



CAPM Annual Meeting Program

7:30 – 8:00	Registration	Hallway outside Marine
8:00 – 8:15	Introductions & welcome	Marine
8:15 – 9:30 Plenary	<p>Cannabis Legalization and Psychiatric Disorders: Caveat H-Emptor <i>Tony George</i></p> <p>Abstract</p> <p>Recreational cannabis use will be legalized in Canada soon. While there are clear advantages and disadvantages about a nationwide cannabis legalization framework, there is growing evidence that there could be disproportionate harms of cannabis legalization for people with mental health and addictive disorders. This lecture will provide a comprehensive approach to this topic, including the epidemiology, neuroscience, clinical phenomenology, assessment and treatment related to problematic cannabis use and mental illness. I will then make a series of recommendations with respect to monitoring, prevention and treatment, which could further reduce harms for this vulnerable subset of the Canadian population. Ultimately, I hope to provide clinicians with an evidence-based clinical framework from which to approach this important issue at clinical and systems levels, and ultimately reduce potential harms to our patients with this impending national policy change.</p> <p>Learning Objectives</p> <ol style="list-style-type: none"> 1. To understand the epidemiology and biology of cannabis and problematic cannabis use. 2. To appreciate the effects of cannabis and cannabinoids in people with mental health and addictive disorders. 3. To develop an evidence-based framework for assessment and management of people at risk for and with existing mental illness in the context of impending cannabis legalization. 	Marine

<p>9:45 – 11:15 Breakout 1</p>	<p>Building an addiction consultation service: a look at the services and skills provided in an inner city hospital <i>Wiplove Lamba, Shree Bhalerao, Alexander Caudarella, Tim Guimond</i></p> <p>Abstract</p> <p>Health Quality Ontario has recently come up with standards for the care of patients with opioid use disorders, and this includes inpatient care. Some of the items listed are providing assessments for people who use substances, developing treatment plans for the medical and psychiatric comorbidities, offering buprenorphine as treatment for opioid withdrawal within 3 hours of presentation, and offering opioid agonist treatment. Attendees will hear of a service that was developed without any initial funding that already offers these services and functions as a consultation liaison service for addiction. The will hear of the gradual evolution over time, as well discuss the typical cases seen and the interventions provided.</p> <p>Physician attendees will receive non-industry sponsored handouts that cover addiction medicine essentials. They will also have the option of being linked to a provincial community of practice as they try to integrate these skills into their practice. This is through the Medical Mentoring in Addition and Pain group funded by the Ministry of Health and Long term care.</p> <p>Learning Objectives</p> <ol style="list-style-type: none"> 1. Describe some of the successes and challenges in building an inpatient consultation liaison service for people who use substances 2. Describe the core skills in addiction medicine that would be relevant for a consultation service 3. Engage in a discussion on how to integrate these skills into their practice. 	<p>Marine</p>
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9:45 – 11:15
Breakout 2

The structure of conversations about quality of life-related issues in patients with pulmonary arterial hypertension
Tasmie Sarker, Vanessa Martin, Emily Slusarek, John Granton, Adrienne Tan, Chris Lo

Dockside 4

Abstract

Background: Pulmonary arterial hypertension (PAH) is a progressive lung condition characterised by elevated blood pressure in the pulmonary arteries. Patients diagnosed with this chronic, life-limiting illness may experience physical health-related issues that compromise quality of life and raise existential concerns about its meaning and value. Conversations about these issues can be difficult and have been little studied in this population.

Rationale: To examine the structure of conversations about quality of life-related issues in patients with PAH.

Method: Thirty PAH patients were recruited in a hospital setting to participate in a 20-60 minute phone interview to discuss their illness experience and its impact on life domains such as social relationships, self-worth and identity, and meaning or value of life. Interviews were transcribed and analyzed using qualitative content analysis.

Results: We developed a comprehensive coding scheme to classify transcript passages according to changes in communicative intent and rapport over the course of the interview. Example codes include “narrative” passages in which participants recounted their personal or illness histories to provide necessary context for the interviewer to understand their adaptation to disease; “disclosures” in which participants chose to share privately-held thoughts and feelings about illness not often shared with others; and “reflections” to identify instances in which participants were actively considering new thoughts and feelings about the impact of illness on their lives.

Conclusion: Understanding the constituent parts of a conversation about quality of life may help clinicians and healthcare providers to inquire about existential or meaning-related issues in patients living with chronic, life-limiting illness.

Learning Objectives

1. To understand the constituent parts of a conversation about quality of life within the context of chronic illness
 2. To understand how existential issues may be explored in conversations about quality of life
 3. To understand how disclosure and reflection is promoted in conversation about quality of life
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A preliminary study of heightened emotions in existential conversations with patients with pulmonary arterial hypertension

Emily Slusarek

Abstract

Rationale: Pulmonary Arterial Hypertension (PAH) is a progressive illness associated with increased mortality. The diagnosis of a life-limiting disease may raise existential concerns about the quality and meaning of one's life, eliciting powerful feelings.

Objective: To examine the range of emotions that can emerge when discussing existential concerns affecting PAH patients' sense of meaning in life.

Methods: 30 adult patients with PAH were recruited from outpatient clinics and participated in a semi-structured interview about their illness. Transcripts were examined for moments of heightened emotion and content analysis was used to categorize the expressed emotions. A correspondence analysis is underway to examine patterns in the co-occurrence of emotions and their association with existential themes.

Results: The sample was 77% females with a mean age of 52 years (SD = 18) and mean illness duration of 6.3 years (SD = 5.3). 10-13% of the sample had a history of depression or anxiety. Moments were associated with between 1-3 emotions. Emotions were placed into 6 distinct categories: negative emotions about the past (e.g. regret), the future (e.g. fear), about oneself (e.g. helplessness) or involving external events and people (e.g. anger), positive emotions (e.g. gratefulness) and static states (e.g. contentment). These emotions were analyzed in relation to existential themes associated with loss and disruptions to the sense of self and relationships.

Conclusion: By understanding the nature and multiplicity of emotions that arise during existential conversations, health care providers may be better able to explore and alleviate negative feelings, promoting adaptation to life-limiting illness.

Learning Objectives

1. To understand the nature and multiplicity of emotions
 2. To explore the range of emotions that existential conversation elicits
 3. To understand the pairing of various emotions with specific topics surrounding a progressive illness
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Patterns of Approach and Avoidance in Existential Conversations with Patients with Pulmonary Arterial Hypertension

Vanessa Martin

Abstract

Rationale: Patients coping with pulmonary arterial hypertension (PAH), a chronic life-limiting illness, may experience existential concerns about the meaning and value of life. Such concerns can be emotionally difficult for patients to acknowledge and disclose, although their expression can also be associated with clinical benefit.

Purpose: To examine sequences in which patients with PAH approached or avoided the discussion of existential concerns when interviewed about their illness experience.

Design: 30 adult outpatients with PAH were recruited for a 20-60 minute phone interview about their illness experiences, which were transcribed. Using qualitative content analysis, we developed a coding system to identify different types of communication (e.g. disclosure, avoidance) about existential issues as they occurred over the course of the interview.

Results: Illustrative passages are presented in which participants spontaneously raised an uncomfortable existential or death-related issue, and then proceeded to explore these feelings to the best of their abilities, or else avoided discussing them further. Notable avoidance strategies included subtly shifting the subject matter being discussed toward more comfortable topics, or downplaying the importance of the concern that was raised.

Implications: Research on discussing existential concerns may help clinicians and researchers to better communicate and intervene with patients about these issues.

Learning Objectives

1. To recognize different strategies used to avoid discussing difficult topics.
2. To better detect topics of distress for patients.
3. To understand why different strategies of avoidance are used.

<p>9:45 – 11:15 Breakout 3</p>	<p>Support for Implantable Cardioverter Defibrillator Recipients: A Pilot Psychoeducational Project <i>Ruth Stewart</i></p> <p>Abstract</p> <p>Implantable cardioverter defibrillators (ICDs) are indicated for primary and secondary prevention of sudden cardiac arrest via VT and VF. Despite their life-saving function, the experience of shocks is intensely aversive and can lead to a variety of disabling psychological sequelae, including anxieties about the device and its function, hypervigilance to physical sensations that might signal another discharge, and profound avoidance of behaviours that might raise the heart rate, and of actions, emotions and situations associated with past shocks. Many patients who experience multiple shocks meet criteria for PTSD.</p> <p>The ICD clinic at RJH (Royal Jubilee Hospital) serves all of Vancouver Island, and inserts around 140 new ICDs per year (2015-2016 data). Its cardiologists are increasingly encountering patients with severe post-shock anxiety and recognizing a need for supportive resources to augment the available psychiatric care.</p> <p>A review of the literature on psychosocial intervention with ICD recipients strongly supported the importance of integrated medical/technical and psychological education and support delivered in person. CBT principles were critical to addressing anxiety and avoidance, but it was equally important to address and validate existential and relational concerns and facilitate the process of adjustment. Interviews conducted with ICD patients, physicians, and nursing staff at RJH supported these findings and identified local gaps and barriers to delivery of psychological support.</p> <p>A psychoeducational presentation is being developed for cardiac nursing staff at RJH, to be accompanied by patient handouts and support materials. These will be piloted and revised over the spring and summer of 2018 as part of an ongoing QI project.</p> <p>Learning Objectives</p> <ol style="list-style-type: none"> 1. Review the psychological sequelae and unique support needs of ICD recipients 2. Review caregiver obstacles to providing support 3. Present a pilot psychoeducational package for caregivers and recipients <hr style="border-top: 1px dashed black;"/>	<p>Dockside 5</p>
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	<p>The effects of being on long-term disability or pursuing a legal claim on the recovery of patients with chronic dizziness <i>Mohamed Attia</i></p> <p>Abstract</p> <p>Authors: Mohamed Attia, Parita Shah, Wanda Dillon, John Rutka, Dave Pothier, Philip Gerretsen Introduction: Chronic dizziness (CD) is defined as a sense of chronic disorientation and unsteadiness due to multiple aetiologies. CD demonstrates a strong psychiatric and psychological link, thus a multidisciplinary approach with psychopharmacological intervention is recommended. Intriguingly, the recovery of individuals with CD that pursue long-term disability (LTD) or a legal claim (LC) to this approach appears hampered. The goal was to characterize the connection between LTD/LC and halted progress in CD recovery, and to explore why LTD/LC are deleterious for psychosomatic illnesses like CD. Methods: 120 adult outpatients with dizziness-related diagnoses from the Multidisciplinary Neurotology Clinic at the Toronto General Hospital, were extracted for a retrospective chart review. Patients with baseline Dizziness Catastrophizing Scale (DCS) and Dizziness Handicap Inventory (DHI) assessments between August 2012 and December 2016 and a follow-up visit within approximately one year were included in the study. The study participants were categorized into two groups: 'On LTD/LC' (n = 48) or 'No LTD/LC' (n = 52). Results: There was a difference in the mean percentage changes in DCS (t (104) = 2.31, P = 0.023) and DHI (t (109.46) = 2.15, P = 0.034) scores between patients on LTD/LC and patients not on LTD/LC. Conclusions: The recovery of CD patients on LTD/LC appear hampered when compared to the no LTD/LC cohort. This finding is likely rooted in the destructive degree of anxiety the LTD/LC process can instil in patients and the deleterious effects of assuming a sick-role while afflicted with a psychosomatic illness</p> <p>Learning Objectives</p> <ol style="list-style-type: none"> 1. To understand chronic dizziness and link with psychiatric presentations 2. To highlight and characterize the link between attenuated CD recovery and diasbility claims 3. To explore potential deleterious effects if the disability process on recovery from psychosomatic presentations 	
11:30 – 12:30	AGM & Lunch	Marine
12:30 – 13:00	Poster Presentations	Hallway

<p>13:00 – 14:30 Breakout 1</p>	<p>Building an addiction consultation service: a look at the services and skills provided in an inner city hospital <i>Wiplove Lamba, Shree Bhalerao, Alexander Caudarella, Tim Guimond</i></p> <p>Abstract</p> <p>Health Quality Ontario has recently come up with standards for the care of patients with opioid use disorders, and this includes inpatient care. Some of the items listed are providing assessments for people who use substances, developing treatment plans for the medical and psychiatric comorbidities, offering buprenorphine as treatment for opioid withdrawal within 3 hours of presentation, and offering opioid agonist treatment. Attendees will hear of a service that was developed without any initial funding that already offers these services and functions as a consultation liaison service for addiction. They will hear of the gradual evolution over time, as well discuss the typical cases seen and the interventions provided.</p> <p>Physician attendees will receive non-industry sponsored handouts that cover addiction medicine essentials. They will also have the option of being linked to a provincial community of practice as they try to integrate these skills into their practice. This is through the Medical Mentoring in Addiction and Pain group funded by the Ministry of Health and Long term care.</p> <p>Learning Objectives</p> <ol style="list-style-type: none">1. Describe some of the successes and challenges in building an inpatient consultation liaison service for people who use substances2. Describe the core skills in addiction medicine that would be relevant for a consultation service3. Engage in a discussion on how to integrate these skills into their practice.	<p>Marine</p>
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<p>13:00 – 14:30 Breakout 2</p>	<p>A Collaborative 4-Phase Approach to Treating Pediatric Somatization <i>Tyler Pirlot, Claire De Souza</i></p> <p>Abstract</p> <p>Collaborative care is required when working with somatic symptom disorders (SSDs) yet treatment of SSDs has often been characterized by referrals back and forth between subspecialties who often have different diagnostic labels and approaches, varying professional skill and comfort with this population, patient complaints and poor engagement. Families caring for children with SSDs often deal with numerous referrals back and forth between subspecialties without a coherent plan or message or even diagnosis. We will describe a systematic approach to diagnosing and treating SSDs patients using 4 phases, authored by members of the Canadian Pediatric Consultation Liaison Psychiatry (members Drs. Pirlot, Chapman and De Souza). This approach is improving poor engagement and delays in diagnosis and facilitating the sharing of costs between Pediatrics, Rehabilitation Medicine and Mental Health. Co-management by Rehabilitation and Mental Health assists with role clarification, helps improve role clarity between specialists and creates a more rewarding work experience in working with SSDs. Improved role clarity yields greater willingness for multidisciplinary professionals to be involved with this population. Improved engagement of families results from pacing the treatment as we move professionals and families from confusion about the diagnosis to making mind-body connections and eventual clarity about the diagnosis. We will work through a case example of using the 4 Phases of Somatization Treatment: Confusion, Mind-Body Connections, Integrated Treatment and finally Recovery and Relapse Prevention. Each phase can be used to clarify roles for parents and families, address and prevent iatrogenic harm and attempt to improve engagement. A structured approach to co-management by Rehabilitation Medicine and Mental Health greatly clarifies patient complaints, protects professionals from role diffusion and builds optimism in treating this population. The audience will hear about a case example in order to understand how to use the 4 phases.</p> <p>Learning Objectives</p> <ol style="list-style-type: none"> 1. Review the challenges somatization presents to patients and clinicians in hospital settings 2. Learn about a 4-phase approach to simplify and expedite somatization patient treatment 3. Learn the advantages of this simplified and collaborative approach as well as the ongoing challenges 	<p>Dockside 4</p>
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<p>13:00 – 14:30 Breakout 3</p>	<p>Agreement between primary care and hospital diagnosis of schizophrenia and bipolar disorder <i>Braden O'Neill</i></p> <p>Abstract</p> <p>Introduction: People with serious mental illness die 10-25 years sooner than people without these conditions. One barrier to improving the health of people with mental illness relates to a lack of coordination between mental and general health services. Accurate diagnostic information across settings is a key facilitator of coordinated care. We aimed to identify whether labeling for schizophrenia and bipolar disorder is concordant between primary care and hospital records, and to explore predictors of concordant labeling.</p> <p>Methods: We conducted a retrospective cross-sectional observational study using the 'Health Databank Collaborative', a linked primary care-hospital database in Toronto, Canada. This database links data from the North York Family Health Team (a group of 77 family physicians in Toronto) and North York General Hospital (a large community hospital). Patients 16 years of age or more with schizophrenia and bipolar disorder were included.</p> <p>Results: We identified 196 patients with schizophrenia and 370 patients with bipolar disorder. Overall diagnostic concordance between primary care and hospital records was low: 19.9% for schizophrenia and 15.7% for bipolar. Patients with multiple inpatient visits (2+) were more likely to have concordant diagnostic information than those with no inpatient visits (for schizophrenia: OR 5.75; 95% CI 1.47 – 22.42, for bipolar: OR 7.92; 95% CI 2.89 – 21.68). Capture-recapture modelling estimated that 39.1% of the total patients identified with schizophrenia (95% CI 28.3–49.8) and 26.4% with bipolar (95% CI 17.4–35.4) had missing labels in both settings.</p> <p>Conclusion: In this sample of patients accessing care at a large family health team and community hospital, concordance of diagnostic information about serious mental illness between hospital and primary care records was low. Interventions should be developed to improve labeling and continuity of care.</p> <p>Learning Objectives</p> <ol style="list-style-type: none"> 1. To recognize that appropriate primary and hospital care of patients with serious mental illness depends on identification of these conditions in medical records. 2. To understand that a substantial proportion of patients with serious mental illness do not have accurate labelling of their conditions. 3. To identify a shared aim between primary and hospital mental health care for quality improvement. <hr/>	<p>Dockside 5</p>
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Psychosocial variables and cancer mortality: What are we missing here?

Alan Bates

Abstract

INTRODUCTION:

We examined associations between cancer mortality and psychosocial variables in a large sample of patients attending a major cancer centre.

METHODS:

All patients who attended BC Cancer from April 2011-2016 and completed the PSSCAN-R were included. We asked if patients lived alone, had help with IADLs, had regular contact with others, had lost a life partner recently, and had emotional support. We also identified patients with moderate to severe anxiety and/or depression, with analysis to-date being limited to patients 65 and older. Overall survival was estimated using the Kaplan-Meier method with log rank comparison and multivariate analysis conducted using the Cox regression method.

RESULTS:

The study included 48,954 patients; median age 66, 55% female, 17% metastatic disease. All measures of social isolation were associated with shorter median survival; living alone: 37 months vs. 57 months, $p < 0.001$; no help with IADLs: 49m vs. 52m, $p = 0.019$; no regular contact with others: 39m vs. 49m, $p < 0.001$; recent loss of spouse: 34m vs. 55m, $p < 0.001$; no emotional support: 44m vs. 52m, $p < 0.001$. Multivariate analysis including baseline disease characteristics demonstrated that older age, male sex, metastatic disease, living alone, recent loss of spouse and no emotional support were significant negative prognostic factors. In the subsample of patients 65 and older, median survival was reduced in patients with significant anxiety (34 m vs 43 m, $p < 0.001$) and depression (31m vs 43m, $p < 0.001$). Multivariate analysis including age, sex, metastatic status, anxiety, and depression showed all variables contributing (increasing age HR 1.05, male HR 1.11, M1 vs M0 HR 3.62, anxiety HR 1.30, depression HR 1.50).

CONCLUSIONS:

This large dataset replicates findings of psychosocial variables being significant risk factors for mortality in cancer patients. Further research aimed at developing effective interventions is needed.

Learning Objectives

1. Describe some social determinants of cancer mortality
2. Be able to better advocate for psychosocial services for cancer patients
3. Compare the effects of different kinds of social isolation on cancer mortality

Bodymind Trouble: Embodiment, Psychosis, and Frictions in the First Episode Clinic

Suze Berkhout

Abstract

Introduction

Western biomedicine is intertwined with a legacy of Cartesian dualism, separating mind from body, culture from nature, and real from unreal. Even in psychiatry there is a tendency to categorize afflictions as either “in” the body or “in” the mind (Scheper-Hughes and Locke 1987; Kendler 2001). And while the reductive materialism of contemporary medical sciences has generated profound advances in knowledge, it limits the understanding of experiences that are decidedly more liminal, including aspects of psychosis.

Methods

This paper discusses findings from an ongoing ethnographic study examining meanings and experiences of psychosis within an early intervention program in Toronto, Canada. Combining participant observation with formal and informal open-ended, serial interviews of service users, family members, and clinic staff, a reflexive, interpretivist analysis of the data was undertaken. Emerging themes were triangulated against subsequent interviews and through member-checking, in an iterative process.

Results

Service users frequently described both the experience of psychosis and its treatment using locutions that denoted physicality, viscerality, and bodily experience. This was juxtaposed with family, friends, and health care providers’ depictions of psychosis as mentally bounded phenomena. It was in the coming together of body-and-mind that the realness of psychosis existed for many participants, often linked to embodied experiences of their lives prior to psychosis. Frictions in the clinical environment arose when this embodied quality was not well understood or taken up by service providers.

Conclusions

Drawing on feminist disability studies, I suggest the experiences of first episode service users can be understood through the concept of bodymind: a socio-political and material entity that emerges through structural contexts and lived experience (Price 2015). And while I do not raise this issue to have physical and sensory experience supersede the mental, my analysis offers insights regarding the imbrication of body-and-mind that are pertinent to psychosomatic medicine.

	<p>Learning Objectives</p> <ol style="list-style-type: none"> 1. Understand how mind/body dualism has impacted psychiatric medicine 2. Discuss recent findings concerning embodiment and psychosis from an ethnographic study of first episode service users 3. Introduce key concepts in feminist disability studies and their relevance to psychosomatic medicine 	
14:45 – 16:30	<p>The Future of CL Psychiatry in Canada <i>Danny Nashman</i></p> <p>Abstract</p> <p>Over the last ten years, there have been increased recognition of the heightened morbidity and mortality for individuals who have co-occurring physical and mental health issues (Vreeland 2007). Similarly, much discourse has been dedicated to highlighting the challenges in providing comprehensive physical and mental health care to this population (Sartorius 2013; CMHA 2008). Research suggests that coordinated care may improve both health and functional outcomes (Katon et al. 2015). In this facilitated workshop, participants will discuss the history of consultation-liaison and medical psychiatry in Canada. They will have the opportunity to explore how best this type of coordinated care may be developed throughout Canada. Moreover, participants will learn more about how to advocate for this type of coordinate care at individual, institutional, and systemic levels.</p> <p>Learning Objectives</p> <ol style="list-style-type: none"> 1. To learn about the progress we have made within our professions and in our health systems over the past 5 to 10 years 2. To develop a vision for how medical and psychiatric care should be working together in our health systems in Canada 3. To highlight priorities for action and advocacy to help move our work in medical psychiatry forward over the next 2-3 years 	Marine
16:30 – 16:45	Closing Remarks	Marine