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)
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:

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 psychedelics 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 = 1.306, 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 FRCP 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 doses 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.