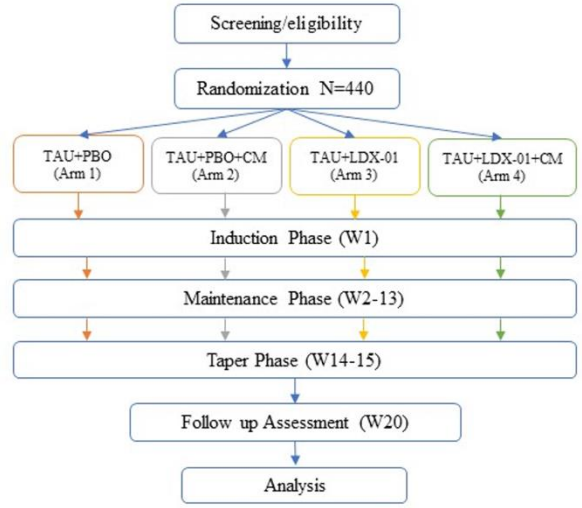
- Limited data from RCTs
- RCTs can evaluate only a narrow range of intervention combinations
- Significant heterogeneity of interventions both within and between sites
- High costs and limited generalizability to real-world clinical settings depending on design

Purposeful combination approach: why, what and how to combine

Addition of high dose Stimulant and engagement Contingency management, alone and in combination, to treatment as usual for the management Methamphetamine use disorder (ASCME): a pan-Canadian multisite randomized controlled trial

Lead PI: D Jutras-Aswad; site PIs: P Bach, S Davidson, M Gosh, B Le Foll, G Poulin
Funding: Canadian Institutes of Health Research/Canadian Research Initiative in Substance Matters

- Aim: determine if adding high-dose LDX and CM, alone in combination, to TAU reduces MA use and improves other relevant outcomes in individuals with moderate to severe MA use disorder
- Combined double-blinded (LDX component) and open-label (CM component) randomized clinical trial*
- 4 arms (N=440; 110/arm):
- 1) TAU + placebo
- 2) TAU + high-dose LDX
- 3) TAU + placebo + CM
- 4) TAU + high-dose LDX + CM
- 15-week intervention phase and a 4-week post-intervention follow-up assessment



Study design
* CM, contingency management; LDX, lisdexamfetamine; PBO, placebo; TAU, treatment as usual

*LDX: lisdexamfetamine - target dose 250mg
CM: contingency management - focused on engagement in treatment
TAU: motivational, relapse prevention, harm reduction, clinical management, treatment of comorbidities

- **Extension study – ASCME**
- **Qualitative Evaluation of Research Participation (QERPA)**

Enhancing treatment outcomes

Single interventions are unlikely to be sufficient

↓

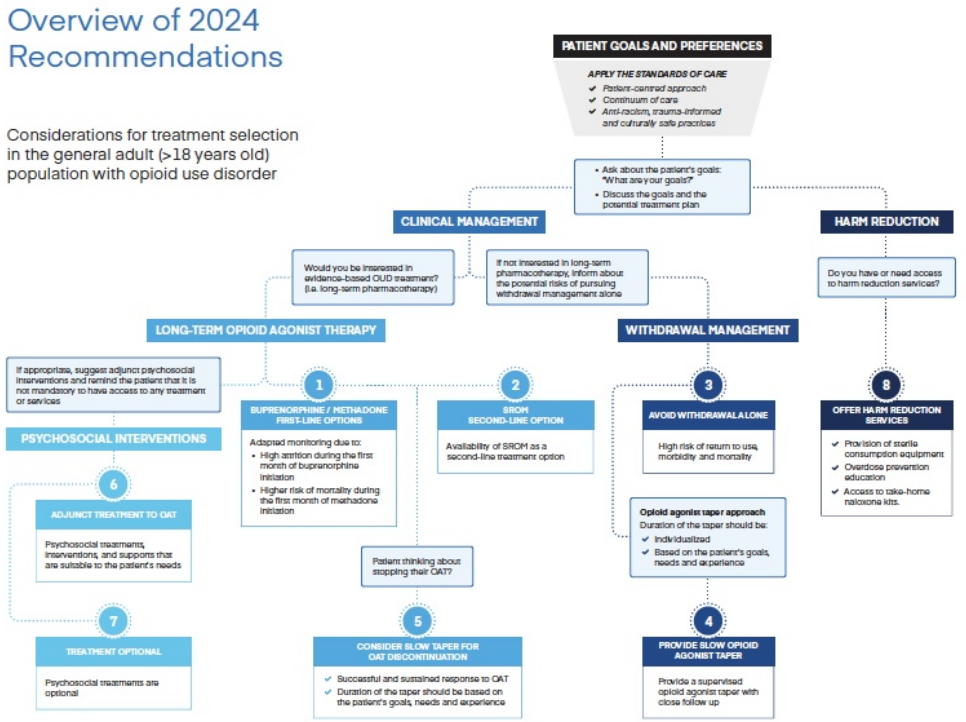
Combination approaches

↓

Personalized care pathways

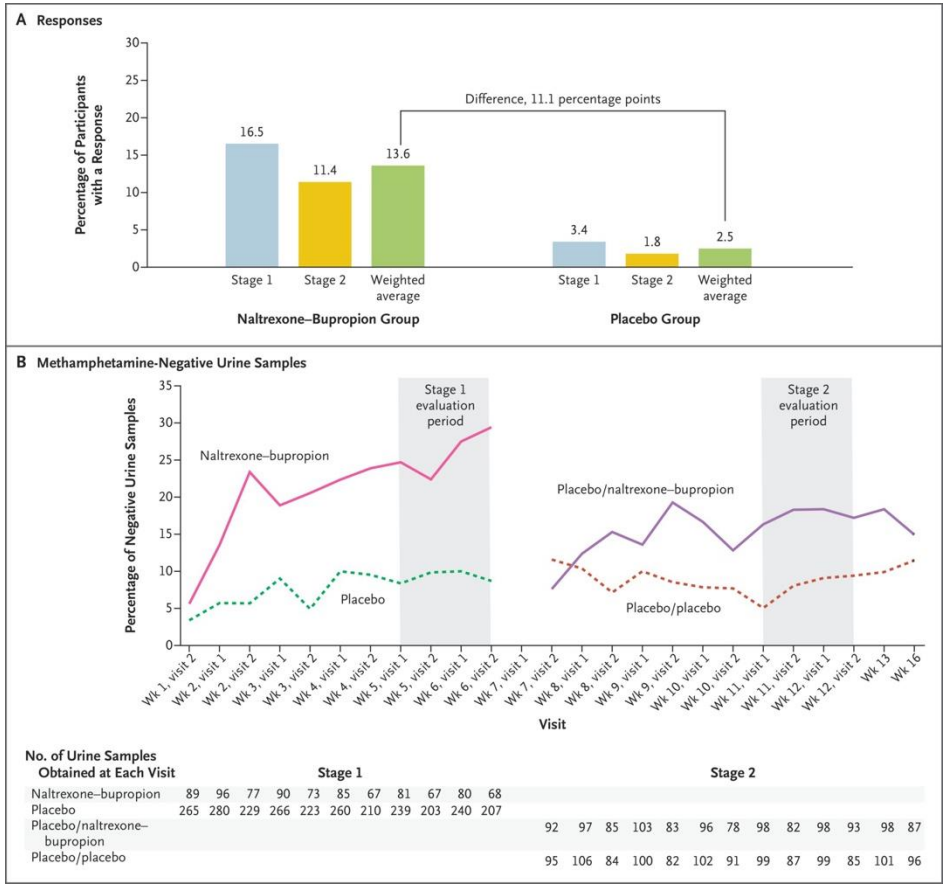
↓

Improved outcomes



Limits of interventions aiming to assist with reduction and cessation of use

- Even with advances in treatment, many individuals will continue to use stimulants and remain exposed to significant risks
- Treatment innovation must therefore be complemented by effective harm reduction and public health strategies



Trivedi MH et al. N Engl J Med2021;384:140-153

Integrating harm reduction into the continuum of care

Harm reduction refers to policies, programs, and practices aimed at reducing the health, social, and legal harms associated with substance use, without necessarily requiring abstinence

- Integrated harm reduction approaches are increasingly recommended, but remain debated and variably implemented across jurisdictions and settings
- Existing tools (e.g., safe consumption sites) often not adapted beyond opioids - no “naloxone equivalent” for stimulants
- Different challenges: sedation/respiratory depression (opioids) vs. agitation/disorganization (stimulants)
- Stimulant overdose response needs to be multisystem, includes behavioral components
- Mental health must be central - integrated strategies are essential

nature mental health

Comment

https://doi.org/10.1038/s44220-026-00612-w

Psychostimulant use in Canada requires enhanced intervention strategies to reduce harm

Benedikt Fischer, Simon Dubreucq, Bernard Le Foll & Didier Jutras-Aswad

Check for updates

Canada is home to a prolonged public health crisis of overdose deaths, which increasingly involves psychostimulant drugs that are neglected in the intervention response. In this Comment, we examine the risks and harms of psychostimulant use, available interventions, and gaps for improved prevention and treatment.

Canada has been experiencing an unprecedented public health crisis of excessive drug-related deaths for over a decade. The country has a total population of approximately 41.5 million, of which about 5% are Indigenous people and about 18% live in rural areas. Drug-related deaths claimed over 52,000 lives between 2016 and 2024, with most deaths from illicitly produced, highly potent and toxic synthetic opioid drugs (such as fentanyl or its analogues). Overdose deaths have become the leading cause of unnatural deaths and adversely affect life expectancy in the general population[1,2]. On this basis, the crisis has been framed as the ‘opioid’ or ‘fentanyl’ crisis, with extensive interventions aimed at reducing risks for opioid-related overdose either vastly ramped up or newly implemented over the past decade.

Rethinking mental health and stimulant use comorbidity

Received: 5 November 2025 | Accepted: 13 February 2026
DOI: 10.1111/add.70393

ADDICTION OPINION AND DEBATE

ADDICTION SSA

A call for action: Closing the evidence gap in management of stimulant-induced psychosis

Anne Bouthillier[1,2] | Heidar Sharafi[2] | Adam Bisaga[3] | Didier Jutras-Aswad[1,2]

- Comorbidity is the norm, not the exception
- Integrated mental health and addiction care should be the standard, not the aspiration
- Time to move beyond rigid diagnostic categories toward flexible, mechanism- and needs-based approaches to treatment

	ACUTE PHASE	SUBACUTE PHASE	LONG-TERM PHASE
	Prominent agitation, disorganization, and psychotic symptoms	Partial remission of psychotic symptoms but persisting vulnerability and relapse risk	Relapse prevention and management of chronic or recurrent psychosis
PRIORITIES	• Ensure safety and stabilization • Provide low-stimulation environment, supportive care • Short-term pharmacologic management for agitation and psychotic symptoms • Physical restraints should be avoided unless absolutely necessary for safety	• Diagnostic clarification • Psychoeducation and relapse prevention planning • Initiate StUD treatment	• Integrated intervention for StIP • Integrated treatment for StUD and other co-occurring psychiatric disorders • Maintenance pharmacotherapy when indicated • Long-term relapse prevention • Multidisciplinary coordination
EVIDENCE GAPS & RESEARCH NEEDS	• No specific pharmacologic recommendations for agitation within the context of StIP • Limited evidence for environmental and behavioral interventions	• Lack of structured diagnostic algorithms • No evidence guiding duration of antipsychotic therapy • Absence of structured follow-up algorithms post-discharge	• No evidence-based integrated intervention for StIP • No validated criteria to determine when antipsychotic maintenance is indicated or can be safely discontinued • Lack of data on the role of long-acting injectable antipsychotic

Approaches to Substance Regulation

International Journal of Drug Policy 150 (2026) 105181

Contents lists available at ScienceDirect

International Journal of Drug Policy

journal homepage: www.elsevier.com/locate/drugpo

Viewpoint

Outcomes and implications of British Columbia's 'drug decriminalization initiative' for health-oriented drug policymaking

Benedikt Fischer[a,b,c,d,e,f,*], Didier Jutras-Aswad[g,h], Bernard Le Foll[c,f,i,j,k], Daniel T. Myran[l,m,n,o,p]

Decriminalization is neither a panacea nor a failure. Its impact should be rigorously evaluated within a comprehensive public health framework.

Accelerated international efforts


The final, peer-reviewed published version of this preprint can be found here:

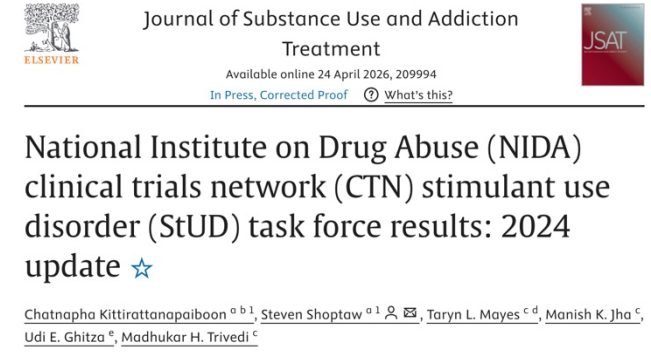
Harm Reduction Contingency Management for Stimulant Use Reduction and Antiretroviral Therapy Adherence in HIV Primary Care: Protocol for an Implementation Effectiveness Study


BMJ Open

Impact of dextroamphetamine substitution on the use of illicit amphetamines in adults with amphetamine dependence: a study protocol for the multicentre double blind randomised controlled trial ATLAS4Dependence


JAMA Psychiatry | Original Investigation

Mirtazapine for Methamphetamine Use Disorder
A Randomized Clinical Trial


Journal of Substance Use and Addiction Treatment

Available online 24 April 2026, 209994

In Press, Corrected Proof

National Institute on Drug Abuse (NIDA) clinical trials network (CTN) stimulant use disorder (StUD) task force results: 2024 update ☆

Chatnapha Kittirattanapaiboon, Steven Shoptaw, Taryn L. Mayes, Manish K. Jha, Udi E. Ghitza, Madhukar H. Trivedi

COMPASS

COmprehensive **M**eta-analysis and meta-regression of **P**sychiatric disorders in people with **A**mphetamine-type **S**timulant use disorder **S**tudy


NIHR | National Institute for Health and Care Research

PROSPERO
International prospective register of systematic reviews

The efficacy and acceptability of psychosocial interventions for the treatment of Methamphetamine use disorder: A systematic review and network meta-analysis of randomized-clinical trials

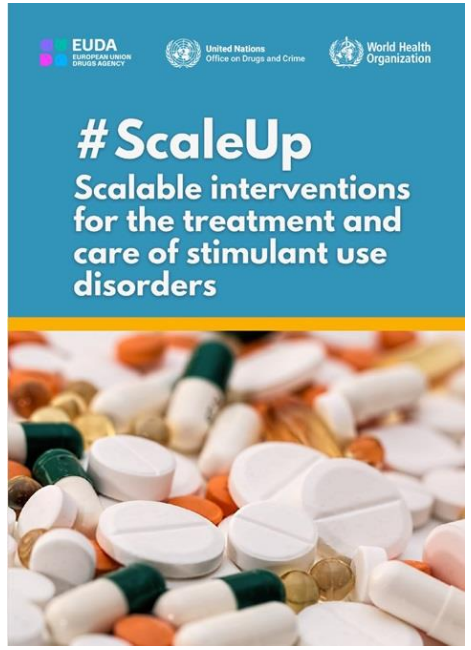
Arash Bahremand, Heidar Sharafi, Gabriel Bastien, Lucy Chester, Nicolas Garel, Hamzah Bakouni, Christina McAnulty, Stephanie Coronado-Montoya, Ovidiu Tatar, Emiliana Matus, Didier Jutras-Aswad

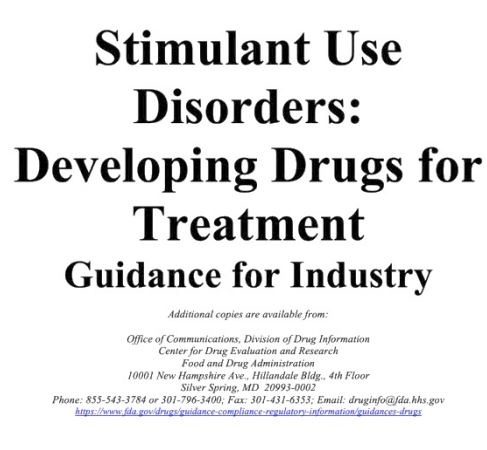

NIHR | National Institute for Health and Care Research

PROSPERO
International prospective register of systematic reviews

Pharmacological Interventions for the Treatment of Amphetamine-type Stimulant Use Disorder: A Systematic Review and Network Meta-analysis

Heidar Sharafi, Anne-Marie Bissonnette, Christina McAnulty, Hamzah Bakouni, Laurent Elkrief, Gabriel Bastien, Daniela Ziegler, Didier Jutras-Aswad



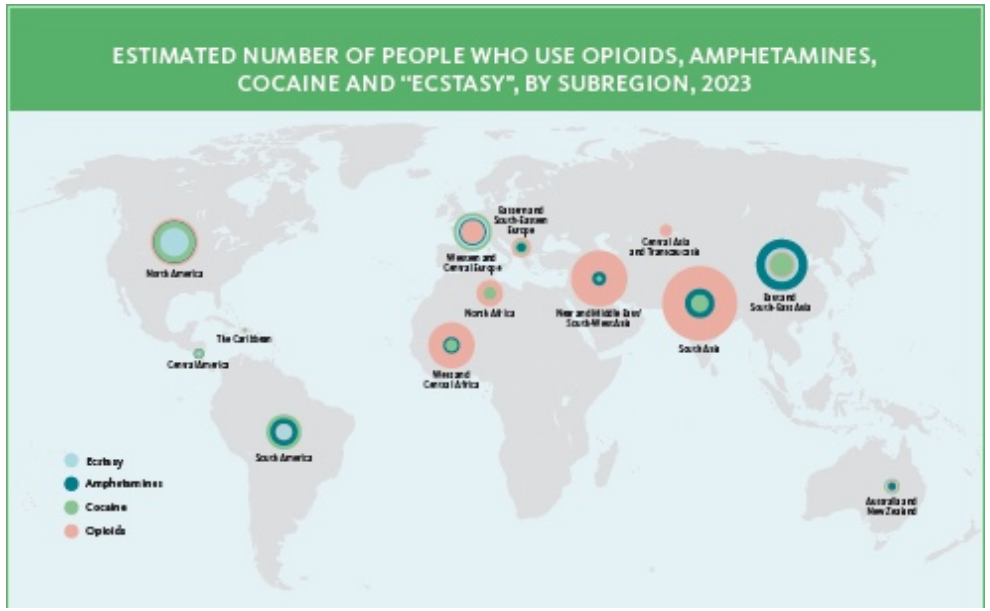

Stimulant Use Disorders: Developing Drugs for Treatment

Guidance for Industry

Additional copies are available from:

Office of Communications, Division of Drug Information
Center for Drug Evaluation and Research
Food and Drug Administration
10001 New Hampshire Ave., Hillandale Bldg., 4th Floor
Silver Spring, MD 20993-0002
Phone: 855-543-3784 or 301-796-3400; Fax: 301-431-6353; Email: druginfo@fda.hhs.gov
https://www.fda.gov/drugs/guidance-compliance-regulatory-information/guidances-drugs

A global public health challenge requires coordinated scientific, clinical, and public health responses



- No single intervention will solve the stimulant crisis
- The challenge is no longer simply to discover new interventions, but to ensure that effective interventions are scalable, affordable, accessible, and implemented across diverse settings

Zhu DT et al., PLoS One. 2025; World Drug Report 2025, UNODC

Université de Montréal

CRCHUM
CENTRE DE RECHERCHE
Centre hospitalier de l'Université de Montréal

Remerciements

- People with lived and living experience
- Study participants
- Families and caregivers
- Research team members
- Students and trainees
- Clinicians and service providers
- Colleagues, co-investigators, and collaborators
- Community and partner organizations
- Knowledge users and policymakers
- Funding agencies and institutional partners

CIHR IRSC Canadian Institutes of Health Research Instituts de recherche en santé du Canada
CRISM
Santé Canada Health Canada
Fonds de recherche Santé Québec
Santé et Services sociaux Québec
CRCHUM Centre de recherche
Université de Montréal
CECTC Centre d'expertise et de collaboration en troubles concomitants
IUD Institut universitaire sur les dépendances

Merci!

Université de Montréal

CRCHUM
CENTRE DE RECHERCHE
Centre hospitalier de l'Université de Montréal