### Schedule-at-a-Glance

#### As of Jul. 31, 2023

**Wednesday, Oct. 18**

<table>
<thead>
<tr>
<th>Time</th>
<th>Title</th>
<th>Room</th>
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<tbody>
<tr>
<td>14:00 – 17:00</td>
<td>Preconference courses</td>
<td>Junior Ballrooms (3rd floor, North Tower)</td>
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<tr>
<td>08:00 – 17:00</td>
<td>CAPE Annual Meeting</td>
<td>Pavilion Ballroom D (3rd floor, North Tower)</td>
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<tr>
<td>08:30 – 16:30</td>
<td>CACLP Annual Meeting</td>
<td>Azure (3rd floor, South Tower)</td>
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**Thursday, Oct. 19**

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<thead>
<tr>
<th>Time</th>
<th>Title</th>
<th>Room</th>
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<tr>
<td>09:00 – 10:30</td>
<td>Keynote plenary</td>
<td>Grand Ballroom (Grand Ballroom level, North Tower)</td>
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<tr>
<td>08:00 – 17:00</td>
<td>Junior Investigator Research Colloquium (invitation only)</td>
<td>Constellation (34th floor, North Tower)</td>
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<tr>
<td>10:30 – 10:45</td>
<td>Transition break</td>
<td>various</td>
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<tr>
<td>10:45 – 11:45</td>
<td>Concurrent sessions</td>
<td>Junior Ballroom AB Foyer (3rd floor, North Tower)</td>
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<tr>
<td>11:45 – 12:00</td>
<td>Transition break</td>
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<tr>
<td>12:00 – 13:30</td>
<td>Symposium</td>
<td>Grand Ballroom (Grand Ballroom level, North Tower)</td>
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<tr>
<td>13:30 – 14:15</td>
<td>Networking and nutrition break</td>
<td>Pavilion Ballroom Foyer (3rd floor, North Tower)</td>
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<tr>
<td>14:30 – 15:30</td>
<td>Concurrent sessions</td>
<td>various</td>
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<tr>
<td>15:30 – 15:45</td>
<td>Transition break</td>
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<tr>
<td>15:45 – 16:45</td>
<td>Concurrent sessions</td>
<td>various</td>
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<tr>
<td>15:45 – 16:45</td>
<td>Research poster session I</td>
<td>Junior Ballroom AB Foyer (3rd floor, North Tower)</td>
</tr>
<tr>
<td>17:00 – 19:00</td>
<td>Welcome reception (open to all registrants)</td>
<td>Pavilion Ballroom Foyer (3rd floor, North Tower)</td>
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**Friday, Oct. 20**

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<thead>
<tr>
<th>Time</th>
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<tr>
<td>09:00 – 10:30</td>
<td>Keynote plenary</td>
<td>Grand Ballroom (Grand Ballroom level, North Tower)</td>
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<td>10:30 – 10:45</td>
<td>Transition break</td>
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<tr>
<td>10:45 – 11:45</td>
<td>Concurrent sessions</td>
<td>various</td>
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<tr>
<td>10:45 – 11:45</td>
<td>Early investigator poster session II</td>
<td>Junior Ballroom AB Foyer (3rd floor, North Tower)</td>
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<tr>
<td>11:45 – 12:00</td>
<td>Transition break</td>
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<tr>
<td>12:00 – 13:30</td>
<td>Symposium</td>
<td>Grand Ballroom (Grand Ballroom level, North Tower)</td>
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<tr>
<td>13:30 – 14:15</td>
<td>Resident trivia competition</td>
<td>Pavilion Ballroom Foyer (3&lt;sup&gt;rd&lt;/sup&gt; floor, North Tower)</td>
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<tr>
<td>13:30 – 14:15</td>
<td>Networking and nutrition break</td>
<td>Pavilion Ballroom Foyer (3&lt;sup&gt;rd&lt;/sup&gt; floor, North Tower)</td>
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<tr>
<td>14:30 – 15:30</td>
<td>Concurrent sessions</td>
<td>various</td>
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<tr>
<td>15:30 – 15:45</td>
<td>Transition break</td>
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<tr>
<td>15:45 – 16:45</td>
<td>Concurrent sessions</td>
<td>various</td>
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<tr>
<td>15:45 – 16:45</td>
<td>Research poster session II</td>
<td>Junior Ballroom AB Foyer (3&lt;sup&gt;rd&lt;/sup&gt; floor, North Tower)</td>
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<tr>
<td>16:45 – 17:45</td>
<td>Naloxone training session</td>
<td>Junior Ballroom D (3&lt;sup&gt;rd&lt;/sup&gt; floor, North Tower)</td>
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<tr>
<td>17:00 – 19:00</td>
<td>Resident reception (open to trainee and early career psychiatrist registrants; ticket required)</td>
<td>Constellation (34&lt;sup&gt;th&lt;/sup&gt; floor, North Tower)</td>
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**Saturday, Oct. 21**

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<thead>
<tr>
<th>Time</th>
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<tr>
<td>09:00 – 10:30</td>
<td>Keynote plenary</td>
<td>Grand Ballroom (Grand Ballroom level, North Tower)</td>
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<tr>
<td>10:30 – 10:45</td>
<td>Transition break</td>
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<tr>
<td>10:45 – 11:45</td>
<td>Concurrent sessions</td>
<td>various</td>
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<tr>
<td>12:00 – 13:30</td>
<td>Annual General Meeting (CPA members only)</td>
<td>Grand Ballroom (Grand Ballroom level, North Tower)</td>
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<tr>
<td>13:30 – 14:15</td>
<td>Networking and nutrition break</td>
<td>Pavilion Ballroom Foyer (3&lt;sup&gt;rd&lt;/sup&gt; floor, North Tower)</td>
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<tr>
<td>14:30 – 15:30</td>
<td>Concurrent sessions</td>
<td>various</td>
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<tr>
<td>15:30 – 15:45</td>
<td>Transition break</td>
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<tr>
<td>15:45 – 16:45</td>
<td>Concurrent sessions</td>
<td>various</td>
</tr>
<tr>
<td>18:00 – 00:00</td>
<td>President's Gala (ticket required)</td>
<td>Grand Ballroom (Grand Ballroom level, North Tower)</td>
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Wednesday, October 18
As of Aug. 16, 2023

Pre-Conference Course
PC01 - Electroconvulsive Therapy: A Core Review of Current Practice
Wednesday, Oct. 18
14:00 - 17:00 (3 hrs)
Meeting Room: Junior Ballroom C (3rd floor - North Tower)
Caroline Gosselin*, MD, FRCPC; Peter Chan, MD, FRCPC; Lisa McMurray, MD, FRCPC

CanMEDS Roles:

1. Medical Expert
2. Health Advocate
3. Collaborator

At the end of this session, participants will be able to: 1) Describe indications and assess risk when selecting electroconvulsive therapy (ECT) for patients and obtaining consent; 2) Formulate how ECT technique, including ECT device parameters, can affect clinical outcome; and 3) Explain the role of maintenance ECT, various anaesthetics, and medications in ECT outcome.

Electroconvulsive therapy (ECT) continues to provide a life-saving and effective mode of treatment for a host of serious psychiatric syndromes. This session offers a comprehensive review of core practice principles for both novice and more experienced ECT providers. Indications, pre-ECT work-up, and the process of consent will be outlined. Recommendations for anesthetics will be discussed. The evidence behind and indications for bifrontal, bitemporal, and right and left unilateral electrode placements will be reviewed, including for patients with intracranial metal. Discussion will further focus on various dosing protocols in use, including titration techniques with ultrabrief or brief pulse width settings, and age or gender-based dosing formulas. The EEG parameters that are markers of a therapeutic seizure will be taught. Strategies to minimize adverse effects and maintain symptom recovery will be offered, including the effects of concurrent medication use and the benefits of maintenance ECT. These university-based ECT clinicians, who are involved in active ECT practice, teaching, and research, provide this course through both didactic and small-group hands-on sessions. The rotating small group sessions are divided into EEG interpretation, device parameters, and electrode placement/skin preparation.

References:

Pre-Conference Course  
PC02 - Integrating Cognitive-Behavioural Therapy for Insomnia Into Psychiatric Practice  
Wednesday, Oct. 18  
14:00 - 17:00 (3 hrs)  
Meeting Room: Junior Ballroom D (3rd floor - North Tower)  
Christopher Earle, MD, FRCPC; Raed Hawa, MD, FRCPC, DABPN; Atul Khullar, MD FRCPC FAASM; Elliott Lee, MD, FRCPC, DABPN; Michael Mak, MD, FRCPC, FCPA; Malgorzata Rajda, MD, FRCPC; DABPN;  

CanMEDS Roles:  
1. Medical Expert  
2. Scholar  
3. Communicator  

At the end of this session, participants will be able to: 1) Assess insomnia and identify cases suitable for cognitive-behavioural therapy for insomnia (CBT-I); 2) Implement core CBT-I interventions into psychiatric practice; and 3) Manage insomnia with comorbid psychiatric disorders and sedative-hypnotic use.  

Insomnia is highly prevalent in psychiatric practice and successful treatment improves both the incidence and severity of psychiatric comorbidities. Cognitive-behavioural therapy for insomnia (CBT-I) is the first-line treatment for chronic insomnia, although access to trained therapists is a limiting factor in implementation. This introductory course will focus on practical skills and resources to allow implementation of evidence-based CBT-I interventions as part of general psychiatric practice. Case discussion will highlight particular skill sets and strategies useful in managing insomnia comorbid with other psychiatric disorders.  

In a series of interactive presentations, the following topics will be discussed:  
1. CBT-I Overview, Assessment, and Core Components  
2. Sleep Diary and Sleep Hygiene  
3. Behavioural Treatment of Insomnia  
5. Sedative-Hypnotic Use in CBT-I and Managing Comorbid Psychiatric Conditions  
6. Troubleshooting CBT-I and CBT-I Resources  

Pre-Conference Course  
PC03 - Interpersonal Psychotherapy (IPT), Culture, Attachment Patterns of Relating and Mentalizing  
Wednesday, Oct. 18  
14:00 - 17:00 (3 hrs)  
Meeting Room: Junior Ballroom AB (3rd floor - North Tower)  
Paula Ravitz*, MD; Priya Watson, MD FRCPC  

CanMEDS Roles:  
1. Communicator  
2. Medical Expert  
3. Scholar  

At the end of this session, participants will be able to: 1) Use IPT in bio-psycho-social-cultural case-formulation and depression treatment; 2) Describe IPT clinical guidelines to help patients in the contexts of stressful life events of loss/grief, life changes/social role transitions and relational conflicts/role disputes; and 3) Apply culturally sensitive, trauma-informed, relationally-focused principles to the delivery of mental healthcare and psychotherapy.  

IPT is an evidence-supported psychotherapy with numerous RCTs and meta-analyses establishing its effectiveness locally and globally including in low-and-middle-income countries. It is recommended as
a first line depression treatment in consensus treatment guidelines by the WHO, CANMAT, the APA and NICE and has been culturally adapted for many settings.

Principles of IPT are relevant to bio-psycho-social-cultural case formulation and depression treatment for patients whose illness onset or worsening is associated with relational life events of loss, change, conflict, or isolation. Mentalizing principles are compatibly integrated into IPT for patients with unresolved developmental trauma and insecure attachment.

This case-based, interactive workshop provides a foundational overview of IPT with emphasis on culturally-sensitive, trauma-informed clinical care with attention to individual patient differences in attachment patterns of relating and mentalizing.

References:
Thursday, October 19
As of Jul. 31, 2023

Keynote Plenary
Thursday, Oct. 19
09:00 – 10:30 (1.5 hr)
Meeting Room: Grand Ballroom
Nickie Mathew, MD, FRCPC, DABPN, DABAM; Leslie Buckley, MD, FRCPC

Symposium
S01 - Suicide Loss in Psychiatric Practice: Patient and Clinician Perspectives
Thursday, Oct. 19
10:45 - 11:45 (1 hr)
Meeting Room: TBC
Zainab Furqan*, MD; Juveria Zaheer, MD, MSc; Yvonne Bergmans, PhD; Gina Nicoll, College Diploma

CanMEDS Roles:

1. Collaborator
2. Professional
3. Communicator

At the end of this session, participants will be able to: 1) Demonstrate knowledge about the prevalence of suicide attempts and suicide deaths in psychiatric practice; 2) Gain insight into patient perspectives about interacting with health care providers before and after a suicide attempt; and 3) Understand the various emotional and behavioural responses clinicians can have to patient suicide.

This symposium combines three distinct perspectives on suicide in psychiatric practice. We start with the perspective of a patient, Gina Nicolls, who has lived through suicidality and suicide attempts, and what it’s like to bring that part of herself into the clinical setting. We will then turn to Dr. Bergmans, who has worked with people with recurrent suicide attempts for over 21 years in group and individual work contexts. She will speak to the care provider about risk tolerance issues, understanding suicide attempts, and the experience and subsequent ways of dealing with a client who has died by suicide—lastly, Drs. Furqan and Zaheer will share their perspectives as researchers examining suicide prevention. The main topic of their segment will be their recent publication, “I Was Close to Helping Him but Couldn’t Quite Get There”: Psychiatrists’ Experiences of a Patient’s Death by Suicide. They will share research on the affective and behavioural impacts of patient suicide on clinicians and positive and negative changes in practice patterns that may be seen after this important event. Together, these perspectives will shed light on a topic often not discussed openly, though encountered frequently in the clinical setting.

References:

Symposium
S02 - A Review of the Prevalence and Risk Factors for Suicidality in Neuropsychiatric Patient Populations
Thursday, Oct. 19
10:45 - 11:45 (1 hr)
Meeting Room: TBC
Valerie Primeau*, MD, FRCPC; Benjamin Cassidy, MD BSc MA Psychology

CanMEDS Roles:
1. Medical Expert
2. Collaborator
3. Health Advocate

At the end of this session, participants will be able to: 1) Describe the prevalence and clinical correlates of suicidal ideation in MNCD, Parkinson disease, multiple sclerosis, myasthenia gravis, and amyotrophic lateral sclerosis; 2) Describe the association between general cognitive function as well as specific cognitive domains and suicide risk across the life span; and 3) Summarize the common risk factors for suicidal ideation across neuropsychiatric patient populations.

Increased prevalence of suicidality has been documented in multiple neuropsychiatric patient populations, including those diagnosed with neurocognitive disorder, multiple sclerosis, Parkinson disease, and amyotrophic lateral sclerosis. Additionally, clinical correlates of suicidal ideation have been identified in many of these patient populations, such as cognitive deficits, perceived disability, recency of diagnosis, and comorbid mood and anxiety symptoms. Further, studies in general have demonstrated an association between cognitive performance and suicidal ideation. In this symposium, we explore the prevalence and risk factors for suicidal ideation in various neuropsychiatric patient populations and outline how these data highlight 1) the need for increased suicidal ideation screening in those with neurological diagnoses and 2) the disorder-specific risk factors to consider when performing these suicide risk assessments.

References:

Symposium
S03 - Employing Implementation Science Research to Enhance Access to Evidence-Based Mental Health Care: Lessons for Canada from Asia-Pacific Research Collaborations
Thursday, Oct. 19
10:45 - 11:45 (1 hr)
Meeting Room: TBC
Jill K. Murphy*, PhD; Raymond Lam, MD, FRCPC, FCAHS; Kenneth Fung, MD FRCPC MSc DFAPA D; Josephine Pui-Hing Wong, RN, BScN, MScN, PhD; Leena Chau, PhD (C); Jill Murphy, PhD, MA

CanMEDS Roles:
1. Scholar

At the end of this session, participants will be able to: 1) Understand the importance of implementation science (IS) for promoting uptake of evidence-based practice; 2) Understand the role that international collaborative research plays in knowledge exchange that is beneficial for Canadian clinicians and researchers; and 3) Understand how IS research can be employed in a practical way to mitigate barriers to evidence-based practice across several contexts.

Access to evidence-based mental health care is a global challenge, with the ‘know-do’ gap- whereby research evidence is not translated into clinical practice and policy change- contributing to this
disparity. Implementation science (IS) is the scientific study of methods, strategies and processes that promote the adoption and sustained use of evidence-based practice (EBP). IS is recognized as essential to ensuring that research evidence leads to real world improvements in the delivery of EBP, ultimately resulting in improved mental health outcomes.

In this symposium, we present findings from three IS studies based on collaborations between Canadian researchers and colleagues in the Asia-Pacific: Barriers and Facilitators to the use of Measurement-Based Care for Depression in China and Canada; Implementing Acceptance and Commitment to Empowerment (ACE) to improve student mental health in Jinan, China, and; Fidelity and adaptation testing of a digital depression intervention in Vietnam: a mixed-methods implementation study. The findings from these studies include: 1) barriers and facilitators of the uptake of standard and technology-enhanced measurement-based care for depression among clinicians and patients in China and Canada, 2) the use of an established IS framework (RE-AIM) to overcome several implementation challenges in the context of the pandemic, and, 3) considerations for balancing fidelity with flexibility when adapting intervention cross-culturally and from in-person to digital delivery. Drawing on these findings, we will reflect on lessons learned for the Canadian context, recognizing that IS research evidence from other contexts has great potential to inform improved uptake of EBP in Canada.

References:


Workshop
W01 - Disability Determination and Insurance
Thursday, Oct. 19
10:45 - 11:45 (1 hr)
Meeting Room: TBC
Carmen Bellows*, MA, BA; Carmen Bellow, MA; Sam Mikail, PhD; Valerie Legendre, MA

CanMEDS Roles:

1. Health Advocate
2. Professional
3. Leader

At the end of this session, participants will be able to: 1) Understand various definitions of disability utilized by insurance providers; 2) Understand the value of evidence-based care when working with insurance; and 3) Understand how to make return to work recommendations for individuals with mental disorders.

The concept of “disability” is notoriously difficult to define. No universal definition of the concept exists. Yet, within healthcare, clinicians regularly face requests by their patients to complete forms in support of their disability claims. The workshop will review several definitions of disability and their implication for clinical assessment and intervention. Emphasis will be placed on disability due to mental disorders as these conditions can be particularly challenging due to the subjective nature of the association symptoms and the relative absence of biological markers typically used in disability determination of physical conditions. Topics to be covered include the concept of measurement-based care and working with third party carriers, the importance of setting clear treatment objectives aligned with functional impairments related to work functions, the phases of treatment, and determining necessary accommodations.

References:


Workshop
W02 - The Future of Psychiatry: Innovations in Clinical and Research Settings
Thursday, Oct. 19
10:45 - 11:45 (1 hr)
Meeting Room: TBC
Nikhita Singhal*, MD; Jacquelyn Paquet, MD; Raveen Virk, MD; Katherine Aitchison, MD; Alexander McGirr, MD
Supported by the Members-in-Training & Fellows' Section

CanMEDS Roles:

1. Leader
2. Health Advocate
3. Medical Expert

At the end of this session, participants will be able to: 1) Describe key developments in the fields of neuro-informatics genetics research, neurostimulation, and psychedelics; 2) Consider how trends in psychiatric research and treatment might impact their training and career trajectories; and 3) Identify strategies to integrate innovative therapies into clinical practice.

Psychiatry is at the frontier of research and innovation as we develop new insights into the underlying etiologies of psychiatric disorders and integrate novel treatment modalities into clinical practice. Significant promise exists for novel therapies, including interventional psychiatry and psychedelic-assisted psychotherapy, artificial intelligence and digital interventions, wearable technologies and virtual reality, microbiome-altering treatments, and nanotechnology-based delivery systems. However, given how rapidly the field is evolving — and the discrepancies in opportunities across the country — it can be challenging to stay apprised.

For those seeking information on psychiatry’s hottest topics, this workshop provides a forum to learn more and engage with pioneering experts in their respective areas. The session will feature a panel of psychiatrists commenting on new developments in neuro-informatics genetics research, neurostimulation, and psychedelics. In addition, they will speak about their journeys — including how they developed an interest in their respective fields, sought out training opportunities, and overcame challenges associated with integrating novel, nonconventional modalities into their research work and clinical practice. Participants will have the chance to reflect on their interests and develop strategies to help translate these into potential career trajectories. Although it is difficult to determine what psychiatry might look like in the future, this workshop aims to inspire confidence and promote the integration of innovative therapies into practice.

References:


Workshop
W03 - Measuring, Understanding, Addressing and Ameliorating the Effects Leading to Workplace-Based Violence and Code Whites at University Health Network
Thursday, Oct. 19
10:45 - 11:45 (1 hr)
Meeting Room: TBC
Rickinder Sethi*, MD; Brendan Lyver; Christian Schulz-Quach; Trevor Hanagan

CanMEDS Roles:

1. Leader
2. Collaborator
3. Health Advocate

At the end of this session, participants will be able to: 1) Understand the impact of workplace violence in the health care setting; 2) Appreciate the Delphi method for developing and guiding clinical management for WPV; and 3) Appraise innovative strategies to manage WPV in the healthcare setting.

UHN, among other health care providers across Ontario and internationally, is contending with the increasingly challenging patient and visitor behaviours in its emergency departments (“EDs”), including a growing prevalence of violence and abusive behaviours that together jeopardize the safety and morale of staff, physicians, patients and visitors.

Workplace violence (WPV) in healthcare was already a problem, but since the pandemic, HCPs have reported an increase in WPV. UHN has been no exception, as the rate of WPV during the pandemic has more than doubled the rate of WPV in the three months prior to the pandemic, rising from 1.13 incidents per 1000 visits to 2.53 incidents per 1000 visits. Underreporting of WPV incidences poses an ongoing barrier to quality improvement in healthcare. A survey of healthcare workers found that 57% of healthcare providers (HCPs) filed a formal report of WPV despite 68% of HCPs experiencing physical violence and 83% of HCPs experiencing non-physical violence within the year prior to the survey. UHN Security and Safety-related entities are in the process of a concerted revamping of current policies and interventions to address WPV and Code White incidences, such as enhanced security measures, innovative educational interventions for staff and clinicians, technological solutions and implementation of a dyad leadership model for UHN Security.

References:

   https://doi.org/10.1177/21650799211031233

Workshop
W04 - Exploring Meaning in Suffering and Mental Disorders
Thursday, Oct. 19
10:45 - 11:45 (1 hr)
Meeting Room: TBC
Joseph Burley*, M.D; Casimiro Cabrera Abreu, MD.

CanMEDS Roles:

1. Communicator
2. Professional
3. Collaborator

At the end of this session, participants will be able to: 1) Understand the importance of meaning in diagnosing and treating mental disorders; 2) Be aware of their beliefs about meaning and suffering; and 3) Recognize the importance of whole person–centered lived experience in exploring meaning.
The experience of mental illness is often (always?) immersed in the existential reality of suffering. It is accompanied by feelings of passivity, helplessness, and puzzlement. Jasper’s limit situations describe paradoxical life events (antimonies) through which there appear to be no solutions. Mental illness can be seen as a limit situation, which Jaspers considered an underlying cause of mental illness.

Manualized psychotherapy and our DSM diagnostic approach encourages us to make a diagnosis and apply some form of therapy. However, patients come to us with underlying questions that need to be addressed, such as, “Why is this happening?”; “Have I done something to deserve this?”; “Should I just die?”. Suffering without reason leaves us feeling trapped and robs us of meaning.

Jaspers and Frankl interpreted limit situations as related to existential themes, including guilt, randomness, suffering, conflict, love, death, illness as punishment etc. These are common themes underlying the suffering in our patients’ illness experience and beliefs related to developmental and life-world experience. Jaspers and Frankl believed that healing occurs via understanding the inner experience of the whole person. Although not always explicit, we often wrestle with these meaning-related issues as part of psychiatric care. Psychiatry requires that we be willing to explore these issues in ourselves and our patients.

This workshop will discuss finding and understanding meaning through relationship, dialogue, creativity, and responsibility as a way through their suffering.

References:


Workshop
W05 - Top 10 Journal Articles in Psychiatry
Thursday, Oct. 19
10:45 - 11:45 (1 hr)
Meeting Room: TBC
David Gratzer*, MD, FRCPC

CanMEDS Roles:

1. Scholar
2. Communicator
3. Medical Expert

At the end of this session, participants will be able to: 1) Better understand and appreciate the evolving psychiatric literature by considering ten papers; 2) Better understand and appreciate the strengths and weakness of these papers; and 3) Better understand and appreciate the way the latest literature can inform your clinical decisions.

Can mindfulness be used to treat anxiety disorders? Is there evidence for psilocybin for treatment-refractory depression? What does the literature say about virtual care for mental illness? And what should you say to your patients when they ask one of these questions? It’s challenging to keep up with the latest papers with so many journals - and, of course, our other obligations.

In this invited, annual workshop, Dr. David Gratzer, a CAMH psychiatrist, reviews the top journal articles of the past year. Dr. Gratzer is well versed in the latest in the literature; he writes a summary in his popular and award-winning Reading of the Week program (www.davidgratzer.com). In this workshop, he runs through important papers from big journals - and not-so-big journals.

The workshop will be interactive, allowing audience members to offer up their own suggestions and criticisms. And there is no pre-reading required. Dr. Gratzer will summarize the papers, consider their limitations and strengths, and offer his comments about clinical considerations.
The papers will include: the Goodwin paper on psilocybin (NEJM) and several Canadian choices.

References:


Early Investigator Poster Session I
Thursday, Oct. 19
10:45 – 11:45 (1 hr)
Meeting Room: Junior Ballroom AB Foyer (3rd floor, North Tower)

Codeveloped Symposium
Thursday, Oct. 19
12:00 – 13:30 (1.5 hr)
Meeting Room: Grand Ballroom

Networking Break
Thursday, Oct. 19
13:30 – 14:15 (.75 hr)
Meeting Room: Pavilion Ballroom Foyer (3rd floor, North Tower)

Research Paper
PS01a - Placebo Controls in Psychedelic Research: A Systematic Review and Qualitative Analysis of Clinical Trials
Thursday, Oct. 19
14:30 - 15:30 (N/A)
Meeting Room: TBC
Nikhita Singhal*, MD; Cory Weissman, MD; Alexander Wen, BSc; Brett Jones, MD; Richard Zeifman, PhD

CanMEDS Roles:

1. Medical Expert
2. Scholar
3. Professional

At the end of this session, participants will be able to: 1) Appreciate the methodological challenges associated with conducting clinical trials involving psychedelic substances; 2) Consider the role of placebo controls and the potential contribution of placebo mechanisms to psychedelic therapy outcomes; and 3) Identify ways in which future psychedelic clinical trials can address blinding challenges and mitigate the risk of bias.

The use of classic psychedelic as potent mental health treatments is gaining traction, yet significant challenges remain in conducting trials with these substances. Both the role of placebo control subjects and the importance of placebo mechanisms in explaining the efficacy of psychedelic therapy remain understudied. We thus conducted a systematic review of placebo use in clinical trials involving classic psychedelic administration to enhance understanding of this complex area. The characteristics and findings of included studies are presented as a systematic narrative synthesis including qualitative outcomes and summarized in tabular format. Of 1,053 studies retrieved through our search, 55 were eligible for inclusion, with publication dates ranging from 1963 to 2020. The most common forms of placebo used were empty capsules, niacin, and IV saline. Clinical outcomes
included subjective mental states, physiological measures, creative imagination and mental imagery tests, BDNF and cortisol levels, eyeblink responses, and formal measures of clinical depression and anxiety. Our review suggests that most placebo-controlled psychedelic therapy studies involve healthy participants; there is a limited number of placebo-controlled studies among psychiatric populations, and the quality of placebo control subjects has been questionable. The use of adequate placebo controls, as well as assessment and balancing of expectancy, is severely lacking in existing trials. Future psychedelic clinical trials should include adequate assessment of blinding, more appropriate control subjects, and randomization of treatment arms and treatment expectancy. Active psychopharmacological controls (such as other rapid acting agents), in addition to head-to-head comparison with active treatments, should be considered as alternatives.

References:


Research Paper

PS01b - Intranasal Esketamine Versus Intravenous Ketamine: An Observational Study Comparing the Efficacy and Tolerability of Two Novel 'Standard-of-Care' Treatments for Treatment-Resistant Depression

Thursday, Oct. 19
14:30 - 15:30 (N/A)
Meeting Room: TBC
Gilmar Gutierrez*, MD; Gustavo Vazquez MD, PhD

CanMEDS Roles:

1. Leader
2. Health Advocate
3. Medical Expert

At the end of this session, participants will be able to: 1) Compare and consider the effectiveness and tolerability of intravenous ketamine and intranasal esketamine in real-world clinical practice; 2) Consider the benefits of these novel therapies and potential applications in the management of treatment-resistant depression; and 3) Use this real-world clinical perspective to inform clinical practice and management of patients with treatment-resistant depression.

Intravenous (IV) ketamine and intranasal (IN) esketamine are novel therapies for management of treatment-resistant depression (TRD). This study compared the real-world effectiveness and tolerability of IV ketamine and IN esketamine in the management of unipolar TRD.

Methods: This observational study is still in progress, recruiting patients with moderate to severe TRD referred to receive IV ketamine or IN esketamine treatment. Effectiveness of these treatments is assessed with the Montgomery–Åsberg Depression Rating Scale (MADRS) for depression severity and Item 10 of the MADRS for suicidal ideation (SI). Tolerability is assessed by tracking side effects and depersonalization with the six-item clinician-administered dissociative symptom scale (CADSS-6) depersonalization scale. The data are analyzed with descriptive statistics, risk ratio (RR), and Cohen's d.

Results: These are preliminary results, with 17 patients referred to IV ketamine and 7 referred to IN esketamine recruited so far. Both IV ketamine (d = 3.07, p < 0.0001) and IN esketamine (d = 1.39, p = 0.0086) significantly reduced depressive symptoms. Patients receiving IV ketamine treatment had a significant reduction in SI (d = 1.14, p = 0.0027), significantly higher risk of developing side effects (RR = 1.62, p = 0.0046), significantly lower depersonalization score (d = 1.30, p = 0.013), compared to those receiving IN esketamine. All side effects reported were mild and transient.
Conclusions: These preliminary results suggest that both IV ketamine and IN esketamine are effective in managing depressive symptoms and well tolerated. Thus, the results of this study could serve to guide clinical practice and health policy.

References:


Research Paper
PS01c - Safety and Tolerability of Intramuscular and Sublingual Ketamine-Assisted Therapy in a Group Psychotherapy Setting
Thursday, Oct. 19
14:30 - 15:30 (N/A)
Meeting Room: TBC
Vivian W. L. Tsang*, MD MPH; Brendan Tao, BSc; Shannon Dames, RN, MPH, EdD; Zach Walsh, PhD; Pam Kryskow, MD, CCFP

CanMEDS Roles:

1. Scholar
2. Health Advocate
3. Communicator

At the end of this session, participants will be able to: 1) Understand the safety and tolerability of ketamine-assisted therapy; 2) Describe the risks involved in ketamine-assisted therapy; and 3) Understand common medications used to mitigate symptoms.

In the last few years, ketamine has become increasingly common in treating mental health conditions. Still, safety data informing intramuscular and sublingual dosing in a community-focused group psychotherapy setting are lacking. The Roots to Thrive Ketamine-Assisted Therapy (RTT-KaT) is a unique twelve-week program with twelve Community-of-Practice (a form of group therapy) sessions and three ketamine medicine sessions.

Methods: A chart review of the RTT-KaT program was performed retrospectively on four cohorts (n = 128) who participated in 448 sessions between September 2020 and December 2021. Baseline characteristics and adverse events were captured, including medication administration before, during, and after the RTT-KaT sessions. Analyses both by session and by individual were conducted. Chi-squared test with Yates’ continuity correction was used to assess side effects in subgroups from ketamine administration.

Results: RTT-KaT was well tolerated, with none of the 128 participants dropping out of the program. From the 448 sessions, 49.16% had elevated blood pressure post-KaT, session by session. Regarding other adverse effects, 12.05% of participant sessions experienced nausea, 2.52% had an episode of vomiting, 3.35% had a headache, and seven experienced dizziness. Analysis by individual revealed congruent findings.

Conclusion: These findings suggest good safety and tolerability for RTT-KaT among people seeking treatment for mental health issues. Most participants did not experience adverse reactions, and the recorded events involved transient symptoms resolved with rest and (or) medications.
References:


Symposium
S05 - Early Psychosis Intervention: Spreading Evidence-based Treatment: Improving Early Psychosis Care Through the EPI-SET Study
Thursday, Oct. 19
14:30 - 15:30 (1 hr)
Meeting Room: TBC
Aristotle Voineskos*, MD, PhD, FRCPC; Nicole Kozloff, MD, SM, FRCPC; Janet Durbin, PhD, MSc; George Foussias, MD, PhD, FRCPC; Sanjeev Sockalingam, MD, FRCPC, MHPE

CanMEDS Roles:

1. Scholar
2. Collaborator
3. Leader

At the end of this session, participants will be able to: 1) Describe the NAVIGATE model for early psychosis care and patient level outcomes following implementation of this model in Ontario; 2) Reflect on barriers and facilitators to implementing the NAVIGATE early psychosis care model across multiple provincial sites; and 3) Identify training needs and how evidence-based education models can support capacity building in early psychosis care.

Despite evidence to support their real-world effectiveness, early psychosis intervention (EPI) programs struggle to deliver consistent, coordinated, recovery-based care. ‘NAVIGATE’ is an evidence-based, manualized model of coordinated EPI care that incorporates 4 treatment components: individualized medication management; individual resiliency training; supported employment and education; and family education. Chaired by Dr. Voineskos, this symposium will describe an innovative clinical trial known as EPI-SET (Early Psychosis Intervention – Spreading Evidence-based Treatment). EPI-SET evaluated the implementation effectiveness of NAVIGATE in six geographically diverse settings with the aim of improving quality and consistency of care. Dr. Kozloff will examine the current state of early psychosis programs, situating EPI-SET within the broader EPI movement. Dr. Durbin will describe EPI-SET’s primary aim, to assess whether implementation of NAVIGATE improved fidelity to the early psychosis standards (FEPS: Addington et al, 2020). Despite being implemented during turbulent times, study programs sustained and improved EPI practice, particularly in psychosocial treatments and team function. Dr. Foussias will describe longitudinal patient-level outcomes of participants receiving NAVIGATE. Over the first 12 months of NAVIGATE treatment, participants exhibited significant improvements in quality of life scores (QLS: (F(82.2,2) = 13.129, p

References:

Course  
**C02 - Managing Metabolic Health in Mental Illness: Data-Driven Approaches and Clinical Tools for Practice**  
Thursday, Oct. 19  
14:30 - 16:30 (2 hrs)  
Meeting Room: TBC  
Sri Mahavir Agarwal*, MBBS, MD, PhD; Sanjeev Sockalingam, MD, MHPE, FRCPC; Stephanie Cassin, C.Psych.; Raed Hawa, MSc MD FRCPC DABSM  
Supported by the Psychosomatic Medicine Section  

**CanMEDS Roles:**  
1. Medical Expert  
2. Scholar  
3. Health Advocate  

**At the end of this session, participants will be able to:**  
1) Review the prevalence, pathophysiology, and approach to the assessment of obesity in mental health; 2) Understand the pillars of obesity treatment, including the role of behavioural interventions, pharmacotherapy, and surgery; and 3) Appreciate how a data-driven algorithmic approach can inform and improve the management of obesity in mental illness.  

Obesity is a growing public health concern in Canada. Obesity and mental health have a complex relationship, and mental health professionals are increasingly faced with challenges in treating psychiatric illness that are complicated by obesity and related metabolic health concerns. Importantly, metabolic dysfunction can compromise adherence with treatment, leading to poor mental health outcomes. In spite of the clear importance of metabolic health, rates of treatment for metabolic comorbidities remain low. This course will therefore discuss the relation between obesity and mental health and provide an in-depth review of clinical tools available to clinicians to address this complex problem.  

Presenter one will discuss the prevalence of obesity in mental health and provide an overview of the pillars of obesity treatment, including behavioural and nutritional interventions, pharmacotherapy-based approaches, and the role of surgery. Presenter two will focus on the clinical assessment of obesity and comorbid respiratory and non-respiratory sleep disorders. Presenter three will provide an overview of evidence-based cognitive-behavioural therapy (CBT) interventions for obesity, including psychoeducation, goal setting, self-monitoring, adopting a routine of regular eating, problem solving, and challenging maladaptive thoughts and will discuss the effect of CBT interventions on improving disordered eating and psychological distress. We will discuss the application of data-driven algorithmic pharmacological approaches to managing obesity in people with severe mental illness. Finally, we will review the role of bariatric surgery for obesity management in people with mental illness. Guideline-related resources, including Obesity Canada toolkits and additional resources developed by the presenters will be shared.  

**References:**  

**Course  
C03 - Continuous Quality Improvement: Train the Trainers**  
Thursday, Oct. 19  
14:30 - 16:30 (2 hrs)  
Meeting Room: TBC  
Kamini Vasudev*, MBBS, MD, MRCPsych (UK); Tara Burra, MA, MD, FRCPC; Aditya Nidumolu, MD; Andrea Waddell, MD, MEd, FRCPC
CanMEDS Roles:

1. Medical Expert
2. Scholar
3. Collaborator

At the end of this session, participants will be able to: 1) Identify and apply common quality improvement (QI) tools to analyze a quality problem; 2) Write an aim statement and select a team for a QI project; and 3) Describe and apply the QI model for improvement, including plan-do-study-act cycles, to a clinical case.

Continuous quality improvement (CQI) and patient safety training has become a top priority for residency training programs. The launch of Competence by Design in Canada, along with new accreditation standards for residency programs, has led to the increased demand for CQI training resources in psychiatry residency programs. However, many clinician-educators have not been trained in QI. This course aims to help address this gap by teaching clinicians core QI principles relevant to both their own practice and the supervision of trainees. First, participants will be introduced to core CQI concepts, including the dimensions of healthcare quality, principles of patient safety, approaches to picking a quality problem, and strategies to build a QI team (including trainees). In small groups, they will learn to apply common CQI tools, such as process maps, Ishikawa diagrams, aim statements, CQI measures, and plan-do-study-act cycles, to a clinical case. Just-in-time feedback provided by small group facilitators and peers will help participants identify various approaches to analyze and solve quality gaps.

Structure:
1) Presenter 1: Didactic introduction to CQI covering the Institute for Healthcare Improvement model
2) Breakout 1: Root cause analysis using fishbone to understand suboptimal physical health monitoring of mental health patients on atypical antipsychotic medications
3) Big group discussion
4) Presenter 2: Overview of CQI methods and tools
5) Breakout 2: Develop an aim statement, think about the team members for this QI project, and identify change ideas to improve the physical health monitoring in the above patients
6) Big group discussion

References:


Course
C04 - Co-Occurring Autism Spectrum and Obsessive–Compulsive Disorder: A Review and Synthesis of Diagnosis, Treatment, and Clinical Considerations
Thursday, Oct. 19
14:30 - 15:30 (1 hr)
Meeting Room: TBC
Rahat Hossain, MD; Alex Porthukaran, PhD; Peggy Richter, MD; Natasha Fernandes, MD; Pushpal Desarkar*, MD

CanMEDS Roles:

1. Medical Expert
2. Scholar
3. Leader

At the end of this session, participants will be able to: 1) Develop a detailed knowledge of the assessment and treatment for both autism spectrum disorder (ASD) and obsessive–compulsive disorder (OCD); 2) Learn to navigate challenges in the diagnosis and misdiagnosis of co-occurring
Co-occurring obsessive–compulsive disorder (OCD) in people with autism spectrum disorder (ASD) requires specialized assessment and management, given evidence of poorer insight, greater functional impairment, increased symptom severity, and reduced efficacy of treatment. This course will help participants better understand and learn to manage these co-occurring conditions. OCD and ASD can be differentiated on the basis of their respective repetitive behaviours, whereby in OCD they are egodystonic and resisted and in ASD they are egosyntonic and pleasurable. Even so, there is limited understanding of the function and mental state behind OCD repetitive behaviours in ASD, as obsessions are uncommon in ASD and there are altered and ambiguous presentations of OCD in those with ASD. The Obsessive-Compulsive Inventory-Revised (OCI-R) is a brief self-reported measure validated for use in verbal adults to help differentiate between ASD and OCD. Treatment with pharmacotherapy remains under-investigated, with only fluoxetine showing promise for OCD in children and youth with ASD. Treatment with standard CBT programs for OCD have reduced efficacy in people with OCD and ASD; however, adapted CBT programs for ASD and OCD can result in large effect sizes and gains may persist for up to 11 years. Some adaptations to CBT for OCD in people with ASD include focusing on exposure and response prevention rather than cognitive elements, using the individuals’ own special interests to promote engagement, and presenting information visually rather than verbally. Participants will be equipped with a review of this literature, expert opinion, and pearls for their clinical practice.

References:


Symposium
S04 - Cognitive-Behavioural Therapy Group Medical Visits: From Shared Care Pilot to Successful Provincial Spread
Thursday, Oct. 19
14:30 - 15:30 (1 hr)
Meeting Room: TBC
Joanna Cheek*, MD; Erin Burrell, MD

CanMEDS Roles:

1. Collaborator
2. Collaborator
3. Leader

At the end of this session, participants will be able to: 1) Outline the steps that enabled a rapid increase in accessibility of publicly funded self-management skills training for mental health; 2) Compare virtual versus inperson experiences, including symptom changes, satisfaction ratings, and preferences for group medical visits; and 3) Describe how cofacilitating is an efficient and valuable way to train primary care providers to run mental health group medical visits.

Psychiatrists trained family physicians to deliver manualized eight-week cognitive behavioural therapy–based skills groups, addressing the unmet need for early intervention for people with depression and anxiety. The program served over 5,100 patients with inperson groups from 2015 to 2019 in large urban centres in British Columbia, with up to 34 groups running in a given month, by 19 physicians. A centralized referral centre was the key to a lean, economically sustainable administrative structure. It increased participant acceptability as they could choose between various group offerings. In 2018, a nonprofit society was formed to administrate the program, financially
sustained through overhead physician payments, no-show fees, and the health authority funding an administrative assistant. When the COVID-19 pandemic began in 2020, the team pivoted to telehealth. Virtual groups were offered within a week, and a comparable-sized program resumed within three months. Quality improvement data indicated patient improvements and satisfaction ratings comparable to those obtained with inperson groups. Many patients reported that the telehealth format was preferred or made the groups accessible for the first time. Shared care funded the provincial spread of the program, with experienced physician facilitators able to train new physicians in distant communities virtually through cofacilitation. With expansion and funding, the group prioritized equity, diversity, and inclusivity as key values, with many learnings along the way. More than 10,000 patients have now been served, and virtual groups will remain part of the ongoing program, postpandemic.

References:


Workshop
W06 - Capacity Building to Address the Trauma Care Gap: Spread and Scale of 3MDR in the Canadian Context
Thursday, Oct. 19
14:30 - 15:30 (1 hr)
Meeting Room: TBC
Lisa Burbach*, MD; Eric Vermetten, MD; Lisa Burbach, MD; Suzette Bremault-Phillips, PhD; Olga Winkler, MD

CanMEDS Roles:
1. Medical Expert
2. Health Advocate
3. Scholar

At the end of this session, participants will be able to: 1) list and appreciate barriers to recovery from PTSD, 2) describe the components of 3MDR and how they represent psychotherapy innovation for PTSD and 3) consider how scale and spread of 3MDR within the public health system may address care gaps and issues of equity, diversity and inclusion.

Posttraumatic stress disorder (PTSD) is a complex disorder with contributions from genetics, premorbid developmental and adverse experiences, stress sensitization, altered neurocircuitry and neurohormonal responses, and contextual aspects of trauma. World events, such as the COVID-19 pandemic, war in the Ukraine, mass shootings, and civil unrest globally have highlighted the need for effective treatments to address trauma’s consequences, including PTSD. However, multiple barriers contribute to successful recovery, and many patients with PTSD suffer from chronic and debilitating symptoms despite receiving first line therapies, demonstrating the need for treatment innovation. Further, there is a need to address issues of equity, diversity and inclusion (EDI) limiting access to and engagement with trauma focused psychotherapy.

Multi-modal Motion-assisted Memory Desensitization and Reconsolidation (3MDR) is a brief, novel, virtual reality assisted therapy, which targets factors linked to treatment failure, including avoidance. Initially successfully trialed in military populations, work is underway to study its use in civilian populations and to embed this treatment within mental health clinics. This workshop will introduce this psychotherapy innovation, review the current evidence base and then focus on current efforts to scale and spread 3MDR within the Canadian public health care system. This includes establishing and evaluating a training program for therapists within community clinics. Opportunities to address EDI imbalances will also be discussed. Presenters include COL (ret'd) Eric Vermetten, MD, PhD, an
internationally recognized expert in PTSD, who is also the creator of 3MDR, as well as Canadian researchers conducting 3MDR studies in Edmonton, Alberta.

References:


Workshop W07 - Induction Without Withdrawal: Low-Dose Buprenorphine Inductions
Thursday, Oct. 19
14:30 - 15:30 (1 hr)
Meeting Room: TBC
Pouya Azar*, MD; Pouya Azar, MD; James Wong, MSc; Nick Mathew, MD, MSc; Martha Ignaszewski, MD
Supported by the Addiction Psychiatry Section

CanMEDS Roles:

1. Health Advocate
2. Scholar
3. Medical Expert

At the end of this session, participants will be able to: 1) Use buprenorphine/naloxone low-dose inductions in inpatient and outpatient settings, chronic pain and prescription opioid-tolerant setting, and complex populations, such as geriatric patients, youth, and adolescents; 2) Use buprenorphine/naloxone to rapidly induce patients onto buprenorphine extended release; and 3) Use transdermal buprenorphine to rapidly induce patients onto buprenorphine/naloxone and buprenorphine extended release.

Buprenorphine is the recommended first-line treatment for opioid use disorder due to its similar efficacy and superior safety profile compared to other opioid agonist treatment medications. However, because of its high binding affinity at μ-opioid receptors (μORs) and high lipophilicity, buprenorphine abruptly displaces other opioids from μORs and has persistent but lower intrinsic efficacy at brain μORs, compared with full agonists, which can lead to precipitated withdrawal. To avoid this outcome, patients are instructed to abstain from opioids and experience at least moderate withdrawal before initiating buprenorphine. This requirement of prior withdrawal and risk of precipitated withdrawal, which can lead to treatment dropout, relapse with unregulated opioids, and subsequent overdose, are major barriers to buprenorphine use among patients and health care staff. Low-dose inductions (also known as micro-dosing and micro-inductions) involve administering small, frequent does of buprenorphine, negating the need for a period of withdrawal and opioid abstinence prior to starting treatment and aims to reduce the risk of precipitated withdrawal. Building on the Bernese method, we have developed novel more rapid methods of low-dose buprenorphine inductions. Using practical real-life cases and patient testimonial videos, we will teach low-dose induction techniques (low-dose induction, rapid low-dose induction, ultra-rapid low-dose induction, and rapid transdermal buprenorphine induction) for complex patient populations (e.g., chronic pain, geriatric, child, adolescent) and clinical scenarios (e.g., mechanically ventilated patients, inpatient and outpatient settings).

References:


Symposium
S06 - Eating Disorders: A Quality Standard to Guide Evidence-Based High-Quality Care in Ontario
Thursday, Oct. 19
15:45 - 16:45 (1 hr)
Meeting Room: TBC
Jennifer Couturier*, MD; Kathryn Trottier, PhD; Linda Liu, RN

CanMEDS Roles:

1. Health Advocate
2. Collaborator
3. Medical Expert

At the end of this session, participants will be able to: 1) Identify the nine key opportunities for improving care for people with eating disorders and their caregivers, 2) List first- and second-line eating disorder treatments for adolescents and adults with eating disorders according to evidence and expert consensus, 3) Discuss barriers and gaps in practice to equitably assessing, treating, monitoring and caring for people with eating disorders.

Description: This workshop will provide an overview of the Eating Disorders Quality Standard, emphasizing areas for quality improvement. Each presenter will demonstrate how the various quality statements can be applied to improve care for adolescents and adults with eating disorders, and their caregivers, particularly in relation to promoting equitable access to treatment, transitions from youth to adult services, and evidence-based psychotherapies. Discussion with the audience pertaining to implementation facilitators and barriers will be sought.

Methods: In February 2022, Ontario Health began development of the Eating Disorder Quality Standard. This process included recruiting an expert advisory committee, analyzing available Ontario data, prioritizing outcomes and key topic areas, developing quality statements and indicators, identifying tools and resources to support implementation, and consulting groups of interest. Quality statements and indicators were developed through an environmental scan, guideline review, and public feedback.

Results: The advisory committee prioritized nine areas for improvement including: comprehensive assessment; level of care; transition from youth to adult health care services; psychotherapy; monitoring and medical stabilization; support for family and caregivers; physical, mental health, and addiction comorbidities; promoting equity; and care for people who are not receiving active treatment.

Conclusions: This quality standard is an evidence-based resource outlining what high-quality care looks like. The goal is to help people with eating disorders, and their families and caregivers, understand what high-quality care should look like from clinicians and health care organizations and to encourage these same clinicians and organizations to prioritize improvement efforts and measure success.

References:

Symposium
S07 - MAID and Mental Illness: From Legalization to Implementation
Thursday, Oct. 19
15:45 - 16:45 (1 hr)
Meeting Room: TBC
Peter Chan*, MD, FRCPC, FCPA, iSAM; Ashok Krishnamoorthy, MD FRCPC MRCPsych FA

CanMEDS Roles:

1. Collaborator
2. Communicator
3. Leader

At the end of this session, participants will be able to: 1) List key differences between MAID for physical illness compared to MAID for mental illness; 2) Understand how an oversight process regarding MAID and mental illness can be implemented locally; and 3) Identify safeguards in the assessment and provision of MAID for mental illness.

With proclaiming Bill C-14 in 2016, Canada became one of the few countries in the world offering euthanasia, as coined by the term “MAID” (Medical Assistance in Dying), for those with terminal physical illnesses who are suffering grievously and irremediably. Since then, the criteria for MAID have expanded with Bill C-7 in 2021 to include illness that does not require a reasonably foreseeable death and laid the groundwork for inclusion of those with mental illness as the sole underlying medical condition (MAID-SUMC) by March 2024.

With Bill C-7, debate in the psychiatric community centres on what defines enduring and intolerable suffering, and what constitutes irremediability in the context of chronic mental illness in which symptoms may be potentially remediable with new therapeutic options, social supports, and environmental determinants such as appropriate housing. Recommended safeguards including oversight, as discussed in the 2022 CPA discussion paper and the Federal expert panel report on MAID and Mental Illness report, have been disseminated.

Within Vancouver Coastal Health Authority, a process is being developed to provide regional oversight over MAID-SUMC by designated lead psychiatrists, and to provide education and support for those clinicians whose patient has been deemed eligible. After a brief overview of MAID in Canada in comparison to other countries allowing euthanasia, results of a survey of regional psychiatrists’ opinion on how MAID should be implemented will be presented at this workshop. Participants will be invited to share their experience in grappling with the impending legalization of MAID-SUMC in their region.

References:


Workshop
W07 - Managing Insomnia in Clinical Practice
Thursday, Oct. 19
15:45 - 16:45 (1 hr)
Meeting Room: TBC
Nick Kates*, MBBS, FRCPC
CanMEDS Roles:

1. Medical Expert
2. Communicator
3. Health Advocate

At the end of this session, participants will be able to: 1) Understand the common causes of insomnia and how it may present in primary care; 2) Be able to use a simple framework to assess a sleep problem; and 3) Become familiar with the major approaches to managing sleep disorders.

It has been estimated that up to 60% of Canadian adults do not get sufficient sleep, and insomnia is one of the commonest problems encountered in clinical practice, although rarely the primary presenting problem. Many factors can contribute to poor sleep, including lifestyle, mental health problems, other general medical problems, medications, or primary sleep disorders. This workshop discusses the importance of sleep and the consequences of insufficient sleep and presents a framework for understanding, assessing, and treating commonly encountered sleep problems. It summarizes the five-stage sleep cycle, circadian cycle, and sleep-wake cycle and outlines the different ways these changes can contribute to sleep problems. It differentiates between a primary sleep disorder (e.g., sleep apnoea, narcolepsy, restless leg syndrome, delayed sleep onset disorder) and primary or secondary insomnia and the potential consequences of each of these. It reviews the major causes of insomnia and presents simple questions that can be introduced into any health assessment. It outlines a comprehensive but relatively concise evaluation of a sleep problem and offers simple screening tools, including a sleep log, to assist with this. It then reviews the four major approaches to managing a sleep problem: sleep hygiene strategies, cognitive-behavioural therapy for insomnia, medications, and over-the-counter drugs. Finally, it outlines an approach to managing the four primary sleep disorders listed above and the criteria for referral to a sleep clinic.

References:


Workshop

W09 - Thriving, Not Just Surviving: Exploring Work-Life Balance in Psychiatry
Thursday, Oct. 19
15:45 - 16:45 (1 hr)
Meeting Room: TBC
Nikhita Singhal*, MD; Rhys Linthorst, MD; Tina Guo, MD
Supported by the Members-in-Training & Fellows' Section

CanMEDS Roles:

1. Professional
2. Leader

At the end of this session, participants will be able to: 1) Understand key considerations in maintaining personal well-being during psychiatric training and practice; 2) Identify personal and career-related goals and resources to assist with achieving these; and 3) Develop mentoring relationships with colleagues from a diverse array of geographical and professional backgrounds.

Although we may be aware of the risk of burnout — and often advise patients to strive for an optimal work-life balance, knowing how detrimental overworking can be to one's mental health — it can be extremely challenging to attain or maintain this ourselves during medical training and beyond. This workshop highlights that it is possible to thrive, not just survive, both as a psychiatrist in training and
as a practising psychiatrist.

The session will open with a panel discussion featuring a medical student, a resident, several early career psychiatrists (ECPs), and a more senior staff psychiatrist that resident facilitators will moderate. The panel discussion will address important questions surrounding physician wellness and factors that might contribute to preserving a positive outlook on professional duties and career development. General thematic areas will include the unique challenges psychiatrists face, barriers to wellness, and practical strategies to protect against burnout. Consideration will be given to the challenges of maintaining balance at various stages of one’s career trajectory and lifespan, including navigating parenthood. The session will culminate with an open question-and-answer period, during which participants can ask more specific follow-up questions and engage in a deeper exploration of the topics raised.

References:


Workshop
W10 - How to Overcome Procrastination and Increase your Productivity
Thursday, Oct. 19
15:45 - 16:45 (1 hr)
Meeting Room: TBC
Joseph Sadek*, MD, FRCPC, DABPN

CanMEDS Roles:

1. Communicator
2. Collaborator
3. Professional

At the end of this session, participants will be able to: 1) Describe important causes and effects of Procrastination; 2) List some useful steps in increasing work efficiency and overcoming procrastination; and 3) List some scales that are used to assess procrastination.

Procrastination is a prevalent form of maladaptive behavior and self-regulatory failure that is not entirely understood. Some researchers defined procrastination as a tendency to delay important tasks despite the negative consequences. A meta-analysis of procrastination's possible causes and effects showed that strong and consistent predictors of procrastination were “task aversiveness, task delay, self-efficacy, and impulsiveness, as well as conscientiousness and its facets of self-control, distractibility, organization, and achievement motivation”. Research guided by self-determination theory has focused on the social-contextual conditions that improve the natural processes of self-motivation and healthy psychological development. This workshop examines the different theories of procrastination, provide a link to different psychiatric disorders and suggests specific management strategies for each specific condition.

References:

Workshop
W11 - Diagnostic and Treatment Considerations for Supporting Physicians with Neurodevelopmental Disorders and Executive Skill Deficits
Thursday, Oct. 19
15:45 - 16:45 (1 hr)
Meeting Room: TBC
Elisabeth Baerg Hall*, MD, CCFP, FRCPC; Doron Almagor, MD, FRCPC

CanMEDS Roles:
1. Professional
2. Health Advocate
3. Medical Expert

At the end of this session, participants will be able to: Identify diagnostic features in Adult ADHD and related neurodevelopmental comorbidities such as ASD. Evaluate factors that contribute to delayed diagnosis of neurodevelopmental disorders in adults who are intelligent, hardworking and persistent. Consider challenges faced by physicians with ADHD and offer practical strategies for supporting Executive Function skills and patient care.

Despite advances in the science of ADHD and its comorbidities, biases and misunderstandings prevail, causing needless suffering and potential harm. The science is clear; individuals with high intelligence are diagnosed with ADHD and comorbidities like ASD later in life than those with average or lower IQ. High intelligence paired with high persistence can further obscure diagnostic clarity.

Success in the medical profession requires high intelligence and impressive grit. Work is unrelenting—with never catching up feeling common and difficult patient exchanges happening to everyone at times. In this context of shared expectations, smart, hard-working physicians are at high risk for remaining undiagnosed and untreated when their own neurodevelopmental differences exist, making a tough job even harder. Astute diagnosticians may also fail to recognize challenges in themselves given limited insight consistent with disorders that compromise frontal lobe functioning. New diagnoses can bring new challenges as well. Physicians may feel perplexed by their inability to function at expected levels, leading to potential shame, doubt, anxiety or depression in the wake of unexpected news delivered later in life.

In this workshop, we’ll use video segments, discussion, and didactic case-based approaches to review key diagnostic features of ADHD and ASD. We’ll provide a practical lens for diagnosing neurodevelopmental disorders in adults and discuss diagnostic and treatment approaches for physicians challenged by these conditions. We’ll also share practical strategies and preliminary data from a British Columbia initiative for supporting Executive Function skills in physicians with ADHD and related comorbidities.

References:

Research Poster Session I
Thursday, Oct. 19
15:45 – 16:45 (1 hr)
Meeting Room: Junior Ballroom AB Foyer (3rd floor, North Tower)

Welcome Reception
Thursday, Oct. 19
17:00 – 19:00 (2 hrs)
Meeting Room: Pavilion Ballroom Foyer (3rd floor, North Tower)
All registered delegates welcome.
Poster Sessions

Thursday, October 19
As of Jul. 31, 2023

Early Investigator Poster Session I

Poster - Early Investigator
PE01 - A Review of Clinical Practice Guidelines for the Treatment of Borderline Personality Disorder in Anticipation of Medical Assistance in Dying
Thursday, Oct. 19
10:45 - 11:45 (1 hr)
Meeting Room: TBC
Hira Aslam*, MSc

CanMEDS Roles:
1. Medical Expert
2. Scholar

At the end of this session, participants will be able to: 1) Understand the background of medical assistance in dying (MAiD) where mental illness is the sole underlying condition (MI-SUMC) in Canada; 2) Understand the role of clinical practice guidelines in determining MAiD eligibility; and 3) Appreciate the current state of evidence for borderline personality disorder treatment and how this interfaces with decision making for MAiD eligibility in Canada.

Countries permitting assisted dying for mental illness as the sole underlying condition (MI-SUMC) find that people with borderline personality disorder (BPD) constitute a significant proportion of people requesting MAiD (i.e., Thienpont et al., 2015). Anticipating changes to Canadian MAiD legislation, clinical practice guidelines will be important in the decision-making process for MAiD eligibility to ensure that evidence-based treatments have been exhausted in determining irremediability (Mehlum et al., 2020). Currently, no Canadian treatment guidelines for BPD exist. This study was a systematic review of international, English-language treatment guidelines for BPD with two primary objectives: First, to identify areas of consensus and disagreement in best practice for the treatment of this disorder, and second, to assess whether the guidelines offered insight into defining irremediable BPD and (or) its management. We performed a systematic review and found only five guidelines in English. Two authors independently performed data extraction on the core components of these treatment guidelines, which was synthesized into a narrative review. This yielded several conclusions: (1) psychological therapies were broadly considered the preferred treatment modality for BPD, but there was no consensus regarding whether any one intervention was preferable; (2) all guidelines felt that pharmacotherapy might have a role in the management of BPD, but the nature and extent of this were disputed; and (3) there was no guidance alluding to, defining, or commenting on the management of irremediable BPD. The implications of these findings for MAiD for MI-SUMC in Canada are discussed.
References:


Poster - Early Investigator

PE02 - Changes in Adult Psychiatric Inpatient Admissions and Length of Stay During the COVID-19 Pandemic: Results From a Large Urban Hospital Setting

Thursday, Oct. 19
10:45 - 11:45 (1 hr)
Meeting Room: TBC
Angela Russolillo*, PhD; Michelle Carter, MSN; Pulkit Singh, MD; Julia Raudzus, MD

CanMEDS Roles:

1. Scholar
2. Professional

At the end of this session, participants will be able to: 1) Discuss changes in psychiatric admissions before and during COVID-19; 2) Identify factors related to the length of hospital stay before and during COVID-19; and 3) Discuss how systems of care must adapt to changing acute care use patterns for psychiatric populations.

The COVID-19 pandemic placed unprecedented stress and fear on people, which may have impacted patterns of seeking psychiatric care. We describe patient characteristics and compared admissions and length of stay (LOS) for psychiatric-related hospitalizations before and during the COVID-19 pandemic.

Methods: A retrospective analysis involving health administrative data among people in Vancouver with an acute psychiatric admission were compared between two periods: March 1, 2019, to December 31, 2019 (pre-COVID); and March 1, 2020, to December 31, 2020 (during-COVID). Multivariable negative binomial regression was used to model the association between diagnosis type and the two periods to hospital LOS.

Results: The cohort comprised 989 people who were predominately male (60.3%) and with a severe mental illness (schizophrenia or mood affective disorder; 72.7%). In the during-COVID period, admissions related to schizophrenia-related disorders were significantly higher (p = 0.007) and substance disorder admissions were significantly lower (p = 0.015) when compared to the pre-COVID period. In the multivariable analysis, anxiety disorders (relative risk [RR] 0.63, confidence interval [CI] 0.4 to 0.99) and adult personality (RR 0.52, CI 0.32 to 0.85) disorders were significantly associated with a shorter length of stay when compared to people without those disorders at the pre- and during-COVID periods.

Conclusion: We observed a significant difference in the type and length of admissions for various psychiatric disorders during the COVID-19 period. These findings will support how systems of care must adapt to changing use during the pandemic and inform pandemic-related strategies and interventions for psychiatric populations.

References:

Poster - Early Investigator
PE03 - Characterizing the Relation Between Psychosis and Violence in the Forensic Psychiatry Population: A Scoping Review
Thursday, Oct. 19
10:45 - 11:45 (1 hr)
Meeting Room: TBC
Angad Singh*, BHSc; William Pereira, BHSc; Sapriya Birk, BHSc; Rhys Linthorst, MD; Gary Chaimowitz, MB ChB; Andrew Olagunju, MBBS PhD

CanMEDS Roles:

1. Medical Expert
2. Health Advocate
3. Scholar

At the end of this session, participants will be able to: 1) Describe the prevalence and known risk factors for violence in the forensic population; 2) Better understand the relation between psychosis and violence in forensic psychiatry; and 3) Incorporate key factors that mediate the relation between psychosis and violence into risk assessment.

Violence is prevalent in forensic psychiatry and comprises an integral component of risk assessment. While many studies report that psychosis has an important role in precipitating violence, less is known about mediating variables that underlie their relationship. This scoping review characterizes the relation between psychosis and violence in forensic psychiatric studies and proposes recommendations for risk assessment and management.

Methods: Following PRISMA guidelines, we searched five databases, using keywords for violence, psychosis, and forensic psychiatry. After removing duplicates, our search yielded 914 articles that are currently undergoing data extraction. All articles are screened by two reviewers and conflicts are resolved by a third reviewer.

Results: Preliminary findings indicate that forensic patients with psychosis are more likely to be convicted of violent offences and may perpetrate further violence if not mitigated. Further, psychotic symptoms in conjunction with a constellation of personal and external factors underlie the association between psychosis and violence. Many variables, including specific psychotic symptoms, comorbid disorders, concurrent substance use, personality traits, neurobiological changes, environmental exposures, and demographic factors have been shown to mediate this relation. Importantly, these mediating variables differ based on the type of violence and between forensic and non-forensic patients with psychosis.

Conclusion: Psychosis is an important predictor of violence. Conducting a comprehensive assessment of psychotic symptoms in forensic patients requires an integration of other factors to contextualize symptoms. The audience will have learned about key factors that underlie the link between psychosis and violence and methods to incorporate them into risk assessment and management.

References:


Poster - Early Investigator
PE04 - Cultural Humility Training: A Detailed Look at Existing Literature to Increase Cultural Safety in Today’s World
Thursday, Oct. 19
CanMEDS Roles:

1. Collaborator
2. Communicator
3. Professional

At the end of this session, participants will be able to: 1) Deepen their understanding of key concepts in cultural humility, cultural safety, microaggression, and health inequities experienced by racialized patients; 2) Differentiate between the different ways of teaching cultural safety and cultural awareness; and 3) Identify the needs regarding cultural safety in medical training.

Cultural competence has been the gold standard of health care practice with multicultural populations. However, given the limitations of the cultural competence framework, as an alternative, integrating cultural humility into postgraduate training for health care professionals in Canada is a necessary step for providing the highest quality of care to diverse populations.

Method: The present systematic scoping review aimed to assess the advances in integrating cultural humility into postgraduate education in Canada. We studied existing educational models and pertinent literature to identify key concepts related to this topic. The demographic region, year, participants, and evaluation method are extracted from these publications, consulted from July 2022 to January 2023. Data sources were PubMed, ScienceDirect, and MEDLINE.

Results: This paper discusses the integration of cultural humility in medical residency training in Canada. We discern cultural humility from the various way of teaching different concepts. This review demonstrates that teaching related to cultural humility in the Canadian psychiatry residency curriculum is minimal. The search identified at least 32 articles that specifically related to cultural humility in the training of health workers. Multiple studies underline the importance of implementing a curriculum around cultural humility, but the same studies highlighted the difficulty of it.

Conclusion: This literature review provides learners and health care professionals with tools to understand the different ways of thinking and methods used worldwide concerning cultural diversity that can be applied in Canada.

References:


Poster - Early Investigator
PE05 - Evaluating the Efficacy of Cognitive–Behavioural Therapy for Social Anxiety Comorbid with Psychiatry in an Early Psychosis Population
Thursday, Oct. 19
10:45 - 11:45 (1 hr)
Meeting Room: TBC
Tara Gralnick*, Ph.D.; Larry Baer, PhD (C. Psych); Sandi Johnson, MHI; Asees Dhinsaa, BSc; Brian Cooper, M.Sc.(OT); Elmar Gardizi, PhD (C.Psych); Heather McNeely, PhD (C. Psych); Michele Korostil, MD, PhD, FRCPC
Supported by the Psychotherapy Section

CanMEDS Roles:

1. Scholar
At the end of this session, participants will be able to: 1) Better understand the complex relation between social anxiety and psychosis and the clinical features associated with co-occurring social anxiety and psychosis; 2) Appreciate the need to explicitly address this comorbidity in treatment contexts; and 3) Gain exposure to a recently developed group cognitive-behavioural therapy for social anxiety treatment intervention designed specifically for people with psychosis and learn about its efficacy.

Social anxiety (SA) is a significant clinical issue in people with psychosis-spectrum disorders, with prevalence rates of SA in this population up to five times that of the general public. People with both SA and psychosis have been found to experience increases in depression and a reduced quality of life, compared to those with psychosis alone. In light of the negative prognostic implications and unique clinical features associated with co-occurring SA and psychosis, it is relevant to explicitly target this comorbidity in treatment. Yet, many existing cognitive-behavioural therapy (CBT) interventions for SA are not tailored to the unique needs of people experiencing psychosis. CBT for SA comorbid with psychosis (CBT-SAP) is a recently developed group treatment intervention designed specifically for people with psychosis. Key elements of the intervention involve addressing hallucinations and delusions in the context of SA exposures and acknowledging the role of self-stigma in promoting SA. The intervention, however, has yet to be evaluated in a randomized controlled trial design. This study evaluates the efficacy of CBT-SAP in patients enrolled in early psychosis clinics experiencing significant SA symptoms. The study is currently in progress, with 44 participants anticipated to be randomized to receive either CBT-SAP (delivered virtually) or treatment as usual. Participants complete measures of SA, self-stigma, and self-compassion at pretreatment, midtreatment, and posttreatment. Results will be available at the time of presentation. Anticipated findings may inform future research and guide policy decisions about the effectiveness of incorporating targeted treatment for SA in first-episode clinics.

References:


Poster - Early Investigator
PE06 - Increasing Engagement and Reducing Harm: Effective Cannabis and Mental Health Education for Youth

Thursday, Oct. 19
10:45 - 11:45 (1 hr)
Meeting Room: TBC
Kiah Ellis-Durity*, 1

CanMEDS Roles:

1. Health Advocate
2. Collaborator
3. Communicator

At the end of this session, participants will be able to: 1) Meaningfully engage with young people in ways that empower them by amplifying and centering youth leadership and expertise; 2) Demystify and destigmatize topics and discussions relating to cannabis and mental health; and 3) Consider the specific needs of youth who may be at higher risk of experiencing harm from cannabis use.

Participants will understand the benefits of engaging with youth in developing effective and relevant cannabis and mental health resources. Research shows that youth have the highest rates of cannabis use compared to other age groups. Youth are at an increased risk for harms related to use and have generally not received sufficient education on the effects of cannabis.
The Cannabis and Mental Health Project promotes awareness of the relation between mental health and cannabis. Using social media in innovative ways, the project employs evidence-based knowledge translation products to promote balanced, accessible, and youth-centered dialogues about cannabis and mental health.

The project engages with researchers, youth, service providers, educators, and those with lived experience to develop resources anchored in principles of harm reduction. We co-created a barrier-free online certificate course: The Cannabis and Mental Health Course and Mentor Guide for youth and youth workers, in partnership with YouthREX and MHCC.

Our reach has continued to grow, with 58,569 website users and 5,000 or more social media engagements. Evaluations on the efficacy and uptake of our course will be presented at the conference.

Centering lived experience and empowering marginalized voices is essential in our work. We support harder-to-reach youth, especially those who feel their realities aren’t reflected by mainstream public health approaches to cannabis and mental health. The Cannabis and Mental Health Project encourages others to incorporate lived experience and harm-reduction principles in related work, demonstrating the effectiveness of engaging youth in developing mental health and substance use resources.

References:

1. Canadian Cannabis Survey 2022: Summary

Poster - Early Investigator
PE07 - International Consensus Study of Antipsychotic Dosing 2023 Update: ICSAD-2
Thursday, Oct. 19
10:45 - 11:45 (1 hr)
Meeting Room: TBC
Matthew McAdam*, MD; Ross Baldessarini, MD; Andrea Murphy, PharmD; David Gardner, PharmD

CanMEDS Roles:

1. Collaborator
2. Medical Expert
3. Scholar

At the end of this session, participants will be able to: 1) Learn expert dosing recommendations and clinical equivalencies for 26 antipsychotic drugs (15 oral, 7 long-acting injectable, and 4 short-acting injectable); 2) Understand methods used to derive antipsychotic dosing recommendations and how these lead to prominent dosing discrepancies across sources; and 3) Appreciate the role of Delphi survey methodology for establishing consensus.

Dosing discrepancies exist across methods of estimating dosing equivalencies and recommendations for antipsychotic drugs. We aimed to establish dosing recommendations and equivalencies via expert consensus for antipsychotics that have been approved recently and those with dosing discrepancies in the literature.

Using a two-step Delphi process for establishing consensus, we surveyed a broad international sample of research and clinical experts regarding 26 antipsychotic drugs to obtain dosing recommendations (starting, target range, and maximum doses), and estimates of clinical equivalencies.
Participants (N = 72) from 24 countries provided dosing recommendations for treatment of psychotic disorders for 15 oral formulations, 7 long-acting injectable (LAI) agents, and 4 short-acting injectable (SAI) agents. They estimated clinical equivalencies relative to oral olanzapine 20mg daily or intramuscular haloperidol 5mg. Overall consensus improved from Stage I to Stage II of the survey; however, consensus for SAIs remained low.

Randomized controlled fixed-dose antipsychotic trials are useful for establishing dosing guidance but are rare. Expert consensus remains a valuable method to obtain clinical equivalencies and dosing recommendations. These findings may support clinical practice, as well as research design and implementation.

References:


Poster - Early Investigator
PE08 - Online Therapy, Medication, or Both? Comparing the Effectiveness of Different Treatment Modalities for Generalized Anxiety Disorder
Thursday, Oct. 19
10:45 - 11:45 (1 hr)
Meeting Room: TBC
Callum Stephenson*, Gutierrez G, Kumar A, Omrani M, Alavi N

CanMEDS Roles:

1. Health Advocate
2. Scholar
3. Medical Expert

At the end of this session, participants will be able to: 1) Understand the accessibility and scalability benefits of implementing an online psychotherapy program; 2) Understand the differences and similarities between online psychotherapy, medication, and a combination of the two when treating anxiety disorders; and 3) Understand the importance of patient preference and lifestyle when building a treatment plan.

This study investigated the treatment efficacy of electronic cognitive-behavioural therapy (e-CBT) compared to and in conjunction with pharmacotherapy for generalized anxiety disorder (GAD). This study employed a quasi-experimental design, where patients selected their preferred treatment modality in consultation with their psychiatrist. Patients diagnosed with GAD were enrolled in one of three arms: e-CBT, medication, or combination. The twelve-week e-CBT program was delivered through a secure cloud-based digital mental health platform. The medications prescribed in the medication and combination arms followed standard clinical practice guidelines. The efficacy of each arm was evaluated with clinically validated questionnaires that measured depression, anxiety, and stress severity, as well as changes in quality of life. All three arms showed significant improvements in anxiety questionnaire scores after treatment. The medication and combination of arms provided substantial improvements in depression scores. The e-CBT and combination arms significantly improved quality of life scores, and the combination arm also significantly improved stress scores. No significant differences among the groups in depression, anxiety, or stress scores post-treatment. However, the combination arm had a significantly different improvement in quality-of-life scores. A combination of e-CBT and medication offers significant improvements, though not necessarily superior to either arm independently. The findings suggest all three options are viable interventions with similar benefits. When deciding on a treatment modality, it is recommended that the patient’s preferred treatment route, lifestyle, personality, and beliefs be considered.

References:

**Poster - Early Investigator**

**PE09 - Quality Measurement and Improvement for Schizophrenia Care: A Scoping Review**

Thursday, Oct. 19

10:45 - 11:45 (1 hr)

Meeting Room: TBC

Jennifer Anderson*, BSc; Dallas Seltz, MD PhD; David Crockford, MD; Rebecca Barry, MSc PhD; James Bolton, MD; Valerie Taylor, MD PhD; Don Addington, MBBS; Paul Kurdyak, MD PhD; Julia Kirkham, MD MSc

**CanMEDS Roles:**

1. Scholar
2. Professional
3. Leader

**At the end of this session, participants will be able to:** 1) Identify the most common quality indicators for the measurement of schizophrenia care; 2) Describe areas of high and low quality of care in schizophrenia; and 3) Propose evidence-based interventions that may improve identified areas of low quality of care in schizophrenia.

People with schizophrenia routinely receive poor quality health care, such as inadequate routine screening for common cancers, lack of metabolic monitoring with antipsychotic medication use, or undertreatment for such comorbid conditions as cardiovascular disease. The complex underlying issues related to poor quality of care (QoC) in schizophrenia will require multifaceted solutions at each stakeholder level and rigorous evidence-based implementation strategies. Measuring QoC is a necessary first step for improving care. To inform efforts in the measurement and improvement of QoC for schizophrenia at the population level, this study seeks to identify 1) all established quality indicators (QIs) for the measurement of QoC, 2) areas of low and high QoC, and 3) interventions to target improvement of QoC in schizophrenia.

**Methods:** A scoping review following the Arksey and O’Malley framework and reported as per the PRISMA-ScR checklist is underway. Academic databases and grey literature sources were searched for studies reporting QIs, describing QoC, and/or quality improvement interventions for people with schizophrenia. Abstracts, then full texts, were reviewed for inclusion based on eligibility criteria.

**Results:** Academic databases identified 12,216 articles. After full-text screening, 748 academic and 97 grey literature sources were included. Data charting is in progress. Findings will be summarized and synthesized into categories based on the key dimensions of health care quality. Results for objectives 1 and 2 will be presented.

**Conclusion:** Results of this review will comprehensively address QoC, including measurement, persistent quality issues, and quality improvement interventions, in schizophrenia over the past two decades.

**References:**


**Poster - Early Investigator**

**PE10 - Ryan Séguin Peer Support Program: A One-on-One Peer Support Program for Medical Students**

CPA Annual Conference
Posters – Oct. 19, 2023
Last updated: Jul. 31, 2023
Thursday, Oct. 19
10:45 - 11:45 (1 hr)
Meeting Room: TBC
Alexander Simmons*, MD; Kelsey Mongrain, MD; Isabel Shore, MD; Xavier Prinja, BSc; Michael Reaume, MD, MSc
CanMEDS Roles:

1. Health Advocate
2. Leader
3. Professional

At the end of this session, participants will be able to: 1) Understand the prevalence of depression, depressive symptoms, suicidal ideation, and burnout among medical students; 2) Understand the process involved in developing and implementing a one-on-one peer support program for medical students at the University of Ottawa; and 3) Understand the perceived barriers to seeking professional faculty of medicine services compared to peer support services among medical students.

Medical students experience high levels of burnout and face barriers to accessing support services; however, few studies have considered the feasibility and (or) effectiveness of one-on-one peer support programs for medical students. This presentation describes the development and implementation of such a program, the Ryan Séguin Peer Support Program, at the University of Ottawa (August 2018 to June 2020).

Method: Thirty-five medical students were selected to participate in a training course to develop the necessary skills to provide one-on-one support to their peers. The main responsibilities of peer supporters were to reach out to classmates, provide basic counselling, and refer at-risk students to professional services. Information on interactions between students and peer supporters was recorded in an electronic database. An end-of-year survey collected information on barriers to seeking help perceived by medical students.

Outcomes: A total of 303 interactions were recorded. Interactions took place in various formats, including in person, via telephone or video call, and via texting or online messaging. Interactions were initiated by both students and peer supporters. Respondents identified more barriers to seeking help from faculty of medicine services, compared to peer support services, including fear of impact on career (22.2% vs. 2.5%; P < 0.01) and belief the services would not be helpful (42.0% vs. 23.5%; P = 0.02).

Conclusion: We plan to quantify well being through both academic and mental health outcome measures. Future studies should also consider whether peer support services increase help-seeking behaviours and (or) the use of professional services.

References:


Poster - Early Investigator
PE11 - Subjective Cognitive Complaints Impact Treatment Response to Repetitive Transcranial Magnetic Stimulation Among Adults with Treatment-Resistant Depression
Thursday, Oct. 19
10:45 - 11:45 (1 hr)
Meeting Room: TBC
Ayan Dey*, MD/PhD
Supported by the Neuropsychiatry Section

CanMEDS Roles:

1. Medical Expert
2. Scholar
Persistent deficits in cognition are common among adults with major depressive disorder (MDD), with an estimated prevalence between 30% and 50% even among those who have achieved remission of depressive symptoms. (1) Unfortunately, cognitive dysfunction remains overlooked in the diagnosis and treatment of these conditions, despite the negative impact of the deficits on patient-reported outcomes of quality of life and self-rated disability. (2) Subtle cognitive deficits in depression patients may evade detection by traditional tests designed to screen for cognitive decline in older adults. One tool gaining popularity for the treatment of depression is repetitive transcranial magnetic stimulation (rTMS), especially among those who have not fully responded to pharmacological and psychotherapeutic interventions. This study investigates how the presence of patient-reported cognitive deficits impacts antidepressant response to rTMS among adults with MDD. In our sample of 349 adults referred for rTMS, 78.9% and 40.4% of patients reported having moderate to severe attentional deficits and memory complaints, respectively. The presence of subjective cognitive impairment was associated with worse self-reported functional impairment, as measured by the World Health Organization Disability Assessment Scale (p < 0.001). Those without persistent subjective attentional deficits were three times more likely to achieve remission following rTMS than those who reported those symptoms (35.9% vs. 12.8%; p = 0.012). Logistic regression revealed that subjective attentional deficits, but not memory complaints, negatively impacted the likelihood of achieving remission of depressive symptoms following an acute course of rTMS, after controlling for age and medical comorbidity.

References:

Expectations can influence a patient’s response to treatment; however, the extent to which pretreatment expectations influence depression outcomes for patients receiving repetitive transcranial magnetic stimulation (rTMS) is unknown.

Methods: A retrospective single-centre observational chart review of patients receiving open-label rTMS at Sunnybrook Health Sciences Centre between 2019 and 2021 for treatment-resistant depression (TRD) was undertaken. Depressive symptoms were evaluated with the Hamilton Rating Scale for Depression (HAM-D-17). Treatment consisted of rTMS to the left dorsolateral prefrontal cortex (dlPFC) five days a week for four to six weeks. All patients completed the Stanford Expectancy of Treatment Scale (SETS), a measure of both positive (placebo) and negative (nocebo) expectations prior to starting any treatment. The relation between pretreatment expectations (average placebo score, average nocebo score, and the difference between the two, i.e., “positivity bias”), depression remission and drop-out rates with rTMS were explored.

Results: We reviewed records for 130 patients with TRD (60% female, average age 41 years). Following an acute course of rTMS, 26% achieved remission. The likelihood of remission by four to six weeks of treatment was significantly higher for those with higher average positive pretreatment expectations and higher positivity bias (odds ratio [OR] 1.32; 95% confidence interval [CI] 1.05 to 1.66; p = 0.002). Results remained significant after adjusting for age, sex, degree of treatment resistance, TMS protocol, and baseline depression score (p = 0.016). Average nocebo scores were not significantly correlated with drop-out rate.

Conclusions: Positive, but not negative, pretreatment expectations appear to influence the antidepressant outcomes of an acute course of rTMS for TRD.

References:


Poster - Early Investigator
PE13 - The Psychosocial Impact of Long-COVID: A Systematic Review
Thursday, Oct. 19
10:45 - 11:45 (1 hr)
Meeting Room: TBC

Yevin Cha, BMSc., MD; Alyssa Canitelli, HBSc, MHSc; Matthew Tobis, BSc Kin; Ethan Jiang, BSc., MD; Andrew Olagunju*, MBBS, MSc, PhD

CanMEDS Roles:

1. Health Advocate
2. Scholar
3. Communicator

At the end of this session, participants will be able to: 1) Understand the long-term psychosocial outcomes in people with COVID-19 from studies that included negative comparators; 2) Identify potential risk factors for increased psychosocial sequelae after COVID-19; and 3) Understand the general limitations of studies investigating the psychosocial impact of long-COVID.

The World Health Organization (WHO) defined long COVID as occurring within three months of illness onset, with a duration of at least two months (WHO, 2021). However, the psychosocial impact of long-COVID has yet to be well characterized.
Objective: We aimed to characterize the long-term psychosocial impact of COVID-19 and assess the quality of included studies.

Methods: A systematic search of MEDLINE, Embase, PsycINFO, the WHO COVID-19 database, and Cinahl was conducted, and we formulated a descriptive synthesis of long-term psychosocial consequences after COVID-19 infection.

Preliminary Results: A total of 3,894 abstracts and 466 full texts were screened for eligibility, and 18 studies were included. Participants spanned 12 different countries and people of all ages were included. Depression and anxiety were commonly investigated, yet findings were not consistently worse in cases than control subjects. Conversely, chronic fatigue and sleep disturbance was frequently reported among case subjects. Long-term quality of life in cases was adversely impacted in three of four studies. Commonly cited risk factors for worse psychosocial outcomes included severity of the acute COVID-19 infection and female gender. Quality of most studies was moderate to strong; however, the nature of self-report questionnaires and low generalizability increased risk of bias and limited transferability of the findings.

Conclusion: Although some studies suggest COVID-19 infection can lead to long-term psychosocial sequelae, findings were not universal. Moreover, heterogeneity of studies limits direct comparisons and generalizability. Further research with negative comparators and risk factors is needed to guide public health recommendations.

References:


Poster - Early Investigator
PE14 - Trajectories and Risk of Hospitalization for Psychosis Following Psychostimulant Initiation in People with Psychotic Disorder: A Real-World Study
Thursday, Oct. 19
10:45 - 11:45 (1 hr)
Meeting Room: TBC
Olivier Corbeil*, PharmD, MSc

CanMEDS Roles:

1. Medical Expert
2. Scholar
3. Health Advocate

At the end of this session, participants will be able to: 1) Summarize the most recent scientific data concerning safety issues related to the use of psychostimulants in psychotic disorders; 2) Analyze the results of a Quebec population-based study on the risk of hospitalization for psychosis with psychostimulants in psychotic disorders; and 3) Conceive the potential clinical implications of the results presented.

The use of psychostimulants in people with psychotic disorders and attention-deficit hyperactivity disorder (ADHD) is limited by a lack of evidence and long-standing concerns about an increased risk of psychotic events. This study examined whether psychostimulant initiation in these people was associated with an increased risk of hospitalization for psychosis.

Methods: This was a retrospective cohort study using RAMQ data, including all Quebecers who initiated a psychostimulant between January 2010 and December 2016, covered by the public drug
insurance plan. The primary dependent variable was time to hospitalization for psychosis within one year of psychostimulant initiation. A control cohort was composed of control subjects matched for sex, year of birth, and date of first psychosis.

Results: A total of 2,226 people initiated a psychostimulant during the observation period, of whom 1,589 (71.6%) took methylphenidate. Compared with matched control subjects, substance use disorders, personality disorders, and psychotropic drug use were more common. After adjustment, the risk of hospitalization for psychosis was reduced in those receiving an antipsychotic and psychostimulant within one year of starting treatment (adjusted rate ratio 0.36, 95% confidence interval 0.25 to 0.54, p < 0.0001).

Conclusion: These results suggest that psychostimulant use in people with psychotic disorder may be safer than generally conveyed and justify that some patients may benefit from adequate and optimal treatment of comorbid ADHD to support their recovery.

Research Poster Session I

Poster - Research
P01 - "Somebody Pull Me Onto This Life Raft": A Nested Mixed-Methods Cohort Study of Unmet Youth Mental Health Support Needs During COVID-19
Thursday, Oct. 19
15:45 - 16:45 (1 hr)
Meeting Room: TBC
Caitlin Slomp*, MSc; Anna MacLellan, BA; John Best, PhD; Zainab Naqqash, BA; Boyee Lin, BS; Cynthia Lu, BA; Hasina Samji, PhD; S. Evelyn Stewart, MD

CanMEDS Roles:

1. Health Advocate

At the end of this session, participants will be able to: 1) Describe the prevalence of unmet mental health (MH) care needs among Canadian youth; 2) Identify barriers to accessing MH supports during COVID-19; and 3) Describe desired changes to MH supports in Canada from the perspectives of youth and their parents.

Canadian youth experienced profound mental health (MH) impacts and support access challenges throughout the COVID-19 pandemic (Stewart et al., 2023). Given the risk of long-term negative outcomes from unmet MH needs (Malla et al., 2018), it is critical to understand and target access barriers. We used a mixed-methods approach to explore MH needs and support access among Canadian youth during the COVID-19 pandemic.

Methods: The Personal Impacts of COVID-19 Survey (PICS) was administered to parents regarding their youth at baseline (November 2020 to July 2021) and follow-up time points (May to October 2022). Descriptive statistics were applied to key outcome measures: MH supports accessed, unmet MH support needs, and barriers to accessing MH supports. Concurrent qualitative interviews were conducted with select youth and parent proxies and analyzed for themes.

Results: Data from 507 baseline surveys and 88 follow-up surveys were analyzed. Use of MH supports among youth increased over time, though 19% reported an unmet need for formal MH support at follow up. Youth participants described difficulties with waitlists and finding the “right” therapist and a reliance on informal support throughout the pandemic. Parents described significant challenges navigating the MH system (knowing where to get help, limited availability, cost) that profoundly impacted their families’ ability to access care and mitigate negative MH outcomes.
Discussion: Canadian youth and their parents report persistent challenges accessing MH support. Increased clinician availability, school MH supports, parental education, and tools for accessing and navigating the MH system are needed to better support families.

References:


Poster - Research
P02 - A Literature Review of Workplace Violence in Health Care Settings and Effective Solutions
Thursday, Oct. 19
15:45 - 16:45 (1 hr)
Meeting Room: TBC
Brendan Lyver*, HBSc; Rickinder Sethi, MD; Trevor Hanagan, N/A; Christian Schulz-Quach, MD

CanMEDS Roles:

1. Communicator
2. Professional
3. Leader

At the end of this session, participants will be able to: 1) Appreciate the scale of the workplace violence issue in health care settings; 2) Understand effective interventions to address workplace violence, such as agitation management and de-escalation; and 3) Appreciate the effectiveness of code white simulation training as a teaching method for health care providers.

Since the start of the COVID-19 pandemic, many health care institutions have contended with increasingly challenging patient and visitor behaviours taking the form of workplace violence (WPV). Research has reported that the annual rate of WPV-related non-fatal injuries is 10.4 per 10,000 full-time health care workers compared to 2.1 per 10,000 full-time workers for all other private industries combined. Meanwhile, reported WPV rates have more than doubled since the pandemic's start. Literature has provided several solutions to address WPV, including agitation management, de-escalation, and simulated code white scenarios. Many studies have tried to avoid treating agitated patients with physical restraints and involuntary medication and engage in de-escalation techniques instead. Taking a patient-focused approach by determining the etiology of the patient's agitation and their exposure to psychological trauma can be an effective method of de-escalation. Through the education of health care providers, the provision of decision aids, and restraint alternatives, health care institutions have successfully minimized their use of physical restraints. Immersive simulation-based training has demonstrated improvements in health care providers' ability to assess and manage a patient's needs and improve health care providers' verbal de-escalation strategies. Although there are many aspects of addressing WPV in health care settings, providing health care workers with the necessary training to manage and de-escalate agitated patients is an effective starting point.

References:

Poster - Research
P03 - A New Model of Care: A Co-Designed University-Hospital Partnership to Improve Access and Navigation of Acute Mental Health Services for Students
Thursday, Oct. 19
15:45 - 16:45 (1 hr)
Meeting Room: TBC
Andrea Levinson*, MD MSc FRCPC; Kristin Cleverley, RN, PhD, CPMHN; Christina Bartha, MSW, RSW; Sandy Welsh, PhD

CanMEDS Roles:
1. Leader
2. Collaborator
3. Medical Expert

At the end of this session, participants will be able to: 1) Identify key principles of authentic codesign in designing a new service, as it applies to this university-hospital partnership; 2) Learn about the implementation process of the Stepped Care 2.0 model; and 3) Understand key organizational barriers and facilitators arising from the design and implementation of an innovative university-hospital partnership.

In this presentation, attendees will learn about the University of Toronto mental health redesign, including a new hospital partnership to provide students with an acute mental health care navigation pathway. This project integrates Stepped Care 2.0, emerging evidence about mental health navigator roles, and innovative and inclusive approaches to the model's codesign and evaluation. Presenters, which include student affairs professionals, mental health practitioners, faculty researchers, and senior university and hospital leaders, will illuminate the key processes, strengths, challenges, and potential opportunities for replicating the design and evaluation of this innovative model at their institutions. Early data and results will be shared, highlighting presenting concerns, transition readiness of students in this new service, key aspects around the consent process, and adoption of measurement-based care. The codesign aspects of the model will be discussed, as well as opportunities for student engagement moving forward.

References:

Poster - Research
P04 - A Scoping Review of Validation Studies for Commercially Available Smartphone Applications for Cognitive-Behavioural Therapy to Treat Insomnia
Thursday, Oct. 19
15:45 - 16:45 (1 hr)
Meeting Room: TBC
Michael Mak*, MD; Armin Rahmani, MD

CanMEDS Roles:
1. Medical Expert
2. Health Advocate
3. Scholar

At the end of this session, participants will be able to: 1) Review the literature and identify digital cognitive-behavioural therapy for insomnia (dCBT-I) applications supported by validation studies; 2) Review the validation studies and highlight the study design; and 3) Identify gaps in dCBT-I validation and potential future areas of development.

References:
Cognitive-behavioural therapy (CBT) remains the first-line treatment for insomnia disorder. Multiple studies have compared CBT for insomnia (CBT-I) with sedative hypnotics and found CBT-I to be equally as effective and durable, with relatively few adverse effects. Unfortunately, access to this intervention remains limited. Digital CBT-I (dCBT-I) aims to address the problem of scale in delivering CBT, traditionally a one-on-one affair.

Many smartphone applications claim to deliver evidence-based CBT-I. The goal of this study is to examine whether smartphone applications are delivering CBT-I through validated methods. We searched the two most popular smartphone application platforms, Google Play and Apple Store, using the search terms "sleep," "insomnia," and "CBT-I." We searched for validation studies for these applications on Google Scholar and included studies conducted in the past ten years. Our second search consisted of reviewing PubMed and Google Scholar for validation studies for CBT-I applications. Our search terms were "CBT-I and smartphone," "CBT-I and application," and "CBT-I and digital." We found a total of twelve applications that claimed to provide English CBT-I for adults. We then searched Google Scholar for validation studies for those applications and identified five studies that met inclusion criteria.

Most smartphone applications focused on insomnia do not follow CBT-I principles. Meditation, relaxing sounds, and relaxation techniques are popular approaches. Of the twelve dCBT-I applications commercially available on Google Play and Apple Store, only five are validated by studies published in peer reviewed journals.

**References:**


**Poster - Research**

**P05 - Developing and Implementing Simulation for Psychiatric Training in Emergency Situations**

Thursday, Oct. 19
15:45 - 16:45 (1 hr)
Meeting Room: TBC
Yunlin Xue*, MD

**CanMEDS Roles:**

1. Communicator
2. Medical Expert
3. Leader

**At the end of this session, participants will be able to:** 1) Understand the role of simulation training in helping psychiatry residents bolster confidence in Code White and Blue; 2) Learn about the process of simulation design in psychiatry education; and 3) Consider the broader potentials of simulation training in psychiatric education.

Psychiatry residents are often first responders to agitated (Code White) and medically unwell (Code Blue) psychiatric patients. Training in a multisite residency program lacks standardization when a focus is placed on “on-the-job training.” There is often a lack of opportunities to encounter these situations for adequate training. This may compromise resident learning and ultimately patient safety. Simulation has been proven to effectively train medical learners and professionals for high-risk situations in other medical disciplines, with recent data showing similar benefits in psychiatric settings. Objective: We aimed to improve and standardize training for psychiatry residents in Code Whites and Code Blues across six hospital sites.
Method: A committee of residents, simulation centre educators, and psychiatry staff codeveloped and implemented simulation scenarios on Code Whites and Code Blues. Nine residents engaged in a pilot study on a Code Blue (seizures) and Code White simulation, including prereadings, prebrief and debrief, and completion of entrustable professional activities (EPAs). Pre- and post-surveys were conducted to explore resident confidence, comfort, and knowledge when attending to psychiatric emergencies.

Results: A five-point Likert scale was used in pre- and post-surveys. Results indicated improvement in confidence and knowledge after completing the simulation. A total of 87.5% of residents found the debrief provided new insights and learning that they will apply in practice.

Conclusion: We hypothesize that simulation is a promising option for psychiatry residents to develop confidence, knowledge, and comfort in responding to psychiatric emergencies.

References:


Poster - Research
P06 - Effectiveness of a Parent Psychoeducation Intervention to Improve Symptoms in Children with Common Mental Health Disorders: A Systematic Review
Thursday, Oct. 19
15:45 - 16:45 (1 hr)
Meeting Room: TBC
Jenna Nensi*, N/A; Amrita Pannu, MBBS, MHPE; Yan Deng, MD, MSc; Sarosh Khalid-Khan, MD, DABPN, FRCPC

CanMEDS Roles:

1. Medical Expert
2. Communicator
3. Health Advocate

At the end of this session, participants will be able to: 1) Review parent psychoeducation to improve symptoms in children with common mental health disorders; 2) Identify the effectiveness of parent psychoeducation to guide treatment of youth with mental health disorders; and 3) Determine psychoeducation treatment recommendations of youth with mental health disorders.

Current practice guidelines for the treatment of youth with psychiatric disorders include integrating pharmacological treatment with psychosocial interventions. This systematic review will determine the effectiveness of psychoeducation as a treatment modality for parents of children with mental health disorders.

Method: The authors searched databases such as MEDLINE, Embase, PsycINFO, and EBM reviews. Using various keywords and subheadings, the search was divided into four concepts: psychoeducation, parenting, mental disorders, and child/adolescent psychiatry. Based on the predetermined inclusion and exclusion criteria, 19 journal articles were finalized from an initial result of 1,179 articles. Covidence Systematic Review was used for article screening and data extraction. Cochrane risk-of-bias in randomized trials (RoB 2) was used for risk-of-bias assessment. Due to the heterogeneity of the study measurement, the included studies were classified into different themes. Review Manager 5.0 was used to compare the effectiveness of psychoeducation versus the control group.
Outcomes: Because all the included studies were randomized controlled trials, we expected the risk-of-bias to be low to medium. We hypothesized that the participants who received psychoeducation would have more knowledge of the diseases than the control group and that patients in the study group have an improvement in mental health symptoms.

Conclusion: In summary, psychoeducation has been used as a treatment modality for parents of children with mental health disorders. Using the data collected from this systematic review, the effectiveness of parent psychoeducation will be measured to guide future treatment of youth with mental health disorders.

References:


Poster - Research
P07 - Efficacy and Safety of Aripiprazole Augmentation in Schizophrenia: A Meta-Analysis of Randomized Controlled Trials
Thursday, Oct. 19
15:45 - 16:45 (1 hr)
Meeting Room: TBC
David Kim*, PhD. Alasdair Barr, PhD; Randall White, MD; William Honer, MD; Ric Procyshyn, PharmD, PhD

At the end of this session, participants will be able to: 1) Understand how dopamine D2 receptor partial agonism may have additional clinical benefits in patients with schizophrenia; 2) Acknowledge the lack of evidence for dopamine D2 receptor partial agonists other than aripiprazole; and 3) Acknowledge the need for more studies to generalize our findings to treatment-resistant patients.

Background: Antipsychotic polypharmacy is a common practice in the treatment of schizophrenia, despite the need for more evidence for its efficacy and safety. A systematic review and meta-analysis was conducted to better understand the efficacy and safety of dopamine D2 receptor partial agonist augmentation in patients with schizophrenia.

Methods: Randomized controlled trials that compared the efficacy (overall, positive, negative, and depressive symptoms) and safety (trial discontinuation, akathisia, prolactin levels, and body weight) between antipsychotic monotherapy and D2 partial agonist augmentation (aripiprazole, brexpiprazole, and cariprazine) in patients with schizophrenia were included. Standardized mean differences (SMDs) and risk ratios (RRs) were calculated with random-effects models.

Results: Sixteen studies with 1,299 patients were included, all involving aripiprazole augmentation (mean dose = 11.4 mg/day; mean duration = 12.3 weeks). Compared with monotherapy, aripiprazole augmentation demonstrated a greater reduction in overall [n = 14, SMD = −0.45 (−0.70 to −0.19)] and negative symptoms (n = 9, SMD = −0.41 [−0.68 to −0.15]), but not positive (n = 7, SMD = −0.41 [−1.54 to 0.73]) or depressive symptoms (n = 4, SMD = −0.08 [−0.28 to 0.11]). Moreover, aripiprazole augmentation significantly reduced prolactin levels (n = 10, SMD = −1.24 [−1.69 to −0.80]), and there were no significant changes in the incidence of trial discontinuation or akathisia, or in body weight. Meta-regression analyses revealed that longer trial durations were associated with higher all-cause discontinuation rates (p = 0.029), and higher baseline prolactin levels were associated with greater reductions in their levels (p = 0.049).

Conclusions: Our meta-analysis suggests that aripiprazole augmentation is efficacious and safe in patients with schizophrenia. Future studies should examine the effects of other D2 partial agonists (brexpiprazole and cariprazine).

References:


Poster - Research
P08 - Impact of the COVID-19 Pandemic on the Health of People with Intellectual Disability: A Systematic Review
Thursday, Oct. 19
15:45 - 16:45 (1 hr)
Meeting Room: TBC
Anupam Thakur*, MBBS, MD, MSc; Laura Koch, BSc; Sabrina Campanella, BSc; Amandi Perera, BSc
CanMEDS Roles:

1. Scholar
2. Health Advocate
3. Collaborator

At the end of this session, participants will be able to: 1) Understand the impact of COVID-19 on the mental health of adults with intellectual and developmental disabilities; 2) Discuss the impact of COVID-19 on the physical health of adults with intellectual and developmental disabilities; and 3) Discuss the psychosocial impact of the COVID-19 pandemic on adults with intellectual and developmental disabilities.

The COVID-19 pandemic has negatively impacted the physical, social, and mental well being of people with intellectual disability (ID), largely due to pre-existing health conditions, mental illness, cognitive challenges, social exclusion, and inequities in pandemic response plans.

Objectives: This systematic review explores the health and psychosocial impact of the COVID-19 pandemic on adults (aged 18 years and over) with ID.
Methods: A review protocol and search strategy following PRISMA guidelines were compiled and registered with PROSPERO. Following full-text screening by two independent reviewers, a total of 62 articles have been reviewed.

Results: Studies included in the review present data from various perspectives, such as formal and informal caregivers, and direct accounts from people with ID, as well as administrative health data. Preliminary findings highlight the vulnerability of people with ID to COVID-19, as this population experienced higher hospital and ICU admissions and increased mortality compared to people without ID. This population was more likely to become infected with COVID-19 if they lived in a congregate setting, had poor access to or difficulty wearing personal protective equipment, and required close-contact care. Overall, the pandemic has led to poor mental and physical health, loss of skills, increase in behaviours that challenge, and a loss of social supports and community engagement.

Conclusion: People with ID were disproportionately impacted by the COVID-19 pandemic. Responsive pandemic recovery solutions require the meaningful inclusion of the perspectives of people with ID and their caregivers, given their unique experiences throughout the past few years.

References:


Poster - Research
P09 - Improving Access to Peripartum Depression Treatment: Identifying Barriers and Facilitators
Thursday, Oct. 19
15:45 - 16:45 (1 hr)
Meeting Room: TBC
Huda Al-Shamali*, BSc; Margot Jackson, PhD; Nataliia Zinchuk, MD; Setayesh Modanloo, MSc; Gina Wong, PhD; Bo Cao, PhD; Lisa Burback, MD; Xin-Min Li, PhD; Andrew Greenshaw, PhD; Yanbo Zhang, MD, PhD

CanMEDS Roles:

1. Collaborator
2. Health Advocate
3. Scholar
At the end of this session, participants will be able to: 1) Identify barriers that prevent patients with peripartum depression from receiving treatment; 2) Become aware of possible strategies/initiatives to improve patients with peripartum depression’s access to treatment; and 3) Better understand what repetitive transcranial magnetic stimulation (rTMS) treatment is.

Peripartum depression (PPD) is a prevalent and debilitating disorder linked with adverse maternal health outcomes and impaired child development. Medication is considered the first-line treatment for depression, but many mothers are reluctant to receive medication due to side effects and potential negative impacts on their children. Repetitive transcranial magnetic stimulation (rTMS) is a non-pharmacological treatment that is safe and effective; however, few patients with PPD are receiving rTMS treatment. In this study, we will use a mixed-method design to identify barriers and facilitators that may impact a person with PPD’s ability to receive treatment in general and rTMS treatment specifically. An equity, diversity, and inclusion (EDI) perspective on sex, gender, and ethnicity will be followed. We created and shared two anonymous five-minute online surveys offered in five languages. One survey is targeted to health professionals, and the second is for people who are currently or have previously experienced depressive symptoms and their families. Additionally, we are conducting interviews and focus groups. Recruitment is currently ongoing. Thus far, we have received 98 completed survey responses and are conducting eight interviews. Of the responses, 77% are people who are currently or have previously experienced depressive symptoms and their families. 4% are family members of PPD patients, and 19% are health professionals. Fifty-five percent of patient responders received treatment for PPD; however, only 16% of responders were aware of the existence of rTMS. There is a need for more education and improved access to available treatment options for PPD.

References:


Poster - Research
P10 - Inflammatory Changes with Repetitive Transcranial Magnetic Stimulation: The Search for Biomarkers of Post-Traumatic Stress Disorder Treatment
Thursday, Oct. 19
15:45 - 16:45 (1 hr)
Meeting Room: TBC
Raechelle Gibson, MD, PhD Meng Wang, MSc Christina Campbell, PT, MSc Alison Wilson, BA, BCOM Chantel Debert*, MD, MSc, FRCPC, CSCN

CanMEDS Roles:

1. Medical Expert
2. Scholar

At the end of this session, participants will be able to: 1) Describe the recent evidence for repetitive transcranial magnetic stimulation as a treatment for post-traumatic stress disorder (PTSD); 2) Identify potential sources of variability pertaining to inflammatory markers for people with PTSD; and 3) Consider future directions and barriers for the identification of biomarkers for PTSD.

Post-traumatic stress disorder (PTSD) is a mental illness associated with a considerable burden of psychiatric and medical comorbidities (Passos et al., 2015). While repetitive transcranial magnetic stimulation (rTMS) may be an effective treatment (McGirr et al., 2021), there are not yet biomarkers for PTSD to help refine treatment (Passos et al., 2015). We investigated whether there is a relation between serum inflammatory markers and PTSD and whether rTMS of the dorso-lateral prefrontal cortex (DLPFC) versus the DMPFC (dorso-medial prefrontal cortex) is associated with inflammatory changes.
Twenty-five adults with PTSD participated in a double-blind, concealed allocation, randomized controlled trial. Participants completed a one-week sham rTMS lead-in followed by a four-week rTMS treatment protocol of either the right DLPFC or DMPFC. Measures of PTSD, quality of life, depression, and 17 cytokines with roles in inflammation were collected at baseline, after sham rTMS, and after treatment rTMS. Analyses included Spearman correlation and partial rank-order correlation coefficients and linear mixed-effect regression. PTSD measures were not significantly correlated with inflammatory markers at baseline (p > 0.17). There was also no relation between cytokines and other measures of mental health at baseline (p > 0.11). Cytokine values did not significantly change over time, and rTMS did not influence changes in cytokines, with and without adjusting for age, sex, and the placebo effect. The relation between PTSD and inflammation is complex, with many potential sources of variance, such as the ictal interval from trauma and head injury; further investigations are needed to delineate the time course of these inflammatory changes.

References:


Poster - Research
P11 - Integrated Care Model for Addiction Services
Thursday, Oct. 19
15:45 - 16:45 (1 hr)
Meeting Room: TBC
Faiza Khalid-Khan*

CanMEDS Roles:

1. Health Advocate
2. Collaborator
3. Scholar

At the end of this session, participants will be able to: 1) Discover ways to reduce emergency department recidivism; 2) Understand the improvement of access and flow; and 3) Understand the full spectrum of addiction services in one place, from high- to lower-intensity needs with no silos.

William Osler Health System Addiction Services focused on program re-design to meet the changing needs of the community. Harm reduction and abstinence-based programs were developed to address these needs. These programs created a full spectrum of services from high to lower intensity. The focus was to reduce emergency department (ED) recidivism and create an integrated care model with no barriers to services or wait times.

To address community need, our addiction services created low-barrier immediate access to comprehensive treatment. Self-referral access to care begins with a phone call to our centralized intake team. Calls are answered live by addiction clinicians who provide support, assessment, and referral throughout our program options. All services work together to provide individualized treatment plans based on clients’ stages of change and readiness. Outpatient services have a range of groups to meet client needs, including workshops, psycho-education, evidence-based cognitive-behavioural therapy skills, and process groups with open admission. We also offer aftercare, support groups, and family programming. A digital behaviour change program (Breaking Free) is integrated throughout the services.

All clinicians are concurrent disorder-capable, which is reflected in the development of all programming. This framework was introduced in 2021 and has continued to evolve. We will present data comparing the current vs. previous siloed approach. These data will compare ED revisit rates,
volumes (number of clients served 1:1, aftercare, and in group settings), attendance, wait times, drop-out rates, and client perceptions of changes.
References:


Poster - Research
P12 - Peripheral Insulin Sensitivity Modulates Effort-Based Behavioural Response to Intranasal Insulin in People with Mood Disorders

Thursday, Oct. 19
15:45 - 16:45 (1 hr)
Meeting Room: TBC
Aniqa Tabassum*, HBSc; Rodrigo Mansur, MD, PhD

CanMEDS Roles:

1. Scholar
2. Collaborator
3. Leader

At the end of this session, participants will be able to: 1) Identify the implications of a bidirectional epidemiological association between mood and metabolic disorders; 2) Understand the role that insulin may play in modulating behaviour in overweight people with mood disorders; and 3) Recognize the underpinnings and implications of a potential neurobiological association between mood and metabolic disorders.

Mood disorders (i.e., major depressive disorder [MDD]) and bipolar disorder [BD]) and metabolic disorders (e.g., type 2 diabetes [T2D]) have a bidirectional epidemiologic association. To uncover mechanisms underlying the mood-metabolic disorders comorbidity, this study investigated the role of peripheral insulin resistance (IR) in effort-based reward behaviour in overweight (body mass index [BMI > 25.0) people with mood disorders. This randomized crossover trial assessed effort-based decision making in 17 participants (10 BD, 7 MDD) using the Effort-Expenditure for Rewards Task (EEfRT) in a functional MRI paradigm after intranasal insulin and placebo. Peripheral interventional radiology (IR) was calculated with the Homeostatic Model Assessment for Insulin Resistance (HOMA-IR). Peripheral IR moderated the behavioural response to intranasal insulin (condition [insulin vs. placebo] by IR interaction: Wald χ² = 10.907, p < 0.001). Insulin-resistant participants (HOMA-IR > 1.3) showed no differences in likelihood of choosing the hard over the easy task on the EEfRT between the conditions (insulin 38%, standard error [SE] = 6.8, placebo 41%, SE = 6.6). In contrast, insulin-sensitive participants (HOMA-IR < 1.3) were more likely to select the hard task in the placebo (67%, SE = 7.3) versus the insulin condition (49%, SE = 7.2). There were no effects of BMI and adjustments for age, sex, Montgomery-Asberg Depression Rating Scale (MADRS) scores and medications did not modify the moderating effect. Insulin-induced differences in reward-seeking behaviour between insulin sensitive and resistant people provides support for a neurobiological association between mood and metabolic disorders. The data collected from fMRI are expected to elucidate potential underlying differences in brain activity.

References:


Poster - Research
P13 - Predicting Child and Youth Mental Health Service Use with Deep Learning Models

Thursday, Oct. 19
15:45 - 16:45 (1 hr)
Predicting adverse outcomes in clinical settings with artificial intelligence (AI) is increasingly common but limited in the field of child and youth mental health. In this study, we investigate the application of deep learning in child and youth mental health service use. We used two sources: i) a set of mental health questionnaires for children and youth and their caregivers and ii) the youth’s history of medical service use (e.g., outpatient, inpatient, and emergency department [ED] visits). Data were extracted from a database of patients aged under 18 years who had their first outpatient mental health intake at the Ron Joyce Children’s Health Centre, McMaster Children’s Hospital, between April 01, 2002, and July 31, 2021. The dataset is heterogeneous as it contains information of different types. We show the effectiveness of deep learning models with questionnaire and service use data in predicting future ED visits. We developed three models: 1) a pre-trained BERT model to extract information from questionnaire and symptom scales and predict six-month ED visits after outpatient intake, achieving area under the receiver operating curve (ROC AUC) of 0.77; 2) a Graph Neural Network (GNN) that uses patient graphs extracted from the medical records to predict 30-day readmission rates with F1-measure of 0.65; and 3) another GNN model that uses questionnaire data to predict six-month ED visits, achieving ROC AUC of 0.78. Although preliminary, these risk predictive models demonstrate potential clinical usefulness and may eventually help inform clinical decisions to prevent negative outcomes.

References:


Poster - Research

P14 - Resident Transition to Practice and Service Impact of a Restricted Registration Resident “Moonlighting” Pilot Project in a Community Hospital Mental Health Department

Thursday, Oct. 19
15:45 - 16:45 (1 hr)
Meeting Room: TBC
Michael Tseng*, MD, PhD, FRCPC; Certina Ho, RPh, BScPhm, MISt, M

CanMEDS Roles:

1. Communicator
2. Professional
3. Scholar

At the end of this session, participants will be able to: 1) Identify the potential impact of a restricted registration resident (RRR) program on service delivery at a community hospital mental health department; 2) Describe the opportunities for improvements in residency training through participation in an RRR program; and 3) Relate lessons learned from the RRR pilot to the Royal College ‘Transition to Practice’ stage of the Competence by Design continuum.
“Restricted registration” (RR) is a College of Physicians and Surgeons of Ontario (CPSO) certificate offered to residents of all specialties across five Ontario medical schools that permits the provision of clinical services for remuneration outside their training program. In March 2021, the North York General Hospital Department of Psychiatry conducted a five-month RR pilot project, where two psychiatry residents were credentialed to provide coverage for 24-hour psychiatry on-call shifts involving child, geriatric, and adult inpatient rounds; consultation and liaison; and emergency department (ED) consultations. Supervision was provided by a staff psychiatrist (the most responsible physician).

This study examined the stakeholder perspectives of the restricted registration resident (RRR) pilot project, given the lack of literature in this area. Stakeholder (residents, supervisors, EDs, and inpatient staff) interviews were completed with a semistructured focus group guide.

The residents noted a significant improvement in Transition to Practice skills, including increased clinical and billing confidence, autonomy, and excellent remuneration. Supervisors found that resident performance met expectations and that they spent less time on-site, compared to non-RRR on-call shifts, with no medicolegal concerns. The ED crisis and inpatient teams noted improved disposition time through ED and inpatient support. Residents noted the workload could be considerable, while supervisors contemplated the effect of the RRR program on-call expectations.

Given the multisource positive feedback to our pilot, the RR program has been opened to qualified University of Toronto residents relevant to the Department of Psychiatry Transition to Practice curriculum. Interest from stakeholders remains promising, with continued opportunity for ongoing quality improvement.

References:


Poster - Research
P15 - Semaglutide for the Treatment of Cognitive Dysfunction in Major Depressive Disorder
Thursday, Oct. 19
15:45 - 16:45 (1 hr)
Meeting Room: TBC
Rodrigo Mansur*, MD, PhD; Joshua Di Vincenzo, MSc.; Andrea McKenzie, HBSc.; Aniqa Tabassum, HBSc.; Hartej Gill, PhD. Candidate; Sebastian Badulescu, HBSc.; Roger McIntyre, M.D.; Joshua Rosenblat, M.D., MSc.

CanMEDS Roles:

1. Scholar
2. Leader
3. Health Advocate

At the end of this session, participants will be able to: 1) Understand the rationale for using semaglutide and other antidiabetes drugs as a potential treatment for cognitive dysfunction in major depressive disorder and the current state of evidence supporting this use; 2) Learn about the design and methodology of the clinical trial, including the sample size, study population, randomization process, and primary and secondary outcome measures; and 3) Describe preliminary results of the trial, including mediators/predictors of cognitive function and depression severity and adverse events.

Evidence suggests glucagon-like peptide-1 (GLP-1) receptor agonists may have cognitive-enhancing effects. In a small randomized placebo-controlled trial, liraglutide was found to significantly improve cognition in patients with major depressive disorder (MDD) (Mansur et al., 2017). Similarly, an open-label trial found liraglutide to significantly improve all included measures of cognitive function in 50 people with type 2 diabetes mellitus, compared to the standard-of-care control group (Li et al., 2021).
Further research is needed to confirm the cognitive-enhancing effects of GLP-1 agonists in MDD and to determine the optimal dosage and regimen. Semaglutide, a GLP-1 receptor agonist, is an effective antidiabetic and weight-loss agent. However, the efficacy and safety of oral semaglutide in people with MDD has not been ascertained. This double-blind, randomized, placebo-controlled trial evaluates the effects of 16 weeks of oral semaglutide on cognitive dysfunction in adults with MDD, with a target enrolment of 60 participants. The sample has been enriched for cognitive dysfunction; only people with impaired executive function at baseline are eligible. The primary outcome measure is change in Trail Making Task B score from baseline to Week 16. Cognitive function is assessed at baseline and weeks 4, 10, and 16, with an additional post-endpoint assessment at Week 20. To date, 23 participants have been enrolled. Secondary outcome measures include change in depressive symptoms, functional impairment, quality of life, and safety. This study will provide insights into the potential role of semaglutide as a treatment for cognitive dysfunction in MDD and will inform future clinical practice.

References:


Poster - Research
P16 - Talk-In, Walk Out: A Hospital-Based Single-Session Counselling Model
Thursday, Oct. 19
15:45 - 16:45 (1 hr)
Meeting Room: TBC
Emma Blake*, MSW, RSW; Shabbir Amanullah, DPM, MD, FRCPsych, Shelly-Lynne Muldoon, MSW, RSW.

CanMEDS Roles:

1. Professional
2. Medical Expert

At the end of this session, participants will be able to: 1) Implement a single-session counselling model to an acute care outpatient hospital setting; 2) Value single-session therapy as an intervention strategy for treating acute patients; and 3) Adapt a new hybrid model of prebooked and same-day walk-in sessions.

Single-session counselling models have been implemented throughout Canada since the 1990s, with most clinics being offered through community-based mental health agencies or fee-for-service family counselling centres. Extensive waitlists for mental health counselling services are common, and offering a single-session or walk-in counselling model has become a popular intervention for managing waitlists. A comparison study revealed that walk-in clients improved quicker after a four-week follow-up and were less distressed than those accessing a traditional counselling model involving a waitlist (Stalker et al., 2016). Acute-care facilities that offer outpatient psychiatric and counselling services are not exempt from these waitlists. Young suggests that organizations must consider that, regardless of the satisfaction of a single session, it is vital that clients know further support may be available. (Young 2020) To manage an ever-growing counselling waitlist for outpatient referrals received from their outpatient psychiatry clinic, this hospital developed and implemented a walk-in counselling model that has changed the landscape of service delivery by increasing collaborative patient care between social work and psychiatry teams, reducing the overall wait time for outpatient counselling services and offering brief follow up to patients if appropriate. Rebranding as a “talk-in” clinic to adapt to the COVID-19 pandemic, this clinic has also implemented a new hybrid model to accommodate patient needs while maintaining the health and safety measures required to operate a clinic within a hospital setting.
At the end of this session, participants will be able to: 1) Gain knowledge about clinical characteristics and treatment approaches in major depressive disorder (MDD) and bipolar disorder (BD); 2) Learn more about clinical and biological markers specific to the assessment, diagnosis, and treatment of patients with MDD and BD; and 3) Learn more about the affects of the insulin-signalling pathway in mood disorders.

Anhedonia and reduced reward response are two hallmark features of mood disorders. Insulin signalling plays a crucial role in the measures of anhedonia and reward behaviours in people with both bipolar disorder (BD) and major depressive disorder (MDD). We hypothesized that people with MDD and BD will display decreased effort in reward response / increased anhedonia, measured by validated behavioural tasks and clinical scales and that the use of intranasal insulin may affect their response.

Methods: Ten eligible BD and seven MDD patients aged 18 to 60 years participated in an ongoing three-week double-blind crossover study with reward-based assessments and questionnaires focusing on behavioural / anhedonic measures. Each participant received an intranasal dose of Humulin R insulin (100 U/mL), and placebo spray, randomized between Week 2 and Week 3. The primary behavioural measurement was an effort-based decision-making task (effort-expenditure for rewards task [EEfRT]), performed inside an fMRI directly after the intranasal spray. This task is designed to measure willingness to exert greater effort to receive a larger reward. Other assessments included the Snaith-Hamilton Pleasure Scale (SHPS), Montgomery-Asberg Depression Rating Scale (MADRS), Young Mania Rating Scale (YMRS), Monetary Incentive Delay, Probabilistic Reward, and four-armed bandit tasks.

Results: Seventeen participants were included in this preliminary analysis. Results indicated that intranasal insulin modulated the reward response in people with mood disorders. There was an overall main effect of condition (insulin vs. placebo) on the likelihood of choosing the hard over the easy task on the EEfRT (Wald χ² = 7.991; p = 0.005). Participants on the insulin condition chose the hard task on average 44% of trials (standard error [SE] = 4.9), whereas on placebo the average was 54% (SE = 5.8). There were no effects on reaction time nor of randomization order or diagnosis. Adjustments for age, sex, MADRS scores, and medications did not modify the main results.

Conclusion: Intranasal insulin was shown to modulate the reward response in people with MDD and BD. Further research will be done to investigate the effects of intranasal insulin in the reward responses of patients with mood disorders.

References:

Poster - Early Investigator PE15 - Treatment Consequences with the Emergence of New Synthetic Opioids: A Rapid Review
Thursday, Oct. 19
10:45 - 11:45 (1 hr)
Meeting Room: TBC
Fiona Choi*, PhD; Jane Kim, BSc; Michael Krausz, MD, PhD
Supported by the Addiction Psychiatry Section

CanMEDS Roles:
1. Scholar
2. Professional
3. Medical Expert

At the end of this session, participants will be able to: 1) Understand how the current system of care is impacted by the emergence of new synthetic opioids; 2) Appraise the quality of available evidence; and 3) Build a framework for treatment strategies moving forward.

Emergency response to overdose, treatment strategies, and withdrawal management from new highly potent synthetic opioids (HPSO) are more complex, and the potential onset of severe withdrawal symptoms and increasing overdose risk calls for better evidence-based practices. The objective of this paper is to review evidence for different levels of care in response to HPSO, appraise the quality of evidence, and discuss the strategic responses needed to better address opiate use disorder and overdose. The literature search was performed with Medline and 46 papers were reviewed: 13 community care, 6 emergency care, 1 primary care, and 26 tertiary care levels. Briefly, different levels of the treatment system have responded to the emergence of HPSO; however, the responses have been reactive and limited evidence is available to support new approaches. For example, new formulations, such as extended-release buprenorphine, offer several advantages over existing pharmacotherapies and efforts should be made to fully explore their feasibility, and similar injectables, in the Canadian context. Evidence suggests baseline prevalence of opioid agonist therapy (OAT) dissatisfaction has increased, potentially due to the high rates of HPSO in the illicit drug supply making it more challenging to stabilize patients on OAT. To adequately respond to the crisis, care providers and treatment guidelines need to expand to address unmet service needs and incorporate patient-centred decision-making in the treatment approach. Most importantly, the value of well-documented results should not be neglected, so that solutions are evidence-based and constructive.

References:
Friday, October 20
As of Jul. 31, 2023

Keynote Plenary
KP02 - A Lens of Equity and Intersectionality on Mental Health: Where Inclusion and Wellness Meet
Friday, Oct. 20
09:00 – 10:30 (1.5 hr)
Meeting Room: Grand Ballroom
Samra Zafar

CanMEDS Role(s)
1. Health Advocate
2. Medical Expert
3. Communicator

At the end of this session, participants will be able to: 1) Recognize how people move on with trauma, not from it, 2) Understand intersectionality and cultural competence in mental health, 3) Identify and navigate systemic barriers to mental health in diverse populations, 4) Identify and recognize privilege to make way for better collaboration and 5) Exhibit true allyship through the power of compassion and empathy.

Abstract
Trauma and mental health challenges are universally prevalent. Yet, the experience of going through these challenges is highly unique due to the intersectionalities that shape our identities, especially when layered with underlying experiences of racism, sexism, shame, stigma and other forms of oppression. When caring for our patients, families, and loved ones, it is imperative to not only empathize with their unique experience, but also meet them where they are to help them feel seen and create a safe space of belonging and healing. In this presentation, Samra Zafar weaves her personal story of healing with trauma with lessons, insights and strategies to help eliminate systemic barriers, knee-jerk reactions to connectivity, and one-size-fits-all approaches to wellness, and instead build inclusive and positively motivating healing environments.

Symposium
S08 - Supporting Effective Use of Digital Mental Health Apps and Websites in Patients and Clinicians
Friday, Oct. 20
10:45 - 11:45 (1 hr)
Meeting Room: TBC
Sagar Parikh*, MD; Andrew Kcomt, B.Pharm.; Erin Michalak, Ph.D.

CanMEDS Roles:
1. Medical Expert
2. Professional
3. Scholar

At the end of this session, participants will be able to: 1) Identify ways to teach clinicians about mental health apps and websites; 2) Clarify key strategies to teach patients and the general public about digital mental health tools; and 3) Identify challenges in teaching digital literacy to patients with bipolar disorder and one solution using a video.
Mental health apps and websites can be effective and complementary to traditional face-to-face care by enhancing help-seeking behaviour and providing immediate treatment. Although such digital tools are widely promoted, little training exists on how to use them. Our symposium describes and evaluates several approaches to using these tools. In the first presentation, Mr. Kcomt will describe the needs survey, learning objectives, and workshop outcomes to teach patients and the general public key digital mental health resources and how to use them. Remarkably, 95.6% of the 113 attendees reported overall high satisfaction. Dr. Parikh will describe three different CME events—a webinar, an online course, and a previous CPA workshop—designed to teach clinicians how to evaluate, choose, and implement digital mental health tools in practice, together with detailed evaluations. Ratings from 247 attendees were high, with 72% indicating immediate use in practice. Dr. Michalak will describe the codevelopment (with people with bipolar disorder) of a digital mental health literacy video and its evaluation. Emphasis will be on the community-based participatory framework used to create the video. These presentations illustrate how to apply various evidence-based education principles and their evaluation. Further, they provide various models of teaching digital tools with different pedagogic approaches for diverse learner populations. Such models invite a broader uptake, with the authors seeking partners for widespread implementation and dissemination of teaching digital mental health tools.

References:


Symposium
S09 - What's New in the Canadian Network for Mood and Anxiety Treatments Depression Guidelines 2023 Update?
Friday, Oct. 20
10:45 - 11:45 (1 hr)
Meeting Room: TBC
Raymond Lam*, MD; Sidney Kennedy, MD; Anees Bahji, MD; Elisa Brietzke, MD, PhD; André Do, MDCM; Lena Quilty, PhD

CanMEDS Roles:

1. Medical Expert
2. Professional
3. Scholar

At the end of this session, participants will be able to: 1) Describe the evidence review process and criteria used for the Canadian Network for Mood and Anxiety Treatments depression guidelines 2023 update; 2) Discuss the limitations of the clinical evidence and the advantages and disadvantages of expert consensus in developing evidence-based recommendations; and 3) Discuss four updated recommendations for managing depression in adults.

The Canadian Network for Mood and Anxiety Treatments (CANMAT) is currently updating the widely cited and internationally used 2016 CANMAT guidelines for the management of major depressive disorder (MDD). The depression guidelines 2023 update retain the familiar CANMAT methodology to evaluate clinical data and present recommendations in a Q and A format, with the updated evidence review focusing on systematic reviews and meta-analyses published since 2015. This new edition includes consensus recommendations from more than 50 Canadian experts in mood disorders representing diversity in region, seniority, expertise, and equity, as well as people with lived experience. The CANMAT depression guidelines 2023 update, to be published in the Canadian Journal of Psychiatry, adopts a person-centred approach organized along the care pathway, from screening and diagnosis to selecting an initial treatment, and providing treatment options for difficult-to-treat and persistent depressive disorders. Co-leads from four of the eight sections will present...
highlights of the depression guidelines 2023 update, with new and controversial recommendations. Sample questions and answers will be used to illustrate the process, including the following: What factors influence choosing specific psychotherapy, pharmacotherapy, or neurostimulation as an initial treatment? What lifestyle and self-management interventions are effective? What is the evidence to support measurement-based care, pharmacogenomic testing, and treatment discontinuation? When in the care pathway should novel therapeutics (e.g., esketamine / ketamine infusion, repetitive transcranial stimulation, psychedelics) be considered?

References:


Symposium
S10 - Managing Complex Patients: What Happens When Standard of Care Fails?
Friday, Oct. 20
10:45 - 11:45 (1 hr)
Meeting Room: TBC
Martin Katzman*, BSc, MD, FRCPC; Irvin Epstein, BSc, MD, FRCPC; Tia Sternat, MS, MPsy, PhD (cand)

CanMEDS Roles:

1. Professional
2. Medical Expert
3. Health Advocate

At the end of this session, participants will be able to: 1) Critically evaluate the appropriateness of nootropics, cannabis, ketamine, and psychedelics as part of a comprehensive treatment regimen; 2) Conceptualize comorbid cases by understanding the shared etiology across disorders; and 3) Consider the incorporation of mindfulness approaches in their practice.

Despite advances in research and pharmacology, most treatment outcomes in psychiatry remain unsatisfactory. The severity of psychiatric illness is often associated with comorbid psychiatric and medical conditions. Up to 34% of people with difficult-to-treat depression may also have undetected attention-deficit hyperactivity disorder (ADHD). Treating severe and highly comorbid cases requires an understanding of underlying neurobiological mechanisms that contribute to shared presentations, including poor sleep, concentration difficulties, or anhedonia. By identifying these mechanisms, targeted approaches may be employed with the aim of improving outcomes in difficult-to-treat cases. This presentation will review the relevant biology of common and overlapping symptoms and how novel therapeutic options might improve psychiatric outcomes. Presenters will consider the potential of nootropics based on the current evidence in psychiatric disorders. The next area of focus will be recent studies of the neurobiology of cannabis, ketamine, and psychedelics in difficult-to-treat cases, highlighting multiple systems of interest, and therapeutic potential based on the self-medication hypothesis. Comprehensive and multimodal care includes the use of mindfulness meditation, which has shown benefits in reducing ruminations, increasing levels of self-compassion and episodes of emotional reactivity. This presentation will additionally address the evidence supporting the structural application and functional benefits of mindfulness. Finally, the speakers will invite the audience for a discussion regarding their conceptualization of complex cases and future directions of novel therapeutics in the context of improving personalized and precision medicine.

Symposium
S11 - Perspectives on Canadian Psychiatry: The Vision of Three CPA Presidents
Friday, Oct. 20
10:45 - 11:45 (1 hr)
CanMEDS Roles:

1. Leader
2. Health Advocate
3. Professional

At the end of this session, participants will be able to:

1. To present informed perspectives on the future of Canadian psychiatry by three leaders of the CPA – past, present, and future CPA Presidents
2. To identify the established strengths and emerging challenges that the mental health care system in Canada faces in the next decade
3. To discuss the value of resiliency and positive psychiatry techniques for building healthier communities and institutions

This symposium convenes three CPA Presidents from across Canada discussing their concerns, values, and visions for Canadian psychiatry in the next decade, moderated by a member of the CPA Board of Directors.

Presenters:
Douglas Urness, CPA Past President (2021-2022) – Alberta
Gary Chaimowitz, CPA President (2022-2023) – Ontario
Hygiea Casiano, CPA President-Elect (2023-2024) – Manitoba

Moderator:
Vincenzo Di Nicola, CPA Board of Directors (2021-2025) – Quebec

Douglas Urness, Immediate Past-President, considers Continued Professional Development (CPD), advocacy, and collegiality, reflecting the CPA’s official strategic priorities, as the primary deliverables of our member-driven organization and the starting point for continuity and renewal. Professional and public polarizations now make collegiality crucially important.

Current President, Gary Chaimowitz, addresses key issues facing psychiatry in the next decade, ranging from critical challenges in health care organization and delivery (access to care, privatization, quality of care, human resources) and Canadian psychiatry’s collegial relationships among ourselves (including work stress and physician burnout) and with others (clinical psychologists, allied professions; interdisciplinary and international collaborations) to social issues (eg, environmental anxiety) and advocacy (ie, equality, diversity, inclusiveness).

Hygiea Casiano, President-Elect, values resiliency and using positive psychiatry techniques for building healthier institutions and communities. This value orientation is particularly impressive given her role in Forensic Child and Adolescent Psychiatry, working with youth confronting trauma and self-harm.

The moderator, Vincenzo Di Nicola, a socially-oriented Child and Adolescent Psychiatrist, offers bridging comments on these perspectives of Canadian psychiatry and animates a discussion with symposium participants.

References:


Workshop
W12 - Collaborative Mental Health Care in Canada: Challenges and Opportunities for the Psychiatrist
Friday, Oct. 20
10:45 - 11:45 (1 hr)
Meeting Room: TBC
Nick Kates*, MBBS, FRCPC

CanMEDS Roles:

1. Collaborator
2. Communicator
3. Medical Expert

At the end of this session, participants will be able to: 1) Outline the key components of effective collaborative mental health care programs; 2) Discuss the roles that a psychiatrist can play when working in primary care; and 3) Incorporate the principles on which collaborative care needs to be based within their practice.

The 25 years since the CPA and CFPC published their groundbreaking 1997 position paper on Shared (Collaborative) Mental Health Care in Canada have seen an acceptance of the importance of better collaboration between mental health and primary care services at the clinician, service and system level, with many innovative and effective programs across the country. But it has also seen some challenges with a lack of standardized approaches, difficulties with resource availability and sustainability, and insufficient Canadian evidence about what works, at a time when the expectations of consumers and family members for better collaboration are increasing.

In response to this, the CPA and CFPC recently updated the 1997 position paper to present a vision for the next 10 years. It provides a framework for collaboration that includes common values, principles and goals and an integrated “Canadian” model which has 9 dimensions. Care should be equitable, person and family centred, population-focused, stepped, evidence-informed, and team-based, and which includes quality measurement and builds capacity, and is supported by necessary system changes. It discusses how better collaboration can address wider problems facing our health care systems. This workshop summarises the key areas and recommendations in the position paper, and looks at the implications for psychiatrists whether working in primary care or any mental health service, with practical tips about ways to improve communication, to co-ordinate care, to develop a collaborative partnership with a primary care practice, and for working effectively in primary care as part of the primary care team.

References:


Workshop
W13 - Reducing Wait Times for Hospital-Based Ambulatory Mental Health Care: What Works?
Friday, Oct. 20
10:45 - 11:45 (1 hr)
Meeting Room: TBC
Kamini Vasudev*, MRCPsych (UK); Kamini Vasudev, MBBS, MD, MRCPsych; Melissa Sheehan, BSc, MD, FRCPC; Heather Oneschuk, BA, RN

CanMEDS Roles:

1. Collaborator
2. Leader
3. Health Advocate
At the end of this session, participants will be able to: 1) Describe an interdisciplinary team-based model of mental health care in outpatient service; 2) Design a referral form for outpatient services to efficiently assess patient needs; and 2) Evaluate hospital-based outpatient services with quality indicators.

Before the pandemic, the General Adult Ambulatory Mental Health Services at Victoria Hospital delivered urgent and nonurgent psychiatric care for adults aged 18 to 64 years through a physician-first-service delivery model. In the context of suboptimal physician resources and the consequences of the COVID-19 pandemic, a crisis backlog of 812 nonurgent psychiatry referrals accumulated between August 2020 and March 2021 with a predicted wait time of more than a year to see a psychiatrist. Process mapping was conducted, and quality improvement (QI) change ideas were applied with PDSA cycles. Redesign of the referral form, implementation of an interdisciplinary team-based model of care, introduction of a virtual application tool and standardization of physician contracts were some of the QI strategies that decreased wait-list time from an average of over 12 months to five months. In addition, the capacity for new consults seen per nonurgent psychiatrist each week increased from 2 in 2020 to 5.3 in 2022. This project is the first of its kind in Canada and was implemented without the addition of any project management resources or additional staff. The presenters will share their experience implementing the above interventions so that the attendees may replicate the same at other hospital-based outpatient services across Canada and other countries to improve access to mental health care. The workshop will begin with an interactive discussion on a clinical scenario followed by three presentations covering a) the problem faced, b) interventions made, and c) outcomes achieved.

References:


Workshop
W14 - Le suicide dans la communauté médicale et la promotion du bien-être parmi les professionnels de la santé
Friday, Oct. 20
10:45 - 11:45 (1 hr)
Meeting Room: TBC
Popa Ileana*, R3; Othmani Amina, R1

CanMEDS Roles:

1. Health Advocate
2. Professional
3. Leader

At the end of this session, participants will be able to: 1) Connaître les particularités du suicide au sein de la communauté médicale; 2) Identifier des signes de détresse chez soi et chez les collègues; et 3) Envisager des pistes de solution lorsque nous-même ou un collègue manifeste de la détresse psychologique.

Les médecins sont reconnus pour leur vocation altruiste. Ceci ne les exempter pas des adversités de la vie et de leur contexte professionnel exigeant, qui peuvent mener jusqu’aux pensées suicidaires et même, parfois, à un passage à l’acte. Le suicide des étudiants en médecine et des médecins est un sujet que nous jugeons insuffisamment abordé dans le cadre de notre formation académique, bien qu’il soit présent dans le décor depuis de nombreuses années. Ce sont 36% des résidents en médecine et médecins qui ont eu des pensées suicidaires au cours de leur carrière. Ponctuellement, un cas de suicide fait les manchettes, mais rarement sommes-nous amenés à explorer les particularités de ce phénomène.
Cet atelier se veut un exercice de prise de conscience, dans lequel nous vous invitons à ouvrir la voie vers l’auto-compassion, et à pratiquer la reconnaissance des signes de détresse chez soi et chez les collègues.

Cet atelier, construit en français, afin d’encourager la participation et le sentiment d’appartenance des membres francophones de l’Association des psychiatres du Canada, permettra aux participants d’explorer le phénomène du suicide chez les médecins, pour en comprendre les mécanismes, de reconnaître les signes de détresse chez soi et chez les collègues, ainsi que de parcourir les pistes de solutions.

References:


Workshop
W15 - Weapons in the Workplace
Friday, Oct. 20
10:45 - 11:45 (1 hr)
Meeting Room: TBC
Edwin Tam*, FRCP

CanMEDS Roles:

1. Health Advocate
2. Professional
3. Leader

At the end of this session, participants will be able to: 1) Learn the general sequence of response in dealing with an armed aggressor; 2) Acquire the physical skills of basic evasive footwork, blocking, parrying, control and counter-offence; and 3) Adopt the mindset necessary to survive.

This hands-on course addresses the worst-case scenario of encountering an armed aggressor at work. Participants are assumed to possess basic verbal de-escalation skills, and thus the focus will be on physical strategies for surviving these life-threatening situations. General principles of dealing with weapons will be covered, with attention to dealing with a knife, due to its combination of lethality and easy accessibility in Canada. We will examine the different tactics possible at different ranges and cover the role of evasion, parrying, blocking, control, counter-offence and equalizing tools/weapons in attempting escape. Legal considerations will be addressed. Although the theory will be presented, the emphasis will be on acquiring basic motor skills to increase the participant’s ability to survive a weapon attack. Various defensive drills will achieve this. Participants will engage in moderately strenuous activity and should dress in regular work attire unless such clothing restricts movement. Safety in training is a priority. The 25% discussion will be intermixed with the teaching, as questions and comments are encouraged throughout the course.

References:


Workshop
W16 - Sleep Disruption in Schizophrenia: Clinical Considerations and Case-Based Discussion
Friday, Oct. 20
10:45 - 11:45 (1 hr)
Meeting Room: TBC
Matthew McAdam*, MD; Malgorzata Rajda, MD
CanMEDS Roles:

1. Health Advocate
2. Medical Expert
3. Communicator

At the end of this session, participants will be able to: 1) Describe the sleep changes and disorders frequently associated with schizophrenia, 2) Identify the role that disrupted sleep plays in worsening the primary, secondary and co-morbid symptoms of schizophrenia, 3) Plan an approach to the assessment and management of disordered sleep in schizophrenia.

Most patients with schizophrenia live with sleep disruptions that can worsen clinical outcomes and are often underrecognized and undertreated. The prevalences of insomnia, obstructive sleep apnea (OSA), circadian rhythm abnormalities, restless leg syndrome (RLS) and periodic limb movement disorder (PLMD) are elevated in this population. Reductions in slow wave sleep and sleep spindle density have been consistently detected in sleep studies – changes which may hinder memory consolidation. The etiology of these sleep abnormalities is multifactorial, with influences from irregularities in neural circuits and atypical neurotransmission. Positive symptoms, aberrant daily routines, and other lifestyle factors can also contribute to sleep disruption. The impacts of sleep disturbances in schizophrenia are extensive and have been linked to worsening positive and negative symptoms, cognitive and functional impairments, metabolic dysfunction, reduced quality of life, elevated suicide risk, and exacerbation of comorbidities. In this workshop we will review an approach to assessing sleep using practical tools. We will also cover nonpharmacologic and pharmacologic management strategies. Cognitive behavioural therapy for insomnia remains a powerful tool but may benefit from certain modifications based on patient needs. While antipsychotic agents can improve sleep, potential pitfalls include worsening of OSA, RLS and PLMD. The role for other hypnotic agents is also considered. Using a case-based approach with time for discussion, participants will learn to incorporate these assessment and management techniques into their practices.

References:


Early Investigator Poster Session II
Friday, Oct. 20
10:45 – 11:45 (1 hr)
Meeting Room: Junior Ballroom AB Foyer (3rd floor, North Tower)

Codeveloped Symposium
Friday, Oct. 20
12:00 – 13:30 (1.5 hr)
Meeting Room: Grand Ballroom

Networking Break
Friday, Oct. 20
13:30 – 14:15 (.75 hr)
Meeting Room: Pavilion Ballroom Foyer (3rd floor, North Tower)

Research Paper
PS02a - Attitudes and Preferences of Women with Schizophrenia and Bipolar Disorder and Their Mental Health Care Providers Toward Contraception Counselling, Provision, and Methods
Friday, Oct. 20
14:30 - 15:30 (N/A)
Meeting Room: TBC
Rebecca Zivanovic*, BSc MD FRCPC; Ella Hardie, BSc; Marianne Vidler, PhD
CanMEDS Roles:

1. Health Advocate
2. Medical Expert
3. Collaborator

At the end of this session, participants will be able to: 1) Identify unmet need regarding contraception for women with serious mental illness; 2) Identify systemic, individual, and psychosocial factors that constitute potential barriers; and 3) Be encouraged to consider potential next steps in research, quality improvement, education, and clinical care to address this gap.

Despite compelling evidence that women with schizophrenia and bipolar disorder experience high rates of unintended pregnancy, induced abortion, obstetrical complications, poor neonatal outcomes, and child apprehension, little has been done to address this unmet need for contraception. This systematic literature review and narrative summary explored attitudes and preferences of women and their care providers to identify barriers to overcoming this unmet need.

Methods: We searched databases (PubMed, Embase, MEDLINE, Scopus, PsycINFO, and Cochrane Database of Systematic Reviews), reference lists, and conference proceedings between 1990 and 2022. Search terms included bipolar or schizophrenia coupled with contraception, birth control, family planning, contraception behaviour, unintended pregnancy, unplanned pregnancy, unwanted pregnancy, induced abortion, sexual health, and reproductive health. Two authors did a full-text review of 136 papers.

Results: Nineteen qualitative and quantitative studies were included. Client perspectives highlight challenges in the use of contraception and reinforce the significant burden of unintended pregnancies and unsupported parenthood. Studies consistently found client interest in having mental health care providers engage with them around issues of reproductive health, including contraception. Studies of care providers found issues of stigma, perceived lack of adequate training or education to address this in clinical practice, concern about working outside of their scope, and uncertainty about client preferences.

Discussion: Barriers to overcoming this gap include client and provider knowledge, stigma, concerns around coercion and boundaries, and systemic and socioeconomic issues. This research indicates potential points of intervention within clinical practice and the broader social context.

References:

1. Nikolajski CE. Contraceptive and family planning experiences, priorities, and preferences of women with serious mental illness. Dissertation presented to the University of Pittsburgh; 2018.

Research Paper
PS02b - Paradigms and Politics in the Definition of Treatment Resistance in Mental Health: A Metanarrative Review and Qualitative Pilot Study

Friday, Oct. 20
14:30 - 15:30 (N/A)
Meeting Room: TBC
Suze Berkhout*, MD/PhD; Oshan Fernandes, PhD; Vanessa Lockwood, SSW; Gary Remington, MD, PhD; Peter Giacobbe, MD, MSc.; Sophie Soklaridis, PhD; Melanie Anderson, MLIS; Carol Borlido, BSc.; Araba Chintoh, MD, PhD; Csilla Kalocsai, PhD

CanMEDS Roles:

1. Scholar
2. Collaborator
At the end of this session, participants will be able to: 1) Understand the historical and social contingencies that have shaped the definitions of treatment resistance in schizophrenia and depression; 2) Critically engage with the ways experimental methods, interventions, and technologies contribute to diagnostic labels and categories; and 3) Understand the impact of labelling treatment resistance for psychiatry service users.

Across various diagnoses, a minority of people only minimally respond to standard treatment. Being classified as having a treatment resistant (TR) form of mental illness mobilizes interventions, but what constitutes TR is in flux and little is known about the designation’s impact.

Methods: Through a metanarrative review, we constructed a sociohistorical map of TR in schizophrenia-spectrum and major depressive disorders, examining changing definitions of TR over time. Simultaneously, we explored meanings and impacts of TR as a classification within a qualitative pilot. Open-ended narrative interviews were conducted with service users and providers and thematically analyzed in an interpretivist-critical frame.

Results: In depression and schizophrenia-spectrum illnesses, attempts to resolve the conceptual heterogeneity of TR rely on pharmacocentric definitions, reinforcing biological determinism and the centrality of a curative framework. In contrast, service users’ experiences of symptom refractoriness engaged a broader landscape. Naming an experience as “TR” helped some people make sense of their experiences, but the label was simultaneously seen as foreclosing futurity. For providers, the TR construct was sometimes a dramatization of therapeutic nihilism and not easily disclosed, particularly in psychosis.

Discussion: Bringing the lived experience of TR into conversation with a metanarrative review enabled us to explore the experience of being labelled as “treatment resistant” alongside the practices, methods, and technologies that generate the classification itself. Critical scholarship in psychiatry can benefit from layering methodologies—a systematic approach to thinking about similarities, differences, particularities, and tensions embedded within definitions of TR and how these are embodied.

References:


Research Paper
PS02c - Cognitive-Behavioural Therapy with Mindfulness Classes for Preventing Mental Health Problems Among Public Safety Personnel: A Pilot Randomized Controlled Trial
Friday, Oct. 20
14:30 - 15:30 (N/A)
Meeting Room: TBC
Jitender Sareen*, MD

At the end of this session, participants will be able to: 1) Review the evidence for cognitive-behavioural therapy with mindfulness classes for depression and anxiety; 2) Review the high prevalence of mental health problems among public safety personnel; and 3) Present findings from a pilot randomized controlled trial.
Cognitive-behavioural therapy (CBT) has evidence in preventing depression among at-risk populations. Public safety personnel (PSP) have high rates of mental health problems and are exposed to high levels of stress and trauma. We conducted a randomized controlled trial to test the feasibility and acceptability of a five-class CBT with mindfulness classes (CBTm) intervention on variables contributing to workplace resilience among PSP.

Methods: We recruited 120 active duty police officers, firefighters, and paramedics into a parallel assignment randomized controlled trial. People were excluded if they had any of the following criteria: a) diagnosis of a mental health condition or suicidal ideation in the last six months, b) Patient Health Questionnaire-9 (PHQ-9) scores over 9, c) generalized anxiety disorder (GAD-7) score over 9, and d) post-traumatic stress disorder checklist-5 (PCL-5) score over 36.

Study arms: 1) five CBTm classes (1.5 hours each) delivered once weekly over five weeks; 2) waiting list for three months.

Primary Outcomes: Changes in distress (PHQ-9, GAD-7, PCL-5) and Connor-Davidson Resilience Scale pre-, post- and three months after classes.

Results: Sixty participants were recruited between August 2019 and January 2021. The pilot randomized controlled trial (RCT) was successful in recruiting participants; however, COVID-19 pandemic restrictions impacted recruitment. CBTm classes were found to be acceptable to participants. Although not powered to detect differences, the intervention group differed significantly from the waiting list group on PCL-5 and PHQ-9 measures.

Conclusions: CBTm classes were acceptable to PSP as a prevention tool and showed promising results.

References:


Symposium
S12 - Identifying and Treating Concurrent Mood and Substance Use Disorders in Canada: Current Gaps and Future Opportunities
Friday, Oct. 20
14:30 - 15:30 (1 hr)
Meeting Room: TBC
Sidney Kennedy*, MD, FRCPC, FRCPsych; James MacKillop, PhD; Yelena Chorny, MD, MSc, CCFP(AM); Shannon Remers, MSc; Christian Schütz, MD, Ph.D., MPH, FRCP

CanMEDS Roles:

1. Medical Expert
2. Professional
3. Scholar

At the end of this session, participants will be able to: 1) Recognize the gaps and challenges in treating concurrent disorders; 2) Appreciate the potential role of subtyping disorders to facilitate more personalized approaches to treatment; and 3) Be aware of advances in novel treatments and opportunities for future research.

In Canada, one in three people will be affected by mental illness in their lifetime. Among those experiencing major depressive disorder, up to 40% will also have a concurrent substance use disorder (SUD). People with concurrent disorders are likely to have greater symptom severity, and higher rates of morbidity, mortality, unemployment, homelessness, and other difficulties, compared to those with a single disorder. Despite the prevalence, people with concurrent disorders tend to be
under-diagnosed and undertreated, reflecting the silo approach of identifying and treating single disorders. Notably, a lack of real-world data characterizing the unique needs of people with concurrent disorders or evidence of effective treatment approaches makes it challenging to establish standards of care and treatment guidelines. In this symposium, we will provide an overview of the problem and highlight gaps in the treatment of and research on concurrent disorders (Dr. Sidney Kennedy). In our second presentation, we will provide evidence of the clinical heterogeneity of patients seeking treatment for SUD and highlight important characteristics of those with concurrent disorders, including lower treatment retention, higher craving, and higher impulsivity (Dr. James MacKillop). Our third presentation will demonstrate how an inpatient program was redesigned to treat concurrent mood and substance use disorders at Homewood Health Centre and highlight key evaluation findings (Dr. Yelena Chorny and Ms. Shannon Remers). In our final presentation, we will highlight where the field is going in terms of promising practices and opportunities for future research (Dr. Christian Schütz).
Workshop
W17 - Seeking Solidarity: A Brave Space to Share Experiences with Equity, Diversity, Indigeneity, Inclusion, and Accessibility Issues in Training
Friday, Oct. 20
14:30 - 15:30 (1 hr)
Meeting Room: TBC
Nikhita Singhal*, MD; Marianne Côté-Olijnyk, MD; Liz Rowe, MD candidate; Zoë Thomas, MD; Miranda Sanokho, PhD
Supported by the Members-in-Training & Fellows' Section

CanMEDS Roles:
1. Health Advocate
2. Professional
3. Leader

At the end of this session, participants will be able to: 1) Describe the concepts of intersectionality and implicit bias and identify ways in which issues related to equity, diversity, Indigeneity, inclusion, and accessibility (EDIIA) manifest in their daily work; 2) Increase awareness of their implicit biases and how they may manifest in their personal and professional experiences; and 3) Develop strategies to address EDIIA-related issues in their professional practice and within their respective institutions.

The Royal College of Physicians and Surgeons of Canada has committed to meaningful change in the direction of equity, diversity, Indigeneity, inclusion, and accessibility (EDIIA) principles. However, racialized medical students and residents remain underrepresented and continue to experience discrimination by patients, peers, and supervisors. Although multiple Canadian medical schools have developed pathways to increase diversity within their programs, few spaces within medical training and clinical institutions discuss these experiences of discrimination and collaborate towards change.

This workshop is meant as the first step in this direction, with the aim of opening up a brave space for conversation about experiences facing (and/or) witnessing discrimination within training. In this session, we will briefly present guidelines to set the frame for discussion and provide an overview of intersectionalities and implicit bias. Participants will be invited to discuss experiences related to EDIIA and to reflect on their own biases, guided by prompts offered by the facilitators. Depending on the number of participants, small groups may be formed, with representatives relaying experiences to preserve anonymity. Participants will then be invited to reflect on strategies to address these experiences in their respective institutions. Finally, we will summarize key takeaway points and elaborate action items; possible next steps might include attending related workshops, such as one focused on developing a process-based antiracism curriculum at McGill.

References:

Workshop
W18 - Training in Substance Use Disorders: What Current Psychiatrists and Residents Need to Know
Friday, Oct. 20
14:30 - 15:30 (1 hr)
Meeting Room: TBC
David Crockford*, MD, FRCPC; Anees Bahji, MD, FRCPC; David Crockford, MD, FRCPC
Supported by the Addiction Psychiatry Section
CanMEDS Roles:

1. Medical Expert
2. Health Advocate
3. Leader

At the end of this session, participants will be able to: 1) Recognize the changes in the updated Canadian Psychiatric Association position papers on substance use disorders; 2) Apply the knowledge, skills, and attitudes required to manage patients with primary and comorbid substance use disorders in psychiatric practice; and 3) Recognize the Entrustable Professional Activities applicable to substance use disorders and be able to evaluate and (or) meet them.

There are patients with substance use disorders (SUDs) in all psychiatric practice settings. Concurrent disorders are the norm rather than the exception. Despite the prevalence and consequences of SUDs and their frequency of presentation for potential intervention, most people with or without a comorbid psychiatric disorder do not receive any treatment. If they do, they often report unmet needs. Psychiatrists are crucial in treating people with concurrent psychiatric symptoms and SUDs. All psychiatrists need the knowledge, skills, and attitudes necessary to identify and help manage primary and comorbid SUD in the patients they see. Clinical practices have rapidly evolved and training requirements have shifted with Competence By Design, necessitating the update of the 2015 Canadian Psychiatric Association position paper on SUDs due to be published this year. Dr. Bahji will review Part 1, describing the knowledge, skills, and attitudes of current practising psychiatrists necessary to competently assess and manage people with SUDs in their psychiatric practice. Dr. Crockford will review Part 2, identifying psychiatry residency training program requirements for SUD training, Entrustable Professional Activities (EPAs) applicable to SUD, how staff should evaluate the EPAs, and how residents can meet each EPA’s requirements.

Workshop
W19 - Mental Health Research Funding: What Should We Advocate For?
Friday, Oct. 20
14:30 - 15:30 (1 hr)
Meeting Room: TBC
Katherine Aitchison*, PhD FRCPsych; Rajamannar Ramasubbu, M.D, FRCPC, MSc; Sophia Frangou, MD, Ph.D., FRCPsych; Kathleen Sheehan, MD, DPhil, FRCPC; Yanbo Zhang, MD, PHD; Simon Hatcher, MRCPsych FRCPC; Arlene MacDougall, MD, MSc, FRCPC
Supported by the Research Committee

CanMEDS Roles:

1. Scholar
2. Communicator
3. Leader

At the end of this session, participants will be able to: 1) Name a health research funding priority of the Canadian Institutes of Health Research (CIHR) Institute of Neurosciences, Mental Health, and Addiction; 2) List inequities in mental health research funding that have been identified globally; and 3) Discuss potential priority areas for mental health research funding in Canada.

In November 2020, the International Alliance of Mental Health Research funders published a report on mental health research funding inequities. (1) Analyzing global data between 2015 and 2019, the report found that the median size of research grants in Canada was smaller than in all other regions. It also raised concerns, such as a) the majority of global mental health research investment being on basic research rather than clinical/applied research, and b) the young not being the focus of mental health research investments, despite anticipated long-term benefits of intervening at this age.

Currently, six Canadian Institutes of Health Research (CIHR) mental health research funding priorities exist. (2); however, these may perpetuate concerns raised in the above report (e.g., youth mental health is not a stated priority). Given the need to advocate for priorities for clinical/applied research in...
mental health, the Canadian Psychiatric Association (CPA) has a role to play. This workshop will review and discuss priorities for mental health research funding with a view to reaching a consensus regarding priorities for advocacy. The workshop will be led by members of the CPA Research Committee, working in collaboration with representation from the CPA Public Policy Committee; representation from stakeholder organizations will be invited. Material for review and discussion will include the above report, data from a member survey on mental health research funding priorities, and statements by such relevant organizations as the World Health Organization, World Psychiatric Association, and Royal College of Psychiatrists (UK).

References:


Workshop
W20 - New Reflections in the Virtual One-Way Mirror: Developments in Virtual Psychotherapy Supervision in the Post-COVID Era
Friday, Oct. 20
14:30 - 15:30 (1 hr)
Meeting Room: TBC
Christian Schulz-Quach*, MD, MSc, MA, FHEA; Michael Armanyous, MBBCH, MRCPsyCh

CanMEDS Roles:

1. Professional
2. Communicator
3. Medical Expert

At the end of this session, participants will be able to: 1) Define the term 'telesupervision' and three different forms of provision (asynchronous, synchronous, direct observation); 2) Evaluate the advantages and challenges of direct virtual observation during psychotherapy supervision; and 3) Reflect on the impact of frame shifting on supervisees.

The global COVID-19 pandemic changed the clinical supervision landscape in psychiatry virtually overnight. Virtual care/psychotherapy and virtual supervision for all modalities became the norm, with profound consequences on setting and framing expectations. This workshop will explore different established formats of virtual supervision (telephone, online platforms, and chat services) as described and reviewed in the literature. We will also highlight the discourse on 'digital dissociation' and the 'constant presence of each other's absence,' which play a significant role in the phenomenology of online psychotherapy and supervision. We will demonstrate a case example of telesupervision as implemented at the University Health Network and the Division of Psychotherapy, Humanities and Psychosocial Interventions (PHPI) at the Department of Psychiatry, University of Toronto. We will present a summary of the limited literature available to date on the experiences of supervisees and supervisors with telesupervision. We aim to engage other psychotherapy supervisors across Canada in a conversation about their experiences, benefit findings, and critical thoughts on shifting psychotherapy supervision into a digital space. Finally, we will use creative methodology to help workshop members express their sense of identity in their new roles as digital psychotherapy supervisors.

References:


Course
C06 - Using Gamified Virtual Reality Simulations to Teach Psychiatric Emergencies: Suicide Risk Assessment and Opioid Overdose
Friday, Oct. 20
14:30 - 16:30 (2 hrs)
Meeting Room: TBC
Petal Abdool*, MD; Michael Mak, MD; Fabienne Hargreaves, MA; Tucker Gordon, N/A; Rachel Antinucci, MHE; Stephanie Sliker, MEd; Chantalle Clarkin, PhD; Allison Crawford, MD; Ahmed Hassan, MD; Sanjeev Sockalingam, MD

CanMEDS Roles:
1. Medical Expert
2. Health Advocate
3. Communicator

At the end of this session, participants will be able to: 1) Conduct a virtual reality (VR) suicide risk assessment and identify risk factors, protective factors, and level of risk using a VR simulation followed by a facilitator-led debrief; 2) Manage an unconscious patient in a VR simulation, recognize opioid overdose, administer the required treatment, and support patient postresuscitation; and 3) Review the evidence for using VR simulation in medical education.

Deaths from opioid overdose and suicidal ideation are on the rise in Ontario and Canada and have become a significant public health concern (COVID-19 Science Table and Government of Canada). Many disciplines in medicine have begun to use innovative simulation technologies such as virtual reality (VR) to teach trainees, which allows for exposure to rare or high-risk situations in a safe learning environment (Jiang H et al., 2022; Zagury-Orly et al., 2023). There is a dearth of literature supporting the use of VR in psychiatric education.

Participants in this interactive, experiential course will learn how VR is used to improve clinical skills in high-risk scenarios within psychiatry. Participants will have the opportunity to engage in up to four scenarios with VR avatars in a virtual environment: two suicide risk assessment scenarios (a 45-year-old man and 19-year-old woman) and two opioid overdose scenarios (a hospital setting and community setting). Each participant will don a VR headset (supplied by the team during the course) and select a scenario. All VR scenarios respond dynamically and in real time to participant decisions, build on complexity, and provide immediate feedback to each participant. Participants will actively engage in a facilitated debrief after VR simulations, which will include appraisal of the emerging literature related to the use of VR in psychiatric education, lessons learned, limitations, and best practices. Facilitators will also share the results of their current VR research and draw on the experience and expertise of all participants to stimulate a lively discussion.

References:

Course
C08 - Current Approaches in the Treatment of Alcohol Use Disorder (with a review of Canada's Guidance on Alcohol and Health: Final Report)
Friday, Oct. 20
15:45 - 16:45 (1 hr)
Meeting Room: TBC
At the end of this session, participants will be able to: 1) Describe the evidence-based medications used to treat alcohol use disorder (AUD), from acute withdrawal to community maintenance treatment; 2) Discuss the 2023 Canada's Guidance on Alcohol and Health: Final Report, which recommends fewer than two standard drinks a week to avoid harm; and 3) Identify the importance of concurrent integrated treatment and recognize the impact of the COVID-19 pandemic on the prevalence and treatment of AUD.

In any given year, one in five Canadians experiences a mental health or addiction problem. People with mental illness are twice as likely to have a substance use disorder, with at least 20% of people with mental illness having a co-occurring substance use disorder. For people with schizophrenia, the number may be as high as 50%. Similarly, people with substance use disorders are up to three times more likely to have a mental illness, with more than 15% of people with substance use disorders having a co-occurring mental illness. Alcohol use disorder (AUD) is the most prevalent substance use disorder. Since the COVID-19 pandemic, frequency of drinking, days of heavy drinking, and alcohol-related consequences have all increased, especially in women. This is troubling given the recent release of the 2023 Canada's Guidance on Alcohol and Health: Final Report, which recommends a maximum of two standard drinks a week to avoid alcohol-related consequences. Despite the high prevalence of AUD, psychiatrists are not always familiar with the available evidence-based treatments, and there is significant variability in what is offered to patients. Some psychiatrists are not comfortable prescribing anticraving medications. Some may feel it is best to wait for abstinence before treating underlying mental illness. There is strong evidence that treating mental health and addictions concurrently has the best outcome, leading to a decrease in relapse rates and health care costs. This course will review evidence-based guidelines and clinical strategies for the treatment of AUD and concurrent mental illness in an interactive format.

References:

Symposium
S13 - Irremediability, Palliation, and Futility in Psychiatry: Understanding Philosophical, Cultural, and Historical Perspectives to Inform Practice
Friday, Oct. 20
15:45 - 16:45 (1 hr)
Meeting Room: TBC
Suze Berkhout*, MD/PhD; Csilla Kalocsai, PhD; JJ Rasimas, MD, PhD; Sarah Levitt, MD, MSc.; Dan Rosenbaum, MD; Dan Buchman, PhD; Kenneth Fung, MD, MSc; G. Eric Jarvis, MD, MSc.; Marie Gojmerac, MD, MA; Laurence Kirmayer, MD
Supported by the History and Philosophy of Psychiatry Section

At the end of this session, participants will be able to: 1) Discuss how definitions of treatment resistance (TR) have arisen and the limitations and challenges from philosophical and cultural
Notions of futility, treatment resistance (TR), and provision of palliation in mental health have divergent meanings and practices. These issues are embedded in social, cultural, and historical contexts: what concepts mean and how they are translated into practice differ across time, space, and place.

Methods: Through historical and philosophical analysis as well as cross-cultural case study, this joint symposium will offer a facilitated discussion for participants to critically engage with the ways that TR, futility, and palliation are understood and operationalized in psychiatry—concepts that shape notions of irretrievability, a central consideration for providing medical assistance in dying. The symposium will be hosted by the Canadian Psychiatric Association (CPA) section on transcultural psychiatry and the CPA section on the history and philosophy of psychiatry.

Results: Presenters will explore (1) how historical and philosophical issues relating to TR, futility, and psychiatric palliation impact the application of these concepts in practice and (2) the ways that social and cultural context shape interventions, including palliation. The symposium will conclude with reflection on additional aspects of culture that inform the limits of psychiatric intervention.

Conclusions: Holistic, comprehensive, and patient-centred views of healing need to address the totality of patients’ relational existence. This includes understanding how psychological and spiritual well-being mediates suffering and how broader economic, religious, cultural, and geopolitical contexts influence recovery, illness, suffering, death, the end of life, and the afterlife. These have deep implications for when interventions are considered futile as well as undesirable. In exploring these issues, the symposium offers critical engagement with irretrievability in psychiatry.

References:


Workshop
W21 - Two for One: How to Earn Section 3 Credits Through Practice Improvement
Friday, Oct. 20
15:45 - 16:45 (1 hr)
Meeting Room: TBC
Tara Burra*, MA, MD, FRCPC; Lesley Wiesenfeld, MD, MHCM, FRCPC; Andrea Waddell, MD, MEd, FRCPC

CanMEDS Roles:

1. Medical Expert
2. Leader
3. Professional

At the end of this session, participants will be able to: 1) Identify key tools used in quality improvement methodology; 2) Describe how quality improvement methodology can be applied in psychiatric clinical practice; and 3) Develop a work plan for an improvement initiative.

Knowledge and application of quality improvement (QI) is increasingly a required professional activity, yet few practicing psychiatrists in Canada have received formalized training in QI methodology and even fewer have experience applying QI in practice. Over the last several years, the Royal College of Physicians and Surgeons of Canada (RSPSC) has evolved its Maintenance of Certification (MOC)
Program to integrate QI and continuing professional development (CPD) of specialist physicians. One of the challenges faced by psychiatrists in engaging in this facet of CPD has been a lack of available tools, resources, and illustrative examples of QI in mental health and addiction care. This workshop is intended to help bridge this gap for psychiatrists. We will focus on the development and implementation of individual psychiatric practice improvement. In the first portion of the workshop, participants will learn from an applied example and gain familiarity with fundamental QI tools such as aim statements, cause-effect diagrams, and run charts. In the latter portion of the workshop, through small group discussion, participants will work on the development of their own QI initiative, using a RCPSC template. Participants will leave the session with a work plan for individual practice improvement. Participants who implement the work plan following the workshop will not only acquire experience applying QI in psychiatric practice, but also be eligible to claim Section 3 Practice Assessment MOC credits.

References:


Workshop

W22 - The Integration of Physical and Mental Health: Where's The Money?

Friday, Oct. 20
15:45 - 16:45 (1 hr)
Meeting Room: TBC
Matthew Kelsey*, MHSc; Susan Abbey, MD, FRCPC; Kathleen Sheehan, MD, DPhil, FRCPC; Emma Scott, BSc (Hons)

CanMEDS Roles:

1. Health Advocate
2. Leader
3. Medical Expert

At the end of this session, participants will be able to: 1) Develop an awareness of the need for sustainable approaches for integrating mental health services for patients with physical illness; 2) Be able to describe current and proposed funding sources for mental health services for patients with physical illness; and 3) Be able to identify gaps in funding and the implementation of mental health services for patients with physical illness.

The synergistic relation between physical and mental health is well established. People with physical illnesses are more likely to experience comorbid mental health issues compared to the general population. (1) Concurrently, patients with chronic illness with comorbid mental health disorders typically require more costly care. (1) Despite this knowledge, a major barrier to providing integrated mental health services to patients with physical illness is a lack of sufficient, sustainable funding. (2) The following workshop will provide an overview of the funding and enablement of mental health services in the context of physical health.

The goal of the workshop is to highlight the need for a more comprehensive approach to funding-integrated physical and mental health services and encourage a dialogue to develop practical funding solutions.

• Dr. Kathleen Sheehan will briefly review the importance of integrated physical and mental health and broader aspects of Canadian health care systems to consider when funding and implementing mental health services for patients with physical illness.
• Ms. Emma Scott will root discussions in the Ontario context, providing perspectives on facilitators, barriers, and practical solutions for providing mental health services to patients with major physical illnesses.
• Mr. Matthew Kelsey will discuss philanthropic efforts and current sources of funding for mental
health services for medically ill patients.
• Acting as workshop moderator, Dr. Susan Abbey will share her knowledge on developing medical psychiatry programs, including funding and organizational considerations.

References:


Workshop
W23 - Learning Health Systems: What Are They and Why Do Psychiatrists Need to Know?
Friday, Oct. 20
15:45 - 16:45 (1 hr)
Meeting Room: TBC
Alison Freeland*, MD, FRCPC; Gary Chaimowitz, MD FRCPC

CanMEDS Roles:

1. Collaborator
2. Health Advocate
3. Scholar

At the end of this session, participants will be able to: 1) Explain what a learning health system is and how it can effect mental health system transformation; 2) Understand how psychiatrists can, and why they should, contribute to learning health system work; and 3) Appreciate the need for rapid mental health system transformation within Canada.

Mental health care systems are under pressure due to increased demand for access, escalating costs, health human resource shortages, and fragmented services. New approaches are needed to effect the system transformation to address these challenges. One such approach is the learning health system (LHS), which differs from traditional research that can take years to complete and deliver results to support system change. Instead, the LHS model leverages available population health data and health system informatics; creates partnerships among researchers, clinicians, patients, and families; ensures alignment with research, clinical priorities, and community need; and drives ideas and innovation to achieve system transformation.

Psychiatrists are essential to mental health care and, as such, must continue to adapt their skills and knowledge to ensure their continued contributions and leadership in evolving health system transformation. This includes understanding all elements of an LHS, including concepts of population health, big data and informatics in evolving health services methodologies; how to effectively collaborate with researchers and implementation scientists; and partnering with patients to co-design new ways to develop mental health care services.

This workshop introduces how LHSs can evolve and transform mental health service delivery and discuss the role of psychiatrists within an LHS and the importance of this to the future of psychiatry.

References:

Residents’ Reception
Friday, Oct. 20
17:00 – 19:00 (2 hrs)
Meeting Room: Constellation (34th floor, South Tower)
Registered residents, fellows and medical students are welcome to attend.
Canadian Psychiatric Association
73rd ANNUAL CONFERENCE
October 18-21, 2023
Vancouver, British Columbia

Poster Sessions

Friday, October 20
As of Jul. 31, 2023

Early Investigator Poster Session II

Poster - Early Investigator
PE16 - A Quality Improvement Project on a Six-Week Micro Mindfulness Pilot for Patients on an Acute Psychiatric Unit
Friday, Oct. 20
10:45 - 11:45 (1 hr)
Meeting Room: TBC
Tamara Hoppe*, FRCPC; Roisin Byrne, FRCPC
Supported by the Psychotherapy Section

CanMEDS Roles:

1. Health Advocate
2. Medical Expert
3. Leader

At the end of this session, participants will be able to: 1) Identify potential benefits of evening mindfulness therapy for patients on acute inpatient psychiatric units; 2) Define micro-mindfulness in the context of acute inpatient psychotherapy; and 3) Learn how mindfulness therapy can potentially reduce nursing care burden in the evenings.

Psychiatric inpatient units offer little evening programming despite high patient needs and nursing demands. Mindfulness-based interventions (MBIs) have shown to benefit psychological and physical well being and psychiatric disorders (Kabat-Zinn, 1990). There is a paucity of research using MBIs for adult psychiatric inpatients, though existing studies have demonstrated benefits (Sams, 2018).

Objective: We assessed feasibility and acceptability of a novel MBI for adult inpatients.

Methods: Stakeholder engagement included a survey sent to inpatient unit nurses and a voice of customer (VOC) engagement with inpatients by the Advanced Practice Clinical Leader (APCL). A 20-minute “micro mindfulness” group was offered once weekly, after hours, run by study authors over six weeks. Each group included a brief introduction, followed by a guided meditation. Patient feedback was collected following the pilot.

Results: Seven nurses responded to the survey and ten inpatients participated in the VOC discussion. All nurses thought there was insufficient programming; 71% of nurses thought patients would attend; all nurses thought issues could arise due to insufficient evening programs. A total of 67% of patients felt understimulated in the evenings, and all patients were interested in more evening groups. Between 6 and 11 patients attended per group. Post-pilot feedback from patients was positive.

Conclusions: There was a perceived need from both patients and staff for enhanced evening programming on our adult general psychiatric inpatient unit. Our brief mindfulness program was feasible and acceptable, with broad benefits as reported by patients.
Poster - Early Investigator
PE17 - An Investigation of Pharmacological Sleep Aids and Environmental Factors Affecting Sleep on a Brain Injury Rehabilitation Unit
Friday, Oct. 20
10:45 - 11:45 (1 hr)
Meeting Room: TBC
Tyler Pettes*, MD; Rebecca Wood, BSc; Elvina Chu, MD
Supported by the Neuropsychiatry Section

CanMEDS Roles:
1. Health Advocate
2. Collaborator
3. Scholar

At the end of this session, participants will be able to: 1) Recognize when to use pharmacological sleep aids in brain injury; 2) Characterize changes in sleep quality following brain injury; and 3) Consider effects of caffeine and alcohol intake following brain injury.

Patients with brain injuries typically require significant neurorehabilitation, including pharmacological and psychoeducation-based interventions. This study compares sleep quality, prescribed sleep medication, and caffeine and alcohol consumption in patients with brain injury during admission for rehabilitation and after discharge.

Methods: This ongoing study collects data at two timepoints. Time point 1 (T1) is during admission to the inpatient unit and time point 2 (T2) is after discharge. Medication chart review was carried out, alongside a structured patient interview consisting of self-perceived sleep quality and intake of caffeinated and alcoholic beverages. Medications were classified according to the American Hospital Formulary Service Pharmacologic-Therapeutic Classification System. Paired-samples t tests were conducted to evaluate polypharmacy, sleep quality, and caffeine consumption at T1 and T2.

Results: Eleven participants (mean age 49.5 years, range 25 to 74 years; 45% men) had a significant reduction in the number of medications prescribed at T1 (mean [SD] 14.5 [+/-3.5]) compared to T2 (mean [SD] 11.5 [+/-5]; t[10] = 4.8, p < 0.001). Despite a similar number of sleeping aids prescribed at T1 (mean [SD] 0.8 [+/-0.8]) compared to T2 (mean SD 1.1 [+/-0.7]; t[10] = 1.9, p = 0.082), participants rated their sleep quality as worse in hospital compared to after discharge (mean 8.3 [+/-2], t[10] = 3.9, p = 0.003). Participants consumed more caffeinated beverages after 15:00h on the rehabilitation unit compared to after discharge (p = 0.002), and two participants regularly consumed alcohol within a week after discharge.

Conclusion: Following admission to a brain injury rehabilitation unit, patients had reductions in medication burden; however, prescribing of sleep medications continued despite self-reported sleep quality improving on discharge. Findings suggest a closer clinical review of prescribed sleep medication and caffeine or alcohol intake in this patient population is warranted.

References:

Poster - Early Investigator
PE18 - Characterizing Eating Behavioural Phenotypes in Mood Disorders: A Narrative Review
Friday, Oct. 20
10:45 - 11:45 (1 hr)
Meeting Room: TBC
Elena Koning*, MSc

CanMEDS Roles:
1. Scholar

At the end of this session, participants will be able to: 1) Expand knowledge on the bidirectional relation between eating behaviour and mood; 2) Refine the clinical assessment of eating behaviour in people with mood disorders; and 3) Contribute to the development of treatment strategies tailored to each phenotype.

Mood disorders, including depressive and bipolar disorders, represent a multidimensional and prevalent group of psychiatric illnesses characterized by disturbances in emotion, cognition, and metabolism. Maladaptive eating behaviours in mood disorders are diverse and warrant characterization to increase the precision of diagnostic criteria, identify subtypes, and improve treatment strategies. This study aimed to synthesize evidence for eating behavioural phenotypes (EBPs) in mood disorders and provide advancements in pathophysiological conceptual frameworks relevant to each phenotype. In this narrative review, EBPs were reached by reviewing the literature on eating behaviours in the mood disorder population and characterizing each behaviour into distinct groups. Associations between groups of behaviors and certain characteristics of people with mood disorders were then identified based on current evidence from the literature to date, including preliminary studies, systematic reviews, and clinical trials. Phenotypes include characterizations of maladaptive eating behaviours related to appetite, emotion, reward, impulsivity, diet style, and circadian rhythm disruption. Potential neurobiological underpinnings and treatment strategies relevant to each phenotype are also discussed. Classifying phenotypes of eating behaviour in people with mood disorders has the potential to increase etiological knowledge and the precision of diagnostic and treatment strategies tailored to each phenotype. Future work should aim to empirically test these EBPs and examine their associations with treatment outcomes.

References:

Poster - Early Investigator
PE19 - Descriptive and Network Analyses of Psychiatric Symptoms and Neuroimaging Correlates in Parkinson Disease
Friday, Oct. 20
10:45 - 11:45 (1 hr)
Meeting Room: TBC
Alexander Levit*, MD/PhD; Fidel Vila-Rodriguez, MD, FRCPC, FAPA, PhD
Supported by the Neuropsychiatry Section

CanMEDS Roles:
1. Scholar
2. Medical Expert
3. Health Advocate
At the end of this session, participants will be able to: 1) Recognize prevalence patterns of psychiatric non-motor symptoms in early Parkinson disease (PD); 2) Identify neuroimaging correlates of psychiatric non-motor symptoms in early PD; and 3) Describe endophenotypes of PD with respect to neuropsychiatric symptoms.

Patients with Parkinson disease (PD) have high rates of comorbid depression, anxiety, and other psychiatric symptoms that progress over the course of the disease. Specific psychiatric symptom patterns may associate with subtypes of PD, and characterization of these patterns may support prognosis, anticipatory guidance, and treatment.

Objectives: We aimed to identify longitudinal associations among motor, psychiatric, and other nonmotor symptoms in PD and to identify neuroimaging correlates for nonmotor symptoms in PD.

Methods: The Parkinson Progression Marker Initiative (PPMI) is an observational natural history study of early-stage untreated PD (Hoehn and Yahr Stage 1-2). Descriptive statistics and network analyses were applied with a focus on clinician- and self-rated motor and nonmotor symptom data as well as SPECT dopamine transporter imaging.

Results: Presence of bradykinesia, rigidity, or postural instability at enrollment was more predictive of the progression of psychiatric symptoms than tremor-dominant presentation. By year five, dopamine transporter binding deficit on SPECT imaging was more strongly correlated with nonmotor symptoms than motor symptoms.

Conclusions: Symptom clusters in PD can inform clinical assessment, prognosis, and symptom management. Imaging may be an important biomarker for comorbid psychiatric symptoms.

References:


Poster - Early Investigator
PE20 - Digital Delivery of Trauma Therapy for Trauma-Affected Populations: Lived Experiences of Clients and Clinicians
Friday, Oct. 20
10:45 - 11:45 (1 hr)
Meeting Room: TBC
Sidney Yap*, BSc; Rashell Wozniak, MSc; Katherine Bright, PhD; Matthew R.G. Brown, PhD; Lisa Burback, MD; Andrew Greenshaw, PhD; Suzette Bremault-Phillips, PhD

CanMEDS Roles:

1. Health Advocate
2. Scholar
3. Medical Expert

At the end of this session, participants will be able to: 1) Understand why the shift to the digital delivery of trauma therapy was needed for trauma-affected populations; 2) Identify the strengths and weaknesses of the digital delivery of trauma therapy from the clinician perspective; and 3) Identify the strengths and weaknesses of the digital delivery of trauma therapy from the perspective of trauma-affected populations.

The COVID-19 pandemic significantly impacted the mental health of individuals globally. In response to increased mental health service demands and COVID-19–related restrictions, mental health clinicians rapidly shifted their services from in-person to digital delivery (e.g., teletherapy, telemedicine, eHealth, and mobile health).
This shift has been instrumental in maintaining continuity of care for trauma-affected populations (TAPs; public safety personnel, military members, veterans, and civilian frontline workers). Many TAPs are routinely exposed to potentially psychologically injurious high-risk situations. COVID-19 may compound these traumatic injuries, potentially negatively impacting their well being, mental health, occupational engagement, and relationships.

Little is understood regarding the impact of this rapid shift towards digital delivery. Through this study, we sought to better understand the experiences of TAPs who received and clinicians who delivered digital trauma therapy and identify related benefits and barriers.

Trauma-affected populations (n = 4) who have received and Canadian mental health clinicians (n = 19) who have delivered trauma therapies via digital means were recruited for this study. Data were collected through semistructured focus groups and interviews conducted and recorded through encrypted Zoom and followed an iterative process. Transcripts were coded with thematic analysis.

Overall, participants in both groups shared positive experiences receiving and delivering digital trauma therapies, with notable barriers of equal importance. The themes that arose from the thematic analysis included context, efficacy, safety, and recommendations.

The study findings support using digitally delivered trauma therapies for TAPs and may inform relevant policies and practices in a quasi-post-COVID world.

References:


Poster - Early Investigator
PE21 - Exploring the Effectiveness and Experiences of Treatment for Men with Borderline Personality Disorder
Friday, Oct. 20
10:45 - 11:45 (1 hr)
Meeting Room: TBC
Yevin Cha, BMSc., MD; Paul Links*, MD, FRCPC

CanMEDS Roles:

1. Medical Expert
2. Scholar
3. Health Advocate

At the end of this session, participants will be able to: 1) Learn the various treatment outcomes of psychological therapies and psychopharmacologic treatment for men with borderline personality disorder (BPD); 2) Identify future research priorities and gaps in the literature on treatment and experiences of recovery for men with BPD; and 3) Understand the limitations of research on the effectiveness of treatment for men with BPD.

In clinical settings, people diagnosed with borderline personality disorder (BPD) typically are 75% female and 25% male, although this discrepancy in gender distribution is not found in the community. In the literature, little is known of the effectiveness and experiences of treatment of men with BPD. Objective: We aimed to investigate the effectiveness and experience of treatment for men with BPD and outline future research priorities to better promote their recovery.

Methods: A systematic search of Ovid Medline and PsycINFO was conducted. We generated a narrative synthesis of the treatment effectiveness and experiences of men with BPD.
Results: The search yielded 1,305 abstracts and 34 full-text studies were screened. A total of 17 studies met inclusion criteria, and 7,114 men with BPD from nine countries were represented. Seven studies investigated psychological and five reported on pharmacological interventions. Five studies investigated the service use of men with BPD. Men were less likely to receive treatment compared to women and were more likely to drop out of treatment. Improvements in suicidality and violence, anger, and aggression were observed, with anger and aggression as the prominent outcomes investigated in most studies.

Discussion: Compared with women, men were less likely to access treatment for BPD or find treatment helpful. Our findings suggest psychotherapeutic interventions can be effective for men, although findings are limited by small sample sizes and heterogeneity of studies. Further research with larger sample sizes and qualitative studies are needed to better understand the treatment experience for men with BPD.

References:


Poster - Early Investigator
PE22 - Frequency of Attention-Deficit Hyperactivity Disorder Assessment in a Tertiary Care Mood and Anxiety Program
Friday, Oct. 20
10:45 - 11:45 (1 hr)
Meeting Room: TBC
Nicholas Boucher*, MD; Amol Vaze, MD; Sabrina Paterniti, MD PhD

CanMEDS Roles:

1. Communicator
2. Medical Expert
3. Professional

At the end of this session, participants will be able to: 1) Describe the prevalence of attention-deficit hyperactivity disorder (ADHD) comorbidity in mood and anxiety disorders; 2) Recognize the clinical interest of screening/assessing ADHD among mood and anxiety disorders patients; and 3) Identify factors that may increase or decrease the likelihood of assessing ADHD in tertiary care.

The comorbidity between attention-deficit hyperactivity disorder (ADHD) and affective disorders is frequent and associated with poorer prognosis and treatment resistance. It is therefore relevant to assess for ADHD in all patients. This project evaluated the frequency and factors associated with the assessment of ADHD in a tertiary care mood and anxiety disorders program.

Methods: We reviewed 80 consecutive outpatient consultations undertaken by psychiatrists and psychiatry residents in our program. The following screenings/assessments were recognized: any questionnaire or questions about ADHD symptoms or a mention of need for further assessment. Current psychiatric diagnoses, previous diagnosis of ADHD, and current treatment with medications used in ADHD were recorded.

Results: Of the consultations, 42.5% had recorded some ADHD assessment. Factors associated with higher frequency of assessment were as follows: being a resident (69.2%, p = 0.03), previous diagnosis of ADHD (87.5%, p = 0.007), current treatment for ADHD (66.7%, p = 0.009), mention of ADHD in the referral (72.2%, p = 0.004) or by the patient (80%, p = 0.02), a diagnosis of substance use disorder (66.7%, p = 0.04), and a diagnosis of ADHD (88%, p < 0.001). A diagnosis of post-traumatic stress disorder was associated with a lower frequency of ADHD assessment (5.6%, 0.001).
Conclusions: The frequency of assessment for ADHD was low in our sample, perhaps contributing to treatment resistance. Increased education and use of standardized questionnaires would likely increase the frequency of diagnosis and, therefore, treatment, potentially improving prognosis.

References:


Poster - Early Investigator
Friday, Oct. 20
10:45 - 11:45 (1 hr)
Meeting Room: TBC
Yang Bo Zhang*, BHSc; Angela Wei, BHSc; Emma Robertson; Jeremy Steen, BHSc; Christopher Mushquash, PhD; Christine Wekerle, PhD

CanMEDS Roles:

1. Health Advocate
2. Scholar
3. Communicator

At the end of this session, participants will be able to: 1) Identify relations between global Indigenous gender concepts and gender-based violence (GBV), contextualized in traditional governance, colonialism, and gender diversity; 2) Recognize the prevalence and mental health implications of GBV, patriarchal systems, and colonial wounds in those facing intersecting oppression; and 3) Appreciate the value of decolonization processes in providing trauma-informed, gender-inclusive, resilience-oriented care for Indigenous GBV survivors.

The legacy of colonialism includes ongoing trauma and disruption of traditional teachings on relationality. This has contributed to global Indigenous populations disproportionately exposed to gender-based violence (GBV). Gender analysis of GBV in Indigenous populations is explored to consider resilience.

Objectives: To our knowledge, there is no systematic research review on the intersecting experiences of Indigeneity and gender diversity, as contextualized within GBV and resilience. This study explores conceptualizations of gender and GBV in Indigenous communities globally. We consider issues of governance and whether culture is identified as a resilience pathway.

Methods: A systematic scoping review was conducted in MEDLINE, Embase, PsycINFO, and the Informit Indigenous Collection, using key words for Indigenous peoples, gender concepts, and GBV. Each article was screened and extracted by two reviewers.

Results: Searches yielded one mixed-method study and seven qualitative studies. North American studies identified positive precontact gender relationships, with colonial patriarchy contributing to GBV trends postcontact. Other studies also described patriarchal cultures contributing to GBV. Although research was limited, lack of understanding of Two-Spirit identities was linked with stigma. Traditional matriarchal governance structure and decolonization processes were identified as resilience pathways.

Conclusions: There is limited literature exploring relations between Indigenous gender concepts and GBV. All studies identified colonization-related violence and (or) patriarchal gender norms as a precursor for rigid or disrupted gender roles and GBV. Engagement with cultural practices was
consistently identified as a key resilience process. Limited research is available on GBV victimization in males, Two-Spirit, and LGBTQ+ Indigenous persons.

References:


Poster - Early Investigator
PE24 - Impacts of Clinical Empathy on Self-Perceived Mental Health in Canadians with Chronic Illnesses
Friday, Oct. 20
10:45 - 11:45 (1 hr)
Meeting Room: TBC
Shira Gertsman*, BSc Ioana Cezara Ene, BHSc Sasha Palmert, MD Amy Liu, MD Mallika Makkar, MD Johanna Shapiro, PhD Connie Williams, MD PhD

CanMEDS Roles:

1. Health Advocate
2. Communicator
3. Professional

At the end of this session, participants will be able to: 1) Name the three key components of "clinical empathy" and understand how they differ from common perceptions of the concept of "empathy"; 2) Describe how clinical empathy can directly and indirectly impact the mental health of patients with chronic illness; and 3) Name two practical ways clinicians can increase their enactment of clinical empathy in practice.

Clinical empathy is the ability of a physician to understand a patient's illness experience, communicate this understanding, and act collaboratively to create a treatment plan. Although clinical empathy provides substantial benefits to both physicians and patients, medical students typically experience declining empathy throughout training. The primary objective of this study was to generate a model of clinical empathy and its outcomes, grounded in the perspectives of Canadians with chronic illnesses, to be used to inform empathy-focused curricular development in Canadian medical education.

Methods: Adults with chronic illness who recently saw a Canadian physician were recruited from online support groups. Participants took part in semi-structured virtual focus groups. Transcripts were coded with the constant comparative method and a theory was generated using constructivist grounded theory analysis.

Results: Twenty patients from across Canada participated in six focus groups. Perceived presence of physician empathy engendered positive internal processing by patients, leading to increased efficacy of health care delivery and enhanced mental health outcomes. Negative patient internal processing in response to perceived absence of empathy led to reduced quality and increased use of health care, disruptions in patients' personal lives, and negative physical and mental health outcomes. Impact on mental health was the most prevalent theme, with patients describing exhaustion, hopelessness, helplessness, anxiety, depression, and suicidal ideation as downstream effects of clinical empathy deficiency.

Conclusion: Clinical empathy can have life-altering impacts on patients, and its absence may trigger or exacerbate mental illness. Any intervention to improve clinical empathy must be informed by patient perspectives.
References:


Poster - Early Investigator
PE25 - Integrating Cardiometabolic Bloodwork Monitoring in an Intensive Case Management Mental Health Community Clinic: A Quality Improvement Initiative
Friday, Oct. 20
10:45 - 11:45 (1 hr)
Meeting Room: TBC
Nicole Ilyin*, BScN, MN; Mallory McKey, BScN; Ava Meade, BScN; Karen Shin, MD, FRCPC

CanMEDS Roles:

1. Health Advocate
2. Medical Expert
3. Professional

At the end of this session, participants will be able to: 1) Identify the steps taken to implement the outlined cardiometabolic bloodwork monitoring intervention; 2) Describe the importance of cardiometabolic bloodwork monitoring in populations being prescribed antipsychotic medication; and 3) Support the integration of cardiometabolic bloodwork monitoring into practice.

Cardiometabolic bloodwork monitoring (CBM) allows for early detection and treatment of cardiometabolic side effects of antipsychotic medication used in the treatment of psychotic and mood disorders (DeJongh, 2021; Melamed et al., 2019).

Purpose: This quality improvement (QI) initiative was to increase the completion of CBM for clients on antipsychotic medications, followed by an intensive case management community clinic.

Methods: Data were collected retroactively from client files from February 2021 to January 2022, to determine the most recent dates when clients were tested for fasting or random glucose, HA1C, and a standard lipid panel. The QI initiative started in February 2022 and data were collected over a 12-month period.

A Plan-Do-Study-Act (PDSA) QI framework was implemented. Some key factors were identified as potential causes for poor completion of CBM, like the absence of monitoring infrastructure. A CBM infrastructure was created and implemented to support the integration of CBM into clients’ clinical care.

Results: Prior to the implementation of the CBM intervention, an average of 30% of the clinic’s clients completed CBM. After the QI intervention was implemented, 78% of the clients were offered CBM, with 54% of total clients completing it. These data were analyzed with run charts, which identified an astronomical data point of CBM completion in May 2022.

Conclusion: Through the implementation of a CBM intervention, a community population of clients with severe persistent mental illness receiving antipsychotic medication showed an increased rate of completing CBM, improving clinical care.

References:

**Poster - Early Investigator**  
**PE26 - Integrating Equity, Diversity, and Inclusion Into Child and Adolescent Psychiatry Training: Co-Creation of a Novel Educational Intervention**

**Friday, Oct. 20**  
10:45 - 11:45 (1 hr)  
Meeting Room: TBC  
Nikhita Singhal*, MD; Jenny Chum, MD; Catherine Deschênes, MD; Ayan Dey, MD, PhD; Oshan Fernando, PhD; Arfeen Malick, MD; Jude Sanon, MD; Yezarni Wynn, MD; Raj Rasasingham, MD; Chetana Kulkarni, MD

**CanMEDS Roles:**

1. Health Advocate  
2. Scholar  
3. Collaborator

**At the end of this session, participants will be able to:**  
1) Evaluate the current state of child and adolescent psychiatry training on equity, diversity, and inclusion principles; 2) Appreciate the value of involving people with lived experience in curriculum design; and 3) Consider innovative and evidence-informed approaches to teaching about topics related to equity, diversity, and inclusion.

The current social climate has brought attention to historic and systemic inequities impacting child and youth mental health. Despite this, equity, diversity, and inclusion (EDI) principles have not been a major component of Canadian child and adolescent psychiatry (CAP) training. We aim to address this gap by developing and evaluating a series of co-created evidence-informed virtual educational modules focused on EDI themes relevant to CAP.

Grounded in Kern's six-step framework for curriculum development, our project comprises the following stages: (1) an environmental scan to better understand the current state of CAP EDI training (sampling program directors, current trainees, and recent graduates); (2) co-design and development of case-based online modules alongside youth advisors with lived experience; and (3) evaluation of the modules based on Kirkpatrick's four-level model.

Results from our initial needs assessment surveys and follow-up interviews indicated a significant gap in EDI training across programs; barriers identified included soliciting local expertise and finding time within curricula. Information collected was reviewed and thematically analyzed to identify module topics and potential design elements. Specific topics of interest included cultural formulation, LBGTQ+ considerations, Indigenous issues, anti-Black racism, and refugee mental health.

The first two modules focus on cultural formulation and anti-Black racism. Evaluation outcomes from our initial pilot test among local CAP trainees will inform iterative refinement of these modules and development of the remaining modules in the series. We anticipate these may be adapted for broad applicability to enhance EDI education for various interdisciplinary health care professionals.

**References:**


**Poster - Early Investigator**  
**PE27 - Longitudinal Associations of Depressive Symptom Severity, Suicidal Ideation, Psychopathology, Trauma, and Substance Use in a Precariously Housed Sample**

**Friday, Oct. 20**  
10:45 - 11:45 (1 hr)  
Meeting Room: TBC  
Lianne Cho*, BSc; Andrea Jones, MD PhD; Geoffrey Smith, PhD; Skye Barbic, OT, PhD; William Honer, MD
CanMEDS Roles:

1. Scholar
2. Communicator
3. Health Advocate

At the end of this session, participants will be able to: 1) Identify predictors of depressive symptom severity and suicidal ideation in a community-based, precariously housed sample; 2) Describe relative contributions of psychopathology, trauma, and substance use to depressive symptom severity and suicidal ideation; and 3) Consider multiple social and psychiatric factors when assessing the presence of depression and suicidal ideation in a community-based setting.

Cross-sectional research shows that precariously housed people have high rates of depression and suicidal ideation (SI). This study examined contributions of psychopathology, trauma, and substance use to depressive symptom severity (DSS) and SI over time in a community-based sample.

Methods: Participants (N = 393, 308 men, median age 42 years [interquartile range 33 to 50]) were recruited from a low-income neighbourhood in Vancouver, Canada. Beck Depression Inventory total scores assessed DSS. SI was defined by endorsement of ≥1 on the Maudsley Addiction Profile suicidality item. Mixed effects regression models were used to identify predictors of DSS and SI, respectively.

Results: More severe depressive symptoms were associated with a history of major depression (odds ratio [OR] 3.09, confidence interval [CI] 2.30 to 4.15, p < 0.0001), lifetime trauma (OR 1.14, CI 1.11 to 1.18, p < 0.0001), concurrent anxiety (OR 1.26, CI 1.24 to 1.28, p < 0.0001), psychosomatic symptom severity (OR 1.05, CI 1.03 to 1.06, p = 0.003), recent trauma (OR 1.33, CI 1.19 to 1.46, p = 0.009), and recent nonprescribed opioid use (OR 1.09, CI 1.06 to 1.12, p = 0.003). Among those who experienced moderate to severe depressive symptoms at least once during the year (n = 178), SI was associated with lifetime trauma (OR 1.10, CI 1.05 to 1.15, p = 0.033), history of psychotic disorder (OR 3.03, CI 2.02 to 4.55, p = 0.006), concurrent anxiety severity, (OR 1.27, CI 1.23 to 1.31, p < 0.0001), and concurrent moderate to severe depressive symptoms (OR 4.26, CI 3.49 to 5.20, p < 0.0001).

Conclusions: While living in precarious housing, multiple social and psychiatric factors were associated with higher risk for more severe depressive symptoms. The data also suggest that assessing a history of psychotic disorder in those with moderate to severe symptoms may help identify SI, which may allow for timely and effective intervention.

References:


Poster - Early Investigator
PE28 - Preliminary Results from the Eye Movement Desensitization and Reprocessing: A Transdiagnostic Approach
Friday, Oct. 20
10:45 - 11:45 (1 hr)
Meeting Room: TBC
Sidney Yap*, BSc; Scot Purdon, PhD; Adam Abba-Aji, MD; Lisa Burchack, MD; Olga Winkler, MD; Suzette Bremault-Phillips, PhD; Raman Dhaliwal, MSc; Katie O’Shea, MSc; Andrew Greenshaw, PhD

CanMEDS Roles:

1. Scholar
2. Medical Expert
3. Health Advocate

At the end of this session, participants will be able to: 1) Describe the preliminary results of the virtual eye movement desensitization and reprocessing (EMDR) study; 2) Describe the safety protocol used in the study and the preliminary safety outcomes; and 3) Describe study limitations and research gaps relevant to the future scale and spread of EMDR for suicidal ideation.

Approximately 800,000 suicides occur annually, with profound personal and societal consequences. Many more suffer with episodic or chronic suicidal ideation, and current treatment is limited by suboptimal access and cost effectiveness.

Eye movement desensitization and reprocessing (EMDR) is a trauma-focused psychotherapy effective for post-traumatic stress disorder (PTSD) and major depressive disorder and associated with reductions in suicidal ideation. Emerging evidence supports its use in people presenting with suicidal ideation in the context of depression and trauma-related mental health crisis; however, no studies have evaluated EMDR specifically targeting suicidal ideation, as opposed to a psychiatric disorder, in a transdiagnostic fashion.

This real-world single blind study evaluates the safety and efficacy of using synchronous online EMDR (12 sessions) for adults with suicidal ideation, compared to treatment as usual. Those with psychosis, mania, severe dissociative symptoms, ongoing trauma-focused psychotherapy, electroconvulsive therapy, or imminent suicidal plan were excluded. EMDR was focused on desensitizing and cognitively restructuring experiences and core beliefs associated with suicidal ideation, regardless of diagnosis. Outcome measures were completed at baseline, two months, and four months. Self-report measures of anxiety, depression, posttraumatic symptoms, emotional dysregulation, and suicidal thinking were compared between the groups. Promising preliminary study results, including safety and adverse events, will be presented. Given the high risk population, study safety precautions will also be highlighted. Results indicate that EMDR focused on experiences associated with suicidal ideation is a promising approach; however, results are preliminary, and study limitations and research gaps remain to be addressed.

References:


Poster - Early Investigator
PE29 - Psilocybin-Assisted Psychotherapy as a Potential Treatment for Eating Disorders: A Narrative Review of Preliminary Evidence
Friday, Oct. 20
10:45 - 11:45 (1 hr)
Meeting Room: TBC
Elena Koning*, MSc

CanMEDS Roles:

1. Scholar

At the end of this session, participants will be able to: 1) Expand knowledge about the potential role of psilocybin-assisted psychotherapy in disordered eating behaviours; 2) Consider the limitations of current evidence and the need for more rigorous trial design; and 3) Contribute to the development of therapeutic methods that target the neurobiological underpinnings of eating disorders.
Eating disorders (EDs) are a group of potentially severe mental disorders characterized by abnormal energy balance, cognitive dysfunction, and emotional distress. Cognitive inflexibility is a challenge to successful ED treatment and dysregulated serotonergic function has been implicated in this symptomatic dimension. Moreover, there are few effective treatment options and long-term remission of ED symptoms is difficult to achieve. There is emerging evidence for the use of psychedelic-assisted psychotherapy for a range of mental disorders. Psilocybin is a serotonergic psychedelic that has demonstrated therapeutic benefit to various psychiatric illnesses characterized by rigid thought patterns and treatment resistance. This paper presents a narrative review of the hypothesis that psilocybin may be an effective adjunctive treatment for people with EDs, based on biological plausibility, transdiagnostic evidence, and preliminary results. Limitations of the psychedelic-assisted psychotherapy model and proposed future directions for the application to EDs are also discussed. Although the literature to date is not sufficient to propose the incorporation of psilocybin in the treatment of disordered eating behaviours, preliminary evidence supports the need for more rigorous clinical trials as an important avenue for future investigation.

References:


Poster - Early Investigator
PE30 - Psychosis in Black People in Canada: Current Status and Perspectives
Friday, Oct. 20
10:45 - 11:45 (1 hr)
Meeting Room: TBC
Elisabeth Dromer*, Clinical Psychology; Jude Mary Cénat, Clinical Psychology; Wina Paul Darius; Emmanuelle Bernheim, Sociology of law; Cary Kogan, Clinical Psychology
Supported by the Transcultural Psychiatry Section

CanMEDS Roles:

1. Scholar
2. Health Advocate
3. Communicator

At the end of this session, participants will be able to: 1) Have a better understanding of current Canadian research on psychosis in Black people in Canada; 2) Understand current gaps in knowledge on this topic; and 3) Receive recommendations for future research to help better support Black people with psychosis in Canada.

Psychosis will affect around 3% of Canadians in their lifetime, but not all Canadians will be impacted in the same way. Important health disparities exist in Canada for people of diverse cultural background, such as those from Black communities. Hence, we conducted a scoping review to examine the current status of Canadian research on psychosis among people from Black communities and explore the gaps in research on this topic to streamline future work. A comprehensive search strategy of 10 databases (including MEDLINE and PsycINFO) was used and 14 studies (of 3,240 articles) were selected following a thorough review process. The sample size across the 14 studies totalled 4,325,166 people. Studies explored various topics relating to psychosis, from incidence of the condition (higher in Black people compared to the general population) to risk of involuntary admission after an episode (also higher in Black people). Racial disparities are evident in some topics, such as coercive referrals, which are more common in Black people, but further research is needed for many of the subjects discussed, such as stigma about illness. Significant blind spots exist in research on psychosis in Black individuals, which universities and governments should seek to uncover through research and increased funding.

References:


Poster - Early Investigator
PE31 - Rates of Disability Among Medical Students and Residents at Dalhousie University
Friday, Oct. 20
10:45 - 11:45 (1 hr)
Meeting Room: TBC
Katherine (Katie) Lines*, MD; Cheryl Murphy, MD

CanMEDS Roles:
1. Health Advocate
2. Scholar
3. Health Advocate

At the end of this session, participants will be able to: 1) Increase awareness regarding the potential number of medical students and residents at Dalhousie University who identify as having a disability; 2) Appreciate some of the experiences of medical learners with regards to discrimination, seeking accommodation, and the impact of disability on learning; and 3) Understand general attitudes and beliefs of medical learners about disability in medical training and practice.

There are no Canadian studies estimating the percentage of medical learners who identify as having a disability or elucidating the challenges they face. The primary objective of this study was to estimate the percentage of medical learners at Dalhousie University who identify as having a disability and to capture their experiences and attitudes towards disability in medical training and practice. The study was conducted by distributing a survey to all medical students and residents at Dalhousie via the RedCap portal, with a response rate of 13.5% (143 completed surveys). The results showed that 17.9% of medical learners reported having a disability, with the most common types being psychiatric (25.9%), chronic medical conditions (25.9%), learning (22.2%), sensory (14.8%), and pain conditions (14.8%). Additionally, the study found that many medical learners did not seek accommodations (47.2%), were not comfortable disclosing their disability (44%), feared not being able to complete medical training (56%), and experienced discrimination (48%). Despite these barriers, most respondents felt that medical learners with disabilities could be successful physicians (82%). This study lays the foundation for deeper examination of the national rates of disability among medical learners. The knowledge gained from this research is crucial in providing tailored support and resources to this subset of medical learners.

References:

Poster - Early Investigator
PE32 - The Journey from Concealment to Disclosure of an Obsessive–Compulsive Disorder Diagnosis in the High School Setting: A Qualitative Study Exploring Youth Perspectives
Friday, Oct. 20
10:45 - 11:45 (1 hr)
Meeting Room: TBC
Tanisha Vallani*, NA; Zainab Naqqash, BA; Boyee Lin, BSc; Cynthia Lu, BA; Jehannine Austin, PhD FCAHS CGC; S. Evelyn Stewart, MD

CanMEDS Roles:
At the end of this session, participants will be able to: 1) Understand the phases and associated key characteristics of disclosing a pediatric obsessive–compulsive disorder (OCD) diagnosis in the school setting and youth-based recommendations for improvement; 2) Understand the importance and implications of OCD-affected youth disclosing or concealing their diagnosis in the school setting; and 3) Understand the critical and unique role qualitative methodology plays in child and adolescent psychiatry research.

Pediatric obsessive–compulsive disorder (OCD) commonly impairs school functioning in terms of concentration, homework completion, certain subject material, executive function, and overall graduation rates. Disclosure of an OCD diagnosis in the high school setting may allow for earlier and more individualized school-based support and may subsequently improve functioning. Our study qualitatively explored the experiences of youth around disclosing their diagnosis in the high school setting and their recommendations for improvement.

Twelve participants, ranging from age 13 to 17 years, were recruited using maximum variance-based heterogeneous purposive sampling. Semi-structured interviews were conducted and analyzed inductively through interpretive description, to generate a theoretical model describing the journey from concealment of an OCD diagnosis to disclosure. The model was modified based on feedback obtained from three member-checking meetings. Four phases of youth disclosure were identified: managing negative internalized beliefs and stigma related to the diagnosis, internal bargaining to determine their individualized disclosure boundaries, trust building with school members, and empowerment by being treated as a person first. Participants’ recommendations for the school setting included meaningful education, safe spaces, deep reciprocal connections, and confidential personalized support.

The youth-based model we developed can help inform school disclosure strategies and optimize support to promote best outcomes for youth with OCD. Future research can explore the perspectives and experiences of youth with increasingly varied demographic and clinical factors and the perspectives of school staff and parents on disclosure and the proposed model.

References:


Poster - Early Investigator
PE33 - Towards Postcolonialism in Psychiatry: A Framework for Residency Training and Community Engagement
Friday, Oct. 20
10:45 - 11:45 (1 hr)
Meeting Room: TBC
Jacquelyn Paquet*, MD, PhD(c), BScN, BSc

CanMEDS Roles:

1. Health Advocate
2. Leader
3. Scholar

At the end of this session, participants will be able to: 1) Identify past and current instances of colonialism in Canada and in medicine; 2) Identify the features of a postcolonial framework in medical education; and 3) Reflect on the current national, faculty, and departmental approach to reconciliation.
First Nations peoples in Canada have been affected by compounding detrimental inequities rooted in colonialism that have significantly impacted their health and well being. Colonialism framed as a social determinant of health compels us to address longstanding political, cultural, and economic inequities facing Indigenous peoples. The challenge of decolonizing current societal institutions founded on colonial norms or forms of knowledge is fraught with difficulties—but it must be addressed.

Objective: We sought to identify approaches to decolonizing psychiatry residency education to mitigate ongoing harms and promote culturally informed approaches to improve the mental well being of Indigenous people.

Results: Recognizing that psychiatry is not culture-neutral, we created a framework for integrating postcolonialism within residency education based on the Truth and Reconciliation Commission of Canada's “calls to action.” (1) Topics and concepts to address throughout the curriculum were identified, and the importance of experiential learning and longitudinal clinical experiences were highlighted. Departmental, institutional, and national recommendations for incorporating postcolonial understanding within psychiatry were also provided, including the need for cultural humility and critical reflection to promote the development of historically and culturally informed collaborative relationships with First Nations people and communities.

Conclusions: A thoughtful educational approach to social justice, developed in collaboration with Indigenous communities, is needed to improve relationships between psychiatry and Indigenous peoples and ensure care delivery from a more culturally informed, sensitive, and holistic lens. We recognize an evolving, anticipatory postcolonial discourse. These beginning steps will undoubtedly transform over time as an understanding of deeply entrenched systems of power and privilege in mental health expands.

References:


Research Poster Session I

Poster - Research
P18 - A Novel Start Regime to Abilify Maintena Once Monthly with Two Long-Acting Injectable Antipsychotic Dose Starting Regimen
Friday, Oct. 20
15:45 - 16:45 (1 hr)
Meeting Room: TBC
Ranjith Chandrasena*, MD, FRCP(C); Sivakumaran Devarajan, MD, FRCPC; Lindsay Warriner, PA-C; Julie Handsor, RPN; Cassandra Dauphin, RPN; Maia Zilberman, BSc

CanMEDS Roles:

1. Health Advocate
2. Leader
3. Collaborator

At the end of this session, participants will be able to: 1) Understand the principles of motivational interviews for patients with cognitive deficits; 2) Understand the principles of successful change management in a health care setting; and 2) Identify techniques of empowering allied health staff to motivate patients.
Nonadherence is the main reason for relapse in patients with psychoses. Long-acting injectable antipsychotic medications (LAIs) are known to reduce relapse and are underused in Canada. This abstract describes the benefits, risks, and patient outcomes of 19 patients using this regime in an outpatient setting, with the novel 2 injections on a startup dosing regimen, with a single oral dose. Principles of motivational interviewing (MI) are used, and techniques addressing the cognitive deficits of patients and empowering allied health staff to carry out psychoeducation with MI training are described. Key principles in change management addressing system factors (patient, family, health care providers, the setting) in achieving outcomes are reviewed. A description of the implementation of the double injection regimen is also included.

References:


Poster - Research
P19 - Bridging Research and Routine Clinical Care: Developing the BC Children’s Hospital Mental Health Research Registry
Friday, Oct. 20
15:45 - 16:45 (1 hr)
Meeting Room: TBC
Gordan Andjelic*, BA; Anna MacLellan, BA, MSc; Roberto Sassi, MD; S. Evelyn Stewart, MD

CanMEDS Roles:

1. Collaborator
2. Scholar

At the end of this session, participants will be able to: 1) Describe lessons learned and implications for full implementation and sustainability of a multiclinic research registry in pediatric mental health; 2) Identify strengths and potential barriers to conducting exclusively online recruitment and electronic consenting; and 3) Understand considerations pertaining to the development and establishment of a robust data access and governance process.

Psychiatric research registries have been in place in northern Europe for many decades but have yet to become the norm in Canadian psychiatry departments. Factors influencing the feasible development and sustainability of Canadian health care-related research registries include federal-provincial funding models, health authority privacy concerns, and research ethics board requirements.

Purpose: We will describe the development, implementation, and expansion of a youth-, parent-, and teacher-informed clinical database and research registry within a tertiary care facility department of psychiatry. In 2011, a research registry was integrated with the founding of an obsessive–compulsive disorder clinical research program. In the following decade, it was expanded across mental health subspecialty outpatient clinics, inpatient units, and a residential treatment facility at BC Children’s Hospital. Key decisions and implementation factors related to the use of a REDCap data storage platform, change management approaches, engagement of clinicians and families with lived experience, and determination of standard operating procedures for standardized data collection with new clinical assessments. Ongoing database management and quality maintenance procedures were established. Collaboration with provincial health services administrators, clinicians, and the university research ethics board was crucial in establishing access/governance processes. Differentiation between electronic medical record data and research data will be discussed in addition to future goals.

Conclusion: Many lessons were learned in the development and expansion of a psychiatry clinical database and parallel research registry over the past decade. This presentation aims to share gained knowledge that may inform interested researchers and clinicians.
At the end of this session, participants will be able to: 1) Identify at least one difference in clinical presentation of people with comorbid bipolar disorder (BD) and substance use disorder (SUD) when compared to those with BD only; 2) Describe which medications (e.g., anticonvulsant mood stabilizers) have been found to be more effective in treating those with BD and comorbid SUD according to the literature; and 3) Explain the importance of understanding the intersection of BD and SUD comorbidity for treatment.

People with bipolar disorder (BD) have higher rates of substance use disorders (SUDs) compared to the general population. (1) Given that SUDs (e.g., cannabis, alcohol, stimulant, MDMA, and opioid use disorders) often begin in adolescence, it is important to understand the clinical and phenomenological characteristics and potential differences that can be targeted for treatment development. In our preliminary work, we have found that anticonvulsant mood stabilizers (e.g., lamotrigine, valproate) appear to have preferential effects on substance use and bipolar symptoms in people with co-occurring SUDs and BD, versus lithium. (2)

Methods: We conducted a systematic review of clinical characteristics of patients with BD. Eleven studies were found in PubMed, MEDLINE, and PsycINFO, including 3,030 participants with BD and co-occurring SUD and 2,851 participants with BD without SUD.

Results: These results suggest that co-occurring BD and SUD have the following clinical characteristics, compared to BD patients without SUD: more rapid cycling illness, dysphoric (mixed) mania, younger age of BD onset, more severe depressive symptoms and more time spent in the depressed versus (hypo)manic phase of illness, lower GAF scores, more suicidal ideation and attempts, more criminal justice system involvement, and more often users of cannabis, alcohol, cocaine and (or) opioids.

Conclusion: Because most studies were cross-sectional, well-controlled high-quality studies are needed to better understand this important comorbidity. Moreover, this work could have important implications for the diagnosis, treatment, and prevention of SUDs in youth with BD.

References:

Poster - Research
P21 - Diabetes Canada 2023 Clinical Practice Guideline Update: Executive Summary of the Mental Health Chapter
Friday, Oct. 20
15:45 - 16:45 (1 hr)
Meeting Room: TBC
David Robinson*, MD FRCPC

CanMEDS Roles:
1. Health Advocate
2. Collaborator
3. Scholar

At the end of this session, participants will be able to: 1) Review the highlights of the Mental Health Chapter of the Diabetes Canada Clinical Practice Guidelines; 2) Analyze psychotropic medications to see their effects on metabolic parameters; and 3) Examine the expanded range of psychiatric conditions that increase the risk of developing type 2 diabetes.

This presentation provides learners with an executive summary of the Mental Health Chapter in the Diabetes Canada Clinical Practice Guidelines, which were updated for 2023. The lead author will give the presentation and highlight the practice applications for mental health care practitioners who are also involved in the care of people with diabetes (principally type 2, but with some information provided on type 1). This presentation will focus principally on the expanded range of psychiatric conditions that put people at risk for developing diabetes, updated pharmacology recommendations, and a summary of the psychosocial approaches that are used in specialty clinics.

References:

Poster - Research
P22 - Efficacy of Incorporating a Stepped-Care Approach into Electronic Cognitive-Behavioural Therapy for Depression
Friday, Oct. 20
15:45 - 16:45 (1 hr)
Meeting Room: TBC
Jasleen Jagayat* BSc, Anastasia Shao BA, Anchan Kumar MD, Amrita Pannu MD, Charmy Patel MSc, Amirhossein Shirazi MD PhD, Mohsen Omrani MD PhD, Nazanin Alavi MD FRCPC

CanMEDS Roles:
1. Scholar
2. Communicator

At the end of this session, participants will be able to: 1) Be able to compare online cognitive-behavioural therapy to traditional face-to-face therapy; 2) Be able to describe the role of a stepped-care model and the benefits of incorporating such a model into mental health care; and 3) Be able to consider using additional interventions in their care that can assist psychotherapy outcomes.

Depression is a leading cause of disability, annually affecting up to 300 million people worldwide, yet fewer than one-third of patients receive care. Electronic cognitive-behavioural therapy (eCBT) is an effective treatment for depression, and combining eCBT with supervised care could make therapy scalable with a stepped-care model: a care model that adapts care intensity based on the patient’s progression. This single-blinded randomized controlled trial investigated the efficacy of a stepped-care eCBT model for depression. Participants were randomized to either the eCBT-only group (n =
53) or the eCBT with stepped-care group (n = 26). Participants in the experimental group received additional interventions from their care provider based on their questionnaire scores and textual data. From lowest to highest intensity, the interventions included messages, phone calls, video calls, or a video call with a psychiatrist. The addition of stepped care was not significantly different from eCBT only. Changes in Patient Health Questionnaire (PHQ-9) scores (p = 0.20), quality of life (p = 0.45), and treatment adherence (p = 0.09) did not change significantly, but changes in Quick Inventory of Depressive Symptomatology (QIDS) scores did reflect significance (p = 0.03). Although there were no significant differences observed between the number of participants who completed the program between groups (p = 0.12), participants in the stepped-care group took part in more sessions than those who prematurely terminated participation in the eCBT group. By understanding the therapeutic needs of each patient, we hope to use these results to develop a decision-making process that can effectively triage patients.

References:


Poster - Research
P23 - Implementing a Community of Practice for Mental Health Advocates in an Immigrant Urban Community in the Greater Toronto Area
Friday, Oct. 20
15:45 - 16:45 (1 hr)
Meeting Room: TBC
Sarosh Khalid-Khan*, MD

CanMEDS Roles:

1. Collaborator
2. Communicator
3. Health Advocate

At the end of this session, participants will be able to: 1) Gain knowledge of the benefit of implementing coaching sessions with mental health advocates in a Muslim immigrant community in Toronto; 2) Become aware of developing a community of practice with mental health advocates; and 3) Learn the role of mental health professionals in developing a community of practice with mental health advocates in a Muslim immigrant community.

Youth are at high risk of mental health disorders and youth suicide rates are going up globally. Muslim immigrant communities in dense urban settings are at increased risk of major mental health disorders due to decreased access to mental health treatments and stigma. Developing a community of practice of trained mental health advocates in these communities is important to increase confidence and self-sufficiency in knowledge of mental health disorders, decrease stigma, and increase help-seeking behaviours.

Objective: We assessed the effectiveness of a community of practice of mental health advocates facilitated by mental health professionals within Taskeen Wellness, a nonprofit organization.

Methods: After mental health advocates received training in common mental health disorders, they received weekly coaching sessions. Subsequently, a community of practice was formed with seven advocates and three mental health professionals, with biweekly sessions. Semistructured interviews were done individually with advocates. Some topics included advocates’ attitudes towards mental health and help-seeking behaviours. Purposive sampling methods were used. Transcripts were analyzed with reflexive thematic analysis.

Results: Mental health advocates developed a deeper understanding of common mental health disorders and were at ease discussing these topics. They gained an appreciation of mental health
help-seeking behaviours and were more likely to encourage community members struggling with mental health issues to seek care. They developed problem-solving abilities within their group and did not need the help of professionals in the community of practice after a year.

References:


Poster - Research
P24 - Incorporating a Physician Assistant into an Outpatient Mental Health Clinic to Improve Access to Care
Friday, Oct. 20
15:45 - 16:45 (1 hr)
Meeting Room: TBC
Karen Shin*, MD; Fathima Adamsahib, BSc, BScPA; Nicole Kirwan, BScN MN CPMHN(C); Venkat Bhat, MD

CanMEDS Roles:

1. Collaborator
2. Professional
3. Leader

At the end of this session, participants will be able to: 1) Describe the professional role of a physician assistant (PA) and how this role differs from a physician, a nurse practitioner, or other health discipline professionals; 2) Understand an effective method to incorporate a PA into an outpatient mental health setting to increase volumes for consultations and follow-up visits; and 3) Anticipate targets for increased in-person and virtual visits in an adult general outpatient clinic and a subspecialized mental health program.

Physician assistants (PAs) are a relatively new category of skilled health professionals in Canada. PAs support physicians in all health care settings and can increase access to care. With growing pressures on the mental health care system, and a need to improve structures, incorporating PAs is an important option to consider.

Purpose: The Ambulatory Mental Health Service at St. Michael’s Hospital incorporated a full-time PA into its outpatient department to increase patient volumes and start a new interventional program dedicated to providing repetitive transcranial magnetic stimulation, IV ketamine, and other novel treatments. The PA’s clinical volumes were reviewed to characterize the additional patient visits.

Methods: Patient registration data were reviewed for all PA visits between April 2021 and November 2022. The data were categorized according to the specific ambulatory clinic and the type of clinical visit: in person, by phone, or by video. Descriptive statistics were generated according to these categories.

Results: The PA provided care for 909 patient visits from April 2021 through March 2022. From April 2022 through November 2022, the PA provided care for 452 patient visits. There were a total of 34 in-person visits, 580 telephone visits, and 747 video visits over the 20-month period. Most of these visits were in the interventional program.

Conclusion: Through the implementation of a PA, over a thousand additional patients accessed outpatient mental health services, including difficult-to-obtain interventional treatments. The success of incorporating a PA into an outpatient setting to enhance patient volumes illustrates the importance of innovative clinical team structures.
Poster - Research
P25 - Personal Narratives of COVID-19 Impacts on Canadian Youth: A Qualitative Analysis of Related Life Domains
Friday, Oct. 20
15:45 - 16:45 (1 hr)
Meeting Room: TBC
Anna MacLellan, MSc; Caitlin Slomp, MSc; John Best, PhD; Zainab Naqqash, BA; Cynthia Lu, BA; Boyee Lin, BA; Hasina Samji, PhD; Evelyn Stewart, PhD*
Supported by the Child and Adolescent Psychiatry Section

CanMEDS Roles:
1. Health Advocate
2. Collaborator

At the end of this session, participants will be able to: 1) Be able to identify the five life domains of youth and family functioning that were most impacted by the COVID-19 pandemic; 2) Gain a better understanding of both negative and positive outcomes of the pandemic from diverse perspectives; and 3) Be able to identify individual protective and risk factors for youth outcomes during the pandemic.

The COVID-19 pandemic had widespread impacts on Canadians. Youths were particularly impacted during this time, as COVID-19 occurred during critical social, emotional, and developmental phases. The purpose of this study was to use personal narratives to better understand the far-reaching consequences of the pandemic on youth.

Method: Two cohorts were recruited to complete one-hour semi-structured interviews of 1) youth aged 8 to 18 years and 2) the parents of youth aged 8 to 18 years. Participants were purposively recruited as guided by baseline questionnaire data from a quantitative survey of COVID-19 impacts on Canadians. Interviews were audiotaped, transcribed, and analyzed with interpretive description methods.

Results: A total of 18 youth and 17 parents were interviewed, identifying five life domains impacted by COVID-19: 1) MH, 2) emotional, identity, and developmental; 3) educational, 4) familial, and 5) social. Youth reported being most impacted by social consequences of the pandemic, which subsequently influenced their MH and other life domains. Deteriorating social skills and increased behavioural problems during the pandemic were highlighted. Youth with and without pre-existing clinically significant MH problems experienced symptomatic worsening along with socio-emotional and identity changes. Many youths described transition struggles between at-home and in-person schooling models, with significant learning disruptions. Impacts on family and home life were mixed and seemingly influenced by such factors as location, size of home, and parents’ working status.

Discussion: Canadian youth experience persisting social, educational, and MH impacts as a result of COVID-19. Additional supports may be required in the postpandemic era to bridge the gaps created in these domains.

References:

References:

**Poster - Research**

**P26 - Physician Burnout in the Era of COVID-19**

Friday, Oct. 20  
15:45 - 16:45 (1 hr)  
Meeting Room: TBC  
Ahila Vithiananthan*, MD Imaan Javeed, MD
CanMEDS Roles:

1. Health Advocate
2. Leader
3. Collaborator

At the end of this session, participants will be able to: 1) Gain a further understanding regarding gender differences in the determinants and experience of burnout; 2) Reflect on burnout experience in relation to specialty choice and how this has been affected by the pandemic; and 3) Gain a further understanding of the factors leading to burnout during the pandemic.

Physicians work hard and often in challenging circumstances with limited resources. This has been especially difficult during the COVID-19 pandemic. Dedication to patient care can result in poor self-care and can lead to physician suicide, burnout, and suboptimal patient care. The prevalence of physician burnout has been growing recently and affects individuals differently. It is important to understand who is affected by burnout and how gender, specialty choice, and generational differences may affect how one perceives their quality of life and career. This presentation will also look at how COVID-19 has affected physician burnout and resulted in challenges to the healthcare system. This presentation will identify risk factors for burnout and strategies to address and mitigate this risk.

References:


Poster - Research
P27 - Quick Takes: Bringing Medical Education Directly to Physicians' Ears Through Podcasting
Friday, Oct. 20
15:45 - 16:45 (1 hr)
Meeting Room: TBC
David Gratzer*, MD, FRCPC; Lawrie Korec, BA; Stephanie Sliekers, MA

CanMEDS Roles:

1. Communicator
2. Medical Expert
3. Scholar

At the end of this session, participants will be able to: 1) Better understand and appreciate the literature supporting podcasts for medical education; 2) Better understand and appreciate the benefits and problems of trying to use technology for medical education; and 3) Better understand and appreciate the future direction of medical education.

Engaging physicians in education is challenging. Growing literature suggests that doctors respond well to podcasts. That said, there is a paucity of this type of educational material available in mental health. While podcasting is commonly used in areas like emergency medicine, little has been done in terms of creating such accessible professional learning and knowledge exchange in psychiatry. The primary goal of this project is to create a podcast series to educate time-limited psychiatrists. The podcasts focus on mental health issues relevant to physicians, such as the clinical implications of cannabis legalization. Podcasts are concise (15 minutes) while delivering quality information that physicians can immediately implement in their practices. Working with CAMH Education, the podcasts take on current mental health issues with expert interviews, offering information in a question-and-answer format. The first podcast was emailed to CAMH physicians on October 2018. The work has been promoted through social media and launched on Portico Network. The podcast series is evaluated on an ongoing basis using several metrics (including downloads), as well as learner feedback.
feedback (through short surveys, which include the opportunity for comments). We now have over four years of data: we have released 24 podcasts and have data within CAMH (179 email opens on its launch day) and on Twitter (more than 300,000 impressions), as well as the total downloads (more than 16,000). By the time of the conference, we will have both qualitative and quantitative data to present on the 30 podcasts that will have been released.

References:


Poster - Research
P28 - Safety Pods: An Innovative Approach to Restraint Reduction and Trauma-Informed Care
Friday, Oct. 20
15:45 - 16:45 (1 hr)
Meeting Room: TBC
Joshua Smalley*, MD, FRCPC Roxanna Sheppard, RN, BScN, CPMHN(c), CHE, M.Cert Emily Smith, RN, BScN, CPMHN(c) Sarah Giroux, RN, BN, CPMHN(c) Sarah Hendry, RN, BN, CPMHN(c)

CanMEDS Roles:
1. Leader
2. Medical Expert
3. Health Advocate

At the end of this session, participants will be able to: 1) Identify the role of safety pods as an alternative to traditional methods of physical restraint; 2) Reflect on how a quality improvement framework can be used to reduce physical restraint in an inpatient setting; and 3) Discuss approaches to implementing trauma-informed care when physical restraint is required.

Restraints on inpatient psychiatry units, while at times necessary as a means to protect patients and others from imminent harm, can inadvertently negatively impact patient physical and psychological health. As part of an ongoing commitment to restraint reduction and trauma-informed care, (TIC) the Children’s Hospital of Eastern Ontario (CHEO) introduced the UK Safety Pod to its inpatient psychiatry unit. This was completed as part of a quality improvement initiative targeting restraint reduction and TIC. A first in Canada, CHEO implemented this device in June 2022 to offset the negative effects of restraints, promote youth and staff safety, and reduce the use of both mechanical and ground restraints. The benefits of the UK Safety Pod are its shape, size, and construction, which allows for a more person-centred approach to restraints. The pod resembles a beanbag chair but with a sturdier and more supportive construction. Since implementation, some of the benefits witnessed so far include less traumatic interventions, reduced risk of injury, increased safety for unit staff, increased comfort during restraint, more dignified approach for patients, and creation of a safe and comforting space outside of restraints to support patients in their own de-escalation. Since implementation, staff have decreased the use of other riskier forms of restraint and the amount of time patients spend in restraints. The UK Safety Pod has positively contributed to supporting the unit’s overall goals in restraint reduction and increased TIC.

References:

Poster - Research
P29 - Solriamfetol Demonstrates Sustained Effects in Improving Cognitive Function in Patients with Excessive Daytime Sleepiness Associated with Obstructive Sleep Apnea

Friday, Oct. 20
15:45 - 16:45 (1 hr)
Meeting Room: TBC
Eileen Leary*, PhD; Hans Van Dongen, PhD; Christopher Drake, PhD; Richard Bogan, MD; Judith Jaeger, PhD; Russell Rosenberg, PhD; Caroline Streicher, BA; Hannah Kwak, MHS; Jay Bates, PhD; Herriot Tabuteau, MD

CanMEDS Roles:

1. Medical Expert
2. Professional
3. Scholar

At the end of this session, participants will be able to: 1) Understand the clinical rationale for evaluating cognitive function in patients affected by excessive daytime sleepiness and obstructive sleep apnea; 2) Understand the results of the SHARP trial, which evaluated the impact of solriamfetol on cognition in patients with cognitive impairment and excessive daytime sleepiness associated with obstructive sleep apnea; and 3) Understand the experimental rationale for using the Repeatable Battery for the Assessment of Neuropsychological Status in measuring changes in cognition.

Obstructive sleep apnea (OSA) is a common disorder resulting in disrupted sleep and excessive daytime sleepiness (EDS). Cognitive impairment is a burdensome symptom in many patients. Solriamfetol is approved to improve wakefulness in adults with EDS associated with OSA, but its effect on cognitive impairment is unknown. The SHARP study evaluated whether solriamfetol improves cognitive function in patients with OSA-associated EDS and impaired cognition.

Methods: SHARP was a randomized double-blind placebo-controlled crossover trial in 59 patients with OSA, EDS, and cognitive impairment. All patients received solriamfetol for two weeks (75mg daily day for three days, then 150mg daily), and placebo for two weeks, separated by a one-week washout. The primary endpoint was change from baseline on the Digit Symbol Substitution Test equivalent of the Repeatable Battery for the Assessment of Neuropsychological Status (DSST-RBANS). Secondary endpoints included duration of effect and Patient Global Impression of Severity (PGI-S) of cognitive impairment.

Results: Solriamfetol improved performance on the DSST-RBANS compared to placebo (6.49 vs. 4.75, p = 0.009), with an effect size (Cohen’s d) of 0.36. The effect was evident in the solriamfetol-placebo difference at each timepoint: 2 hours (1.91, p = 0.033), 4 hours (1.38, p = 0.089), 6 hours (2.33, p = 0.004), and 8 hours (1.58, p = 0.022) post-dose. PGI-S scores were improved during treatment with solriamfetol compared to placebo (–0.90 vs. –0.61, p = 0.034). The most common adverse events were nausea (6.9%) and anxiety (3.4%).

Conclusions: Solriamfetol (150mg daily) improved cognition as measured by the DSST-RBANS, with sustained effects, and reduced perceived symptom severity in patients with OSA-associated EDS and impaired cognition.

References:


Poster - Research
P30 - TikTok's Sick Role Subculture and the Rise of Self-Diagnosis

Friday, Oct. 20
15:45 - 16:45 (1 hr)
CanMEDS Roles:

1. Communicator
2. Health Advocate
3. Collaborator

At the end of this session, participants will be able to: 1) Learn about the contributing factors of why teens avoid seeking professional help for their mental health; 2) Ascertain the factors involved with why teens may want to appropriate mental health symptoms; and 3) Learn what the risks and outcomes of self-diagnosis are.

TikTok is a social media application that was released to the public in 2016 and has since influenced the way teens and young adults perceive their mental health. Although TikTok has helped to destigmatize mental health, it has also led to teens self-diagnosing with various mental health conditions. There has been concern that teens are using mental health to reach influencer status, and there has been a trend to appropriate illness for attention on social media. Individuals have been mislabelling occasional symptoms as identifying with severe mental illnesses. Recommendations to address this phenomenon include asking patients about their relation to social media, understanding the symptoms patients are expressing, and providing psychoeducation about mental health symptoms and diagnostic clarification.

References:


Poster - Research
P31 - Training Mental Health Advocates to Build Mental Health Awareness for Youth in an Immigrant Community in the Greater Toronto Area
Friday, Oct. 20
15:45 - 16:45 (1 hr)
Meeting Room: TBC
Sarosh Khalid-Khan*, MD; Faiza Khalid-Khan, MSW

CanMEDS Roles:

1. Collaborator
2. Communicator
3. Health Advocate

At the end of this session, participants will be able to: 1) Learn strategies to raise mental health awareness in an immigrant community in Toronto; 2) Become aware of change in attitudes after knowledge transfer in mental health advocates; and 3) Gain knowledge of content of mental health training modules for mental health advocates.

Immigrant communities in Canada often struggle due to lack of mental health awareness. With stressors of immigration, there is increased incidence of stigma and major mental illness. Providing mental health training to mental health advocates in immigrant communities is the first step towards building awareness. Taskeen Wellness, a non-profit organization, aims to increase mental health capacity in immigrant communities.

Objective: The aim of this study was to assess the effectiveness of modules on anxiety and mood disorders, attention-deficit hyperactivity disorder (ADHD) and post-traumatic stress disorder (PTSD) delivered to mental health advocates in two communities in Scarborough, Toronto.
Methods: Mental health advocate trainees were recruited. Workshops delivered for three cohorts of parents and youth; 16 people participated. Parent cohorts consisted of community leaders, volunteers, and health workers or ambassadors. The youth cohort consisted of undergraduates, high school students, and community volunteers. Participants filled out knowledge acquisition questionnaires before and after the workshops and provided qualitative feedback.

Results: All participants (100%) “strongly agreed” sessions increased understanding of mood disorders, anxiety disorders, ADHD, and PTSD; 75% of participants “strongly agreed” and 25% “agreed” sessions increased understanding of treatments for mood and anxiety disorders; 83.3% of participants "strongly agreed" that sessions increased knowledge of anxiety disorders. All participants found the workshop format “interactive and engaging,” and all of the participants found workshop content “relevant and useful.”

Conclusions: Stigma of mental illness in immigrant communities is rampant, although there is increased incidence of major mental illness due to the increased stress of immigration. Modules to train mental health advocates in common mental health disorders were effective.

References:

Poster - Research
P32 - Transdiagnostic Online Eye Movement Desensitization and Reprocessing for Suicidal Ideation: Theory, Practice, and Lessons Learned
Friday, Oct. 20
15:45 - 16:45 (1 hr)
Meeting Room: TBC
Lisa Burback*, MD; Olga Winkler, MD; Sidney Yap, MSc Psychiatry

CanMEDS Roles:
1. Scholar
2. Medical Expert
3. Health Advocate

At the end of this session, participants will be able to: 1) List and describe three theories of suicidal ideation and how they relate to using eye movement desensitization and reprocessing (EMDR) for suicidal ideation; 2) Appreciate the transdiagnostic potential, safety, and limitations of EMDR for addressing experiences related to suicidal ideation; and 3) List at least four strategies for targeting suicidal ideation with EMDR, depending on clinical context.

Suicide is a serious public health issue, accounting for 800,000 lives lost annually. Currently available evidence-based psychotherapeutic treatments for suicidal ideation usually focus on stabilization, coping strategies, cognitive interventions, and managing emotional dysregulation. Unfortunately, these approaches are limited by issues of access, acceptability, and efficacy. There is, therefore, an urgent need to explore new, cost-effective approaches that can be scaled. Trauma-focused therapies are associated with reductions in suicidal ideation but are often avoided in those with suicidal ideation, as they can be distressing. Online treatment of this high-risk population became necessary because of the COVID-19 pandemic, despite initial safety concerns. The Virtual Eye Movement Desensitization and Reprocessing (EMDR) for Adults with Suicidal Ideation Study is a real-world, nonblinded, randomized study evaluating the safety and efficacy of remotely delivered EMDR, compared to treatment as usual, for suicidal ideation and symptoms of anxiety, depression, post-traumatic stress disorder (PTSD), emotional dysregulation, and dissociation. This workshop will present the rationale for the novel use of EMDR to target experiences associated with suicidal ideation, contextualized within current theories of suicide and the evolving evidence base. Innovative therapy elements, including reconceptualization of suicidal ideation subtypes, the transdiagnostic nature of the
intervention, and intensive online delivery will be outlined, with interactive case examples and audience participation. Preliminary quantitative and qualitative study results will be presented, as well as cases that challenge current theories of suicide. Opportunities and challenges for implementation into systems of care will be discussed.

References:


Poster - Research
P34 - Eye Tracking to Identify Potential Biomarkers for Adolescent Major Depressive Disorder
Friday, Oct. 20
15:45 - 16:45 (1 hr)
Meeting Room: TBC
Blake Noyes*, BScH; Linda Booij, PhD; Heidi Riek, BScH; Isabell Pitigoi, BScH; Jeff Huang, BScH; Don Brien, PhD; Brian Coe, PhD; Brian White, PhD; Sarosh Khalid-Khan, PhD; Doug Munoz, PhD

CanMEDS Roles:

1. Scholar

At the end of this session, participants will be able to: 1) Understand the use of eye tracking as a noninvasive technique to study neural functioning; 2) Understand the neural circuitry involved with saccades, blinks, and pupil changes; and 3) Identify differences in pupil size, saccade behaviour, and blink rate between people with major depressive disorder and control subjects.

Although numerous potential biomarkers for major depressive disorder (MDD) have been identified, there are yet to be any widely integrated into clinical practice (Strawbridge et al., 2017). In addition to inconsistencies within research, the invasiveness of traditional biomarker techniques, such as blood and genetic analysis, will pose challenges for clinical use. This problem may be addressed via eye tracking; a well-established, non-invasive technique to identify alterations in specific neural networks responsible for cognitive control, arousal, attention, and orienting responses. The goal of this ongoing study is to use video-based eye tracking to compare saccade behaviour, pupil size, and blink rate in people with MDD and healthy control subjects. The current sample includes 33 control subjects (mean age [M] 19.1 years, 30 women, Patient Health Questionnaire [PHQ] score = 2.6) recruited from the community and 14 people with MDD (M = 16.5 years, 10 female, PHQ score = 13.2) recruited from a local psychiatric outpatient program. All participants completed self-report questionnaires for mental health symptoms and the Interleaved Pro-Anti Saccade eye-tracking task (Munoz et al., 2004). Preliminary analyses showed that participants with MDD had slower saccadic reaction time and generated more direction errors when making pro- and anti-saccades, blinked more during important visual instructions, and had blunted pupil responses throughout the task compared to control participants. Data collection is ongoing. These results suggest that eye tracking may be a feasible technique to distinguish people with MDD from control subjects and identify potential eye movement biomarkers for future diagnostic purposes.

References:

Keynote Plenary
Saturday, Oct. 21
09:00 – 10:30 (1.5 hr)
Meeting Room: Grand Ballroom
Joshua Rosenblat, MD, FRCPC; Sarah Hales, MD, PhD, FRCPC; Shannon Dames, RN, MPH, EdD

Symposium
S14 - BC Provincial Obsessive–Compulsive Disorder Program Research Update: Towards Biomarker Development in Childhood Onset
Saturday, Oct. 21
10:45 - 11:45 (1 hr)
Meeting Room: TBC
S. Evelyn Stewart*, MD; Elise Ewing, BSc; Clara Westwell-Roper, MD PhD

CanMEDS Roles:

1. Scholar
2. Medical Expert
3. Health Advocate

At the end of this session, participants will be able to: 1) Define the potential types and prognostic use of biomarkers in childhood-onset obsessive–compulsive disorder (OCD); 2) Describe relations between medical conditions and OCD symptoms in children and youth, focusing on the recent characterization of immune-related comorbidities; and 3) Explain the potential role of epigenetic biomarkers to improve our understanding and treatment of childhood-onset OCD.

Obsessive–compulsive disorder (OCD) is a common neuropsychiatric condition affecting 1% to 2% of children and youth. Although cognitive-behavioural therapy (CBT) and serotonin reuptake inhibitors are effective treatments, nonresponse is common and symptoms often persist into adulthood. Additional strategies are needed to identify subgroups of people who may benefit from targeted treatment approaches.

In this research symposium, we introduce biomarkers in mental health and their potential use in OCD, highlighting novel findings of three provincial research initiatives.

First, we present analyses of salivary immune markers in pediatric OCD, highlighting variables to consider when measuring analytes in the oral compartment and associations between pro-inflammatory cytokine levels and symptom severity. Second, we discuss the importance of medical comorbidities for both clinical management and biomarker development, focusing on the characterization of immune-related comorbidities in youth with OCD compared to those attending other psychiatric outpatient clinics. These data expand on our previous findings from an international multisite study in adults. Finally, we present findings from an epigenome-wide association study examining DNA methylation in buccal swabs from OCD-affected youth, compared to control subjects, before and after a course of CBT. We describe potential functions of co-methylated regions showing significant differential methylation, including annotation to genes with overlapping roles in neuronal development and immune function.
Taken together, these findings suggest novel approaches to combined clinical and laboratory phenotyping that will inform larger-scale studies characterizing the complex interplay between genetic and environmental factors that impact OCD symptoms and treatment response.

**Symposium**

**S15 - Treatment-Resistant Bipolar Disorder: Underlying Mechanisms and Novel Treatments**

Saturday, Oct. 21
10:45 - 11:45 (1 hr)
Meeting Room: TBC
Cynthia Calkin*, MD, CCFP, FRCPC; KN Roy Chengappa, MD; Jessica Gannon, MD

**CanMEDS Roles:**

1. Medical Expert
2. Scholar
3. Health Advocate

**At the end of this session, participants will be able to:**
1) Understand the importance of recognizing and treating insulin resistance (IR) in treatment-resistant bipolar depression (TRBD); 2) Review potential mechanisms underlying TRBD associated with IR; and 3) Discuss the measurement of IR and the clinical predictive models to predict IR reversal with metformin in patients with TRBD.

Treatment-resistant bipolar depression (TRBD) remains highly recalcitrant to pharmacological and somatic interventions. The first speaker will review recent definitions and economic costs of TRBD and introduce an intriguing mechanism that may underlie TRBD in a significant proportion of patients (i.e., insulin resistance [IR]). He will then review how the development of IR and diabetes changes a responsive bipolar illness course to one of poor clinical outcomes and is further complicated by comorbidities and treatment resistance. Our second speaker will present the results of a 26-week, proof-of-concept, quadruple-blind randomized placebo-controlled clinical trial, using adjunctive metformin as an insulin sensitizer in TRBD patients who also met predefined IR resistance criteria. She will review the two-step hypothesis that underscored the study design, the rationale for using metformin, and present data showing improvements in depression and general functioning among those who converted (i.e., switched from IR to insulin sensitive). She will provide suggestive evidence for why improvements in blood-brain barrier disruptions may underlie these positive clinical outcomes. Our third speaker will address improvements noted among converters in anxiety, clinical global impressions, and lack of emergence of suicidality or mania. She will then discuss how front-line psychiatrists might screen for IR in TRBD patients and use office-based clinical and laboratory tools at their disposal to predict which of their TRBD patients might respond to metformin. Finally, future clinical directions, including the use of alternative insulin sensitizers (e.g., semaglutide), and mechanistic underpinnings will be reviewed with the audience.

**Workshop**

**W24 - Cancer and Severe Mental Illness: Navigating the Syndemic Challenges**

Saturday, Oct. 21
10:45 - 11:45 (1 hr)
Meeting Room: TBC
Jenna Nensi*, MD (2025); Oyedeji Ayonrinde, MD, MBA; Sara Mohamed, BS

**CanMEDS Roles:**

1. Health Advocate
2. Scholar
3. Collaborator

**At the end of this session, participants will be able to:**
1) Identify specific challenges or limitations to equitable cancer care for people with severe mental illness; 2) Recognize ethical challenges associated with the elimination of barriers; and 3) Critically review psychiatric aspects of oncology guidelines for common cancers.
Cancer is one of Canada's most common noncommunicable diseases. Cancer screening, treatment, and monitoring can be challenging for people with severe mental illness (SMI), including schizophrenia and bipolar disorder. This is demonstrated as people with SMI experience a substantial disparity in cancer mortality compared to those without SMI. (Kisely et al, 2013) Our study aims to close this gap by identifying specific SMI and equity diversity inclusion (EDI) barriers that affect screening, early diagnosis, and treatment of common cancers, including lung, breast, cervical, and colorectal cancers. Provincial guidelines for common cancers were reviewed by an intersectoral team, including psychiatrists and professionals with lived expertise, to gain insight into the real-life barriers, health inequities, and challenges that may contribute to disparate health outcomes among people with SMI. Specific barriers were identified, highlighting the limitations of cancer care guidelines and practices that potentially impact cancer morbidity and mortality among this population. In this workshop, participants will work through vignettes of patients with an SMI and participate in discussions about the potential barriers these patients may face during cancer screening, treatment, and follow up. Participants will also be faced with ethical considerations regarding the cancer care of people with SMI, such as obtaining informed consent. It is anticipated that participants will gain insight into the real-life barriers, health inequities, and challenges that may contribute to disparate health outcomes among people with SMI.

References:


Workshop
W25 - Opioid Use Disorder: Addiction Medicine Review for Psychiatrists
Saturday, Oct. 21
10:45 - 11:45 (1 hr)
Meeting Room: TBC
Wiplove Lamba*, MD, FRCPC; Valerie Primeau, MD FRCPC

At the end of this session, participants will be able to: 1) Describe the impact of the opioid epidemic on patients presenting to their psychiatric practice; 2) Describe the main treatments for opioid use disorders including harm reduction approaches, opiate agonist treatment, and psychosocial interventions. 3) Develop a learning plan to improve proficiency in these treatments and strategies on integrating it in their practice.

Canada is the midst of an opioid epidemic where prescribing of opioids is increasing along with accidental overdose deaths of opioids. In fact, during COVID, the accidental overdose death rates due to opioids have doubles throughout the country. Some of the causes are iatrogenic in terms of opioid prescribing over the past 20 years while others are related to illicit opiate availability. Psychiatrists have an opportunity to assess and treat these patients in their outpatient practice, as well as in the emergency or inpatient environment. Given their comfort level with mental health issues, psychiatrist can also offer treatment for co-morbid mental illnesses. Here we will cover the basics of an opioid assessment, risks and benefits of different treatments, harm reduction approaches, as well as how to initiate someone on buprenorphine/naloxone in an outpatient setting. Attendees will receive a nonindustry booklet on the assessment and treatment of opioid use disorder. This workshop will cover novel approaches to opioid use disorder including microdosing, macrodosing, and injectable buprenorphine.

References:

Workshop
W26 - In Process: Lessons learned from developing an antiracism process-based curriculum for psychiatry residents
Saturday, Oct. 21
10:45 - 11:45 (1 hr)
Meeting Room: TBC
Xin Qiang Yang*, MD, MSc; Catherine Ouellet; Sarah Hanafi, MD; Laurence Ducharme; Miranda Sanokho; Zoe Thomas; Nabila Boudef; Amanda Sky Domingues-Udovicic
Supported by the Structural Racism and Discrimination Task Force

CanMEDS Roles:
1. Health Advocate
2. Professional
3. Communicator

At the end of this session, participants will be able to: Describe the negative mental health outcomes associated with implicit racist bias and explain the role of process-based learning in antiracism education. List educational techniques used in process-based antiracism education. Identify preliminary steps towards integrating elements of antiracism education in their respective settings.

In response to resident feedback about the dearth of antiracism education, the McGill University Psychiatry Program piloted an antiracism process workshop for residents which was first offered in the fall of 2022. Resident feedback was collected in order to evaluate the workshop and disseminate findings.

This CPA workshop will initially highlight the importance of process-based antiracism education, reviewing the literature around negative health outcomes associated with implicit bias and pitfalls associated with purely didactic equity training. The workshop will then describe how the McGill process curriculum was developed, outlining practical steps taken. The workshop will provide an overview of the four sessions, including specific pedagogical techniques that were used, such as self-reflection, case discussion, role play and mindfulness. We will also share resident feedback, in order to underscore successful aspects of the curriculum and areas for improvement. Our preliminary results suggest positive experience in the antiracism curriculum, due to the creation of a safe, non-judgemental space within which to develop awareness of one’s own cultural identity and biases, and their influences on clinical practice. Logistics, however, proved challenging.

The final 20 minutes of the workshop will be devoted to participant self-reflection and discussion around the pertinence, as well as the feasibility, of implementing a similar antiracist educational initiative in their local setting.

References:

Workshop
W27 - Are Mental Disorders Brain Disorders?
Saturday, Oct. 21
10:45 - 11:45 (1 hr)
Meeting Room: TBC
Joseph Burley*, M.D; Casimiro Cabrera Abreu, M.D.

CanMEDS Roles:
1. Communicator
2. Medical Expert
3. Collaborator

At the end of this session, participants will be able to: 1) Discuss evidence related to the question, "Are mental disorders brain disorders?"; 2) Understand and be able to discuss the difference, similarities, and relation between brain and mind; and 3) Understand a working model of the mind, which applies to clinical practice.

There is no doubt the brain is necessary for the emergence of consciousness and mental disorders. Over the last two decades there have been recurring calls to classify mental disorders as brain disorders, based on the theory that all mental disorders originate from neurobiological pathology. There have been significant advances in understanding the brain, its anatomy, neurobiology, and pathology; however, few of our presently classified mental disorders. It is theorized that with further research we will eventually be able to make the correlation. It is possible that the problem lies with our diagnostic classification system?

The question that remains is "is understanding the brain enough to understand and get to the root causes and most effective treatments of mental disorders? Is it possible that other factors are required to answer this question? Is it possible that the brain and mind are not the same phenomena?

This workshop will briefly present pro and con arguments for these questions as a platform to generate discussion. It is hoped that the discussion amongst participants will generate ideas and concepts relevant to clinical practice and psychiatric research and questions of diagnostic classification.

Workshop
W28 - Lessons for Young Therapists: Getting Started and Staying on Track in Your Psychotherapy Practice
Saturday, Oct. 21
10:45 - 11:45 (1 hr)
Meeting Room: TBC
Vincenzo Di Nicola*, MD PhD FRCPC FCAHS

CanMEDS Roles:

1. Professional
2. Collaborator
3. Communicator

At the end of this session, participants will be able to: 1) Discern the patterns in psychotherapeutic practice based on a survey of the evolution and current practices of psychotherapy; 2) Answer such basic questions as to what to read and how to begin therapy and what motivates both the patient and therapist; and 3) Avoid theoretical riddles and practical traps and focus on the therapeutic relationship and its ethical conduct.

In these seven lessons for young therapists, a practising psychiatrist and psychotherapist with more than 40 years' experience surveys what therapy is about and how it works, from behaviour therapy and family therapy to psychodynamic psychotherapy. Ranging from what to read and how to begin therapy, the lessons cover therapeutic temperaments and technique, the myth of independence and individual psychology, the nature of change, the evolution of therapy, the search for meaning and relational ethics, and finally, when therapy is over.

Overview:

1. People come into therapy in order not to change – When does therapy begin?
2. Therapeutic temperaments – Who conducts therapy and why?
3. The family as a unique culture – Relational psychology and relational therapy.
4. Changing the subject – How does therapy work?
5. One hundred years of invisibility – The evolution of therapy from the 19th-century discovery of the unconscious to the 21st-century values of diversity, decolonization and change.
7. And on the seventh day, the Lord rested – When therapy is over: The myth of closure, flow, and slowness in therapy.

This workshop integrates the author's model of working with families across cultures presented in "A Stranger in the Family: Families, Culture, and Therapy" (1997) and elaborated in his "Letters to a Young Therapist" (2011) with more recent work on trauma-informed therapy in "Trauma and Transcendence" (Capretto & Boynton, eds., 2018), and his "Slow thought manifesto" (2019).

References:


Workshop
W29 - Models of Holistic Mental Health Care on the Streets
Saturday, Oct. 21
10:45 - 11:45 (1 hr)
Meeting Room: TBC
Deborah Pink*, MD, FRCPC; Michaela Beder, MD, FRCPC

CanMEDS Roles:

1. Collaborator
2. Health Advocate
3. Medical Expert

At the end of this session, participants will be able to: 1) Understand the complexity of homelessness and the various models of care that serve this population; 2) Understand the intersection between homelessness and health; and 3) Gain skills related to providing health care to people experiencing homelessness including street homelessness.

Homelessness impacts over 235,000 in Canada every year. In our difficult economic times, and especially in light of the upheaval of the COVID-19 pandemic, there are many paths to homelessness. For some people, job loss leads to loss of homes, while for others mental illness and substance use, coupled with insufficient access to care and social supports leads to years on the streets, in shelters, and in and out of jails.

Psychiatrists often encounter people who are homeless in emergency and inpatient settings, but there is an increasing number of clinicians who work in settings with people during episodes of homelessness. These psychiatrists have developed a clinical approach, as well as an understanding of larger systems issues and health inequities, and have a unique perspective on how to best provide treatment and services for people who are experiencing homelessness and who struggle to access psychiatric and medical care in traditional settings. In this interactive workshop, two psychiatrists working with innovative organizations will provide an overview of evidence-based practises in homelessness mental health care, as well as pearls from their clinical experience.

Access to mental health care remains challenging for many people who are homeless, disconnected from supports, struggling with psychosis and/or substance use, the effects of trauma, and cognitive challenges. Using an interactive case, we will discuss how to enhance health equity for clients who are experiencing homelessness, including a review of clinical pearls, evidence-based practices, models of care, ways of increasing access, and pharmacologic management.
Workshop
W30 - Using Ethno-Psychopharmacology Concepts for Best Practices in Clozapine Prescribing
Saturday, Oct. 21
10:45 - 11:45 (1 hr)
Meeting Room: TBC
Reza Rafizadeh*, BPharm, ACPR, BCPP; Reza Rafizadeh, BPharm, ACPR, BCPP; Harish Neelakant, MD, FRCPC; Randall White, MD, FRCPC

CanMEDS Roles:
1. Collaborator
2. Health Advocate
3. Medical Expert

At the end of this session, participants will be able to: 1) Perform risk stratification analysis at baseline for personalized dosing of clozapine; 2) Recognize and manage major drug-disease and drug-drug interactions that can contribute to clozapine toxicity; and 3) Describe a model for community-based treatment optimization for patients with complex and chronic psychotic disorders.

Clozapine is the only registered treatment for treatment-resistant schizophrenia (TRS), psychosis in Parkinson disease, and, in the United States, suicidality in schizophrenia and schizoaffective disorder. Lack of adequate training in the initiation and optimization of clozapine treatment is identified as a barrier in systematic reviews on widespread underuse of clozapine. Practitioners have identified difficulty selecting suitable patients, inadequate knowledge or experience in the use of clozapine, fear of side effects, ignorance of clozapine side effects, and unclear guidance on clozapine monitoring as major contributors to poor clozapine prescribing. Underuse of clozapine in BC has long been recognized and, in Vancouver, an effort is underway to increase community clozapine initiation across publicly administered mental health teams. In this workshop, we will describe the creation and implementation of various clinical tools and practice supports for treatment optimization of psychosis.

With regard to ethno-pharmacological variations among people with TRS, safer and more individualized prescribing of clozapine is now possible, thanks to advances in our understanding of its pharmacokinetic/dynamic properties. Familiarity with these guidelines for safer clozapine prescribing can help Canadian prescribers gain confidence and promote best practices around initiation and optimization of clozapine treatment. This presentation will illustrate principles of treatment optimization and individualized clozapine prescribing with a combination of evidence review, case reports, and aggregate outcome metrics.

References:

Annual General Meeting (CPA members only)
Saturday, Oct. 21
12:00 – 13:30 (1.5 hr)
Meeting Room: Grand Ballroom
Networking Break
Saturday, Oct. 21
13:30 – 14:15 (.75 hr)
Meeting Room: Pavilion Ballroom Foyer (3rd floor, North Tower)

Course
C12 - Motivational Interviewing Primer: A Beginner to Advanced Experience
Saturday, Oct. 21
14:30 - 15:30 (1 hr)
Meeting Room: TBC
Wiplove Lamba*, MD, FRCPC; Mary Preisman, MD FRCPC

At the end of this session, participants will be able to: 1) Describe, list, and explain the key components of motivational interviewing; 2) Engage in real-play activities where they will demonstrate and get feedback on using open-ended questions, affirmations, and summaries; and 3) Observe and give feedback on an interviewer's use of motivational interviewing principles, using a standardized scoring system.

Substance use rates for alcohol and opiates went up dramatically during the COVID pandemic, as have accidental overdoses and harms related to substance use. In addition to harm reduction, motivational interviewing is one of the most effective tools to engage people who use drugs into treatment. Motivational interviewing has also been shown to increase treatment retention and long-term outcomes in cognitive-behavioural therapy. Although most psychiatrists can describe what motivational interviewing is and have attended lectures, not many have engaged in the experiential exercises.

This will be a highly interactive session for attendees who are just starting or quite familiar with motivational interviewing. The session will cover basic OARS skills (open-ended reflections, affirmations, reflections, and summaries), eliciting change talk versus sustain talk, learning how to score observed interviews, and a discussion around strategies for developing a local community of practice to allow for sustained knowledge translation. Attendees will have hands-on experience being observed interviewing and giving and receiving feedback using motivational interviewing treatment integrity.

References:

Research Paper
PS03a - Prevalence of Mental Disorders Among People with Opioid Use Disorder in British Columbia: 1996 to 2021
Saturday, Oct. 21
14:30 - 15:30 (N/A)
Meeting Room: TBC
Angela Russolillo*, PhD; Fahmida Homayra, MSc; Kristen Morin, PhD; David Marsh, MD; Bohdan Nosyk, PhD

CanMEDS Roles:

1. Scholar

At the end of this session, participants will be able to: 1) Describe the temporal change in prevalence of mental disorders among people with an opioid use disorder (OUD) in British Columbia; 2) Identify demographic characteristics of people with OUD and concurrent mental disorders; and 3) Discuss the importance of access to mental disorder treatment among people with an OUD.

Opioid use is a major public health issue and is robustly associated with a broad range of comorbid psychiatric disorders. For people with opioid use disorder (OUD), psychiatric comorbidities have been associated with worse clinical outcomes. Although the lifetime prevalence of psychiatric disorders among people with an OUD is generally high, there is considerable variability in reported rates across studies. Therefore, we estimate the prevalence of specific mental disorders among people with an OUD using population-level administrative data spanning over two decades in BC.

Using linked population-level administrative health data, we estimated the annual prevalence and temporal trends for mental disorders among people with an OUD between January 1, 1996, and August 31, 2021. Individuals were followed from their first indication of OUD until censoring (death, administrative loss to follow up, or August 31, 2021).

Among people aged 18 years and over with an OUD (n = 109,372; period prevalence), 75.8% indicated a concurrent mental disorder during the observation period. People with an OUD and any other mental illness were predominately male (60.3%), with a median age of 37 (interquartile range [IQR] 28, 49) years. Of these 82,905 dually diagnosed people, 19,237 (23.2%), 10,093 (12.2%), and 7,121 (8.6%) had indications of major depression, schizophrenia, and bipolar disorder, respectively.

Our findings demonstrate a high prevalence of concurrent mental illness and emphasize the need for access to mental disorder treatment among people with an OUD. Estimating specific mental disorder prevalence is a pragmatic step toward informing clinical guidelines, service needs, and health system planning.

References:


Research Paper
PS03b - Treatment Approaches and Efficacy for Post-Traumatic Stress Disorder in Military Populations: A Meta-Analysis
Saturday, Oct. 21
14:30 - 15:30 (N/A)
Meeting Room: TBC
Jenny Liu*, PhD; Anthony Nazarov, PhD; Bethany Easterbrook, MSc; J. Don Richardson, MD
Supported by the Military and Veterans Section
CanMEDS Roles:

1. Medical Expert
2. Scholar
3. Health Advocate

At the end of this session, participants will be able to: 1) Identify the steps towards conducting a meta-analysis exploring treatment efficacy in military and veteran populations; 2) Determine the relative effectiveness of psychological, pharmacological, alternative, and emerging treatments for military-related post-traumatic stress disorder; and 3) Explore factors that might affect treatment use and efficacy.

Data estimate that up to one in five veterans are diagnosed with post-traumatic stress disorder (PTSD) in their lifetime. Given the high rates of PTSD in military and veteran populations, providing care with consideration for the characteristics of the population and treatments are of critical importance. This presentation will overview initial findings from a meta-analysis that evaluates the relative effectiveness of treatment approaches for PTSD in military and veteran populations. The pre-registered review is conducted per PRISMA and Cochrane guidelines. A search was conducted with PsycINFO, MEDLINE, Embase, Cinahl, and ProQuest dissertations and theses. After removing duplicates, we screened 12,002 studies for inclusion. The final sample includes data from over 400 studies providing psychotherapy, pharmacotherapy, and alternative / emerging therapies to treat PTSD. Meta-analytic findings indicate significant heterogeneities in the literature and found that pharmacotherapies and psychotherapies were comparable overall. Finally, results indicate that combining psychotherapy and pharmacotherapy contributed significantly more significant effects than psychotherapy or pharmacotherapy alone. Results confirm the diversity of available treatments for military-related PTSD and the comparability of various treatments and underscore the additive effects of combination therapies. Our work provides a snapshot of current evidence on treatment approaches in military-related PTSD while identifying factors that may influence treatment outcomes. These findings will better inform clinical decision making for service providers and service users and suggest future directions in treatment development and practice recommendations to better support the well-being of military and veteran populations.

References:


Research Paper
PS03c - Exploring the Value of Pharmacogenomic-Guided Treatment for Major Depression: A Model-Based Economic Analysis
Saturday, Oct. 21
14:30 - 15:30 (N/A)
Meeting Room: TBC
Shahzad Ghanbarian*, PhD; Gavin Wong, PhD; Mary Bunka, BA; Louisa Edwards, PhD; Sonya Cressman, PhD MBA; Tania Conte, MSc; Morgan Price, MD PhD; Linda Riches, MSc; Ginny Landry, BSc; Kimberly McGrail, PhD; Jehannine Austin, PhD; Stirling Bryan, PhD

CanMEDS Roles:

1. Collaborator
2. Professional

At the end of this session, participants will be able to: 1) Learn about pharmacogenomic testing to improve antidepressant prescribing for major depressive disorder; 2) Summarize the best available evidence of pharmacogenomic-guided prescribing for major depression from existing randomized controlled trials.
controlled trials; and 3) Share our evaluation of the effectiveness and cost-effectiveness of pharmacogenomic testing for major depression as a routine component of depression care in BC.

Pharmacogenomics (PGx) testing, one of the most promising recent genomic advances, can guide prescribing in search of enhanced efficacy and fewer side effects. People with major depressive disorder (MDD) often receive pharmacological treatment, but finding an effective medication can be a lengthy trial-and-error process. Response to antidepressants partly reflects variation in genes that influence medication metabolism. PGx testing potentially represents a significant therapeutic advance. We sought to establish the cost-effectiveness of PGx for MDD patients.

Methods: We developed a microsimulation Markov model of MDD care pathways in BC to evaluate the effectiveness and cost-effectiveness of PGx testing from the public payers’ perspective over 20 years. The model includes unique patient characteristics (e.g., metabolizer phenotypes) and uses estimates derived from systematic reviews, administrative data analyses, and expert judgements. We estimated incremental costs, life-years (LYs), and quality-adjusted life-years (QALYs) for a representative MDD patient cohort. We conducted a partial probabilistic analysis and several deterministic sensitivity analyses.

Results: If PGx testing is implemented in BC for adult patients with moderate to severe MDD, it is predicted to save the health system Can$848 million and bring health gains of 11,160 LYs and 63,696 QALYs over 20 years. These savings are mainly driven by slowing or avoiding the transition to refractory (treatment-resistant) depression. PGx-guided care is associated with 47% fewer refractory patients over 20 years. All sensitivity analyses supported the robustness of these findings.

Probabilistic analysis revealed that the PGx-guided treatment dominated the current standard of care for most (96%) simulations.

References:

Symposium
S16 - Perinatal Mental Health: Evidence-Based Insights on Assessment and Treatment from the BC Reproductive Mental Health Program
Saturday, Oct. 21
14:30 - 15:30 (1 hr)
Meeting Room: TBC
Prescilla Carrion, MSc; Katarina Tabi, PhD; Barbara Shulman, MD; Catriona Hippman*, PhD; Gabrielle Bossé-Chartier, MD; Deirdre Ryan, MD

CanMEDS Roles:
1. Scholar
2. Medical Expert
3. Communicator

At the end of this session, participants will be able to: 1) Describe the "creating comfort in choice" theory of prenatal antidepressant decision making; 2) List benefits of mindfulness-based interventions for postpartum mental illness; and 3) Summarize current evidence regarding the use of medications for attention-deficit hyperactivity disorder during pregnancy and breastfeeding.

Mental illness affects approximately 20% of birthing people in the perinatal period, and untreated perinatal mental illness can increase risks for obstetric complications, such as preterm birth, and can negatively impact parent-infant bonding and infant development. Notably, there are treatment options...
for perinatal mental illnesses, and many treatments effective outside the perinatal period can be beneficial, potentially with some modifications or sensitivities for this context. The BC Reproductive Mental Health Program is a provincial service providing care at more than 5,000 patient visits a year. The service supports patients with perinatal mental illness through an interdisciplinary model employing pharmacotherapy and diverse psychotherapeutic interventions. In this symposium, we will share results from our research team, including 1) the “creating comfort in choice” theory of antidepressant decision making in pregnancy and its translation into an animated video, 2) exploring the impact of mindfulness-based group interventions for patients and their families, and 3) the latest addition to the BC reproductive mental health guidelines on managing perinatal attention-deficit hyperactivity disorder.

References:


Symposium
S18 - A Life Course Perspective of Stressors in Mental Health
Saturday, Oct. 21
14:30 - 15:30 (1 hr)
Meeting Room: TBC
Xiangfei Meng*, PhD; Yingying Su, PhD; Muzi Li, PhD

CanMEDS Roles:

1. Health Advocate
2. Professional
3. Scholar

At the end of this session, participants will be able to: 1) Demonstrate the complex relations between stressors across different stages of life and common mental disorders; 2) Identify key psychological and social factors in the relations between stressors and common mental disorders; and 3) Understand the roles of biological, psychological, and social factors in the relations between stressors and mental disorders.

Stress has a profound impact on the mind and body. Exposure to a specific stressor (such as childhood maltreatment) or cumulative stressors across the lifespan increases the risk of such mental disorders as major depression and anxiety. Stress has proximal and distal impacts that can last for decades. For instance, people with pre-existing stressors before the pandemic could have increased vulnerability and sensitivity to additional stressors, such as COVID-19-related stressors, transforming predisposition into the presence of psychopathology. Existing health inequalities intensify the potential for COVID-19-related stress susceptibility. Minorities, immigrants, and people of low socioeconomic status have experienced more health and economic consequences of the pandemic, including a higher rate of SARS-Cov-2 virus infection; death; decreased access to health care; and increased food insecurity. This symposium provides a comprehensive overview of the relationships between stressors across the lifespan and mental health outcomes. It articulates the roles of biological, psychological, and social factors in the relationships between stressors and mental health outcomes.

References:

Workshop
W31 - Combining Virtual Psychotherapy with Innovative Monitoring Techniques: Using an Interdisciplinary Approach to a Multi-Level Problem
Saturday, Oct. 21
14:30 - 15:30 (1 hr)
Meeting Room: TBC
Nazanin Alavi*, MD, FRCPC; Jasleen Jagayat, BSc; Jazmin Eadie, BA; Callum Stephenson, BScH MSc; Sarah Zhu, BScH Student; Mohsen Omrani, MD PhD; Georgina Layzell, BBP

CanMEDS Roles:
1. Health Advocate
2. Medical Expert
3. Scholar

At the end of this session, participants will be able to: 1) Understand the accessibility and scalability benefits associated with virtual psychotherapy; 2) Learn to incorporate techniques into their virtual psychotherapy delivery to assist with patient monitoring and improve outcomes; and 3) Understand how to tailor virtual psychotherapy programs to specific population subsets to make content more relatable and digestible.

With an increasing demand for mental health treatments, we are reaching a tipping point in the healthcare system. The gold standard treatment for various mental health disorders is psychotherapy, however, it is often inaccessible, ineffective, and time-consuming. Many have turned to virtually-delivered psychotherapy (e-psychotherapy). While great promise has been shown, additional steps are needed to help e-psychotherapy reach its full potential. The Queen’s University Online Psychotherapy Lab has developed online treatments for many mental health disorders through the Online Psychotherapy Tool (OPTT), a secure, web-based, psychotherapy platform. Through our programs, we can provide geographically and temporally accessible personalized treatments to patients. Through this workshop, Dr. Nazanin Alavi will moderate instruction on several ways we have successfully implemented additional techniques to push the capabilities of e-psychotherapy even further. Jasleen Jagayat will discuss the use of artificial intelligence in patient monitoring and prediction of treatment adherence, as well as using a stepped-care intensity depending on patient needs. Jazmin Eadie and Georgina Layzell will discuss how to tailor e-psychotherapy programs to a specific population subset, specifically oncology and palliative care patients. Callum Stephenson will discuss how neuroimaging can provide further insight into treatment outcomes in e-psychotherapy for OCD patients. Finally, Sarah Zhu will discuss how fitness trackers can be implemented into e-psychotherapy programs for monitoring treatment outcomes, specifically in patients with insomnia. Using these techniques, the capabilities of e-psychotherapy can be augmented, helping to further relieve the overwhelming burden placed on the healthcare system in Canada.

Workshop
W32 - Have We Brought Joy Back to Medicine? Using Informatics and Data to Examine Physician Wellness Initiatives and Strategies
Saturday, Oct. 21
14:30 - 15:30 (1 hr)
Meeting Room: TBC
Treena Wilkie*, MD; Tania Tajirian, MD; Julie Maggi, MD; Brian Lo, MHI; Sanjeev Sockalingam, MD

CanMEDS Roles:
1. Health Advocate
2. Collaborator
3. Leader

At the end of this session, participants will be able to: 1) Explain the opportunities for integrating evidence and data to examine physician wellness and related initiatives and strategies; 2) Identify how a mental health organization leveraged data and informatics tools to look at physician wellness;
and 3) Develop an approach for identifying relevant metrics and data sources to evaluate physician wellness and related initiatives at their organizations.

Physician burnout is at an all-time high and has been attributed to a number of factors, including extensive work hours and high clerical workload. Although many health care organizations have developed wellness committees and strategies to combat physician burnout, there have been limited data-driven approaches for evaluating physician wellness and developing effective targeted initiatives to address the core issues. At this juncture, there is a pressing need to evaluate whether an intervention is effective and to tailor strategies to the varying needs of an organization. To address these gaps, there has been growing interest to identify and examine metrics relevant to physician wellness. As a follow up to the physician wellness workshop held at the Canadian Psychiatric Association 2020 Annual Conference, this one-hour interactive workshop will provide a practical overview of the opportunities, promises, and approaches for embedding metrics in examining physician wellness. Using a rapid-fire approach, the first half of the workshop will outline examples where metrics were used to measure physician wellness and evaluate the impact of initiatives and strategies. Based on the discussion, an interactive exercise will be held for the second part of the workshop, where participants will work in small groups to build out a plan for using metrics to look at physician wellness at their own organizations. In addition to equipping participants with the necessary skills for taking a data-driven approach to physician wellness, this workshop will foster the development of a network of leaders interested in using data to improve physician wellness.

References:


Course
C10 - Integrating Cognitive-Behavioural Therapy into Your Psychiatry Practice: Brief Interventions for Habit Disorders, Illness Anxiety, and Trauma
Saturday, Oct. 21
14:30 - 16:30 (2 hrs)
Meeting Room: TBC
Jesse Renaud*, PhD; Jean-Philippe Gagne, PhD; Gail Myhr, MD, CM, MSc

CanMEDS Roles:

1. Scholar
2. Communicator
3. Medical Expert

At the end of this session, participants will be able to: 1) Use stimulus control and habit reversal to treat habit disorders effectively; 2) Know the "dos and don’ts" of dealing with illness anxiety; and 3) Apply psychological first aid and teach emotion-regulation strategies to help patients tolerate distress associated with traumatic experiences.

Cognitive-behavioural therapy (CBT) is the first-line psychological intervention for most psychiatric disorders; however, long waitlists and systemic barriers can lead to delays or inability to accessing care. For many patients, receiving low-intensity CBT interventions during routine appointments can be a fast and effective way of gaining access to care. The effective integration of CBT theory and interventions in routine practice can also prevent reliance on as-needed medications and prolonged medical leaves that may inadvertently contribute to the persistence of some disorders.

This course is aimed at practitioners who wish to improve patient outcomes by integrating evidence-based CBT interventions into their practice. We will review guidelines for the effective implementation of brief interventions for habit disorders, illness anxiety, and trauma. Participants will learn foundational behavioural interventions (e.g., habit reversal and stimulus control), the importance of
recognizing avoidance and other safety behaviours that contribute to the maintenance of illness anxiety, psychological first aid, and skills to help patients regulate emotional arousal and distress. We will provide recommendations for patient resources, including popular apps and self-help readings, to help engage patients and maximize practitioner time. Demonstrations and interactive exercises will allow participants to increase their skill level using key interventions.

References:


Course
C11 - Interventional Psychiatry for Members in Training: Theory and Practice
Saturday, Oct. 21
14:30 - 16:30 (2 hrs)
Meeting Room: TBC
Peter Giacobbe*, MD MSc FRCPC; Amer Burhan, MD FRCPC; Robyn Waxman, MD FRCPC; Joshua Rosenblat, MD FRCPC

CanMEDS Roles:

1. Medical Expert
2. Health Advocate
3. Scholar

At the end of this session, participants will be able to: 1) Review neurophysiological principles of brain stimulation as applied to the treatment of psychiatric disorders; 2) Increase knowledge of the rationale and evidence for electroconvulsive therapy, repetitive transcranial magnetic stimulation, and ketamine in the treatment of psychiatric disorders; and 3) Appreciate the key role of postgraduate medical education in continued development of interventional psychiatry.

The last two decades have seen dramatic growth in the application of procedurally based interventions for treating refractory psychiatric conditions, leading to interest in developing the foundations for the subspecialty of "interventional psychiatry." However, there is concern that the expansion rate of knowledge in this field may be outpacing the ability of postgraduate curricula to provide sufficient exposure to and teaching and supervision in these treatments. The paucity of adequately trained practitioners in interventional psychiatry in this country further exacerbates inequities in the ability of eligible patients to access and benefit from these approaches.

It is imperative that innovations in pedagogical approaches are needed to increase the current low rates of competency in the delivery of these treatments and can facilitate the more rapid dissemination of interventional psychiatry approaches and neurotechnologies, such as electroconvulsive therapy, repetitive transcranial magnetic stimulation, intravenous ketamine, intranasal esketamine, deep brain stimulation, and focused ultrasound.

This course will provide members in training with an overview of this area. Attendees will receive both didactic teaching in the rationale, known clinical therapeutic effects and side-effects of a wide variety of interventional psychiatry approaches, and a guided hands-on experience in the mode of delivery of these techniques from recognized experts in the area.

References:

Workshop
Saturday, Oct. 21
15:45 - 16:45 (1 hr)
Meeting Room: TBC
Oyedeji (Deji) Ayonrinde*, MBChB, FCPA, FRCPC; Jaswant Guzder, MD; Nikhita Singhal, MD; Mark Hamson, MD; Eric Jarvis, MD; Polina Anang, MD; Shabbir Amanullah, MD; Rahel Wolde-Giorgis, MD; Gary Chaimowitz, MD
Supported by the Structural Racism and Discrimination Task Force

CanMEDS Roles:

1. Health Advocate
2. Leader
3. Professional

At the end of this session, participants will be able to: 1) Have a better understanding of the insidious effects of racism and discrimination, 2) Consider the intersectional impact of mental illness and racism/discrimination on patients and colleagues, 3) Be aware of the opportunities and strategies to address racism and discrimination in psychiatric practice.

The Canadian Psychiatric Association (CPA) created the Structural Racism and Discrimination Task Force to provide leadership and expert advice to the CPA on matters related to current state, indigeneity, social justice, equity, diversity, inclusion and decolonization. This interactive workshop will be an opportunity to hear about the work of the task force and hear from members about what the CPA can do to move this important agenda forward.

Despite a clear call and roadmap to address structural racism in American psychiatry, published in the American Journal of Psychiatry in 1970, this work has been slow. While we know that is more widely accepted now, the negative effects of racism and discrimination have permeated society and our professional organizations. The CPA, in step with other national professional psychiatric associations, has taken steps to address this, but there is much more work to do, especially as the impact of racism and discrimination can be insidious. We will address this within our organization but also have a responsibility of advocacy and allyship, to both speak up and act on behalf of these values. As psychiatrists, we are especially committed to address the profound impact of intersectional impact of racism, discrimination and stigma on the mental health of patients and colleagues.

We will discuss our work to date, including our commitment to updating our policies and procedures, beginning to create a living literature as a repository and raising awareness. We also seek from our members as to next steps.

References:


Workshop
W34 - The Braiding of Indigenous Healing Practices with Contemporary Mental Health Services: Transforming Treatment to Improve Outcomes in Recovery-Oriented Care in Severe and Persistent Mental Illness
Saturday, Oct. 21
15:45 - 16:45 (1 hr)
Meeting Room: TBC
Varinder Dua*, MBBS, FRCPC; Sujata Ojha, MBBS, DMCH, FRANZCP; Ro'nikonkatste (Bill) Hill, RPN, BSW, MSW, RSW

CanMEDS Roles:

1. Collaborator
2. Health Advocate
3. Leader

At the end of this session, participants will be able to: 1) Demonstrate an understanding of the challenges and complexities of intergenerational trauma and mental health in Indigenous peoples; 2) Develop awareness and knowledge about Indigenous healing practices; and 3) Apply the emerging evidence related to using a two-eyed seeing approach, which uses Indigenous knowledge combined with Western medicine that paves the pathway, resulting in holistic health outcomes for Indigenous populations.

The history of Indigenous peoples in Canada is marred by oppression, loss of identity, racism, loss of culture, and loss of language, which has culminated in centuries of intergenerational trauma. This in turn has predisposed them to developing severe mental health and addiction challenges and other social determinants of health that adversely impact quality of life. This has led to a lack of trust and fear of reprisal, discrimination, and maltreatment by the very systems that have been set up to provide care. Hence, there is significant underuse and high rates of attrition with respect to the contemporary mental health services and treatments offered.

There is mounting evidence that braiding traditional Indigenous healing practices with care provided at hospitals has been more meaningful and improved Indigenous peoples' experiences with mental health care and addictions. Validating and using their knowledge in tandem creates a sense of cultural safety and belonging in the community.

To deliver robust and effective care for severe and persistent mental illness, including addictions, evidence shows the need for Indigenous-led mental health services within hospital systems in Canada. This will result in Indigenous communities trusting services from hospitals because they are being treated by their own people, with culture and identity included in tandem with services from the hospital. Intergenerational trauma will require intergenerational healing; this can be achieved by including traditional Indigenous knowledge in the care being provided.

References:


Workshop
W35 - Treating and Evaluating Healthcare Providers: Safety-Sensitive Situations
Saturday, Oct. 21
15:45 - 16:45 (1 hr)
Meeting Room: TBC
Jon Novick*, MDCM FRCPC; Bruce Ballon, MD ESP(C) FRCPC FCPA

CanMEDS Roles:

1. Collaborator
2. Health Advocate
3. Professional

At the end of this session, participants will be able to: describe key concepts when assessing, treating, and/or monitoring patients in safety-sensitive occupations including healthcare providers.
practice as an effective member of the interprofessional team (that may include a Professionals Health Program, the workplace, and other treaters) value the importance of challenging stigma and barriers to successful engagement, recovery and stability of healthcare professionals.

Psychiatrists caring for healthcare workers (such as physicians and nurses) play a pivotal role in their assessment, treatment, recovery, management, and reintegration to training or work. There are many rewarding and joyful aspects to caring for patients in your own profession including the implicit shared knowledge, the opportunity to challenge stigma and reduce barriers, and being a part of your peer’s career transformation. In addition to these opportunities, treating fellow safety sensitive workers also introduces unique challenges and opportunities for the psychiatrist. When caring for a health care professional with a mental health condition or substance use disorder, you may wonder: What if I am criticized or compared to colleagues? Will I have to consider permissive or mandated reporting duties? And what does it mean to the therapeutic alliance if my healthcare provider patient is undergoing monitoring and requests my involvement with their case managers? The medical directors for both the Physician Health Program and Nurses Health Program in Ontario will guide attendees through an interactive exploration of these important questions. Following a brief overview of the main themes in treating, assessing, and monitoring health care professionals, the presenters will lead an interactive discussion that draws on typical cases from the presenters’ and attendees’ experiences. Participating in this workshop will provide attendees with a forum to critically reflect on and learn about the essential role psychiatrists play as members of the inter-professional team supporting safety sensitive workers through each stage of their recovery.

References:


Workshop

W36 - Strategies for Early Identification of Bipolar Disorder
Saturday, Oct. 21
15:45 - 16:45 (1 hr)
Meeting Room: TBC
Kamyar Keramatian*, MD, MSc, FRCPC; Alexander Levit, MD, PhD

CanMEDS Roles:

1. Medical Expert
2. Health Advocate
3. Scholar

At the end of this session, participants will be able to: 1) Learn about current evidence on the duration of untreated illness in bipolar disorder (BD); 2) Understand pathways to treating youth with BD and factors that influence the time taken for each stage of these pathways; and 3) Understand potential facilitators and barriers to early identification of BD, as well as implications for future research.

Bipolar disorder (BD) affects over two percent of Canadians and is the fourth leading cause of disability among people aged 10 to 24 years. However, despite its high prevalence and significant disability burden, BD often goes unrecognized for several years. A recently published Canadian multicentre naturalistic study showed that the median delay between the first mood episode and the accurate diagnosis of BD in Canada is eight years. Even more concerning was the median delay of 15 years for pediatric-onset BD. Such prolonged diagnostic delays usually result in a subsequent delay in appropriate treatment initiation, which is linked to poor clinical and functional outcomes. This interactive workshop will begin by exploring participants’ perspectives on the controversy surrounding overdiagnosis versus underdiagnosis of BD – especially among youth – and review current evidence on the duration of untreated illness in BD. We will then provide a multidimensional
conceptual framework to explore various components of delay in diagnosing and treating youth with BD and identify patient, disease, and health care system or provider factors influencing each part. We conclude the workshop by discussing potential facilitators and barriers to early identification of BD and implications for future research and public policy.

References:


Workshop
W37 - My Psychiatrist is a Quack! Whether and How to Respond to Online Physician Reviews
Saturday, Oct. 21
15:45 - 16:45 (1 hr)
Meeting Room: TBC
Harry Karlinsky*, MD, MSc, FRCPC

CanMEDS Roles:

1. Professional
2. Communicator

At the end of this session, participants will be able to: 1) Distinguish online defamatory reviews from those who represent fair comment; 2) Employ potential strategies that may remedy inaccurate or malicious online physician reviews; and 3) Minimize the occurrence of negative online reviews.

Online physician reviews, such as those found on physician-rating websites like RateMDs, continue to increase and can have significant consequences for physicians. Although most reviews are positive, negative online reviews can damage a physician’s professional reputation and emotional well-being and influence care decisions made by prospective and existing patients and physicians. This workshop will examine the content and determinants of online reviews, their correlation to other physician performance metrics, and the significant limitations of physician-rating websites. Psychiatrists may be particularly vulnerable to negative online reviews given their involvement with involuntary patients and patients with challenging personality disorders, the need to limit access to addictive medications, and the obligatory ‘duty to report’ clinical scenarios. For psychiatrists confronted with online reviews they consider inaccurate or malicious, a range of potential responses will be presented, including possible legal remedies. Proactive measures to minimize the likelihood of negative online reviews will also be described. Throughout the workshop, attendees will be encouraged to share their experiences with online reviews and their management strategies. Sample online reviews and polling questions will be included in the workshop to stimulate discussion.

References:


President's Dinner and Awards Gala
Saturday, Oct. 21
18:00 – 23:00
Meeting Room: Grand Ballroom (ticket required)