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)
Meeting Room: TBC

Vincenzo Di Nicola*, MD PhD FRCPC FCAHS; Douglas Urness, MD, FRCPC; Gary A. Chaimowitz, MB, ChB, MBA, FRCPC; Hygiea Casiano, MD, FRCPC; Vincenzo Di Nicola, MD PhD FRCPC FCAHS

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
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, FRCP; 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) Connaitre 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 exempté 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-compasion, 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

Cet atelier se veut un exercice de prise de conscience, dans lequel nous vous invitons à ouvrir la voie vers l’auto-compasion, 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:

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 FRCP; 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
3. Medical Expert

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

CanMEDS Roles:

1. Medical Expert
2. Leader
3. Professional

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
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 FRC-psych; Rajamannar Ramasubbu, M.D, FRCPC, MSc; Sophia Frangou, MD, Ph.D., FRC-psych; Kathleen Sheehan, MD, DPhil, FRCPC; Yanbo Zhang, MD, PHD; Simon Hatcher, MRCPsych FRCPC; Arlene MacDougall, MD, MSc, FRCPC
Supported by the Research Committee

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 Slieters, 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 a 19-year-old woman) and two opioid overdose scenarios (a hospital setting and a 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
Valerie Primeau*, MD, FRCPC; Andriy V. Samokhvalov, MD PhD FRCPC
Supported by the Addiction Psychiatry Section
CanMEDS Roles:

1. Medical Expert
2. Collaborator
3. Health Advocate

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

CanMEDS Roles:

1. Scholar
2. Medical Expert
3. Health Advocate

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
perspectives; 2) Critically review current frameworks (or lack thereof) for determining TR and futility and offering palliation for mental health conditions; and 3) Reflect on one’s professional experience of palliation, resistance, and refractoriness in clinical care, including conditions that are hard to treat.

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 irremediability, 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 irremediability 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;
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:


Research Poster Session II
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.