CAPM Annual Meeting Program

7:30 – 8:00	Registration	Beauport/Beaumont
8:00 – 8:15	Introductions & welcome	Beauport/Beaumont
8:15 – 9:30 Plenary	**Differentiating Behavioural Variance Fronto-temporal Dementia from Primary Psychiatric Disorders – Current Approach and Future Directions** ***Dr. Simon Ducharme MD, MSc, FRCP(C), Neuropsychiatrist, Montreal Neurological Institute and McGill University Health Centre*** **Abstract** Frontotemporal dementia is an early-onset dementia that has striking overlap with several primary psychiatric disorders. It is not uncommon for those patients to be misdiagnosed in the early stage of the disease. As such, the C-L Psychiatrist can be asked to evaluate those patients to provide their input on diagnosis, particularly when there is debate among the different physicians about the idiopathic or degenerative nature of adult onset behavioral changes. This presentation will review the current approach to the diagnosis of FTD, focusing on the behavioral variant. Novel developments in clinical and biomarker research will be covered. 25% of this session will be dedicated to interactive learning through questions and case discussions with the audience. **Learning Objectives** 1. Review current FTD diagnostic criteria and their limitations. 2. Explore clinical strategies to differentiate bvFTD from primary psychiatric disorders **3.** To discuss current and future FTD biomarkers	Beauport/Beaumont

9:30 – 9:45 **Oral Presentation** **Trainee or Early Career Research Presentation**	**Consultation-Liaison Psychiatry and Medical Assistance in Dying** *Dr. Geraldine Godmaire Duhaime* **Abstract** My submission is not a typical research paper. I propose a discussion about the challenges and pitfalls encountered by CL psychiatrists when they assess a patient requesting MAiD. Following a literature search, the clinical issues of interest are: 1- capacity assessment; 2- assessing and addressing psychological suffering; 3- rational suicide versus pathological death wish. Regarding capacity assessment, inspired by literature from Canada and from other jurisdictions allowing physician-assisted death, I will review and discuss the clinical and ethical issues raising from the 4 cognitive abilities model given its limitation not to take into account the emotional factors impacting on the decision-making, especially at the end of life; and the uncertain level of agreement between clinicians in grey area cases and consequences subjectivity. Following that discussion, the impact of psychopathology (especially depression) at the end of life on the wish to hasten death will be reviewed, and the concept of "unbearable psychological suffering" integrated in the federal law explored. I will then suggest how to distinguish a rational suicide wish from a pathological death wish at the end of life, given the fact that those two concepts could trigger a highly different answer from clinicians in the same context. I will conclude on ideas to try to reduce subjectivity inherent to MAiD assessment, and I would like to open the discussion with the audience about the ways various centers have addressed these concerns. This topic has a great importance in the context that extending MAiD for merely psychiatric issues is currently being studied. **Learning Objectives** 1. Explore the challenges and pitfalls encountered by CL psychiatrists in MAiD assessment 2. Discuss the limitation of the current standard for capacity assessment 3. Share ideas to overcome these challenges	
9:45 – 10:45 **Workshop 1**	**Suicide Attempt Shortly After Being Found Ineligible for MAID: A Case Series** *Dr. Elie Isenberg-Grzeda, Dr. Sally Bean, Dr. Deb Selby, Dr. Carole Cohen* **Abstract** In June 2016, Medical Assistance in Dying (MAID) became legal for Canadian adults with grievous and irremediable conditions who make a voluntary request, possess Canadian health insurance, demonstrate capacity, and provide informed consent. Anyone can request MAID, but eligibility must be confirmed by two independent clinicians. Emerging literature has elucidated the processes around MAID assessment and provision. However, little is reported on the consequences, care needs, and ethical implications of patients found ineligible. Methods: We describe 3 patients who attempted suicide after being found ineligible for MAID. Case details have been de-identified to protect patient confidentiality.	Beauport/Beaumont

	Results: Case 1: 81-year-old female with abdominal pain and weakness. She believed she was dying and requested MAID, despite no objective findings of underlying illness. Case 2: 79-year-old man with mood disorder but no grievous and irremediable conditions. Despite understanding he was likely ineligible, he requested a formal MAID assessment 'to be sure.' Case 3: 91-year-old woman with chronic obstructive pulmonary disease and mild cognitive impairment. She was unable to demonstrate capacity to provide informed consent. Conclusions: All three cases attempted suicide shortly after being found ineligible for MAID. Ineligibility was suspected in all three cases, but formal MAID eligibility assessments were arranged to respect the patients' requests. Prior research demonstrated high rates of dismissive attachment style among MAID requesters. Being found ineligible could represent a devastating blow to such patients' belief systems and personhood. Given underlying risk factors and proximity to the formal MAID assessments, we believe that being found ineligible may have precipitated the suicide attempts. This workshop will provide case description (20-minutes), and consider the ethical tensions between respecting patients' requests for MAID eligibility assessments and the potential harms of being found ineligible (20-minutes). Finally, interactive learning through audience discussion will help clarify the role of CL psychiatry in such cases (20-minutes) **Learning Objectives** 1. Attendees will be able to list 3 common scenarios in which MAID requesters might be found ineligible for MAID 2. Attendees will be able to understand the ethical implications around MAID eligibility assessments when a suspicion of ineligibility already exists 3. Attendees will be able to describe 3 potential roles for CL psychiatrists in managing these challenging cases.	
10:45-11:00	**Coffee Break**	Beauport/Beaumont

11:00 - 11:15 **Oral Presentation** **Trainee or Early Career Research Presentation**	**Dying on the Margins: End of Life Care in Schizophrenia** *Dr. Lauren Thomson* **Abstract** People with schizophrenia die 10-20 years earlier than the general population. This excess mortality is largely attributable to chronic illness. In part, this is due to inadequate treatment of physical illness with delays to the diagnosis and treatment of life threatening illnesses, and deviations from standards of care. Often this results in palliative care as a first line of treatment. The available literature on palliative care in schizophrenia is sparse. The limited research available demonstrates that the care received by this population is sub-par including lack of access to palliative care and physician specialists, lower rates of home care and analgesic prescription, and an increased likelihood of death in a nursing home. This care does not meet the expectations of people living with schizophrenia. Nor does it meet the standard of care developed by the Framework on Palliative Care in Canada, which calls for equitable access to palliative care and the highest attainable quality of life until the end of life, for all Canadians. This disparity is the result of numerous barriers ranging from the individual to systemic levels. Barriers arise in the domains of access to care, provision of care and service integration, capacity, as well as an overarching theme of vulnerability. Schizophrenia is a devastating illness that imparts a large toll on how patients live their life. Vulnerabilities are often experienced in multiple domains ranging from stigmatization, marginalization, inadequate housing, food security, substance use and trauma. The added vulnerability experienced by this population at end of life makes them a "doubly vulnerable" population. In order to provide quality end of life care, these intersecting vulnerabilities must be addressed. To achieve this, a shift in the provision of palliative care to a health equity approach is proposed. **Learning Objectives** 1. Enhance knowledge of increased chronic illness and mortality in individuals with schizoprenia 2. Review the literature surrounding the current state of palliative care in schizophrenia including barriers to providing care 3. Increase awareness of inequalities in end of life care and develop a health equity approach to end of life care in severe and persistent mental illness **An Evaluation of the ECHO Ontario Complex Patient Mangement Pilot Program**	Beauport/Beaumont

11:15 - 11:30 **Oral Presentation** **New Research Papers**	*Dr. Sanjeev Sockalingam, Dr. Kathleen Sheehan* **Abstract** Background: Project ECHO is a "hub and spoke" tele-education model that has been successfully applied to general mental health and addictions, with three complete cycles of ECHO Ontario Mental Health at the Centre for Addiction and Mental Health and the University of Toronto. ECHO Ontario Complex Patient Management (CPM) is a new pilot project focused on building capacity to manage complex patients with co-occurring mental and physical health conditions in varied primary care settings. Objective: ECHO Ontario CPM assists primary care providers by disseminating knowledge on didactic topics and management of complex patient cases with mental and physical health comorbidities. This 10-week pilot project sought to examine the appropriateness and acceptability of the ECHO model as an education tool, with measures examining participant satisfaction and change in self-efficacy pre-post participation. Methods: Change in self-efficacy was assessed using participant-rated confidence in their understanding or ability to perform tasks related to discussion topics at weeks 1 and 10 of the program. Participations rated their satisfaction after each weekly session using a 5-point Likert Scale. Preliminary Results: 27 participants from 20 organizations across Ontario participated in the program. Attendance for the first nine sessions averaged 17.7 participants from 13.4 organizations. Preliminary analysis showed consistently high mean satisfaction ratings among participants (i.e., above 4 on a 5-point Likert scale) for domains regarding professional isolation, enhanced knowledge, addressed learning needs, and overall satisfaction. Changes in self-efficacy have not yet been analyzed, as the pilot has just ended. Discussion/Impact: Preliminary findings from the pilot ECHO Ontario CPM program suggest high participant satisfaction and engagement. Future evaluation work is required to confirm whether this model may be appropriate for building treatment capacity for patients with complex co-occurring mental and physical health concerns across Ontario. **Learning Objectives** 1. To understand the application of the ECHO model to build capacity for integrated care of complex and co-morbid medical and psychiatric conditions 2. To identify differences between the ECHO model and other integrated care and telepsychiatry interventions 3. To identify domains and outcomes of value for participants in the ECHO CPM program **First Canadian Face Transplantation: Psychiatrist's Role**	

11:30 - 11:45 **Oral Presentation** **Project In Progress**	*Dr. Hélène St-Jacques* **Abstract** In this presentation, we will discuss the role of psychiatry in evaluating and treating the first patient in Canada to receive a partial face transplantation. This operation was completed in May 2018 at Maisonneuve-Rosemont Hospital in Montreal. The patient was followed for over one year and we will outline psychiatric complications and their course in the 15 months since receiving the face transplant. **Learning Objectives** 1. To appreciate the psychiatrist's role in selecting and evaluation of a potential face transplantation candidate. 2. Discuss the potential psychiatric complications of face transplantation. 3. Explore the role of the psychiatrist in a multi-disciplinary face transplant assessment and treatment team	
11:45 - 12:00 **Oral Presentation** **Trainee or Early Career Research Presentation**	**Anxious Heart: What Does the Combination of Anxiety & Heart Disease Look Like** *Dr. Judith Brouillette* **Abstract** This presentation focuses on the comorbidity between anxiety disorders and cardiovascular diseases. My research, published in 2018 in the journal Psychotherapy & Psychosomatics (IF = 13.1) will be presented. **Introduction:** Anxiety disorders are the most prevalent mental disorder and are 5 times more frequent in cardiac patients compared to the general population. Anxiety has received less attention than depressive disorder in this medical population. The objectives of our study were to 1) compare the distribution of various anxious disorders in cardiac patients followed in a psychosomatic clinic *vs* in the general population, 2) assess whether there are specific associations between cardiovascular diseases (CVD) and anxiety disorders, and 3) evaluate the proportion of patients referred by a cardiologist for depressive or anxious symptoms that receive a concordant diagnosis by the psychiatrist. **Methods and Results:** 450 medical files of patients referred to the psychosomatic clinic of the Montreal Heart Institute (MHI) were reviewed. 76% of patients referred for anxiety received a concordant diagnosis while only 51% of those referred for depressive symptoms did. Of the 335 patients with CVD, 102 suffered from the following anxious disorders (49, panic disorder; 44, generalized anxiety disorder (GAD), and 9, posttraumatic stress disorder (PTSD), while fifty patients had depression. The distribution of the types of anxiety studied here was different than that of the Canadian population ($p<0.0001$). The type of CVD (coronary heart disease, heart failure, and arrhythmia) had no impact on the type of anxiety but congenital disease was more strongly associated with GAD. **Conclusion:** Anxiety disorders were twice more frequent than depression in cardiac patients that were referred to the MHI psychosomatic clinic. PTSD was probably underrepresented. This study will help the elaboration of interventions	Beauport/Beaumont

	directed to improve the detection of cardiac patients suffering from anxiety. This presentation focusses on the comorbidity between anxiety disorders and cardiovascular diseases. **Learning Objectives** 1. Differentiate the various types of anxiety disorders commonly seen in the general and cardiac populations. 2. Recognize the diagnoses commonly observed in cardiac patients referred in psychiatry. 3. Recognize the uncommon diagnoses of cardiac patients referred in psychiatry.	
12:00 – 1:15	**AGM and Lunch**	

1:15 – 1:30 **Oral Presentation** **Trainee or Early Career Research Presentation**	**The Deadliest Catch: How well are our psychiatry residents equipped in discussing HIV prevention** *Dr. Reihard Dolp* **Abstract** Introduction: As psychiatrists, we see a large subset of patients - such as IV drug users or manic patients - that are at high risk for HIV due to the nature of their mental illness. Psychiatrists need to be able to integrate current scientific advances in that field in their practice to provide optimal patient care. Objective: The objective of this study was to assess current knowledge of psychiatric residents on HIV and their management of high-risk patients. Methods: We conducted a single-centre study on all psychiatric residents at Queen's University to assess their knowledge on HIV prevention, harm-reduction, testing, association with mental diseases and prescribing practice of pre-/post-exposure prophylaxis (PrEP/PEP) for HIV. In addition, we assessed the knowledge and comfort of prescribing psychiatric drugs in patients receiving antiretroviral therapy. Residents received a questionnaire via email. Results: Results of the survey showed that most of the residents have suboptimal knowledge in terms of harm reduction strategies and HIV in general. Important medication such as PrEP and PEP are drastically under-utilized to high-risk psychiatric patients. In addition, residents had concerns about prescribing psychotropic medications to patients on antiretroviral therapy. Almost all residents desire more teaching on HIV. Conclusion: Psychiatric residents need and want more teaching on the management of patients at high risk of contracting or transmitting HIV. **Learning Objectives** 1. Participants will be able to describe the current deficiencies in the management of psychiatric patients at high risk of contracting or transmitting HIV. 2. Participants will gain greater awareness on the need for offering HIV testing and prescribing PrEP and PEP to psychiatric patients. 3. Participants will be able to discuss HIV prevention with their patients.	Beauport/Beaumont

1:30 – 1:45 **Oral Presentation** **New Research Papers**	**Piloting an Addiction Medicine Consultation Team in Kingston, ON** *Dr. Anees Bahji* **Abstract** Objectives: Kingston is a mid-sized urban community in South Eastern Ontario which is currently experiencing an increase in the burden of addictions-related morbidity and mortality. Here, we present the results of a preliminary needs assessment for a pilot multidisciplinary inpatient addictions medicine consultation service to address the growing addictions needs of our community. Methods: A 6-item questionnaire was distributed in June 2018 to all inpatient physicians at Kingston General Hospital. The questionnaire asked if they had patients with a substance use disorder under their care, their perception of skill to manage their substance use disorder, and perceived need for addiction medicine consultation services. In total, 128 surveys were returned. Categorical and numerical data were tabulated from the survey results. The 30-day revisit and readmission rates for the identified substance use disorder patients from the surveys were compared to rates for other medical patients and psychiatric patients at the hospital. Results: Opioids and alcohol were the most commonly identified substances of abuse, while addictions counselling and community supports were the most commonly requested services. Internal medicine, psychiatry, and surgery were the predominant services requesting addictions consultation. The 30-day revisit and readmission rates for inpatients with substance use disorders was significantly higher (40.6% and 25.8%, respectively) than the average rate for patients without substance use disorders. Conclusions: Our needs assessment identified a high need for an inpatient addictions medicine consultation service. Future work will focus on procuring funding and infrastructure for such a service and implementing a multidisciplinary approach to bridging inpatients with community addictions services. **Learning Objectives** 1. Discuss the challenges associated with inpatient addictions care. 2. Discuss the findings of a recent inpatient needs assessment for addicitons consults. 3. Discuss the strategies for the development of an addictions medicine consult team.	Beauport/Beaumont
1:45 – 2:00 **Oral Presentation** **Trainee or Early Career**	**The Adaptive Use of CANMAT Depression Guidelines by Psychiatric Providers: Expanding the Narrative Beyond Strict Adherence** *Dr. Alex Raben* **Abstract**	Beauport/Beaumont

Research Presentation	Introduction: Clinical practice guidelines are meant to improve health care provider decisions in clinical care through the acquisition and application of evidence-based knowledge. Research into the use of guidelines has focused on provider adherence to guidelines in an attempt to minimized "unwarranted" deviations. Research in adaptive expertise, however, has demonstrated that physicians must remain flexible and inventive when faced with complex clinical situations and so strict adherence is likely to represent an oversimplification of a complex process. Thus, we conducted a qualitative study to explore broadly how psychiatric providers utilized CANMAT depression guidelines in different contexts. Methods: We conducted semi-structured interviews with 7 staff psychiatrists and 10 psychiatry residents at the University of Toronto on their use of depression guidelines. We analyzed transcribed interviews using a constructivist grounded theory approach and utilized the conceptual framework of adaptive expertise to interpret the data. Results: We identified 5 themes: 1) Providers viewed the guidelines positively and employed them regularly, 2) Providers recognized limitations of the guidelines and integrated information from numerous other sources, 3) Providers used the guidelines in various ways to accomplish clinical or educational tasks, 4) Provider training and patient care experiences influenced how they used guidelines, and 5) The complexity of the clinical situation influenced how providers used the guidelines. Conclusions: The results of this study contribute to the current discussion regarding the use of guidelines in clinical practice and represent further research on how the framework of adaptive expertise informs understanding of problem-solving in clinical care. **Learning Objectives** 1. To understand the current landscape of studies investigating use of medical guidelines 2. To appreciate the nuanced ways in which CANMAT depression guidelines are being used by psychiatry providers. 3. To be able to list the potential clinical, educational and research implications of this understanding of clinical guidelines use. **Diagnostic and Management Considerations of Loperamide Dependence and Misuse: A Case Report** *Dr. Kathleen Sheehan*	

2:00 – 2:15 Oral Presentation **Trainee or Early Career Research Presentation**	**Abstract** Introduction: The anti-diarrheal loperamide is an opioid agonist acting at the myenteric plexus, without crossing the blood-brain-barrier. However, central effects present at supratherapeutic doses, including euphoria and attenuation of opioid withdrawal. Reports of loperamide misuse are rising, as are its complications: cardiac arrhythmias, respiratory depression, and death. Public websites describe this effect and even recommend synergistic drug combinations. A medical approach to loperamide misuse and dependence is a challenging and increasingly relevant skill. Methods: This case describes a 34-year-old presenting to the emergency department with syncope. Investigations revealed a prolonged QTc (638ms), widened QRS complex and various arrhythmias. A thorough history identified loperamide misuse as the cause. The patient described chronic loperamide use (2-8mg daily) with one day of abstinence causing diarrhea. The patient also endorsed supratherapeutic use (240 mg) for its euphoric effects, approximately three times per month. Collateral information revealed a remote substance abuse history involving analgesics. Attempts to reduce in-hospital opioids were complicated by severe abdominal pain with no etiology determined and he was subsequently discharged. Education regarding substance-use and addictions programs, including suboxone, were provided Results: Limited literature suggests that loperamide miuse carries similar dependence and overdose hazards as opioids, along with fatal cardiac complications. Undetectable to standard laboratory testing, a diagnosis of loperamide misuse depends on patient report and can be intentionally obscured. With increasing rates of loperamide abuse, it should appear on the differential for an opioid-type presentation with cardiac abnormalities. Reports reference naloxone for acute management of respiratory depression; however, this does not address fatal cardiac complications that lack opioid-receptor pathogenicity. The latter warrants close cardiac monitoring and appropriate ACLS interventions. Conclusion: Loperamide is emerging as a substance of abuse for its opioid-like effects. This case highlights the challenge in arriving at this diagnosis, and explores approaches to acute and long-term management. **Learning Objectives** 1. Diagnostic approach to loperamide misuse 2. Management options for loperamide misuse 3. Public knowledge/perspective of loperamide misuse **Public Policy and Administration Organizational Leadership** *Dr. Amanda Degenhardt, Dr. Sarah Hanafi, Dr. George Imbenzi* **Abstract**	

2:15 – 3:00 **Workshop**	Psychiatrists and the CPA are important stakeholders in the public policy dialogue that informs the mental health needs of Canadians. The CanMEDs framework highlights the responsibility physicians have to help shape improvements to our healthcare system through exercising judicious influence on health policy(1). However, many psychiatrists have little understanding of how advocacy happens and how change is affected. Physicians are in a unique position to influence policy based on their understanding of the realities of medicine. Yet, they are challenged to make decisions impacting health care delivery, utilization, access and payment within the constraints of political institutions (2). Given the quickly-changing landscape of Canadian Psychiatry, with developments such as the legalization of cannabis, residents are training, and Psychiatrists are practicing, in an era of tremendous opportunity to advocate for healthier public policy for their patients. During this session, participants will gain the knowledge and tools to contribute to positive systems change through policy and administration. They will learn from guest expert, Dr. George lmbenzi, a professor in leadership and policy specialist for government, private, and public sector. Further, psychiatrists will discuss their experiences engaging in public policy, quality improvement, as well as organization and administration of health systems and services. **Learning Objectives** 1. To understand the political infrastructure and players, particularly the physicians's role and relationship, in the landscape of Canadian health policy. 2. Translate these policies and administration tools into action within their organizational context. 3. Explore how to work with provincial and national professional associations to advance Canadian mental health issues	
3:00 – 4:15 **Closing Plenary**	**Alcohol Withdrawal – Non-Benzodiazepine vs. Benzodiazepine Based Protocols – Discussion and Debate** ***Dr. J.J. Rasimas - MD, PhD, FAPM, Director C-L Psychiatry; Hennepin County Medical Center Minneapolis,***	Beauport/Beaumont

	Professor, University of Minnesota ***Dr. Mike Butterfield – MSc, MD, FRCPC (Psychiatry and Pain Medicine), Director, Pain Medicine Residency Program, Clinical Assistant Professor, University of British Columbia*** **Abstract** Although practically divided by routines of professional training and medical practice, the disciplines of medical toxicology and psychiatry overlap in substantive ways. The vast majority of patients who present to hospital with acute toxicologic problems are in need of psychiatric consultation. Most have been exposed to substances via their own hand – through purposeful overdose, drug misadventure, or by accident. Even the latter group may have mental illness that plays a role in such toxic events, like dementias that lead to confusion around medication use or psychosocial unrest that leads to toxic exposure of vulnerable individuals, including children. Then, there is the issue of iatrogeny. Since the CNS is the physiologic entity most affected acutely by toxins, the role of medications is vital in the assessment and care of patients with delirium – a major proportion of C-L work. Lastly, issues of toxic exposure – suspected, fabricated, and genuine – bring individuals to outpatient settings with very complex, often chronic, psychosomatic distress. It is important for a psychiatrist to be familiar with toxidromes and toxicologic principles to assist other specialists in the care of patients for whom an exposure history may be part of the clinical picture. 25% of this session will be dedicated to interactive learning through questions/debate and case discussions with the audience. **Learning Objectives** 1. To recognize patterns of illness presentation consistent with toxic exposure 2. To apply principles of clinic pharmacology as highlighted from a toxicologic perspective in order to provide better treatments in acute hospital and outpatient settings 3. To work with both the utility and limitations of clinical testing in toxicology to support care that is relevant to psychiatric patients	
4:15 – 4:30	**Closing Remarks**	Beauport/Beaumont