19TH CANADIAN COLLABORATIVE MENTAL HEALTH CARE CONFERENCE

COLLABORATING ACROSS CULTURES

CONFERENCE PROGRAM

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SAVE THE DATE!

20th Canadian Collaborative Mental Health Care Conference
May 10-11, 2019
Sheraton Vancouver Airport Hotel

ADDITIONAL DETAILS COMING SOON!

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CONFERENCE APP

Mobile Devices

1. Download the app on your device by searching: "**The Event App By EventsAir**" on the Apple Store or on Google Play
2. Once installed, enter Event Code: **collab2018**
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Computer

1. Visit our attendee app on your web browser: https://uottawacpd.eventsair.com/attendeeapp/collab2018/collab2018/
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YOUR FEEDBACK IS IMPORTANT TO US!

To evaluate the session at the **conclusion of the presentation**, log into the attendee app, select **Agenda**, click on the session you would like to evaluate and scroll to the bottom of the page to **Start Survey**. To evaluate the **overall conference**, please select the session "Closing Remarks & Overall Evaluation".

WIFI

Connect to network "Hilton Meeting" and enter the credentials below:

Group name: van2019

Passcode: van2019

ACCESS TO PRESENTATIONS

The conference presentations will be posted on the Shared Care website after the conference:

http://shared-care.ca/presentations-2018

Please note that presentations will only be posted if the speaker has granted us permission to do so.

19TH CANADIAN COLLABORATIVE MENTAL HEALTH CARE CONFERENCE

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ABOUT THE CANADIAN COLLABORATIVE MENTAL HEALTH CONFERENCE

The Canadian Collaborative Mental Health Care Conference aims to advance collaborative practice in mental health care in primary care and community settings. Our scope includes intra- and interprofessional collaboration, as well as collaboration with clients and caregivers. We value multiple forms of knowledge and 'evidence' including scientific knowledge, pragmatic knowledge of front line healthcare providers and administrators, and experiential knowledge of people using mental health services, and throughout the conference we seek to promote dialogue between these different perspectives. This year's conference theme is "Collaborating Across Cultures". We define culture broadly to include cultures of people, of organizations and even of different disciplines in the health professions. As providers of mental health care and supporters of people living with mental illness we need to collaborate across these various cultures to provide the best care and support possible.

CONFERENCE GOAL AND LEARNING OBJECTIVES

Increase knowledge about interprofessional collaborative practice in mental health, and in particular…

- Illustrate the value of meaningful engagement of people with lived experience in the design, evaluation and improvement of care services, and in the development of a culture of collaboration"
- Exchange knowledge related to collaborative practice in mental health to support replication and successful implementation of innovative and impactful programs 'evidence-based practice')
- Promote the participatory generation of new knowledge by engaging clinician-innovators, service users and others to evaluate and improve programs in practice ('practice-based evidence' and quality improvement)
- Facilitate dialogue between the various stakeholders who have a key role to play in advancing integrated and collaborative mental health care, including clinicians, service users and carers, policymakers and researchers

ACCREDITATION

This event is an Accredited Group Learning Activity (Section 1) as defined by the Maintenance of Certification Program of the Royal College of Physicians and Surgeons of Canada, and approved by the University of Ottawa's Office of Continuing Professional Development. You may claim a maximum of 14.25 hours (credits are automatically calculated).

This **Group Learning** program meets the certification criteria of the College of Family Physicians of Canada and has been certified by the **University of Ottawa's Office of Continuing Professional Development** for up to 14.25 Mainpro+ credits.

EVALUATION AND QUALITY IMPROVEMENT TRACK

We are pleased to introduce a new track within the conference. The Evaluation and Quality Improvement track is designed to provide training on planning and conducting rigorous research, quality improvement, and program evaluation in real-world health care settings. These presentations will provide practical knowledge, skills and examples of how to evaluate and improve upon a clinical program or innovation. Interested attendees can receive a certificate of completion by attending two or more sessions in the Evaluation and Quality Improvement track. This may be useful who wish to demonstrate they are building their knowledge and skills in this area. Sign in at the sessions is required if you wish to receive a certificate.

WORKS IN PROGRESS (WIPS) SESSIONS

Works in Progress (WIPs) presenters are clinical innovators advancing collaborative mental health care models. WIPs is a newer format at the conference, introduced to provide presenters with an opportunity for feedback on evaluation of their innovation. It's common for clinician innovators to struggle with the design and implementation of an evaluation. The overall educational goal of the WIPs format is to use these projects as learning cases about how to conduct an evaluation that can contribute to generalizable knowledge. Presenters will provide a brief overview of their work and designated Coaches will provide educational points about evaluation that will be of wide interest to attendees. Attendees will have opportunities to ask questions and share their experiences.

Thank you to our Coaches:

Jodi Polaha, Ph.D., Associate Professor, Department of Family Medicine at East Tennessee State University. Dr. Polaha has worked in collaborative care for twenty years and has significant experience with engaging practical studies in real-world settings. She has expertise in Dissemination and Implementation Science.

Jennifer S. Funderburk, Ph.D., Clinical Research Psychologist, VA Center for Integrated Healthcare; Adjunct Associate Professor Syracuse University; Adjunct Associate Professor University of Rochester. Dr. Funderburk has been conducting research on integrated care for over fifteen years, with a special emphasis on the implementation of integrated healthcare as well as brief interventions integrated providers can use within the primary care setting.

PROGRAM AT A GLANCE • FRIDAY JUNE 1

07:00	Registration & Networking Breakfast	Convention Level Foyer
08:00	**Opening Remarks** *Dr. Abbas Ghavam-Rassoul & Dr. Mark Lachmann*	**Toronto Ballroom I/II**
08:15	**The Rewards and Challenges of Collaborating with Families and other Health Professionals** *Dr. Susan McDaniel & Dr. Thomas Campbell* • *Describe 2 strategies for partnering with family members to improve health outcomes* • *Describe the key elements of effective teams in healthcare* • *Describe the major barriers to effective collaboration with professional colleagues and at least 2 solutions to these barriers*	**Toronto Ballroom I/II**
08:55	**Award Presentations: CFPC-CPA 2018 Collaborative Care Award Recipients** *Presented by Dr. Nick Kates & Dr. Nadiya Sunderji*	**Toronto Ballroom I/II**
09:10	Transition	

09:15 **Concurrent Sessions**

Evaluation & Quality Improvement *Governor General Room (2nd Floor)*	Belonging 1 *Tom Thomson Room*	Belonging 2 *Harris/Mcdonald Room*	Working Together *Carmichael/Jackson Room*
09:15 - 10:00 **Works In Progress - Abstract #72** Creative Mental Health Service Delivery: Using Multi-disciplinary Collaboration to Reduce Wait Times - Flora MacKay **10:00 - 10:45** **Works In Progress - Abstract #20** Mental Health On-The-Go: An Exploration of Single Session Counselling and Crisis Support for Homeless and Underhoused Populations in a Mobile Service Setting - Andrea W. Westbrook	**09:15 - 09:45** **Paper Presentation - Abstract #74** Pathways to Mental Health Services for Youth in Care: An Opportunity for Enhanced Collaborative Practices - Kathleen MacDonald **09:45 - 10:15** **Paper Presentation - Abstract #47** Culture in Patient-Centered Clinic: It's Avenue of Expression and Apprehension in Youth Mental Health Care - Dr. Lucie Nadeau, Dr. Janique Johnson-Lafleur **10:15 - 10:45** **Abstract #122** Laughing Like Crazy	**09:15 - 10:45** **Workshop - Abstract #83** Wise practices: Cultural Adaptations to the ECHO Model for ECHO Ontario First Nations, Inuit and Métis Wellness - Dr. Allison Crawford, Julie Bull, Dr. Lisa Richardson, Walter Lindstone, Diane Longboat	**09:15 - 09:45** **Paper Presentation - Abstract #38** How Can Providers Better Engage Service Users and Families in Collaborative Mental Health Care? - Dr. Matthew Menear **09:45 - 10:15** **Paper Presentation - Abstract #11** A Family Caregiver's Story - Carole Ann Alloway **10:15 - 10:45** **Paper Presentation - Abstract #57** A Group Psychotherapy Intervention Supporting Dementia Family Carers: Why We Need It - Dr. Leslie Nickell

10:45	Refreshment Break	Convention Level Foyer

11:00 **Concurrent Sessions**

Evaluation & Quality Improvement *Governor General Room (2nd Floor)*	Becoming *Harris/Mcdonald Room*	Belonging *Tom Thomson Room*	Working Together *Carmichael/Jackson Room*
11:00 - 11:45 **Works in Progress - Abstract #8** People Powered Digital Health Solutions - Katie Robinette **11:45 - 12:30** **Works in Progress - Abstract #97** National Spread of BC PSP Module Based on Results - Dr. Rivian Weinerman	**11:00 - 12:30** **Workshop - Abstract #73** Involving Families/Carers in The Care of Youth with Mental Health Problems: Collaborating with Service Providers Across Cultures and Promoting Family Peer Support - Mary Anne Levasseur, Dr. Manuela Ferrari	**11:00 - 11:30** **Paper Presentation - Abstract #6** Care Coordination Can Enable Interagency Collaboration in Providing Comprehensive Mental Health Care for Persons with Severe and Persistent Mental Illness - Dr. Anton Isaacs **11:30 - 12:00** **Paper Presentation - Abstract #96** Exploring the Ethos of Collaboration – Augustina's Story - Augustina Ampofo **12:00 - 12:30** **Paper Presentation - Abstract #33** The Importance of Embedding Nutrition as an Essential Aspect of Mental Health Care: It's More Than Just Eating Well! - Tricia Brinn, Susan Smith	**11:00 - 11:30** **Paper Presentation - Abstract #58** An Incentive Model to Improve Quality Care of Common Mental Disorders in Ontario Family Health Teams – Findings of a Grounded Theory Study - Dr. Rachelle Ashcroft, Dr. Matthew Menear, Dr. Jose Silveira **11:30 - 12:00** **Paper Presentation - Abstract #61** Mapping Evidence of Patients' Experiences in Integrated Care Settings: A Scoping Review - Alaa Youssef **12:00 - 12:30** **Paper Presentation - Abstract #81** A Case Study of Two Family Health Teams Using a Quality Framework to Measure and Improve Collaborative Mental Health Care - Dr. Priya Vasa, Allyson Ion, Dr. Ann Stewart

12:30	Lunch	Convention Level Foyer

PROGRAM AT A GLANCE • FRIDAY JUNE 1

13:30 Concurrent Sessions

Evaluation & Quality Improvement *Harris/Mcdonald Room*	Becoming *Carmichael/Jackson Room*	Belonging *Governor General Room (2nd Floor)*	Working Together *Tom Thomson Room*
13:30 - 15:00 **Workshop - Abstract #91** How to Use a Quality Framework to Guide Implementation and Evaluation of Collaborative Mental Health Care - Dr. Abbas Ghavam-Rassoul , Dr. Priya Vasa, Dr. Nadiya Sunderji, Dr. Ann Stewart	**13:30 - 14:00** **Paper Presentation - Abstract #25** Walking The Path: An Applied Research Pilot to Improve Service Pathways Between Primary Care and Community-Based Child and Youth Mental Health Services - Dr. Mario Cappelli, Laura Kelly **14:00 - 14:30** **Paper Presentation - Abstract #10** Parents' Experience of Caring for an Adolescent with a Mood Disorder - Robert Meadus **14:30 - 15:00** **Paper Presentation - Abstract #59** Collaboration From the Inside Out: An Evaluation Framework for a Child and Youth Mental Health Collaborative Care Model - Eunice Lee, Dr. Hana Saab, Dr. Rose Geist	**13:30 - 15:00** **Workshop - Abstract #35** The Overdose Crisis Response in Ontario: Taking the Lead from People Who Use Drugs - Lynne Raskin, Jason Altenberg	**13:30 - 14:00** **Innovative Presentation - Abstract #22** We Care Podcast Presented by the East Toronto Sub-Region - Lucinda McGroarty, Priscilla Tang, Diana Raymond-Watts **14:00 - 14:30** **Paper Presentation - Abstract #69** Alberta PCNs Work Together to Present their Progress in Integrated Behavioral Health - Kent Corso **14:30 - 15:00** **Paper Presentation - Abstract #117** P is for Political: Participatory Design and Rebalancing the Power Differential - **Dr.** Tai Huynh

15:00	Poster Viewing and Nutrition Break	Convention Level Foyer
16:00	**Power for the People and of the People - 25 Years of Empowerment** *Ms. Jennifer Chambers* • *Construct a plan for a powerful client/patient voice that is client controlled and independent* • *Identify how to empower clients to organize a client-controlled vehicle for developing this plan* • *Set up opportunities for this organized client voice to identify its community's needs, and for these self-identified needs to create change*	**Toronto Ballroom I/II**
17:00	Day 1 Closing Remarks & Evaluations	Toronto Ballroom I/II
17:15	**Welcome Reception**	Convention Level Foyer
19:00	Day 1 Concludes	

THANK YOU TO OUR PLANNING COMMITTEE

Dr. Alex Caudarella
Dr. Allison Crawford
Dr. Claire De Souza
Dr. Jennifer Funderburk
Dr. Abbas Ghavam-Rassoul*
Dr. Katharine Gillis
Dr. Jack Haggarty
Dr. Kelly Horner
Dr. Nick Kates
Dr. Mark Lachmann*
Dr. Pauline Pariser
Dr. Kristina Powles
Ms. Ashnoor Rahim
Ms. Lynne Raskin
Ms. Gayle Seddon
Dr. Sanjeev Sockalingam
Dr. Nadiya Sunderji
Ms. Debra Walko
Dr. William Watson
**Co-chair*

THANK YOU TO OUR SCIENTIFIC COMMITTEE

Dr. Sabina Abidi
Dr. Supuneet Bismil
Dr. Amy Cheung
Dr. Carole Cohen
Dr. Allison Crawford
Dr. Michel Gervais
Ms. Allyson Ion
Dr. Terry Isomura
Dr. Nick Kates
Dr. Matthew Menear
Dr. Emiko Moniwa
Ms. Marvelous Muchenje
Dr. DJ Rodie
Dr. Carol Ann Saari
Dr. Mireille St-Jean
Dr. Helen Spenser
Dr. Nadiya Sunderji*
Dr. Shirley Sze
Ms. Valerie Testa
**Chair*

THE CANADIAN COLLABORATIVE MENTAL HEALTH CARE CONFERENCE WOULD LIKE TO THANK AND ACKNOWLEDGE ANNIE ZHU FOR THE CREATION OF THIS YEAR'S LOGO!

19TH CANADIAN COLLABORATIVE MENTAL HEALTH CARE CONFERENCE
COLLABORATING ACROSS CULTURES

PROGRAM AT A GLANCE • SATURDAY JUNE 2

07:00	Registration & Networking Breakfast	Convention Level Foyer
08:00	**Shark Tank: Competition to Evaluate Collaborative Care - Moderated by Dr. Nick Kates** *Dr. Jennifer Funderburk & Dr. Jodi Polaha* • *Discuss the importance of placing internal evaluation in the context of the literature before pursuing data collection* • *Define the term "fidelity" and describe its place in the study of an established model or intervention* • *Discuss strategies for honing project ideas to make them "doable" in real world settings* • *Discuss the importance of using established models and methods wherever possible* • *Be inspired to contribute to science!*	**Toronto Ballroom I/II**
09:00	Transition to 2019 Conference Team	Toronto Ballroom I/II
09:15	Nutrition Break	Convention Level Foyer

09:30 Concurrent Sessions

Evaluation & Quality Improvement *Carmichael/Jackson Room*	Collaborative Care Across Canada *Harris/Mcdonald Room*	Working Together *Tom Thomson Room*	Education to Work Together *Governor General Room (2nd Floor)*
09:30- 10:15 **Works in Progress - Abstract #65** How to Setup and Run Patient Wellness Groups for Physical and Mental Health in Ontario Family Practice - Dr. Carlos Yu, Anita Iacono, Jeffrey Yu, Dr. Vivian Lo **10:15 - 11:00** **Works in Progress - Abstract #12** The I aM group: Using Mindfulness-Based Group Interpersonal Psychotherapy to Enhance the Sense of Belonging (for Diverse and Medically Complex Patients) in an In-patient Rehabilitation Setting - Dr. Seema Khan, Susan MacRae	**09:30 - 11:00** **Workshop - Abstract #118** How Can We Evaluate and Improve Collaborative Mental Health Care Across Canada: A Consultation Session to Develop Nationally Relevant and Useful Quality Indicators - Dr. Nadiya Sunderji, Francine Knoops, Bonita Varga, Dr. Matthew Menear, Dr. Gwen Jansz	**09:30 - 10:00** **Paper Presentation - Abstract #43** An Approach to Developing a Regional System for Providing Mental Health Care in Rural and Remote Communities - Dr. Supuneet Bismil, Dr. Jack Haggarty **10:00 - 10:30** **Paper Presentation - Abstract #45** The Myndplan Project: A Strategy for Creating and Implementing Stepped Care Mental Health Treatment Plans that are Client Centred and Empirically Based - Dr. Robert Shepherd **10:30 - 11:00** **Paper Presentation - Abstract #87** Big White Wall and BounceBack: Meeting the Demand in Ontario for Faster Access to Psychotherapy Services for People with Mild to Moderate Depression and Anxiety - Anna Piszczkiewicz, Harriet Ekperigin	**09:30 - 11:00** **Workshop - Abstract #13** How to Train Health Professionals across the Continuum of Professional Development to Work Together - Dr. Olga Heath, Dr. Tyla Charbonneau

11:00	Transition Break

11:15 Concurrent Sessions

Evaluation & Quality Improvement *Carmichael/Jackson Room*	Collaborative Care Across Canada *Harris/Mcdonald Room*	Working Together *Tom Thomson Room*	Working Together 2 *Governor General Room (2nd Floor)*
11:15 - 11:45 **Paper Presentation - Abstract #17** Implementing a Quality Framework in Collaborative Mental Health Care: Advancing Best Practices in a Community-Hospital Partnership - Dr. Rosalie Steinberg, Ann Marie MacDonald **11:45 - 12:15** **Paper Presentation - Abstract #77** Implementing the Collaborative Care Quality Framework to Assess and Strengthen the Clinical, Rehabilitation and Residential Relocation Processes for Alternate Level of Care (ALC) Service Users at the Douglas Mental Health University Institute - Eleanor McGroarty	**11:15 - 11:45** **The Intricacies of Intentional Collaboration: 15 years of Shared Care in Winnipeg -Abstract #119*** Dr. Randy Goossen **2018 CFPC/CPA Collaborative Mental Health Care Award-Large Institutionally Based Program* **11:45 - 12:15** **Paper Presentation - Abstract #98** Collaborative Mental Wellness Care in Sipekne'katik First Nation – Lessons Learned Working in an Indigenous Community - Brian Knockwood, Dr. Tiffany O'Donnell, Dr. Aruna Dhara	**11:15 - 11:45** **Paper Presentation - Abstract #88** Delivering Problem Solving Therapy – Primary Care (PST-PC) As Part Of A Low Threshold Team-Based HIV Primary Care Practice Transformation Model - Dr. Roberta De Oliveira, Rebecca Weiss, Iris Gutierrez **11:45 - 12:15** **Paper Presentation - Abstract #27** Integrating Mental Health and Diabetes Management - A Collaborative Care Model - Sheryl Parks, Dr. Ian S. Zenlea, Dr. Judith Versloot, Dr. Elizabeth Mansfield, Gaya Amirthavasar	**11:15 - 11:45** **Paper Presentation - Abstract #137** Collaborative care for Mild Cognitive Impairment in older adults in Primary Care: from Evidence to Practice - Dr. Pallavi Dham, Dr. Nick Kates **11:45- 12:15** **Paper Presentation - Abstract #99** Expanding Access to Psychotherapy: Mapping Lessons Learned from Australia and the United Kingdom to the Canadian Context - Dr. Mary Bartram, Francine Knoops, Bonita Varga

12:15	Lunch	Convention Level Foyer

PROGRAM AT A GLANCE • SATURDAY JUNE 2

13:15 Concurrent Sessions

Evaluation & Quality Improvement *Carmichael/Jackson Room*	Working Together *Governor General Room (2nd Floor)*	Working Together 2 *Tom Thomson Room*	Education to Work Together *Toronto Ballroom I/II*
13:15 - 14:00 **Presentation TBC** **14:00 - 14:45** **Works in Progress - Abstract #44** Intersectoral Collaboration for Children and Adolescents Mental Health Care: A Preliminary Research Report Within the Public System in Rio De Janeiro, Brazil - Melissa Teixeira	**13:15 - 14:45** **Workshop - Abstract #66** Recovery-Oriented Practice and the Patient's Medical Home: Consultation on College of Family Physicians of Canada's Best Advice Guide - Francine Knoops, Bonita Varga, Artem Safarov	**13:15 - 13:45** **Paper Presentation - Abstract #48** Seniors Crisis Services Initiative: Collaboration Across LHINs and Sectors for Client Centred Care - Julia Chao **13:45 - 14:15** **Paper Presentation - Abstract #15** The Centre for Seniors' Medical Psychiatry: Caring for Seniors with coexisting Physical Illness and Depression/Anxiety Through Integrated Collaborative Care with Primary Care Providers - Christine Dias, Joanne Chen Dr. Judith Versloot **14:15 - 14:45** **Paper Presentation - Abstract #70** SCOPE (Seamless Care Optimizing the Patient Experience) Mental Health Program: Bridging the Gap Between Primary Care and the Mental Health Care System - Jamie Smith , Dr. Jennifer Hensel	**13:15 - 13:45** **Paper Presentation - Abstract #75** Training Psychiatric Residents for Collaborative Mental Health Care - Dr. Natasha Snelgrove, Dr. Andrea Levinson, Dr. Kristina Powles, Dr. Michael Neszt **13:45 - 14:45** **Workshop - Abstract #4** Teaching Behavioural Sciences to Family Practice Residents: the "Share Care" Approach - Dr. Jon Davine

14:45 Nutrition Break — Convention Level Foyer

15:00 Concurrent Sessions

Evaluation & Quality Improvement *Tom Thomson Room*	Belonging 1 *Carmichael/Jackson Room*	Belonging 2 *Governor General Room (2nd Floor)*	Education to Work Together *Harris/Mcdonald Room*
15:00 - 16: 15 **Symposium - Abstract #28** Acceptability of Telephone-Based Mental Health Support for Primary Care Patients - Salaha Zaheer, Vanessa Garofalo **Symposium - Abstract #36** Challenges in Integrated Mental Health Care Research: Understanding Primary Care Providers' Participation in the PARTNERs Study - Annie Zhu **Symposium - Abstract #95** Engagement of Primary Care Providers in the CAMH PARTNERs Project - Alexandra Kubica, Eleni Kelly **Symposium - Abstract #85** Demographic Analysis of the CAMH PARTNERs Integrated Care Project - Eleni Kelly, Alexandra Kubica	**15:00 - 16:15** **Workshop - Abstract #50** Building Positive Space in Primary Care to Improve Access for LGBTQ Patients - Catherine McPherson-Doe, Jackie Bootsma, Tim Elliott	**15:00 - 16:15** **Workshop - Abstract #138** A Life Worth Living: Effecting Change in Homelessness and Mental Health Through Collaborative Education - Draigan LeFebvre, Samuel Gruszecki	**15:00 - 16:15** **Workshop - Abstract #26** Long Term Mentoring to Support Family Physicians to Meet the Challenges of Primary Mental Health Care - Dr. Helen R Spenser, Dr. Arun Radhakrishnan, Dr. Cyndy Sabatino, Dr. Millaray Sanchez, Dr. Jonathan Hunter, Dr. Jonathan Davine

16:15 Transition

16:30 Sub-Plenary Sessions

Toronto Ballroom I/II	Tom Thomson Room
Collaborating Across Cultures To Promote Mental Health and Recovery *Dr. Kenneth Fung* • *Identify cultural factors in mental health, illness, and recovery* • *Describe considerations to facilitate effective cross-cultural collaborations to promote mental health and recovery*	**Don't Let the Bed Bugs Bite: Lessons Learned in Collaborating Across Cultures** *Dr. Carole Cohen* • *Discuss the issues arising in the care of community dwelling seniors with mental health problems* • *Highlight the development of a collaborative bed bug situation table in North Toronto* • *Explore the barriers and facilitators encountered in collaborating across cultures*

17:00 Closing Remarks & Evaluations

17:15 Conference Concludes - *Have a Safe Journey Home!*

CONCURRENT SESSIONS

TEACHING BEHAVIOURAL SCIENCES TO FAMILY PRACTICE RESIDENTS: THE "SHARED CARE" APPROACH

ABSTRACT #: 4
PRESENTATION TYPE: Workshop
Jon Davine, MD, CCFP, FRCP(C), Dr., McMaster University

Learning Objectives: Describe a horizontal teaching program in behavioural sciences for family medicine residents, Develop techniques to use audio visual technology to teach behavioural sciences., Devise an evaluation tool for a behavioural sciences program.

Abstract: In this paper, we describe the approach to the teaching of behavioural sciences to family medicine residents at McMaster University in Hamilton, Ontario, and its relevance to the demands facing family physicians in clinical practice. Instead of a block placement in the psychiatric unit, teaching takes place on a weekly half day, devoted to behavioural science, for the entire duration of the residency during which time a psychiatric consultant is present in the family medicine unit. The training is problem-based, usually within small groups, and utilizes examples from cases residents are seeing in their practice. Multidisciplinary teaching is emphasized. Each half-day usually involves several components, including a review of cases, often on audiovisual tapes, or tutorials on specific topics. Issues, such as evaluation, setting up appropriate standards, funding, instituting a behavioural science curriculum, and achieving collaborative working relationships between psychiatrists and family medicine faculty are also discussed. We will then have an experiential part of the session where we will view a videotape of a patient encounter and discuss how this can be used effectively for teaching purposes. Our teaching concept works on the model of increasing the family physician's skills in treating patients' emotional needs and using psychiatrists more strictly as consultants. It is felt that with respect to community mental health needs, and mental health resources available, this is in keeping with the realities of today and the future.

CARE COORDINATION CAN ENABLE INTERAGENCY COLLABORATION IN PROVIDING COMPREHENSIVE MENTAL HEALTH CARE FOR PERSONS WITH SEVERE AND PERSISTENT MENTAL ILLNESS

ABSTRACT #: 6
PRESENTATION TYPE: Paper Presentation
Anton Isaacs, MBBS, MD, PhD, Senior Lecturer, Monash University School of Rural Health

Learning Objectives: To briefly describe Australia's Partners in Recovery program, To outline the role of the care coordinator in the program, To describe how the care coordinator role enabled interagency collaboration in providing wrap around care to persons with SPMI

Abstract: Background: Multiple needs of individuals with severe and persistent mental illness (SPMI) can be addressed by interagency collaboration. However, several barriers make collaborative efforts quite challenging. As a result, individuals with SPMI do not receive the support they need and eventually fall through the cracks in the system. The purpose of this paper is to highlight the potential of a care coordination role in enabling collaboration of agencies in the provision of comprehensive care for people with SPMI. Aim: To describe how a care coordination role can enable interagency collaboration in providing comprehensive mental health care for persons with SPMI. Methods: Using the example of the care coordinator role in Australia's Partners in Recovery (PIR) initiative and other published literature on the subject, I will argue how care coordination can enable interagency collaboration. Results: In the PIR initiative, the support facilitator (SF) serves as a single point of contact for all the different services supporting the client. With a focus on recovery and patient centred care, the SF coordinates a care team made up of representatives from each service that could meet the different needs of the client. According to a care plan developed by the client and the care team, each service provider takes responsibility to deliver their component of the plan. In this way, different agencies are able to collaborate seamlessly. Conclusion: The care coordination role could hence be a possible solution to overcoming the barriers to interagency collaboration for the benefit of individuals with SPMI.

PEOPLE POWERED DIGITAL HEALTH SOLUTIONS

ABSTRACT #: 8
PRESENTATION TYPE: Works in Progress
Katie Robinette, Sponsor Finder

Learning Objectives: Identify ways to more effectively engage those with lived experience by leveraging technology to facilitate peer support; improve ways to capture data; improve recovery success

Abstract: A talk on people powered digital help. Katie will be discussing the role technology can play in helping to facilitate long term sobriety by helping pair those looking to get and stay sober with those in active recovery.

PARENTS' EXPEREINCE OF CARING FOR AN ADOLESCENT WITH A MOOD DISORDER

ABSTRACT #: 10
PRESENTATION TYPE: Paper Presentation
Robert Meadus, BN, B.VocEd, MSc(N), PhD, RN, CPMHN(C), Memorial University School of Nursing

Learning Objectives: Enhance professional knowledge on the needs of parental caregivers of adolescents with a mood disorder, Facilitate dialogue among health professionals of the needs of parents who are caring for a psychiatrically ill adolescent, Improve health care professionals understanding of parental caregiving

Abstract: Mental health disorders are a major health concern of Canadian children and youth, impacting home, school, and community. When a child or adolescent is diagnosed with a psychiatric illness it is recognized as a crisis for both the child and parents. Parents as primary caregivers play a critical role in recovery. Consequently, the challenges associated with caregiving responsibilities may affect the health of the entire family. Health care professionals have been recognized as the least helpful in assisting families during this difficult time. The purpose of this study was to examine the parents' lived experience of caring for a son or daughter who has a mood disorder. A phenomenological approach was used to explore the personal experience of 12 parents whose adolescent received treatment for a psychiatric illness. The four themes: What's Going On, Decision to Act, Labour of Caring, and Help Services Disconnection relate to the serious disruption in family life, the efforts of trying to get help and to cope while trying to make sense of the experience of parenting in times of turmoil. By understanding the caregiving experience health care professionals may focus greater efforts to provide services and supports while engaging parents as equal partners in the health care experience.

Co-Authors: Robert J. Meadus; Tanya Purchase; Weldon Bonnell; Rajive Rajan; Kimberley St. John, Hubert White & Leslie Wheeler

A FAMILY CAREGIVER'S STORY

ABSTRACT #: 11
PRESENTATION TYPE: Paper Presentation
Carole Ann Alloway, Co-Founder, Family Caregivers Voice

Learning Objectives: Identify the perspective of a family caregiver, Identify the importance of including patients and family caregivers in the health care team, Describe the effect of thephysical, emotional and spiritual toll on the 'invisible' family caregiver

Abstract: One in three Canadians is a family caregiver. Health Quality Ontario has published a report indicating caregiver distress is becoming a serious health concern. This caregiver was prepared to help her husband through one operation with a three-month recovery but instead it turned into a marathon of ten operations over seven years with further complications. As a result, she became a patient of the mental health care system. What went wrong? Could her depression have been avoided? Hospitals are sending patients home sicker and quicker. Who's looking after them when they get home? How can health care professionals prevent family caregivers from becoming patients? To help turn the negative experience into something useful, Carole Ann prepared a Caregivers Wish List. There are simple things that can be done to alleviate the family caregiver's burden and she shares some of her ideas in her story. Carole Ann's story has been featured in Health Quality Ontario's report on Caregiver Distress. She is co-founder of Family Caregivers Voice and is working with The Change Foundation, HQO, the MOHLTC and her local LHIN on raising awareness. She recently brought her ideas to a local hospital and working with a team, the hospital received a $3M grant for a 'caregiver friendly hospital's project. She has worked with other health care agencies and the University of Toronto to provide advice and guidance on approaching and including family caregivers in the health care team.

THE I AM GROUP: USING MINDFULNESS-BASED GROUP INTERPERSONAL PSYCHOTHERAPY TO ENHANCE THE SENSE OF BELONGING (FOR DIVERSE AND MEDICALLY COMPLEX PATIENTS) IN AN IN-PATIENT REHABILITATION SETTING

ABSTRACT #: 12
PRESENTATION TYPE: Works in Progress
Seema Khan, MD, FRCPC, Bridgepoint Active Healthcare; **Susan MacRae,** RN, M.Ed, RP, Women's College Hospital

Learning Objectives: Describe the I aM group's evolution and rationale for the current group format, Identify the benefits of practical mindfulness experience in helping combat institutionalization, Identify opportunities for application of this group format beyond this setting

Abstract: The Interpersonal and Mindfulness (I aM) group is an 80 minute, open format psychotherapy group at Bridgepoint Active Healthcare (a 400+ bed rehabilitation and complex care hospital in Toronto) that seeks to enhance our patients' experiences of belonging. The I aM group is facilitated by an interprofessional team including a psychiatrist, an advanced practice nurse, a spiritual care practitioner and a hospital volunteer. The I aM group supports individuals with complex chronic health needs by offering basic psychoeducational and mindfulness content within a supportive, relational environment. The main aim of the group is to improve patients' quality of life and to help combat institutionalization. This "works in progress" presentation will review the evolution of the group over three years of activity, describe the current format of the weekly sessions, characterize the diversity and complexity of group participants, and reflect on patient feedback. We will look to our audience to offer insights on our long-term goals of formally evaluating this group intervention; standardizing the intervention in such a way as to allow its use in other long-term care facilities; and transferring the knowledge gained from this intervention to other settings and clinicians.

Co-Authors: Seema Khan, MD, FRCPC, Bridgepoint Active Healthcare; Susan MacRae, RN, M.Ed, RP, Women's College Hospital

HOW TO TRAIN HEALTH PROFESSIONALS ACROSS THE CONTINUUM OF PROFESSIONAL DEVELOPMENT TO WORK TOGETHER

ABSTRACT #: 13
PRESENTATION TYPE: Workshop
Olga Heath, PhD, Psychologist, Memorial University; **Tyla Charbonneau,** PhD, Registered Psychologist, Psychologist, University of Calgary and Private Practice

Learning Objectives: Describe the evidence for the value of interprofessional collaboration in mental health care, Explain the importance of life-long learning for effective teamwork, Utilize a novel framework for developing practical, scaffolded interprofessional education opportunities for students and practitioners

Abstract: In this workshop, we utilize research evidence and case examples to highlight how effective collaborative care is particularly critical in mental health and how care teams often struggle to navigate the complexities of working as a team. We then review the literature demonstrating that effective collaboration relies on a complex set of skills that must be taught and reinforced across the continuum of professional development We will assist participants in reflecting on the degree to which their own training and continuing education experiences reflect this ideal, and will discuss common barriers to implementing IPE at the training level and post-licensure as part of Continuing Professional Development (CPD). In the second part of this interactive workshop, we outline a framework for integrating collaborative competencies into health/social professional training for learners at all stages of professional development. Within this framework, we present key principles for developing high-quality didactic and practice-based IPE opportunities, with suggestions for both learner assessment and program evaluation tools. We also demonstrate helpful resources for CPD for individuals and teams and share some examples of how this framework has been applied successfully with both trainees and teams in practice. Working in small groups and in consultation with the presenters, participants will identify enablers and barriers to developing an IPE program in their settings and outline a plan for implementing at least on IPE activity. The presenters represent the perspectives of professor/practitioner (Heath) and recently graduated student (Charbonneau) and highlight the unique implications of both viewpoints.

Co-Authors: Maxine Holmqvist, PhD, University of Manitoba; Tyla Charbonneau, PhD, University of Calgary and Private Practice

THE CENTRE FOR SENIORS' MEDICAL PSYCHIATRY: CARING FOR SENIORS WITH COEXISTING PHYSICAL ILLNESS AND DEPRESSION/ANXIETY THROUGH INTEGRATED COLLABORATIVE CARE WITH PRIMARY CARE PROVIDERS

ABSTRACT #: 15

PRESENTATION TYPE: Paper Presentation

Christine Dias, RN, MN, Master of Nuring, Registered Nurse, Trillium Health Partners; **Joanne Chen,** PT, MHSc, Clinical Manager, Seniors' Services and Primary Care, Trillium Health Partners; **Judith Versloot,** PhD, Research Lead, Research Operations

Learning Objectives: Describe a practice model which advances integrated geriatric medicine and mental health competencies in the primary care setting through education and capacity building, Illustrate the value of collaborative care models that involve partnerships between primary care and hospitals/specialists when caring for complex seniors with co-existing mental and physical health needs, Outline a care management model where geriatric specialist services are utilized more efficiently by providing evidence based speciality recommendations through care manager supervision in situations where patients do not require direct consultation.

Abstract: Literature suggests seniors with co-existing mental and physical health concerns encounter challenges with accessing care including limited availability to geriatric specialists, inadequate navigational support, disjointed communication, and limited provider knowledge/ capacity to manage these complex patients. In conjunction with primary care, a new program was created to assist in addressing these concerns. A novel collaborative care model was developed integrating Geriatric Medicine and Geriatric Psychiatry anchored in primary care, where primary care remains the most responsible provider. Care managers (CMs) work with seniors in the community, for up to 16 weeks, who have at least one chronic health condition affecting function and depressed mood and/or anxiety. There are 4 main interventions: integrated therapeutic care management, systematic case reviews (SCRs), integrated care planning, and education/capacity building. CMs provide comprehensive assessments, system navigation, monitoring using symptom rating scales, and a problem solving psychotherapy for seniors using reward exposure to form action plans. CMs present cases weekly at SCRs, where the team includes a geriatrician, geriatric psychiatrist, primary care, and allied health. Recommendations are made then sent to the PCP for implementation. This makes efficient use of specialists' time and builds capacity with primary care. Education surrounding caring for complex seniors with co-existing mental and physical illness is provided through various modes of communication and educational opportunities. Early results show remission rates of 55% for depression and 57% for anxiety. Function improved by approximately 13%. Almost 80% of recommendations made at SCRs are followed through by the PCP showing successful engagement.

Co-Authors: Chen, Joanne, PT, MHSc, Trillium Health Partners; Shulman, Richard, MDCM, FRCPC, Geriatric Psychiatry, Trillium Health Partners; Versloot, Judith, PhD, Trillium Health Partners

IMPLEMENTING A QUALITY FRAMEWORK IN COLLABORATIVE MENTAL HEALTH CARE: ADVANCING BEST PRACTICES IN A COMMUNITY-HOSPITAL PARTNERSHIP

ABSTRACT #: 17

PRESENTATION TYPE: Paper Presentation

Rosalie Steinberg, MSc, MD, FRCPC, Assistant Professor, University of Toronto, Department of Psychiatry, Sunnybrook Health Sciences Centre; **Ann Marie MacDonald,** BA, CHRL, Executive Director/CEO, Mood Disorders Association of Ontario

Learning Objectives: Identify key components in the delivery of effective collaborative care, Demonstrate how an evidence-based approach can improve outcomes and collaborative care practice in a community-based mental health setting, Describe emerging best practices in the implementation of a collaborative mental health care program

Abstract: Collaborative care in mental health practice has become increasingly more widespread in primary care settings. Evidence is limited, however, about what contributes to effective implementation of these models—particularly in community-based mental health settings. The core principles of effective collaborative mental care include a patient-centered care team that provides evidence based treatment with a shared population and mission, while engaging in continuous quality improvement using a measurement based approach. Such collaborative care is ideally supported by a practice design and/or funding model that enables collaboration beyond direct patient consultation. A community-hospital partnership utilized a quality framework during implementation of a newly developed collaborative mental health program. The team used a self-assessment tool to evaluate its level of integration in keeping with the above core principles. During the implementation phase, partners utilized a continuous quality improvement framework that was both evidence and measurement-based. The framework was used to 1) monitor functional and clinical outcomes of shared clients, 2) provide seamless patient-centered care 3) manage complexity and decrease risk 4) facilitate care coordination to match resource intensity to client need and, 5) build organizational capacity through knowledge exchange. Presenters will share lessons learned from practical application of a quality framework that can inform future implementation of effective and sustainable collaborative care models in real-world community mental health settings.

Co-Authors: Steinberg, Rosalie MSc, MD, FRCPC, Psychiatrist, University of Toronto, Sunnybrook Health Sciences Centr; MacDonald, Ann Marie, BA, CHRL, Executive Director/CEO, Mood Disorders Association of Ontario; Zaretsky, Ari, MD, FRCPC, University of Toronto, Psychiatrist in Chief, Sunnybrook Health Sciences Centre

MENTAL HEALTH ON-THE-GO: AN EXPLORATION OF SINGLE SESSION COUNSELLING AND CRISIS SUPPORT FOR HOMELESS AND UNDERHOUSED POPULATIONS IN A MOBILE SERVICE SETTING

ABSTRACT #: 20

PRESENTATION TYPE: Works in Progress

Andrea W. Westbrook, Master of Social Work; Bachelor of Social Work, Clinical Social Worker and Mental Health Counsellor, Sherbourne Health Centre

Learning Objectives: To discuss the interprofessional and collaborative program development for the newly created role of Mental Health Counsellor on the Sherbourne Health Bus, and to build opportunities for engagement among participants on ways to enhance their understanding, To engage participants in a review of the current tools being used on the Health Bus in Single Session therapy with homeless/underhoused service users accessing mental health support in a mobile health setting, To identify the challenges to meaningful data collection for mental health counselling within a single session framework in a mobile setting

Abstract: This Work in Progress presentation will focus on the newly implemented Mental Health Counselling program on the re-launched Sherbourne Health Bus. The Bus is staffed by a Nurse Practitioner, Mental Health Counsellor, and Program Worker, and operates in Mid-East Toronto. This neighbourhood has multiple large shelters and a dense number of subsidized and low-income residential units, boarding homes, and rooming houses. The neighbourhood supports many highly marginalized individuals who are often living with complex mental and physical health needs. Individuals may also face barriers to social determinants of health, such as food insecurity, inadequate housing, financial insecurity, and judicial involvement. The newly launched Sherbourne Health Bus currently delivers services at three different community sites - a Winter Respite Services program, a Sex Worker drop-in, and a 300-bed men's shelter. The mental health counselling program currently uses a Single Session Therapy service delivery model, utilizing three main therapeutic approaches to support people accessing the bus: Solutions-focused brief therapy; supportive counselling; and single incident verbal thought records. This session is designed for front line workers, mental health practitioners, program managers, students, and researchers. The goal for this workshop is to provide insights about mobile mental health program implementation, challenges to meaningful Single Session counselling evaluation, and to engage the participants in a discussion around building creative practices of non-traditional counselling with homeless/underhoused service users accessing mental health support in a mobile health setting.

WE CARE PODCAST PRESENTED BY THE EAST TORONTO SUB-REGION

ABSTRACT #: 22

PRESENTATION TYPE: Innovative Presentation

Lucinda McGroarty, BID, MDes, Michael Garron Hospital; **Priscilla Tang,** MPP, Manager, East Toronto Sub-Region; **Diana Raymond-Watts,** MHSc, Project Manager, East Toronto Sub-Region

Learning Objectives: Identify key elements of the medical home model, Describe how the medical home model leads to health care system transformation, Describe alternative modes of storytelling within the health care context

Abstract: This is an opportunity for the East Toronto Sub-Region to share our work around primary care transformation in underserved neighbourhoods in east Toronto. We have observed simplicity in what is termed the "medical home", also referred to as the "patient-centered medical home" or "health home". This model is built on the basis of trust—fostered relationships between patients, primary care providers and the wider community. We have seen firsthand the positive impact of the medical home on health outcomes, as well as on system costs and efficiencies. For this presentation, the team will focus specifically on the stories of three neighbourhoods: Oakridge, Taylor-Massey and Thorncliffe Park. These stories will be told through the creation of a podcast mini-series (entitled We Care), where each neighbourhood is featured in one of the episodes. These are firsthand accounts told through the experiences of primary care providers, including doctors, nurses, social workers and case counsellors.

Co-Authors: East Toronto Sub-Region; WoodGreen Community Services; Providence Healthcare; Michael Garron Hospital; Oakridge Medical Home

WALKING THE PATH: AN APPLIED RESEARCH PILOT TO IMPROVE SERVICE PATHWAYS BETWEEN PRIMARY CARE AND COMMUNITY-BASED CHILD AND YOUTH MENTAL HEALTH SERVICES

ABSTRACT #: 25

PRESENTATION TYPE: Paper Presentation

Mario Cappelli, BSc Psychology (University of Ottawa), M.A. (Carleton University), PhD (Carleton University), PhD.,C.Psych, Children's Hospital of Eastern Ontario (CHEO) Research Institute, University of Ottawa; **Laura Kelly,** The Ontario Centre of Excellence for Child and Youth Mental Health

Learning Objectives: Participants will be able to explain the barriers and facilitators of inter-provider communication and collaboration between primary care and community-based child and youth mental health services, Participants will be able to consider how to implement the HEADS-ED within their own practice as a standardized mental health screening tool for children and youth, Participants will be able to adapt the pilot project's activities and outcomes to fit within their own community to improve service pathways from primary care to community-based services for children, youth and families

Abstract: The Centre's policy-ready paper, Paving the path to connected care provided policy recommendations aimed at strengthening the way primary care and community-based child and youth mental health (MH) services work together. Walking the path is a pilot project developed to address three key recommendations: creation of organizational structures and practices that support inter-provider communication; development of guidelines and standardized clinical pathways, and integration of standardized tools in primary care practices. This presentation will focus on the implementation of the recommendations in 2 Ontario regions: Algoma District in Northern Ontario and Toronto. Project partners include the Centre of Excellence for Child & Youth Mental Health, Algoma Family Services & Toronto East Metro Youth Services (Ontario Lead Agencies). Community Advisory Committees comprised of MH service staff, local primary care partners and key stakeholders (youth and families) have been created in each community. Site specific standardized clinical/service pathways using a stepped care approach have been developed. The HEADS-ED, a rapid MH screening tool, is being used to link primary care and the clinical/service pathways. Focus groups with community stakeholders (youth, family members, primary care and community MH practitioners) will be conducted to review and finalize the pathways. The Theoretical Domains Framework will guide the questions and analysis of responses. The experiences related to planning and implementing these recommendations, and the challenges and successes of both sites will be shared. Participants will also be encouraged to brainstorm specific strategies to support the implementation of these recommendations in their own communities.

Co-Authors: Cappelli, Mario, Ph.D., C.Psych., CHEO Research Institute; Kelly, Laura, BSc. MPH, The Ontario Centre of Excellence for Child and Youth Mental Health

LONG TERM MENTORING TO SUPPORT FAMILY PHYSICIANS TO MEET THE CHALLENGES OF PRIMARY MENTAL HEALTH CARE

ABSTRACT #: 26

PRESENTATION TYPE: Workshop

Helen R Spenser, MD CCFP FRCP C, Child and Adolescent Psychiatrist, Spenser Helen, University of Ottawa; **Dr. Arun Radhakrishnan,** Co-Lead CMHN Network , Ontario College of Family Physicians, MD CCFP, Family Physician Ottawa; **Dr. Cyndy Sabatino,** MD CCFP FCPC,, Family Physician , Ottawa, Mentee Group 10 , CMHN Network; **Dr. Millaray Sanchez,** MD CCFP FCPC, Family Physician, Assistant Professor U. of Ottawa, Mentee Group ten CMHN Network; **Dr. Jonathan Hunter,** MD FRCP C , CMHN Mentor and Steering Committee member, Psychiatrist, Mt Sinai Hospital, Associate Professor, Head of the Division of Consultation-Liaison Psychiatry, University of Toronto Department of Psychiatry; **Dr. Jonathan Davine,** MD FRCP C, Mentor CMHN, Psychiatrist, Hamilton Ontario, McMaster University

Learning Objectives: By the end of this workshop, participants will be able to list from reviewing data collected from program participants, ways in which the Collaborative mental health network has increased capacity and confidence in delivery of mental health care, By the end of this workshop, participants will be able to list the features that allow mentoring to facilitate and support family physicians in delivering mental health services across the lifespan of their patients, By the end of this workshop, participants will have had an opportunity to experience being mentored as they bring questions from their own practices to discuss in small group format. They will then be able to make a decision as to whether they would like

Abstract: Specialists, including psychiatrists require a referral from a family physician.Since patients suffering from mental illness visit their family doctors when initially seeking help, supporting primary care clinicians to deliver mental health services, becomes key to the provision of accessible, quality mental health assessment and treatment in primary care. In response to this need, the Collaborative Mental Health Network was launched in 2001. As a mentoring network the CMHN , links family physicians with psychiatrists and G.P. Psychotherapists to engage in ongoing case discussions Unique to collaborative primary care programs is the network's longitudinal mentor-mentee relationships enabling knowledge translation and the ongoing availability of supportive and compassionate spaces for family physicians. In this 90 minute workshop , Dr. Radhakrishnan will begin with an overview of the program using data collected from participants to illustrate the program's ongoing value to participants Dr. Spenser a mentor with the program since its inception and two mentees will demonstrate via case presentations a typical group interchange which take place via a combination of email discussions face to face meetings and an annual conference. The network is unique to shared care models in Canada most of which offer time limited models of combined mentoring and academic detailing. Finally, participants have the opportunity to try the model out by bringing their own mental health patient questions to round table Q and A with CMHN mentors including Dr. Jon Hunter and speakers. Following the conference there will be an opportunity for participants to apply to join the program.

Co-Authors: Arun Radhakrishnan MD CCFP , Family Physician and co-lead CMHN Network; Cindy Sabatino MD CCFP FCPC , Family Physician and Mentee CMHN, Ottawa; Millaray Sanchez MD CCFP FCPC, Family Physician, Mentee CMHN , Ottawa; Jonathan Hunter MD FRCP C Psychiatrist Mount Sinai Hospital Toronto; Jon Davine MD FRCP C Psychiatrist Hamilton, CMHN Mentor

INTEGRATING MENTAL HEALTH AND DIABETES MANAGEMENT - A COLLABORATIVE CARE MODEL

ABSTRACT #: 27

PRESENTATION TYPE: Paper Presentation

Sheryl Parks, MSW, RSW, Trillium Health Partners; **Ian S. Zenlea,** MD, MPH, Trillium Health Partners; **Judith Versloot,** PhD, Trillium Health Partners; **Elizabeth Mansfield,** PhD, Trillium Health Partners; **Gaya Amirthavasar,** MSc, Trillium Health Partners

Learning Objectives: To describe the relationship between type 1 diabetes and mental health disorders, To identify the current gaps in care for adolescents with type1 diabetes, To discuss the findings and learnings from our integrated collaborative care model for the treatment of type 1 diabetes and co-occurring mental health disorders

Abstract: Children with chronic illnesses are more likely to have emotional and behavioral symptoms than their healthy peers and may be psychologically affected or traumatized by medical treatments. Type 1 diabetes is the second most common chronic illness amongst children and youth. The risk of psychiatric morbidity in children and youth with type 1 diabetes is two to three times higher than their peers. Despite recommendations by national and international authorities, there is no provincial strategy to systematically identify and assist these patients. Consequently many depressed youth go undetected and those who do come to attention and seek mental health services are confronted with a fragmented healthcare system without an integrated treatment approach. In 2016, Trillium Health Partners launched a collaborative care model to identify and treat depression in adolescent patients living with Type 1 diabetes. This initiative is part of the Medical Psychiatry Alliance, a program dedicated to transforming the delivery of health services for patients with co-occurring mental and physical health concerns. The project draws on central components of collaborative care and aims to shift the culture of the diabetes clinic to support a more holistic approach to well-being. The model involves 4 steps: 1) screening and monitoring all adolescent patients at the diabetes clinic; 2) identifying high risk patients; 3) diagnostic assessments; and 4) treat-to-target interventions with blended medical and mental health goals. Initial evaluation findings and learnings from the project implementation will be shared

Co-Authors: Ian S. Zenlea, MD, MPH, Trillium Health Partners; Judith Versloot, PhD, Institute for Better Health; Elizabeth Mansfield, PhD, Institute for Better Health

ACCEPTABILITY OF TELEPHONE-BASED MENTAL HEALTH SUPPORT FOR PRIMARY CARE PATIENTS

ABSTRACT #: 28
PRESENTATION TYPE: Symposium
Salaha Zaheer, BSC MPH, Research Analyst, Centre for Addiction and Mental Health; **Vanessa Garofalo,** Centre for Addiction and Mental Health

Learning Objectives: Discuss factors that influence the implementation of evidence-based integrated care models for addressing mental health and addictions issues in the primary care settings, Discuss factors that influence the acceptability and challenges of telephone-based mental health care from patients' perspectives., Review how findings can be used to improve mental health service implementation

Abstract: Background: Depression, anxiety, and at-risk drinking are highly prevalent in primary care settings. Many jurisdictions experience geographical barriers to accessing mental health services, necessitating the development and validation of alternative models of care delivery. Existing evidence supports the acceptability and effectiveness of providing mental health care by telephone. Methods: PARTNERs is a telephone-based research trial comparing an integrated care intervention to usual care enhanced by periodic assessments in adult primary care patients referred for treatment of depression, anxiety, or at-risk drinking; no part of the study involves in-person contact. We analyzed data from PARTNERs to assess the acceptability and potential limitations of telephone-based mental health care from patients' perspectives. Results: During the consent process, 53.7% of 667 patients referred to the study declined to participate, and attributed their refusal to research-related factors (i.e., randomization and time commitment); a further 16.8% declined due to the telephone delivery of the intervention. Among 377 participants who were randomized to the one-year intervention, the overall retention rate was 81.8%. Almost no participants who withdrew from the study identified the telephone components of the study as their reason for withdrawal. Analysis of a qualitative satisfaction survey revealed that 97.4% of comments related to the telephone components were positive, with key reported positive attributes being accessibility, convenience, and privacy. Interpretation: Our results suggest that telephone-based mental health care is highly acceptable to primary care patients with depression, anxiety, or at-risk drinking. In particular, these patients appreciate its accessibility, flexibility, and privacy.

Co-Authors: Garofalo, Vanessa, BA, Centre for Addiction and Mental Health; Rodie, David, MD, FRCPC, Centre for Addiction and Mental Health; Perivolaris, Athina,RN, MN, Centre for Addiction and Mental Health; Mulsant, Benoit, MD, MSc, FRCPC, Centre for Addiction and Mental Health

THE IMPORTANCE OF EMBEDDING NUTRITION AS AN ESSENTIAL ASPECT OF MENTAL HEALTH CARE: IT'S MORE THAN JUST EATING WELL!

ABSTRACT #: 33
PRESENTATION TYPE: Paper Presentation
Tricia Brinn, Masters of Social Work, MSW, RSW, Hamilton Family Health Team; **Susan Smith,** RD, CDE, Nutrition Groups Program Coordinator, Hamilton Family Health Team

Learning Objectives: Review the evidence regarding the therapeutic impact of nutrition in mental health care, Discuss the importance of and how to implement nutritional goal setting in Mental Health Group programs, Summarize the qualitative data evaluating the impact nutritional programming has had on group participants, Discuss how nutrition might be brought more fully into mental health care for both individual and group interventions.

Abstract: Evidence shows that there is a connection between mental wellbeing and adequate nutrition. And yet, how often is this duality recognized in mental health treatment practice? Comprehensive mental health care includes consideration of how nutrition intersects with mental health and how the food we eat is associated with our mood, behaviour and cognition. The Hamilton Family Health Team has taken the initiative to incorporate a more focused nutritional component into some of its mental health group treatment programs including groups for concurrent alcohol use disorder with depression, anxiety, and stress. An example of this focus is how groups explore the interaction of specific vitamins and diet help on reducing the symptomatology of mental health disorders such as depression and anxiety. In addition, we discuss how alcohol can seriously deplete important body nutrients, minerals, and vitamins thereby further complicating mental health. In our groups, adequate focus goes beyond the addition of gratuitous nutritional information, to embedding the concept of healthy eating into the very fabric of the group. We have also stepped into co-facilitation of groups with Mental Health Counsellors and Registered Dietitians, such as our Binge Eating Disorder group. This workshop will review the processes set up to incorporate nutrition into mental health groups and how it has evolved into developing the individualized nutrition goals of group members. Moving forward, we are working towards a more comprehensive care for all patients where Registered Dietitians and Mental Health Counsellors work closely with the shared goal of assessing nutritional goals in conjunction with mental health treatment.

Co-Authors: Brinn, Tricia. MSW RSW, Mental Health Groups Program Coordinator; LaForme, Brad. MSW RSW, Substance Use Program Coordinator; Robinson, Cynthia. MEd RSW, Child and Youth Mental Health Coordinator; Smith, Susan. RD CDE, Nutrition Groups Program Coordinator

THE OVERDOSE CRISIS RESPONSE IN ONTARIO: TAKING THE LEAD FROM PEOPLE WHO USE DRUGS

ABSTRACT #: 35
PRESENTATION TYPE: Workshop
Lynne Raskin, BSc, RN, South Riverdale Community Health Centre; **Jason Altenberg,** Director of Program and Services/South Riverdale CHC

Learning Objectives: Participants will be able to plan design and deliver services in collaboration with people who use drugs, Participants will be able to integrate harm reduction in the provision of care and services, Participants will be able to describe the failures of interventions that are not based on the lived experience and inclusion of people who use drugs

Abstract: The overdose crisis in Ontario is the most serious health and public health crisis we have seen in generations. Responses to the crisis were slow and based on a public health response that privileges expert knowledge above the experience of people who use drugs. The exclusion and discrimination against people who use drugs has played a central role in the creation of this crisis and the responses to it. In this interactive workshop co-presented by people who use drugs and service providers we will share lessons learned from the failed health and public health response to the emergent crisis and the successes of a collaborative response that is based on the meaningful leadership of people who use drugs in policy, direct action, and collaborative service provision. Based on the experience of launching non-sanctioned overdose prevention site(s) and integrated supervised consumption in primary care, participants will learn how to work with active drug users as service providers, policy makers and leaders.

Co-Authors: Jason Altenberg, Director of Program and Services/South Riverdale CHC

CHALLENGES IN INTEGRATED MENTAL HEALTH CARE RESEARCH: UNDERSTANDING PRIMARY CARE PROVIDERS' PARTICIPATION IN THE PARTNERS STUDY

ABSTRACT #: 36
PRESENTATION TYPE: Symposium
Annie Zhu, BHSc, Medical Student, University of Toronto

Learning Objectives: Analyze barriers and facilitators of implementing collaborative care intervention studies in primary care settings, Recommend practical strategies to increase uptake of collaborative care research in diverse primary care practices, Describe how implementation science frameworks can guide study design, data collection, and interpretation of qualitative findings to advance collaborative care

Abstract: Background: Collaborative care is one of the most empirically supported approaches to achieving good outcomes in primary mental health care. The PARTNERs study is a pragmatic randomized controlled trial (RCT) of a collaborative care intervention for people experiencing depression, anxiety, or at-risk drinking in Ontario. A qualitative study was conducted to better understand the reasons contributing to low referral rates to the RCT and delayed uptake of treatment recommendations by primary care providers (PCPs). This study explored PCP's perceptions and experiences of collaborative care models, RCTs, and PARTNERs specifically; and their recommendations for future intervention research. Methods: We conducted telephone interviews with 23 PCPs from 12 of the 14 practices that participated in PARTNERs that were audio-recorded, transcribed, and later thematically analyzed. The study was informed by the Consolidated Framework for Implementation Research and Theory of Planned Behaviour theoretical frameworks. Data collection and analysis were concurrent until achieving thematic and theoretical saturation. Results: Participants valued many aspects of PARTNERs including the unique availability of telephone-based coaching for patients, and expert psychiatric recommendations for PCPs. However, they desired greater integration of the care manager with their practice and improvements in information flow. Sites varied in the extent to which they identified a local champion or integrated the study into existing workflows, with notable effects on continuing awareness of the study and referral rates. Discussion: Extensive planning, training, leadership, and ongoing relationships between the study team and primary care team are needed for successful adoption and implementation of collaborative care interventions.

Co-Authors: Sunderji, Nadiya, MD MPH FRCPC, St. Michael's Hospital, Department of Psychiatry, University of Toronto; Ion, Allyson, MSc (PhD Cand.), St. Michael's Hospital, McMaster University; Perivolaris, Athina, RN MN CAMH, Lawrence Bloomberg Faculty of Nursing, University of Toronto; Rodie, DJ, MD FRCPC, Department of Psychiatry, University of Toronto, CAMH; Mulsant, Benoit H, MD MS FRCPC, Department of Psychiatry, University of Toronto, CAMH

HOW CAN PROVIDERS BETTER ENGAGE SERVICE USERS AND FAMILIES IN COLLABORATIVE MENTAL HEALTH CARE?

ABSTRACT #: 38
PRESENTATION TYPE: Paper Presentation
Matthew Menear, PhD, Laval University

Learning Objectives: Explain the different levels and forms of engagement in which services users and families can be engaged in collaborative mental health care, Describe concrete strategies for engaging service users and families in collaborative care in different ways and at different levels of the health system, Summarize evidence related to three specific engagement strategies: 1) shared decision making, 2) self-management supports, and 3) peer supports.

Abstract: There is a growing consensus that mental health service users and their families should be actively engaged as partners in collaborative care, yet how best to engage them and what impacts this has remains less clear. The objective of our study was to identify strategies for engaging service users and families in collaborative mental health care (CMHC) and determine how these engagement strategies work, for whom, and in what circumstances. To achieve this objective we conducted an update of a Cochrane systematic review of CMHC interventions for depression and anxiety disorders (phase 1), followed by a realist synthesis of the evidence (phase 2). In phase 1, structured searches were performed in Cochrane CCDAN (2011 to present) and CINAHL (2009 to present) databases. Articles were eligible if they described RCTs or clinical controlled trials of CMHC programs meeting the same criteria used in the 2012 Cochrane review. Database searching yielded 4643 unique references, which were screened independently by multiple review authors, resulting in 55 new CMHC programs to add to the 79 previously identified by the 2012 Cochrane review (total = 134). We used directed content analysis guided by a conceptual framework to identify engagement strategies within all programs. We identified 11 different strategies, the most common being psychoeducation, self-management, involvement in care planning, and motivational enhancements. For phase 2, we developed and tested hypotheses about the proposed mechanisms underpinning three priority strategies (shared decision making, self-management, and peer supports), the outcomes they generate, and the contextual factors influencing their effectiveness.

Co-Authors: Michel Gervais, MD MBA; France Légaré, MD PhD

AN APPROACH TO DEVELOPING A REGIONAL SYSTEM FOR PROVIDING MENTAL HEALTH CARE IN RURAL AND REMOTE COMMUNITIES

ABSTRACT #: 43
PRESENTATION TYPE: Paper Presentation
Supuneet Bismil, MBBS, MBBS, FRCPC, St Joseph's Care Group, Northern Ontario School of Medicine; **Jack Haggarty,** St Joseph's Care Group, Thunder Bay

Learning Objectives: Examine the factors affecting delivery of optimal mental health care services to remote and rural communities in North Western Ontario, Compare these factors to other rural and remote communities across other geographical areas, Assess the applicability of presented options for mental health care delivery to other similar communities

Abstract: Northwestern Ontario (NWO) has a large geographical spread, low density of population and high mental health care needs. This presents multiple challenges to providing timely and adequate mental health care facilities in the region. We have developed a menu of options to address some of these challenges and barriers in our region. In this interactive workshop, we will examine various factors affecting mental health care delivery in NWO, compare and contrast the factors in NWO to those in other communities in various parts of Canada and the rest of the world. We will also assess the applicability of options that we have been using in improving mental health care provision in other communities across Canada and the rest of the world.

Co-Authors: Supuneet Bismil; Jack Haggarty

INTERSECTORAL COLLABORATION FOR CHILDREN AND ADOLESCENTS MENTAL HEALTH CARE: A PRELIMINARY RESEARCH REPORT WITHIN THE PUBLIC SYSTEM IN RIO DE JANEIRO, BRAZIL

ABSTRACT #: 44
PRESENTATION TYPE: Works in Progress
Melissa Teixeira, PhD in progress, Assistant Professor, Federal University of Rio de Janeiro

Learning Objectives: To describe the collaborative care strategy components within the context of brazilian public system, To identify possible barries and facilitators to the implementation of a collaborative care strategy, To plan an intersectorial strategy for promoting children and adolescents mental health care

Abstract: Bridging the gap for children and adolescents mental health care depends on the powerful articulation, co-responsability and collaborative work between different sectors. Based on that assumption, we developed a research project to improve access to and to qualify mental health services for children and adolescents by implementing a strategy of collaborative care between different sectors in two low-income communities in Rio de Janeiro, Brazil. This work aims to present the collaborative care components designed for the strategy implementation within the mentioned communities, and to identify barriers and facilitators for children and adolescents mental health care. Its is a qualitative research that used participant observation and focus groups with professionals of distinct sectors as methodological tools for gathering data. The following collaborative care compontents were defined: I) Shared care management; II) Linkage mechanisms between professionals and services; III) Mechanisms for information and knowledge sharing; IV) Actions for permanent health education and V) Actions for childen ans adolescents mental health promotion. Preliminary findings show that the implementation of collaborative care strategy produced the following effects: services articulation improvement; decrase of duplicated efforts and discontinuity of care; creation of new flows and modalities of care. Although, many barriers still need to be overcome, such as: the "non-sharing" culture between professionals; the public system fragmentation; the fragile appropriation of cases by the teams involved; the temporal gap between primary health care teams and mental health services and the dichotomy between mental health care and promotion.

Co-Authors: Couto, Maria Cristina, PhD, Federal University of Rio de Janeiro; Delgado, Pedro Gabriel, PhD, Federal University of Rio de Janeiro

THE MYNDPLAN PROJECT: A STRATEGY FOR CREATING AND IMPLEMENTING STEPPED CARE MENTAL HEALTH TREATMENT PLANS THAT ARE CLIENT CENTRED AND EMPIRICALLY BASED

ABSTRACT #: 45
PRESENTATION TYPE: Paper Presentation
Robert Shepherd, B.A. (Hons), M.A., Ph.D., Psychologist, Huron Community FHT, Myndplan inc.

Learning Objectives: Identify the key client characteristics that guide the design of a empirically-based stepped care plan, Classify validated traditional and e-treatment resources so that they can be allocated more effectively, Expand the use of innovative client-centered tools in an FHT setting to create a more effective circle of care

Abstract: Our Family Health Team is presently engaged in an e-health project in collaboration with a private health internet technology company. We are integrating a client-centered mental health web app into our mental health intake process. In addition to accessing assessment results for use in our clinic, clients can share information with mental health providers from a variety of agencies including CMHA, addiction services, crisis services, community psychiatric services and private practice in the area of Huron and Perth counties in Southwestern Ontario. Use of this prototype client-centered e-mental health system will be reviewed with respect to its impact on collaboration within a family health team and between the team and community agencies, potential barriers and ethical concerns, and implications concerning mental health referral patterns, treatment planning and implementation, allocation of resources, and treatment outcomes. The project is designed to innovate with respect to typical practices for mental health symptom screening, clinical diagnosis, treatment decision-making and the delivery of treatment in community settings.

Co-Authors: Buchanan, Kelly, Executive Director, Huron Community FHT; Bourdage, Renelle, Psychotherapist, Huron Community FHT

CULTURE IN PATIENT-CENTERED CLINIC: ITS AVENUE OF EXPRESSION AND APPREHENSION IN YOUTH MENTAL HEALTH CARE

ABSTRACT #: 47
PRESENTATION TYPE: Paper Presentation
Lucie Nadeau, MD, MSc, Dr, McGill University; **Janique Johnson-Lafleur,** MSc, PhD(c), McGill University

Learning Objectives: Describe various approaches to the consideration of culture in mental health care (cultural competence, cultural safety, cultural humility), Review the complexity of the role of culture in youth mental health care, Identify the benefit of interventions which include openness to diversity and culturally safe work on cultural representations

Abstract: The paradigm of 'cultural competence' has brought the notion of culture to be more salient in the clinic. Although this attention to culture is increasingly adopted in practice, it is not devoid of a risk of stereotyping and stigmatizing if culture fails to be considered contextually. The notions of 'cultural safety' and 'cultural humility' have transformed the way to apprehend culture. Transcultural work joins the spirit of collaborative care when treating culture in its complexity, being inclusive of a patient-centered diversity, and providing a safe dialogue about culture. This paper will present results of a qualitative research which questions the way culture is expressed in the clinic and its inclusion in therapeutic avenues. Semi-structured individual interviews (N=205) were conducted with 44 families (44 children, 39 parents) receiving services in youth mental health in Montreal and their primary clinician (N=42) at two points in time (6 months and 1 year after the beginning of services). A thematic analysis was performed on all transcribed material. Research findings indicate that culture may be explicitly addressed in the clinic or be implicitly present. Participants displayed a range of comprehensions of culture, from refined notions to stereotypical understandings of culture. Most promising interventions include: the clinician's attitude of openness to diversity; providing a culturally safe space to work with cultural representations; understanding the subtleties and complexities of such representations for a given individual or family; and taking into account varied perspectives among family members, especially among youth and their parents.

Co-Authors: Johnson-Lafleur, Janique, MSc, PhD(c), McGill University

SENIORS CRISIS SERVICES INITIATIVE: COLLABORATION ACROSS LHINS AND SECTORS FOR CLIENT CENTRED CARE

ABSTRACT #: 48
PRESENTATION TYPE: Paper Presentation
Julia Chao, B.A., B.S.W., M.S.W., R.S.W., WoodGreen Community Services

Learning Objectives: Describe the Seniors Crisis Services Initiative and how it improves care for seniors in crisis across the City of Toronto, Outline how the model was developed, Identify the opportunities and challenges when working with partner organizations, cross-sectoral, cross LHIN collaboration

Abstract: The Senior Crisis Services Initiative (SCSI) is a cross-sectoral (CMH & CSS) and cross-LHIN partnership that provides seamless crisis responsive and follow-up supports for seniors, caregivers and/or family members in the City of Toronto. SCSI meets a rapidly growing demand for seniors' crisis services and increases system capacity by diverting non-medical crisis cases from acute care hospitals and Toronto Police Services and delivering community-based supports. SCSI standardizes care across the City of Toronto while providing locally relevant services through a governance model that is built on shared principles and definitions. SCSI provides a streamlined continuum of care through telephone support, intervention, triage to mobile in-person outreach, short-term in-person crisis intervention and crisis management services; and warm transitions to follow-up case management services, linkages to primary care, and emergency respite services as required. SCSI represents a best practice for community-led service collaboration that is designed to respond to client experience and leverage existing resources to increase system capacity. SCSI is an example of a regional service with its relevant relationships and linkages that is integrated within the continuum of care of the broader health care system. The presentation will provide an overview of the service delivery model, how SCSI was developed, implemented, and the collaborative process between TC LHIN Home and Community Division, WoodGreen Community Services, Reconnect Community Health, LOFT Community Services with support from three LHINs (Toronto Central, Central, Central East). Key milestones of the process which ensured integration and collaboration will be highlighted.

BUILDING POSITIVE SPACE IN PRIMARY CARE TO IMPROVE ACCESS FOR LGBTQ PATIENTS

ABSTRACT #: 50
PRESENTATION TYPE: Workshop
Catherine McPherson-Doe, MSW, Manager, Mental Health & Nutrition Services, Hamilton Family Health Team; **Jackie Bootsma,** MSW RSW, Hamilton Family Health Team; **Tim Elliott,** MSW RSW, Hamilton Family Health Team

Learning Objectives: Evaluate the degree of positive space for patients and staff in a primary care organization, Demonstrate how increasing positive space improves LGBTQ patient access to mental health services, Build the competencies of health providers to address the mental health needs of this population of patients.

Abstract: The Rainbow Health Organization reports, "due in part to negative past experiences, many LGBT people may delay or avoid seeking health care altogether." A report released by the Social Planning and Research Council of Hamilton, found that only 57% of LGBTQ-identified respondents were out to their family physician. The isolation experienced by LGBTQ people can lead to a higher rate of alcohol and drug use, smoking, mental health issues and suicide (Peterkin and Risdon, 2003). Some members of the LGBTQ community may be reluctant to enroll with a family practice, or disclose certain aspects of their personal history unless they are certain that they will be completely welcome. The Hamilton Family Health Team is comprised of 166 family physicians and their primary care teams. We are committed to inclusion and access for all citizens of Hamilton. The HFHT Positive Working Group was formed in 2012 to discuss ways to create a more LGBTQ friendly organization for our patients and for our providers. This presentation will explore the steps taken, the outcomes and impacts; most specifically those related to developing greater cultural and clinical competency to respond to the mental health needs of LGBTQ persons. Participants will be invited to analyze their own settings and share related learnings.

Co-Authors: Jackie Bootsma, MSW, RSW, Mental Health Counsellor, Hamilton Family Health Team; Tim Elliott, MSW, RSW, Mental Health Counsellor, Hamilton Family Health Team

A GROUP PSYCHOTHERAPY INTERVENTION SUPPORTING DEMENTIA FAMILY CARERS: WHY WE NEED IT

ABSTRACT #: 57
PRESENTATION TYPE: Paper Presentation
Leslie Nickell, BSc, MSW, MD, CCFP, Associate Professor, Medical Lead Caregiver Support Services, Sinai Health System, Bridgepoint Site, Dept of Family & Community Medicine, U of Toronto

Learning Objectives: Explain the health and mental health risks for Caregivers, Describe key elements of the CARERS Group psychotherapy intervention, Identify opportunities in their own clinical practrice to engage and support caregivers

Abstract: In 2013, Statistics Canada reported that 28% of the population 15 years and older provided care at home, to individuals with long term health conditions. Their survey indicated that among the 2.3 million caregiver respondents, 55% were worried and anxious, 52% were tired, 38% were short tempered and irritable, 36% were overwhelmed, 18% were depressed and 17% were lonely and isolated. With the increasing ageing population, both the demands on caregivers, and health concerns of caregivers, can be expected to increase. Unfortunately, the caregiver experience often goes unnoticed by health care providers, with the focus remaining on the identified patient. Indeed, the health care system itself is well known to contribute to caregiver distress. Health providers must recognize the critical role of the caregiver, and be alert to their health/mental health needs. This presentation will provide an introduction to an evidence-based group psychotherapy intervention, for caregivers of individuals with dementia. A brief overview of the caregiver experience, risks and health care system challenges will be provided. Key elements of the unique CARERS group psychotherapy intervention will be described, including use of problem solving therapy and simulations with standardized patients. Sustained effectiveness of the intervention, supported by results of an analysis of multiple groups over time, will be demonstrated using outcome measures related to caregiver burden, distress, coping, and competence. The specific therapeutic experiences at the Bridgepoint site will be shared, and future initiatives to adapt the model to caregivers more generally, in both in-patient and community settings will be discussed.

AN INCENTIVE MODEL TO IMPROVE QUALITY CARE OF COMMON MENTAL DISORDERS IN ONTARIO FAMILY HEALTH TEAMS – FINDINGS OF A GROUNDED THEORY STUDY

ABSTRACT #: 58

PRESENTATION TYPE: Paper Presentation

Rachelle Ashcroft, PhD, Assistant Professor, University of Toronto; **Matthew Menear,** PhD, Postdoctoral Fellow, Université Laval; **Jose Silveira,** MD, Chief of Psychiatry and Medical Director, Mental Health & Addiction Programs St. Joseph's Health Centre

Learning Objectives: Describe some of the financial and non-financial incentives influencing the quality of care for common mental disorders in Family Health Teams, Describe the qualitative process used to create a theoretical incentives model to help stakeholders understand which incentives to leverage to improve the quality of care for common mental disorder in Family Health Teams, Explain how various incentives influence different dimensions of the quality of care for common mental disorders (e.g. access, structural quality, technical quality, person-centred care, equity, efficiency)

Abstract: Our presentation fits perfectly with the stream working together because our incentive model helps to explain how to improve interprofessional collaboration for CMDs in primary care. We are conducting a qualitative study based on grounded theory to develop a theoretical model that describes how various financial and non-financial incentives influence the quality of care provided to people with depression and anxiety disorders in an interprofessional primary care model. Incentives are a key strategy used by policymakers and other stakeholders to bring about collaborative change and influence care quality. However, there are many signs that suggest that the incentives systems currently in place in interprofessional environments are not aligned with the goal of achieving accessible, high-quality care for common mental disorders. This study will help healthcare providers and policymakers know what incentives to leverage in order to improve collaboration so that the broad range of providers in primary care can work together, and are well supported, to provide better mental health care within interprofessional primary care teams in Ontario.

Co-Authors: Menear, Matthew, PhD, Université Laval; Silveira, Jose, MD, St. Joseph's Health Centre; Dahrouge, Simone, PhD, Bruyère Research Institute; Emode, Monica, BA, University of Toronto; McKenzie, Kwame, MD, Wellesley Institute

COLLABORATION FROM THE INSIDE OUT: AN EVALUATION FRAMEWORK FOR A CHILD AND YOUTH MENTAL HEALTH COLLABORATIVE CARE MODEL

ABSTRACT #: 59

PRESENTATION TYPE: Paper presentation

Eunice Lee, MSW, RSW, MS Ed., Project Coordinator, Hospital for Sick Children; **Hana Saab,** BScN, MEd, PhD, Evaluation & Implementation Lead, Hospital for Sick Children; **Rose Geist,** BSc, MD, FRCPC, Psychiatrist, Hospital for Sick Children

Learning Objectives: Identify appropriate data collection methods for systematic monitoring of collaborative practice, Utilize feedback from service users, family members, and other primary care providers for quality improvement, Build a comprehensive evaluation framework to improve programs in practice

Abstract: Advancing collaborative practice in mental health care is a priority, especially in rural communities with limited access to specialized healthcare professionals. This presentation will outline the process of constructing a comprehensive evaluation framework of a collaborative care model through continuous engagement, interprofessional consultation, and application of practice-based evidence. The model is co-staffed by a care manager on a rural family health team and a psychiatrist at an urban tertiary care hospital more than 140 km away. Using telehealth technology, this team provides service provision for paediatric patients with co-occurring medical and psychiatric conditions and enhances interprofessional collaboration with primary care physicians (PCPs) within the community. This is particularly important for this group of service users because PCPs tend to report considerable gaps in skills and knowledge that enable them to address the needs of this complex population (Lempp, Heinzel-Gutenbrunner, & Bachmann; 2016). A robust evaluation framework enables clinicians and evaluators to collaborate with service users (and their families) to systematically monitor intervention effectiveness and implement improvements when necessary. This process of co-creation ensures meaningful collaborative practice across organizational and professional cultures.

Co-Authors: Lee, Eunice, MSW, RSW, MS Ed., Hospital for Sick Children; Saab, Hana, BScN, MEd, PhD, Hospital for Sick Children; Geist, Rose, BSc, MD, FRCPC, Hospital for Sick Children

MAPPING EVIDENCE OF PATIENTS' EXPERIENCES IN INTEGRATED CARE SETTINGS: A SCOPING REVIEW

ABSTRACT #: 61

PRESENTATION TYPE: Paper Presentation

Alaa Youssef, HBSc., MSc. Candidate, Graduate student, Univeristy of Toronto

Learning Objectives: Identify possible barriers or facilitators for active patient engagement in mental health care in your community or care settings, Describe opportunities for creating a collaborative caring culture in your care settings or community, Determine necessary tools (finance, training, expertise) that might seek to improve care accessibility in your care settings.

Abstract: BACKGROUND: Although studies have established the clinical and cost-effectiveness of integrated care (IC) models for patients with comorbid mental and physical illness, little is known about whether these models facilitate a patient-centered care experience from the patient's perspective. OBJECTIVE: This scoping review aims to comprehensively review the literature on the experiences of patients in IC settings to surface the existing gaps in our knowledge around important aspects of care from the patient's perspective to inform quality improvement initiatives. METHODS: A scoping review was conducted in the following databases: MEDLINE, EMBASE, PSYC INFO, CINAHL, AMED, the Cochrane Library, and grey literature. Our search results yielded 2611 unique resources of which 24 qualitative studies, one thesis dissertation, and one summary report met our eligibility criteria for analysis. RESULTS: Analyses of the existing evidence revealed variability in implementation efforts and a lack of clearly examined structural facilitators and barriers to IC implementation. Structural integrity when implementing IC models may be important as it has the power to transform the patient experience by a) alleviating or failing to reduce stigma experienced by patients while accessing care b) facilitating therapeutic alliances and spaces to meet population needs c) individual's experience for timely and personalized care. CONCLUSION: Effective patient engagement and experience of patient-centeredness are shaped by interactions with care providers and structural elements in the care model. Thus, successful implementation and sustainability efforts demand thoughtfully balancing between structural standardization and adaptability of the model to address specific contextual factors related to the targeted population needs.

Co-Authors: Zarah K. Chaudhary; Rosa Constantino; David Wiljer; Maria Mylopoulos; Sanjeev Sockalingam

HOW TO SETUP AND RUN PATIENT WELLNESS GROUPS FOR PHYSICAL AND MENTAL HEALTH IN ONTARIO FAMILY PRACTICE

ABSTRACT #: 65

PRESENTATION TYPE: Works in Progress

Carlos Yu, M.D., BMath, CCFP(EM), FCFP, CTH, Ajax Harwood Clinic Health Education Centre; **Anita Iacono,** BSc candidate, Wellness Group Facilitator, Ajax Harwood Clinic, Ajax Harwood Health Education Centre; **Jeffrey Yu,** BSc, Manager, Ajax Harwood Clinic Health Education Center; **Vivian Lo,** MD, CCFP, Family Physician, Ajax Harwood Clinic

Learning Objectives: Describe why WGs might be useful in primary care practice; Analyze what steps are needed to integrate WGs into their practice; Describe what preparation is needed to facilitate WGs

Abstract: We have experienced a major challenge in family practice: physicians do not have enough time to address multiple health issues at each appointment. Our clinic uses innovative Group Medical Appointments (GMVs) to go beyond the traditional biomedical model, by promoting the holistic concept of wellness, with a special focus on mindfulness practice, known to positively enhance psychological well-being (1). Groups run every week, are drop-in, and free of charge, removing financial barriers to access. Physical health and mental health are strongly linked, and their cross-effects must be considered (2). We address this in our two main wellness groups: Wellness 1, which centers on healthy eating and infection prevention, and Wellness 2, which centers on exercise and mindfulness. We also offer a free 8 week mindfulness course. In our groups, patients are given the opportunity to share their barriers to wellness, while the group brainstorms solutions. Patients support each other in health promoting endeavours.

Co-Authors: Anita Iacono, BSc candidate, Wellness Group Facilitator, Ajax Harwood Clinic, Ajax Harwood Health Education Centre; Jeffrey Yu, BSc, Ajax Harwood Clinic, Ajax Harwood Health Education Centre

RECOVERY-ORIENTED PRACTICE AND THE PATIENT'S MEDICAL HOME: CONSULTATION ON COLLEGE OF FAMILY PHYSICIANS OF CANADA'S BEST ADVICE GUIDE

ABSTRACT #: 66
PRESENTATION TYPE: Workshop
Francine Knoops, BA, Mental Health Commission of Canada; **Bonita Varga,** MA, Knowledge Broker, Knowledge Exchange Centre, Mental Health Commission of Canada; **Artem Safarov,** BSc, Director, Health Policy and Government Relations, College of Family Physicians of Canada

Learning Objectives: Identify resources offered by MHCC and CFPC to support delivery of recovery-oriented primary care, Describe the shared goals of recovery-oriented practice and the Patient's Medical Home, Explain the facilitators of quality, recovery-oriented primary mental health care

Abstract: Many family physicians report having insufficient knowledge and training in assessing and treating mental illnesses and report difficulty in accessing specialized psychiatric assessment services[1]. At the same time, people living with serious mental illness are not getting the physical health care they need and are dying significantly younger than other Canadians. Recognizing the value of family physicians and psychiatrists supporting each other in delivering mental healthcare to all people living in Canada, The College of Family Physicians of Canada (CFPC) and Canadian Psychiatric Association (CPA) are working together as the Collaborative Working Group on Shared Mental Health Care (CWGSMHC). To advance and strengthen this "shared care" approach, the CWGSMHC is working with the Mental Health Commission of Canada (MHCC) on improving the understanding and uptake of a recovery oriented approach to mental health care. Working together, the collaborative is developing a Best Advice Guide to situate recovery-oriented practice in the context of the Patient's Medical Home (PMH). This workshop will introduce participants to CFPC's Best Advice Guide on recovery-oriented practice and the Patient's Medical Home, highlighting available resources, shared goals and facilitators of recovery-oriented practice. Participants will also have the opportunity to validate core concepts and provide input into the final version.

Co-Authors: Varga, Bonita, MA, Knowledge Broker, Mental Health Commission of Canada; Knoops, Francine, Lead Analyst, Mental Health Commission of Canada; Artem Safarov, Director, Health Policy and Government Relations; TBD, MD, Collaborative Working Group on Shared Mental Health Care

ALBERTA PCNS WORK TOGETHER TO MAKE PROGRESS IN INTEGRATED BEHAVIORAL HEALTH

ABSTRACT #: 69
PRESENTATION TYPE: Paper Presentation
Kent Corso, PsyD, BCBA-D, NCR Behavioral Health

Learning Objectives: Explain the rationale for implementing PCBH in a PCN in lieu of outpatient or co-located mental health delivery models, Identify the variety of ways PCBH has been implemented across PCNs in Alberta, Describe the challenges associated with PCBH program implementation and name potential solutions to overcome these barriers.

Abstract: The authors describe their relative progress in launching primary care behavioral health programs in several Primary Care Networks (PCNs) across Alberta. They discuss their rationale for program development and implementation and the differences between each of their programs in the areas of program structure, function, management and measurement. Various program metrics (progress and outcome data) will be compared and contrasted to illustrate how each PCN's is using IBH to help pursuing the Quadruple Aim. Finally, the presenters describe barriers to future program success and potential solutions.

Co-Authors: Nimmock, Micheline, MBA, Highland PCN

SCOPE (SEAMLESS CARE OPTIMIZING THE PATIENT EXPERIENCE) MENTAL HEALTH PROGRAM: BRIDGING THE GAP BETWEEN PRIMARY CARE AND THE MENTAL HEALTH CARE SYSTEM

ABSTRACT #: 70
PRESENTATION TYPE: Paper Presentation
Jamie Smith, Bachelor of Arts, Master of Social Work, Registered Social Worker, Toronto Western Hospital, University Health Network; **Jennifer Hensel,** MD, MSc, Psychiatrist, Women's College Hospital

Learning Objectives: To identify and address mental health needs in the practices of solo primary care providers., To utilize an implementation approach that is agile and responsive to user needs and creates a service that works well within a given context., To observe and evaluate the value and benefits of a mental health service within a multi-disciplinary hub-based model of support for primary care providers.

Abstract: Access to timely and appropriate mental health support is a need in Ontario. Based on feedback from primary care providers enrolled with a pre-existing multi-disciplinary hub-based program (SCOPE: Seamless Care Optimizing the Patient Experience) regarding mental health needs, we introduced a new mental health "spoke" to SCOPE. The program has a full-time social worker and a consulting psychiatrist. This service launched in November 2016, with the motto that we will do our best to help with "any mental health need". The implementation approach was agile and the service intentionally very loosely defined at the outset. We tracked referrals and frequently met with PCP advisors to make modifications to the program in an iterative way within available resources. We launched with a small group of 10 PCPs, and by the end of the first year, the program was serving 35 PCPs. A total of 385 referrals were received for 320 unique patients. PCPs clustered approximately into thirds with respect to their frequency of use of the program. Most requests involve brief intervention and resource navigation for patients with anxiety and/or depression, although a significant subset involve patients with acute and/or very complex needs. The program functions within the SCOPE hub to connect with other SCOPE services as appropriate. Overall, 100% of PCPs surveyed rated the service as valuable, and anecdotal feedback indicates patient users are appreciative. The program continues to adapt. Defining more robust outcomes of impact is challenging and a goal of future evaluation.

Co-Authors: Smith, Jamie, MSW, RSW, Toronto Western Hospital, University Health Network; Hensel, Jennifer, MD MSc, Women's College Hospital; Pariser, Pauline, MD, SCOPE, University Health Network; Kaul, Dharmistha, MD, MPH, Women's College Hospital

CREATIVE MENTAL HEALTH SERVICE DELIVERY: USING MULTI-DISCIPLINARY COLLABORATION TO REDUCE WAIT TIMES

ABSTRACT #: 72
PRESENTATION TYPE: Works in Progress
Flora MacKay, BA, BSW, MSW, Registered Social Worker, Shared Mental Health, Alberta Health Services

Learning Objectives: Describe the challenges facing a small primary care clinic with limited mental health resources, List three strategies that our team used to try to address some of these challenges, Identify the measures we used to evaluate the changes we made

Abstract: Campbell Clinic Coaldale is a small primary care clinic in a rural Alberta town (population 8500). This clinic has been involved in a Shared Mental Health program for 15 years and they currently receive services from a Shared Mental Health Clinician (SMHC) one day per week. In the past few years, the wait time for patients referred to see the SMHC had climbed to six weeks. Patients, physicians and the SMHC were not satisfied with this lengthy wait time. Given budgetary constraints, more time from the SMHC is not an option, so we discussed other ways to make more efficient use of the SMHC's time. One of the RNs in the clinic had some experience and training in mental health and expressed an interest in being involved in the Shared Mental Health program. With the approval of the physicians, the RN and the SMHC developed a clinical pathway, with the goals of streamlining the referral and assessment process, reducing the workload for the SMHC by having the RN provide some services (within her scope of practice) and getting patients help more quickly. We will present our pathway, along with the evaluation strategies we have used. We will also present our outcomes: all patients can now be seen by the RN within a week of being referred, the wait time to see the SMHC has been reduced to one week and Shared Mental Health is being provided in a more collaborative way with more of a team approach.

Co-Authors: Jean Iwaasa, RN, BN, BA, Clinical Educator, Campbell Clinic Coaldale

INVOLVING FAMILIES/CARERS IN THE CARE OF YOUTH WITH MENTAL HEALTH PROBLEMS: COLLABORATING WITH SERVICE PROVIDERS ACROSS CULTURES AND PROMOTING FAMILY PEER SUPPORT

ABSTRACT #: 73

PRESENTATION TYPE: Workshop

Mary Anne Levasseur, Bachelor of Arts, spec. in psychology, Master of Arts, Theological studies, Coordinator, Family Peer Support, PEPP Montreal, ACCESS Open Minds SPOR Network, a CIHR funded initiative and PEPP-Montreal, Douglas Mental Health University Institute; Dr. Manuela Ferrari

Learning Objectives: Identify the barriers that deter families/carers' involvement in supporting youth, and in mental health treatment and evaluation/research, Discover the learning needs of families/carers and service providers in collaborating to care for affected youth, Develop families/carers' capacity to receive support, education and resources in caring for their youth through family peer support

Abstract: Support from families/carers and their involvement in treatment can positively impact youth mental health outcomes. Yet, there are significant barriers to such support and involvement. There is a strong need to increase the capacity of service providers and families to work collaboratively in order to facilitate youths' engagement in treatment and recovery. This workshop addresses this need by offering insights gained and tools developed by the ACCESS Open Minds Family and Carers Council (AFCC), a group of family members/carers with lived experience from diverse contexts (rural, remote, urban and Indigenous). The AFCC was set up and has been operating under the aegis of ACCESS Open Minds, a pan-Canadian CIHR-funded youth mental health initiative. This workshop aims to increase capacity among mental health service providers, families/carers and other pertinent stakeholders to effectively engage families in service (re)design, treatment and evaluation/research, and to offer family peer support. To do so, AFCC will share recommendations and practical tips, based on its experiences, demonstrated successes and ongoing challenges in helping 14 youth mental health hubs in six provinces and one territory involve families/carers in service planning, and offering family-focused services and peer support. Workshop attendees will learn steps involved in (a) identifying local (e.g., related to geography) and universal (e.g., trust) challenges in engaging families/carers; (b) building effective partnerships involving families, youth, clinicians, community organizations and researchers; (c) creating cultures that are conducive to family-service provider collaborations, and family peer support and involvement in treatment; and (d) initiating and sustaining family peer support initiatives.

Co-Authors: Srividya N. Iyer, Psychologist and Researcher, Prevention and Early Intervention Program for Psychosis (PEPP-Montreal) Researcher, Douglas Mental Health University Institute Assistant Professor, Department of Psychiatry, McGill University, Montreal, Scientific-Clinical Director, ACCESS Open Minds

PATHWAYS TO MENTAL HEALTH SERVICES FOR YOUTH IN CARE: AN OPPORTUNITY FOR ENHANCED COLLABORATIVE PRACTICES

ABSTRACT #: 74

PRESENTATION TYPE: Paper Presentation

Kathleen MacDonald, PhD Candidate, PhD Student, McGill University

Learning Objectives: Describe the accessibility of mental health services for young people (aged 12-18) under Youth Protection Services in Montreal., Explain how socio-demographic (e.g, gender, ethnicity), clinical (e.g, symptoms) and systemic (e.g, where services are first sought) factors influence help-seeking trajectories, including length of delays and number of contacts prior to receiving treatmen, Illustrate how increased collaboration between professionals working within distinct organizational systems will improve and simplify pathways into services for this vulnerable population.

Abstract: Background : Mental illness is the leading contributor to burden of disease among adolescents. Young people under Youth Protection Services are particularly affected, as an estimated 50-60% of youth in this group suffer from mental health problems. Objectives : To establish and describe how individuals in Youth Protection Services access mental health services in Montreal, with a focus on the pathways and delays experienced before reaching appropriate services. Methods : 200 clinical files were reviewed, of young people aged 12-18 years old who were under care of Youth Protection Services for at least one year. Data pertaining to symptom onset, pathways to care, mental health service utilization, hospitalization, and treatment delays were collected. Results : As expected, the majority of young people were found to have mental health concerns and a need for treatment. Results also show that delays between onset of mental health problems and obtaining care are common, and often exacerbated by systemic factors such as multiple evaluations and unanswered referral requests in primary care settings. Innovative strategies to foster collaboration between partner organizations (e.g, youth protection and primary care) will be discussed. Conclusions : Young people with mental health problems under Youth Protection services are a particularly vulnerable and underserved population. Their access to mental health services is often tainted by complex and circuitous attempts to get appropriate treatment. In many of these cases, an increased collaboration between professionals working within distinct organizations could simplify pathways into care for this group.

Co-Authors: Laporte, Lise, PhD, Centre de Jeunesse de Montréal; Desrosiers, Lyne, PhD, Centre de Jeunesse de Montréal; Iyer, Srividya, PhD, McGill University

TRAINING PSYCHIATRIC RESIDENTS FOR COLLABORATIVE MENTAL HEALTH CARE

ABSTRACT #: 75

PRESENTATION TYPE: Paper Presentation

Natasha Snelgrove, MD, FRCPC, University of Toronto Department of Psychiatry; **Andrea Levinson,** MD FRCPC, University of Toronto; CAMH; **Kristina Powles,** MD CCFP, University of Toronto; Mt Sinai Hospital; **Michael Neszt,** MDCM FRCPC, University of Toronto; St Joseph's Hospital

Learning Objectives: Review the history of collaborative mental health care training for psychiatrists in Canada and its evolution at the University of Toronto in particular, To discuss the strengths and limitations of a collaborative care curriculum based on an initial implementation evaluation, To situate collaborative care training for psychiatrists in the greater context of national implementation and evolving models of care

Abstract: Collaborative mental health care training has been mandatory for senior psychiatry residents across Canada since 2010. The landscape of collaborative care training in Canada has evolved over the years1,2. The University of Toronto launched a new integrated mental health care rotation in 2016 for PGY-5s that combines longitudinal experience at a primary care or community agency, a core curriculum, an assessment program that includes multisource feedback and a reflective written assignment, and faculty development initiatives. The diversity of training settings and emphasis on disadvantaged populations reflects the University department's effort to increase social accountability to provide accessible care in our communities. We conducted an implementation evaluation in 2017, surveying residents, faculty, and training sites, to understand how the educational program was functioning with respect to the following implementation outcomes: acceptability, adoption, feasibility, fidelity, and penetration. We also examine residents' written assignments to understand opportunities to improve the implementation of collaborative mental health care through trainees' eyes. While the move to core training in the PGY-5 year has been challenging due to loss of resident autonomy in their final year, they appreciate the unique interprofessional and community-based training opportunities. Supervisors appreciate teaching in these settings, identify increased reflective practice, and desire further faculty development regarding collaborative care. Sites appreciate improved access to specialist care through direct and indirect care that residents provide when caring for their complex patients. Based on this data, next steps in further optimization of the experience for residents and training sites will be explored.

Co-Authors: Natasha Snelgrove, MD, FRCPC, University of Toronto; Mark Fefergrad, MD, FRCPC, University of Toronto; Kristina Powles, MD, CCFP, University of Toronto; Andrea Levinson MD, FRCPC, University of Toronto; Amy Cheung, MD FRCPC, University of Toronto; Sunnybrook Health Sciences Centre; Nadiya Sunderji, MD, FRCPC, University of Toronto (senior author)

IMPLEMENTING THE COLLABORATIVE CARE QUALITY FRAMEWORK TO ASSESS AND STRENGTHEN THE CLINICAL, REHABILITATION AND RESIDENTIAL RELOCATION PROCESSES FOR ALTERNATE LEVEL OF CARE (ALC) SERVICE USERS AT THE DOUGLAS MENTAL HEALTH UNIVERSITY INSTITUTE

ABSTRACT #: 77

PRESENTATION TYPE: Paper Presentation

Eleanor McGroarty, BA Psychology, MA Counselling Psychology, Specialist in Administrative Processes, and Mental Health Counsellor, Douglas Mental Health University Institute

Learning Objectives: Distinguish between the targeted length of hospital stay for ALC service users in the Centre Intégré Universitaire de Santé et de Services Sociaux de l'Ouest-de-l'Île-de-Montréal and the reality for patients at the Douglas Mental Health University Institu, Identify key clinical, administrative, rehabilitation and residential relocation processes and healthcare providers central to care plans and trajectories of ALC service users at the Douglas Mental Health University Institute, Analyze the qualitative, quantitative and participatory research methodologies which have been employed to gain a thorough understanding of the challenges and limitations to systemic collaboration in regard to ALC service users' care plans and trajectorie

Abstract: A current research project designed to understand the processes related to Alternate Level of Care (ALC) service users at the Douglas Mental Health University Institute will be critically reviewed. A statistical review and clinical picture of Alternate Level of Care processes across Canada and within the specific sub region of Montreal (Centre Intégré Universitaire de Santé et de Services Sociaux de l'Ouest-de-l'Île-de-Montréal) which encompasses the Douglas Mental Health University Institute will be given. The quality framework for Collaborative Care, as outlined by Dr. Nadiya Sunderji, Dr. Abbas Ghavam-Rassoul, Allyson Ion and Dr. Elizabeth Lin (2016), will provide a structure for the projects overarching goals to measure and improve collaborative care for for ALC service users. The eleven domains within the framework will be considered in the process of prioritizing specific research questions and future steps. The qualitative, quantitative and participatory research methods utilized to gather a systemic and ethnographic understanding of the current limitations within the models of assessment, ongoing collaborative mental healthcare, and residential relocation processes for ALC service users will be assessed. The researcher's position in an administrative role will be considered, and ideally feedback will be offered in regard to how it may leveraged for improvement, for example potential policy changes could be negotiated to streamline communication processes between in-patient unit teams, residential resource teams and primary care teams. The limitations of an administrative position in regard to research methodologies, ongoing quality assessment and collegial cooperation will be reviewed and potentially challenged by coaches and attendees.

A CASE STUDY OF TWO FAMILY HEALTH TEAMS USING A QUALITY FRAMEWORK TO MEASURE AND IMPROVE COLLABORATIVE MENTAL HEALTH CARE

Abstract #81

PRESENTATION TYPE: Pape Presentation

Priya Vasa, MSc MD CCFP, St Michaels Hospital Department of Family and Community Medicine; **Allyson Ion**, MSc, PhD (C) , St. Michael's Hospital Mental Health Research Group; **Ann Stewart**, MD MSc CCFP, St Michaels Hospital Department of Family and Community Medicine

Learning Objectives: Describe how quality improvement (QI) is done at two different Family Health Teams (FHTs) and how mental health related QI can be added to the QI agenda; Analyze factors influencing the selection of foci for mental health related QI at two FHTs; Reflect on their own practice setting and consider implementation of a quality measure in collaborative mental health care

Abstract: Building upon prior work to develop a Quality Framework (QF) for CMHC, this study follows two FHTs through their experience of using the QF to conduct mental health related QI. We use a case study design and draw upon the CFIR theoretical framework to understand how each FHT adopts and implements the QF, and we use a validated scale to assess the quality of the measures the FHTs developed based on our framework. We conducted 12 interviews with clinicians and administrators involved in QI in two FHTs, observed QI committees and other leadership meetings, and incorporated other textual data (e.g. documents, correspondence, and field notes summarizing our observations). We thematically analyzed this qualitative data and triangulated the various types of data to understand whether and how our QF can advance improvements in the implementation of collaborative mental health care, and to explore enablers and barriers to mental health related QI in FHTs. We use descriptive statistics to assess the relevance, validity, feasibility, resource requirements, acceptability, and actionability of each quality measure implemented from the FHT team members' perspectives. In this poster, we share the early experiences from FHTs including successes and challenges in selecting and implementing measures from our QF and using them to drive quality improvement in collaborative mental health care. Preliminary data suggest that the Quality Framework for Collaborative Mental Health Care has been received positively by stakeholders involved in primary mental health care, and can inform other collaborative teams to plan and implement measurement and improvement initiatives.

Co-Authors: Ghavam-Rassoul, Abbas, MD, MHSc, CCFP, St. Michael's Hospital, Department of Family and Community Medicine; Sunderji, Nadiya, MD, MPH FRCPC, St. Michael's Hospital, Mental Health and Addictions Service; Ion, Allyson, MSc, PhD (C) , St. Michael's Hospital Mental Health Research Group; Stewart, Ann, MD MSc CCFP, St Michaels Hospital Department of Family and Community Medicine

WISE PRACTICES: CULTURAL ADAPTATIONS TO THE ECHO MODEL FOR ECHO ONTARIO FIRST NATIONS, INUIT AND MÉTIS WELLNESS

Abstract #: 83

PRESENTATION TYPE: Workshop

Allison Crawford, MD, PhD, FRCPC, Centre for Addiction and Mental Health; **Julie Bull**, MA, PhD Candidate, Centre for Addiction and Mental Health; **Lisa Richardson,** MD, MA, FRCPC, Department of Medicine, University of Toronto; **Walter Lindstone**, MSW, Centre for Addiction and Mental Health; **Diane Longboat**, M.Ed, Senior Project Manager, Aboriginal Engagement and Outreach, Centre for Addiction and Mental Health

Learning Objectives: Review d the Project ECHO model and the gaps in Indigenous healthcare delivery it proposes to solve; Demonstrate how technology can be leveraged to increase collaboration and capacity in indigenous healthcare; Describe how to utilize community engagement to inform areas in the ECHO model for adaptation while maintaining fidelity to the model

Abstract: Resources are often allocated to Indigenous communities in times of crisis, but these have had limited success due to the lack of cultural competence, limited understanding of the local context, and failure to address the wholistic needs of the community. Support for primary care and community providers (PCCP) to address mental and physical health needs in a culturally-relevant way, has been identified as a promising approach to deliver mental and physical health services in First Nations, Inuit, and Métis communities. This support must be collaborative, community driven, and incorporate both cultural approaches to wellness and best practices in mental and physical healthcare to foster community partnerships and the provision of culturally relevant care. Project Extension for Community Healthcare Outcomes (ECHO) achieves this by creating virtual communities of practice, connecting interprofessional specialists with providers to share knowledge and best practices through case-based learning. Project ECHO is a knowledge dissemination model that uses multi-point videoconferencing to leverage scarce healthcare resources in rural and remote communities. ECHO Ontario First Nations, Inuit and Métis Wellness was launched at CAMH and the University of Toronto to build PCCP capacity in Indigenous communities from the perspective of wholism. In this workshop, we will describe a cultural adaptation of the ECHO model and how to incorporate best practices in mental and physical health alongside traditional teaching for wellness drawn from First Nations, Inuit and Métis knowledges. Participants will have the opportunity to participate in the ECHO model, including working through community-engaged approaches to curriculum development and evaluation.

DEMOGRAPHIC ANALYSIS OF THE CAMH PARTNERS INTEGRATED CARE PROJECT

ABSTRACT #: 85

Eleni Kelly, BA, Research Analyst, Centre for Addiction and Mental Health; **Alexandra Kubica,** BSc, Centre for Addiction and Mental Health

Learning Objectives: Identify and discuss the diverse communities that are being served by integrated care projects in Ontario, Determine the unique needs of the different communities participating in this integrated care project, and if they feel adequately supported by this model, Discuss how these findings can be used to inform the design and implementation of other mental health integrated care projects in the future

Abstract: The CAMH PARTNERs Project is a randomized controlled trial that supports primary care patients with depression, anxiety, and at-risk drinking using a telephone-based integrated care model. Patients are randomized to one of two groups: Enhanced Usual Care (EUC) and intervention (INT) for 12 months. Patients in EUC receive comprehensive telephone assessments at baseline, 4, 8, and 12 months; these results are shared with their primary care providers. In addition to these assessments, INT patients will receive regular telephone support from a Mental Health Technician, who monitors symptoms, treatment adherence, and provides education on lifestyle changes. PARTNERs serves a diverse adult client base of participants from a variety of different communities, cultures, and socioeconomic statuses. The project is implemented across Ontario at 18 primary care sites with 184 physicians and nurse practitioners across rural, urban, and suburban settings. Utilizing data obtained from baseline assessments, we will present the demographic information of participants enrolled in PARTNERs. This includes age, gender, ethnicity, financial stability, perceptions of health, and housing circumstances. Satisfaction survey results obtained at the 12 month assessment will also be presented regarding participants perceptions of feeling supported in their cultural needs. This poster presentation will help illustrate the unique population of individuals participating in an integrated care model in Ontario, and indicate which groups are most represented so as to tailor future integrated care projects to better support these and other communities. With this demographic analysis, we will show that our culturally encompassing project provides further data on integrated care models.

Co-Authors: Kubica, Alexandra, BSc, Centre for Addiction and Mental Health; Perivolaris, Athina, RN, MN, Centre for Addiction and Mental Health; Rodie, David, MD, FRCPC, Centre for Addiction and Mental Health; Mulsant, Benoit, MD, MSc, FRCPC, Centre for Addiction and Mental Health

BIG WHITE WALL AND BOUNCEBACK: MEETING THE DEMAND IN ONTARIO FOR FASTER ACCESS TO PSYCHOTHERAPY SERVICES FOR PEOPLE WITH MILD TO MODERATE DEPRESSION AND ANXIETY

ABSTRACT #: 87

PRESENTATION TYPE: Paper Presentation

Anna Piszczkiewicz, MA, Stakeholder Engagement Coordinator, Canadian Mental Health Association, Ontario Division; **Harriet Ekperigin,** Senior Business Lead, Ontario Telemedicine Network

Learning Objectives: Describe the key components of the self-help psychotherapy services and put them into practice at your organization, Determine how the services fit within your current mental health program/practice and how they might be beneficial for your clients, Address opportunities and challenges when rolling out such services across different communities and populations

Abstract: In fall 2017, the Government of Ontario announced funding for the expansion of proven psychotherapy services. These services provide free mental health support to people experiencing mild to moderate depression and anxiety, and constitute the building blocks of Ontario's province-wide, publicly-funded psychotherapy program. They include: - Big White Wall, an online peer support & self-management tool, coordinated by the Ontario Telemedicine Network - BounceBack, a telephone coaching program, managed by the Canadian Mental Health Association (CMHA) Ontario and CMHA York and South Simcoe This is good news for the 100,000+ people living in Ontario who are in need of faster and more equitable access to mental health supports to help them better manage stress, anxiety, and low mood. And this is certainly good news for primary care providers (such as family doctors, nurse practitioners, or psychiatrists) who need alternative or complementary solutions to offer their clients, outside of referring clients to services with long wait lists and prescription medication. Big White Wall and BounceBack are evidence-based, self-help services grounded in cognitive behavioural therapy — the recommended approach to managing anxiety and depression. They provide rapid early intervention (that is accessible and free) and critical to supporting the overall health and well-being of Ontarians. In fact, the successful pilot projects that demonstrate the benefits of these services consistently show a significant decrease in levels of depression and anxiety and an increase in client ability to self-manage. Big White Wall and BounceBack have been active in several countries, including the United Kingdom, United States, New Zealand, and Canada. Since its inception in 2007, Big White Wall has been used by more than 35,000 people, with 70% of clients seeing improvement in at least one aspect of their wellbeing. Since its inception in 2008, when the program was first adopted by CMHA British Columbia, BounceBack has seen over 30,000 referrals and consistently enhanced mood, physical health, and quality of life, which depressive and anxious symptoms reduced by almost 40% at program completion. We are excited to share these innovative and impactful services with the conference audience.

Co-Authors: Ekperigin, Harriet, Senior Business Lead, Ontario Telemedicine Network; Fairbairn, Andrew, Stakeholder Engagement Coordinator, Canadian Mental Health Association, Ontario Division

DELIVERING PROBLEM SOLVING THERAPY – PRIMARY CARE (PST-PC) AS PART OF A LOW THRESHOLD TEAM-BASED HIV PRIMARY CARE PRACTICE TRANSFORMATION MODEL

ABSTRACT #: 88

PRESENTATION TYPE: Paper Presentation

Roberta De Oliveira, MD PhD, Attending Physician, Columbia University Medical Center; **Rebecca Weiss,** NP, Columbia University Medical Center, School of Nursing; **Iris Gutierrez,** LCSW

Learning Objectives: To present our stake-holder driven Practice Transformation Model that aims to expand mental health services within our agency, To describe our process of designing a psychotherapy curriculum to train our Behavioral Health Consultants to best meet our patient population's mental health needs, To list psychotherapy tools that were selected for compilation into a reference manual for our Behavioural Health Consultants based on efficacy in our patient population

Abstract: Our agency is a bilingual hospital-based HIV center that provides primary care (PC) to a predominantly minority patient population in New York City. Our patients suffer disproportionate rates of behavioral health disorders which can frequently interfere with successful linkage. In 2014, our program was funded to design, implement, and evaluate a practice transformation model that hinges on implementing team-based care and on task shifting across the multidisciplinary staff. The initiative (STaR) has resulted in a proposal to further develop licensed Social Workers as Behavioral Health Clinicians, who provide short-term evidence-based psychotherapy, collaborate with PCPs/embedded psychiatrists and also coordinate care with community agencies. METHODS: Psychotherapy modalities selected for the BHC training needed to be efficient in PC; structured and accessible to Social Workers with various levels of psychotherapy training. We chose Problem Solving Therapy-Primary Care (PST-PC) and Screening, Brief Intervention, and Referral to Treatment (SBIRT) as the backbone of our BHC training. Training in these modalities will be delivered by the developers of each manual. Our BHCs will also have lectures on principles/tools of Cognitive Behavioral Therapy, Dialectical Behavioral Therapy, Complex Grief Treatment and Interpersonal Psychotherapy. Working knowledge in these modalities will be developed during weekly group supervision with the embedded psychiatrists. OUTCOMES: We will delineate the process of integrating the above psychotherapy modalities into a curriculum that best addresses competency gaps and that empowers our BHCs to meet the clinical demands of providing mental health care to our patient population.

Co-Authors: Weiss, Rebecca, NP, Columbia University Medical Center, School of Nursing; Gonzalez Davila, Mila, MPH, New York Presbyterian Hospital; Olender, Susan, MD MS, Columbia University Medical Center, Division of Infectious Diseases

HOW TO USE A QUALITY FRAMEWORK TO GUIDE IMPLEMENTATION AND EVALUATION OF COLLABORATIVE MENTAL HEALTH CARE

ABSTRACT #: 91

PRESENTATION TYPE: Workshop

Abbas Ghavam-Rassoul, MD, MHSc,, CCFP, FCFP, St. Michael's Hospital, Department of Family and Community Medicine & Dalla Lana School of Public Health, University of Toronro; **Priya Vasa,** MSc MD CCFP, Department of Family & Community Medicine, St. Michaels Hospital & University of Toronto; **Nadiya Sunderji,** MD MPH FRCPC, Mental Health and Addictions Service, St. Michael's Hospital and Department of Psychiatry, University of Toronto; **Allyson Ion,** MSc, Research Coordinator, St. Michael's Hospital & PhD Candidate, School of Social Work, McMaster University; **Ann Stewart,** MD CCFP, Department of Family & Community Medicine, St. Michael's Hospital & University of Toronto

Learning Objectives: Apply a quality framework for collaborative mental health care in order to choose a specific dimension of quality in their collaborative care setting as a target for improvement, List several measures which would be useful to drive quality improvement in their setting, Develop a plan for implementing collaborative care measurement in their own setting

Abstract: Collaborative Mental Health Care models have demonstrated effectiveness but are variably implemented in primary care settings, leading to a "quality chasm" between the research evidence and real-world performance. Our team developed a comprehensive quality framework by which to evaluate Collaborative Mental Health Care in primary care settings. The quality framework draws upon widely accepted generic quality frameworks from Donabedian and the Institute of Medicine to ensure comprehensiveness, coherence, relevance and transferability. The framework can drive quality improvement by guiding comprehensive and balanced program evaluation, and informing the selection of measures to evaluate Collaborative Mental Health Care services. Workshop participants will have the opportunity to apply the quality framework to their own clinical settings by reviewing several quality improvement methods, identifying priorities and developing plans for measurement and evaluation. The presenters will share general strategies (e.g. use of empirically validated measures, obtaining quality data from clinicians, and use of theoretical frameworks and logic models to guide effort) on how to improve the quality and generalizability of quality improvement efforts. Real-world quality improvement projects will be used as case studies to demonstrate application and highlight how measurement decisions can ultimately impact the end result of the project. Large group teaching will be supplemented by interactive, small-group sessions to assist participants in individualizing plans and apply learned strategies and tools in their own clinical setting. This session is an improved version of a workshop presented in 2017 which was well attended & well reviewed.

Co-Authors: Funderburk, Jennifer S. PhD, Clinical Research Psychologist, VA Center for Integrated Healthcare, Syracuse VA Medical Center, Syracuse, NY; Vasa, Priya, MD, MSc, CCFP, Department of Family & Community Medicine, St. Michaels Hospital & University of Toronto; Jodi Polaha, PhD, Associate Professor, Department of Family Medicine, East Tennessee State University; Sunderji, Nadiya, MD MPH FRCPC, Mental Health and Addictions Service, St. Michael's Hospital and Department of Psychiatry, University of Toronto; Allyson Ion, Research Coordinator, St. Michael's Hospital & PhD Candidate, School of Social Work, McMaster University

ENGAGEMENT OF PRIMARY CARE PROVIDERS IN THE CAMH PARTNERS PROJECT

ABSTRACT #: 95

PRESENTATION TYPE: Symposium

Alexandra Kubica, Honours Bachelor of Science, The Centre for Addiction and Mental Health; **Eleni Kelly,** BA, Centre for Addiction and Mental Health

Learning Objectives: Describe factors for successful implementation of an integrated care project for depression, anxiety, and at-risk drinking, Compare the engagement of primary care providers in Ontario in an integrated care model for depression, anxiety, and at-risk drinking, Utilize data presented in this poster to inform the design and implementation of future mental health integrated care projects.

Abstract: The CAMH PARTNERs Project is a randomized controlled trial that supports adult primary care patients with depression, anxiety, and at-risk drinking using a telephone-based integrated care model. Patients are randomized to one of two groups: Enhanced Usual Care (EUC) and intervention (INT) for 12 months. Patients in EUC receive comprehensive telephone assessments at baseline 4, 8, and 12 month intervals, the results are shared with their primary care providers (PCPs). Additionally, patients in the intervention receive regular telephone support from Mental Health Technicians (MHTs), who monitor symptoms, treatment adherence, and provide education on lifestyle changes. PARTNERs has been implemented at family health clinics, and solo physician practices across Ontario: currently, 184 physicians, nurse practitioners, and social workers are participating. The data explored will compare engagement across project sites and assess factors for successful implementation as demonstrated by PARTNERs. Factors will be measured in the following: referral source (PCP vs inter-professional team member) type of family practice clinic (FHT, FHO, or solo provider) as well as the quality of these referrals. Quality will be measured by matching problems identified by physician to baseline assessment scores (PHQ-9, GAD-7, Timeline Follow Back), and rates of ineligibility at baseline. Furthermore, trends in patient engagement will be assessed via ability to establish contact with participants after being referred and ease of enrolment. Physician collaboration and ongoing engagement is integral to successful implementation of integrated care models for improving access to mental health services, project success, and the quality of care that participants receive from PARTNERs.

Co-Authors: Kelly, Eleni, BA, Centre for Addiction and Mental Health; Perivolaris, Athina, RN, MN, Centre for Addiction and Mental Health; Rodie, David, MD, FRCPC, Centre for Addiction and Mental Health; Mulsant, Benoit, MD, MSc, FRCPC, Centre for Addiction and Mental Health

EXPLORING THE ETHOS OF COLLABORATION –AUGUSTINA'S STORY

ABSTRACT #: 96

PRESENTATION TYPE: Paper Presentation

Augustina Ampofo, BA (Human Rights & Equity Studies), Mental Health and Disability Management Post Graduate Certificate, Mohawk College, (To be completed August 2019)

Learning Objectives: Outlining the value of including those with lived experience with mental illness in the design and improvement of care services; Identifying the challenges that individuals with lived experience, especially those who are women of color, face when navigating the mental health care system; Discussing potential strategies to sensitize care providers to identify and address cultural components that impact care delivery

Abstract: My first episode of psychosis occurred after moving across the country, starting a stressful job, and leaving a bad relationship. I started having hallucinations and hearing voices, 24 hours a day for almost 9 months. It was the scariest and loneliest time of my life, as my family and I did not understand what I was going through. Cognitive behavioral therapy helped me cope and manage my own mental health. This innovative presentation hopes not only to capture the lived experience of a person (and their family) with mental health issues; but also focus on how the inclusion and participation of those from a variety of different cultural communities, must be included in the development and improvement of mental health services. Particularly, in communities which do not talk openly about mental health issues. I aim to take the participants on my journey through psychosis by incorporating poetry, which was formed as part of my healing experience. A short interactive component will give participants an opportunity to engage in self-reflection and ponder on potential strategies they could incorporate in future interactions. I truly believe that the design of care services can be significantly improved with the inclusion of people who have lived experience. True management of mental health extends beyond being labeled with a diagnosis and being prescribed medication but should involve using a collaborative approach, including family, peer support or art. Each individual must be reminded that they are not alone on their journey to recovery.

NATIONAL SPREAD OF BC PSP MODULE BASED ON RESULTS

ABSTRACT #: 97
PRESENTATION TYPE: Works in Progress
Rivian Weinerman MD FRCPC, Medical Staff Honorary Status, VIHA, Associate Clinical Professor UBC, PSP Consultant Mental Health Commission of Canada

Learning Objectives: Review the origins and results of the BC Adult Mental Health Module fitting realistic GP time constraints and fee schedules; List the results of the RCT on this module done in Nova Scotia; Identify the power of Evaluation/Results in motivating Government and other partners in spreading the module throughout Nova Scotia and Newfoundland

Abstract: We developed and subsequently evaluated a realistic GP time, fee based, adult mental health module in BC that allowed family physicians to diagnose and treat anxiety and depression without initially necessarily reaching for the pill bottle. Based on evaluations this was spread throughout BC, and a randomized trial in Nova Scotia subsequently endorsed the benefits of the module, reducing healthcare provider stigma, improving outcomes, decreasing the need for medications. Based on these results, the module is being spread across Nova Scotia as we speak, and Newfoundland will do this next.

COLLABORATIVE MENTAL WELLNESS CARE IN SIPEKNE'KATIK FIRST NATION – LESSONS LEARNED WORKING IN AN INDIGENOUS COMMUNITY

Abstract #: 98
PRESENTATON TYPE: Paper presentation
Brian Knockwood, BA, CACII, Addictions Prevention Counsellor; **Tiffany O'Donnell**, MD, CCFP; **Aruna Dhara,** MD, MPH, CCFP

Learning Objectives: Provide an approach to collaboration in a First Nations community in rural Nova Scotia; Describe the application of collaborative principles in the development and roll out of a OAT program; Attempt to understand the client experience using a first voice approach.

The collaboration between Indigenous and non-Indigenous clinicians presents a unique learning opportunity. Principles that have led to continued success include the adoption of a posture of listening on the part of non-Indigenous clinicians, commitment to treatment of individuals as part of the community, and the adaptation of standard practices to meet the needs of patients. Using the client/patient experience as a guide, clinicians have attempted to integrate Indigenous knowledge and healing practices into the therapeutic program. Despite the fact that each First Nation in Canada will have a unique history and community composition, we believe certain principles can support a collaborative relationship between Indigenous and non-Indigenous providers. Adapting these principles to local environments is key to successful programs.

Co-Authors: Tina Nevin-Sack - Mental Wellness Coordinator/Acting Health Director, Patricia Augustine - Addictions Prevention Counsellor, Timothy Holland MD CCFP(EM), Melissa Stoddart NP

EXPANDING ACCESS TO PSYCHOTHERAPY: MAPPING LESSONS LEARNED FROM AUSTRALIA AND THE UNITED KINGDOM TO THE CANADIAN CONTEXT

ABSTRACT #99
PRESENTATON TYPE: Paper presentation
Mary Bartram, PhD, Independent Researcher and former Director of the Mental Health Strategy, Mental Health Commission of Canada; **Francine Knoops**, Lead Analyst and Stakeholder Engagement Specialist, Mental Health Commission of Canada; **Bonita Varga**, Knowledge Broker, Mental Health Commission of Canada

Learning Objectives: Describe the differences in approaches between grant and insurance based approaches to expanded access – UK v AU models; Identify policy options for expanding access to psychotherapies in the Canadian context

Abstract: In 2017, the Canadian federal government announced $5B in targeted federal transfers to improve access to mental health services. This investment presents a significant opportunity for provincial and territorial governments in Canada to implement reforms that will increase access to psychotherapies. The long-standing exclusion of allied mental health professional services from provincial and territorial health insurance plans has contributed to (a) high rates of unmet need (particularly for psychotherapy) (b) greater financial barriers for the estimated 12 million Canadians without access to employment-based psychotherapy benefits, and (c) broader underfunding of mental health services (at only 5 to 7% of total public spending on health in Canada). Facing similar challenges, Australia and the UK have been able to introduce major reforms to improve access to psychotherapy. This presentation will provide an overview of expanded access to psychotherapy models used in the UK and Australia and contrast them with the current policy and service delivery context in Canada. By mapping key lessons learned from international experiences on to unique features of Canada's context, participants will be invited to consider opportunities to improve service delivery models to better meet the needs of all people living in Canada.

Co-Authors: Francine Knoops, Lead Analyst and Stakeholder Engagement Specialist, Mental Health Commission of Canada; Bonita Varga, Knowledge Broker, Mental Health Commission of Canada

P IS FOR POLITICAL: PARTICIPATORY DESIGN AND REBALANCING THE POWER DIFFERENTIAL

ABSTRACT #117
PRESENTATON TYPE: Paper presentation
Tai Huynh, MDes, MBA, Creative Director, OpenLab, University Health Network

Learning Objectives: Identify the reasons why some segments of the population are often excluded from co-design efforts; Discuss the frameworks and methods for inclusive engagement; Assess, through real-world examples, the different ways participatory design could improve patient care

Abstract: Poorly designed health services affect those from marginalized communities the most, and yet, people from these communities are often excluded from co-design efforts. Those affected by design should have a say in the design process. This was the tenet of participatory design in Scandinavia in the 1970s, which sought to involve workers in the design of workplace information systems previously controlled exclusively by management. In a similar way, but separated by several decades, public services such as healthcare are now acknowledging that for far too long, the design of services has been controlled by providers, with limited involvement from users, particularly those from marginalized groups who, arguably need services the most. Failure to acknowledge the role of power and politics in design often leads to bad experiences and outcomes for users, and perpetuates social inequality. In this talk, I will discuss the opportunities and challenges for participatory design in the contemporary context. This will be illustrated through several exciting projects undertaken by UHN OpenLab, a multi-disciplinary design and innovation shop located at the University Health Network, Canada's largest research hospital. These projects include working with persons who use drugs to build technologies that make it safer to use alone, with seniors to create new ways to combat social isolation, and with people with low income to find ways to humanize the experience of being on social assistance.

Co-Authors: Howard Abrams, MD, Director, UHN OpenLab; Jen Recknagel, Strategic Design Lead, UHN OpenLab; Shoshana Hahn-Goldberg, Post-Doctoral Fellow, UHN OpenLab

HOW CAN WE EVALUATE AND IMPROVE COLLABORATIVE MENTAL HEALTH CARE ACROSS CANADA: A CONSULTATION SESSION TO DEVELOP NATIONALLY RELEVANT QUALITY INDICATORS

ABSTRACT #118
PRESENTATION TYPE: Workshop
Dr. Nadiya Sunderji, MD MPH FRCPC, Medical Director, Quality Improvement, St. Michael's Hospital Mental Health and Addictions Service; Associate Scientist, Li Ka Shing Knowledge Institute; Assistant Professor, University of Toronto Department of Psychiatry; **Francine Knoops,** Lead Analyst and Stakeholder Engagement Specialist, Mental Health Commission of Canada; **Bonita Varga**, Knowledge Broker, Mental Health Commission of Canada; **Dr. Matthew Menear,** PhD, Laval University; **Dr. Gwen Jansz,** MD PhD CCFP FCFP, Family Physician, St. Michael's Academic Family Health Team, Assistant Professor, University of Toronto Department of Family and Community Medicine

Learning Objectives: Identify the dimensions of quality collaborative care; Apply their lived experience, clinical and program management expertise to identify priority measures of quality indicators for collaborative care

Abstract: The College of Family Physicians of Canada (CFPC) and Canadian Psychiatric Association (CPA) have been working together as the Collaborative Working Group on Shared Mental Health Care (CWGSMHC) for two decades to advance collaborative mental healthcare in Canada. However, measurement and evaluation of collaborative care programs has been limited, hampering quality improvement efforts and the uptake of best practices. In 2017 the CWGSMHC partnered with the Mental Health Commission of Canada (MHCC) and with the Quality Indicators for Collaborative Care (QI4CC) research team at St. Michael's Hospital to develop and promote three or four key pan-Canadian indicators to measure, and steer further progress in, the implementation of collaborative mental health care models in the primary care context. The research team has been hosting consultations across Canada to validate a national framework for high quality collaborative mental health care, and to select priority dimensions measurement. These efforts are informed by our previous work, *Driving improvements in the implementation of collaborative mental health care: A quality framework to guide measurement, improvement and research* (2016), as well as the system-level indicators developed by the MHCC. This workshop provides an opportunity for participants to take part in the process. This workshop will introduce participants to the 11 dimensions of collaborative care identified in the framework (2016). Participants will be invited to apply their lived experience, clinical and program management expertise and other knowledge to identify priority measures, facilitators and barriers to measurement and quality improvement, and input into communication and implementation strategies. This workshop will involve active participation, reflective observation, and strategic thinking.

Co-Authors: Allyson Ion, PhD(c), Research Coordinator, St. Michael's Hospital; Dr. Pamela Wener, PhD, O.T. Reg. (MB), Associate Professor, Department of Occupational Therapy, College of Rehabilitation Sciences, Rady Faculty of Health Sciences, University of Manitoba

THE INTRICACIES OF INTENTIONAL COLLABORATION: 15 YEARS OF SHARED CARE IN WINNIPEG

ABSTRACT #119
PRESENTATION TYPE: 2018 CFPC/CPA COLLABORATIVE MENTAL HEALTH CARE AWARD-LARGE INSTITUTIONALLY BASED PROGRAM
Dr. Randy Goossen, MD CCFP FRCPC , Medical Director of Community Mental Health, Assistant Professor, The Max Rady College of Medicine, Rady Faculty of Health Sciences, University of Manitoba; Winnipeg Regional Health Authority

The Presenter will delve into the work and theory of intentionally and collaboratively bridging the gap between parallel systems – Regional Health Authority/primary care providers. Dr. Pam Wener's Collaborative Model and the presenter's anecdotes of relationship building will be reviewed to highlight the privilege and importance of co-located work with primary care partners.

Co-Authors: Dr. Pam Wener – Acting Head, Department of OT; U of Manitoba; Jaik Josephson MSW – Manager of Shared Care Mental Health WRHA

LAUGHING LIKE CRAZY

ABSTRACT #122
Presenters TBC

Laughing Like Crazy aims to empower participants and audiences alike, breakdown isolation and anxiety, build self-esteem, and challenge stigma. Looking at difficult issues through the lens of humour provides an empowering perspective on mental health issues, builds confidence, and improves communication

COLLABORATIVE CARE FOR MILD COGNITIVE IMPAIRMENT IN OLDER ADULTS IN PRIMARY CARE: FROM EVIDENCE TO PRACTICE

ABSTRACT #137
PRESENTATION TYPE: PAPER PRESENTATION
Dr. Pallavi Dham, Dr. Nick Kates

Learning Objectives: Identify the role that primary care can play in detecting mild cognitive impairment in seniors; List the components of a treatment pathway for MCI that can be introduced within primary care settings; Discuss the challenges in implementing a treatment pathway within primary care

Abstract: The prevalence of mild cognitive impairment, depression and anxiety in individuals over the age of 60 being seen in primary care is high, but these problems frequently go unrecognized and untreated although there is increasing evidence that evidence based interventions in primary care can increase identification and treatment rates. We briefly discuss the literature review of collaborative care models among older adults in terms of the components and impact. We also discuss a project with two goals. The first was to design and introduce an evidence-based pathway for the recognition and treatment of MCI, depression or anxiety within the primary care practices in two cities. The second was to identify changes and system adjustments practices needed to accommodate the new program and the pathway. We will present the pathway developed, the process for introducing into primary care, and the adjustments that primary care practices needed to make to accommodate a change in their routines. It is early in the project, but there is clear evidence of the appetite for primary care providers for assistance with managing seniors with cognitive and mood-related problems, of the need to tailor or adapt existing guidelines to fit with the realities of primary care and of the willingness of primary care practices to make adjustments to accommodate the new protocol.

Co-Authors: Pallavi Dham, Sarah Colman, Carrie McAiney, Karen Saperson, Doug Oliver, Fiona Parascandalo, Jessica Gaber, Noor Malik, Lillian Lourenco, Lisa Dolovich, Christina Gojmerac, Tarek Rajji, Nick Kates

A LIFE WORTH LIVING: EFFECTING CHANGE IN HOMELESSNESS AND MENTAL HEALTH THROUGH COLLABORATIVE EDUCATION

ABSTRACT #138
PRESENTATION TYPE: WORKSHOP
Draigan LeFebvre ; Samuel Gruszecki, Peer Support Specialist

Learning Objectives: Identify what it means to work in coproduction; List some common challenges and effective solutions; Experience and practice coproduction first-hand with a member of the STAR Learning Centre

Abstract: The housing challenges in Canada have reached that of epidemic proportions and as the number of individuals seeking shelter increases, the amount of available space has been declining. Attempts are on-going to ensure housing first is a priority and great strides are being made through funding, organizational, and individual efforts. Housing is often touted as the only needed change to support those dealing with this particular challenge, and is a desire of the majority who are facing this struggle. After seeing a 30 percent maintenance rate in housing following the At Home/Chez Sois program there was a realization of the need for something more. Using a recovery college model, traditionally developed for mental health, The STAR Learning Centre was developed to support the impact of homelessness. This presentation proposes that more effort is needed in other areas of facing the housing epidemic and supporting the individual while we work through the lengthy process of systemic and institutional change. This presentation will also propose that more action is readily available and the most effective changes come when those facing this distress are integrated into creating the solution.

POSTER PRESENTATIONS

A COMPARISON OF PSYCHIATRIC AND PRIMARY CARE FOLLOW-UP AFTER ED PRESENTATIONS OF DELIBERATE SELF-HARM

ABSTRACT #: 9

Jon Hunter, Bsc MD FRCPC, Psychiatrist

Learning Objectives: Discuss the rate of mental health follow-up after an emergency presentation for self-harm, Compare the outcomes of follow-up by family doctors, psychiatrists, or both, Investigate strategies for improving outcomes

Abstract: Abstract INTRODUCTION: Morbidity and mortality after deliberate self-harm (DSH) are high, so mental health care shortly after DSH is recommended. Using population-level health data we determined the association between a mental health visit and risk for repeat DSH with or without intensive care unit (ICU) admission or all-cause death. RESULTS: Over two years, 23,140 individuals had emergency department treatment for DSH. Within 30 days, 10.7% had a family physician mental health visit, 17.1% visited a psychiatrist, 3.6% visited both and 68.6% neither. Individuals who received mental health follow-up had more chronic and severe mental illness and higher acuity DSH. Over five years, repeat DSH occurred in 4792 (20.7%). Repeat DSH was more common in those who had a mental health visit within 30 days. Adjusting for baseline characteristics attenuated these differences. Similar results were found for DSH with ICU admission (5.0%) and death (7.6%). More frequent follow-up was not associated with better outcome. Timely access to mental health care after DSH was poor at 31%. DISCUSSION: Follow-up care had virtually no association with subsequent risk, so treatment as usual is insufficient. Post-DSH care augmented with evidence based interventions is required. Other models of care will be reported.

Co-Authors: Robert Maunder; Paul Kurdyak; Andrew S. Wilton; Andrea Gruneir; Simone Vigod

OPTIMUM: OPTIMIZING OUTCOMES OF TREATMENT-RESISTANT DEPRESSION IN OLDER ADULTS - OPERATIONALIZING A MULTI-CENTRE PRAGMATIC RANDOMIZED CONTROLLED TRIAL WITH FAMILY DOCTORS AND PSYCHIATRISTS

ABSTRACT #: 16

Athina Perivolaris, RN, MN, Director, Medical Psychiatry Alliance & Collaborative Care; **Renee Campbell,** BSc, MPH, Research Analyst

Learning Objectives: Describe the epidemiology and complexities of late-life treatment resistant depression, Explain the processes and procedures required to develop, operationalize and implement a pragmatic study to respond to the current knowledge gaps with respect to treatment of treatment-resistant depression in primary care, Discuss and evaluate potential future initiatives to engage primary care in research.

Abstract: Statement of Purpose: Treatment-resistant depression (TRD) is a major health problem for the aging population: in most older adults, depression fails to remit with first-line antidepressant pharmacotherapy. Older adults with persistent depression experience significant medical consequences, place high burdens on caregivers, and suffer high suicide rates. Making it worse is the paucity of evidence-based treatments at a stage in life when medications benefit vs. risk ratio is crucial. OPTIMUM is a five city (4 US and 1 Canadian) large study that will use both quantitative and qualitative methods. It includes a pragmatic, adaptive randomized controlled trial (RCT) to evaluate the comparative benefits and risks of antidepressant strategies (augmentation versus switching medications) and how aging changes this balance of benefits and risks. Methods: OPTIMUM will randomize 1500 older adults aged 60+ to 10 weeks of one of three treatment strategies: aripiprazole augmentation, bupropion augmentation, or switch to bupropion. Participants who fail to remit will be randomized a second time to one of two treatment strategies: lithium augmentation or switch to nortriptyline. Participants who complete acute treatment will be followed for one year. This pragmatic RCT will be carried out in real-world primary care clinical settings and psychiatric clinics in Ontario. Primary care providers will provide treatments, with decision support from the study team. Stakeholder engagement including patients and professional or family caregivers will ensure the study methods and results are relevant to both patients and providers. Results: We will report on the challenges and results of operationalizing OPTIMUM with respect to REB approval, physician and patient recruitment strategies, partnerships and progress to date. Conclusions: Operationalizing and implementing pragmatic studies in primary care require attention to a variety of barriers and enablers which will be discussed in the poster.

Co-Authors: Campbell, Renee, BSc, MPH, Centre for Addiction & Mental Health; Perivolaris, Athina, RN, MN, Centre for Addiction & Mental Health; Mulsant, Benoit, MD, MS, FRCPC, University of Toronto, Centre for Addiction & Mental Health; Flint, Alastair, MB, FRCPC, University of Toronto, University Health Network - Toronto General; Selby, Peter, MBBS, FCFP, Centre for Addiction & Mental Health; Fitzgibbon, Kyle, BSc, Research Analyst II, Centre for Addiction & Mental Health

A COLLABORATIVE MENTAL HEALTH CLINIC FOR ADULTS WITH INTELLECTUAL DISABILITY

ABSTRACT #: 21

Paula Walsh-Bergin, MD, FRCPC, CMHA

Learning Objectives: Discuss how a collaborative approach for outpatient care for individual with ID and mental health needs was developed in Ottawa, Identify how collaboration between primary and mental health care teams, and other specialists improve the outcomes for adults with ID with mental health needs, List the benefits and limitations of this model of collaborative mental health clinic for this population

Abstract: An innovative approach to long term care of adults with ID with mental health needs will be described. In collaboration with community social services organizations and Canadian Mental Health Association, an open-ended mental health care clinic has served over 130 clients since 2004. The approach to care, types of collaboration and demographics and diagnoses of clients treated will be described. The benefits and limitations of this model of care will be discussed.

COMMUNICATION BETWEEN PRIMARY CARE PHYSICIANS AND PSYCHOGERIATRIC CONSULTANTS CARING FOR LONG-TERM CARE RESIDENTS: A QUALITATIVE STUDY

ABSTRACT #: 23

Aviva Rostas, MD FRCPC, Geriatric Psychiatry Resident, University of Toronto

Learning Objectives: Describe the importance of effective communication between primary-care physicians and psychogeriatric consultants in long-term care., Identify areas of variability in current processes of communication between primary-care physicians and psychogeriatric consultants in long-term care., List barriers to improved communication between primary-care physicians and psychogeriatric consultants in long-term care.

Abstract: Purpose: Mental health conditions are highly prevalent in the long-term care home (LTC) setting. Ensuring effective communication between LTC primary care physicians (PCPs) and geriatric mental health outreach team (GMHOT) psychogeriatric consultants is essential. However, communication is challenging and processes of communication are poorly understood. This study aims to qualitatively understand barriers to PCP-psychogeriatric consultant communication. Methods: Eight GMHOT clinicians and four PCPs serving 36 LTCs in the Toronto Central LHIN were interviewed and provided feedback on current methods of communication. Communication barriers were recorded using an Ishikawa fishbone diagram. Results: Most GMHOT-LTC dyads were not using any standardized approach to facilitate communication between PCPs and psychogeriatric consultants. Areas of variability included GMHOT clinicians having access to LTC electronic medical records, designation of a point person within the LTC to facilitate communication, and use of standardized forms for GMHOT charting. Several key communication barriers were identified including poor legibility of handwritten notes, delays in receipt of information, and lack of shared charting systems. Other barriers included involvement of many "layers" of staff in communication, LTC staff perceptions of psychogeriatric consultation being not helpful and the process being time consuming for LTC staff, and lack of provider availability and funding for direct communication about cases. Conclusions: Improving communication between PCPs and psychogeriatric consultants caring for LTC residents is essential. There are multiple communication barriers. Understanding the barriers serves as a starting point to enhancing communication. Next steps may include examining facilitators of effective communication and identifying potential interventions for improvement.

Co-Authors: Cohen, Carole, MD FRCPC, Sunnybrook Health Sciences Centre

CLINICAL PATHWAY IN EARLY PSYCHOSIS INTERVENTION PROGRAM: COLLABORATIVE DEVELOPMENT, SUCCESSFUL IMPLEMENTATION, AND ENCOURAGING COMPLIANCE

ABSTRACT #: 29

Elham Sadeh, BHA, MSc., Epidemiologist, Program Evaluator, The Ottawa Hospital; **Avril Mcintosh,** RN., BA., CPMHN, Department of Psychiatry, On Track- Champlain District Regional First Episode Psychosis Program, The Ottawa Hospital; **Crystal Morris,** Occupational Therapist; MSc OT Reg. (Ont.), Department of Psychiatry, On Track- Champlain District Regional First Episode Psychosis Program, The Ottawa Hospital

Learning Objectives: Identify benefits of applying a standardized clinical pathway on patient quality of care and teamwork, Explain how a multidisciplinary collaboration was used to develop clinical pathway for a community based Early Psychosis Intervention program, Evaluate the use of the clinical pathway as a guiding tool, identify challenges and improve the clinical pathway compliance through Quality Improvement initiatives

Abstract: Clinical pathways (CPs) have been developed to improve quality of care by standardizing care and reducing variations in clinical practice. They facilitate measuring patient progress, encouraging teamwork, and defining measurable outcomes and timelines as well as providing patients and families with clear expectations1. Due to the complexity of patient needs and variation in available treatments for early psychosis, the use of clinical pathways has been limited2. In July 2014, a multidisciplinary team at On Track program in Ottawa developed a clinical pathway as a guiding tool to enable consistent best practices for Early Psychosis Intervention clients. The four -stage recovery based care plan allows each client to be assessed and assigned to a pathway according to their individual needs. Pathways are designed to prompt clinicians to complete required scales and clinical interventions at recommended intervals as well as to consider offering complementary services to enhance the client's progress towards recovery. Pathways stages are dynamic and clients may flow in a non-linear manner between stages based on their individual status. Following implantation of the pathways, 80-90% of patients were on one of the four pathways; however, in beginning of 2017 the use of the clinical pathways decreased significantly (42%). We present our Quality Improvement initiatives as a way to increase clinical pathway compliances. The root causes of the problem were identified through 5 WHYs and Fishbone diagrams, and a new process was developed by the team. The process was monitored monthly and team used Plan, Do, Study, Act Cycles for continuous improvement.

Co-Authors: Mcintosh, Avril (Primary author), RN, BA, Nurse Educator, The Ottawa Hospital; McMillan, Greg, BA,BSW., MSc., Clinical Manager, The Ottawa Hospital; Morris, Crystal, BA, MSc. (OT.),OT Reg. (Ont.), The Ottawa Hospital; Robertson, Sharman, BSc, MD, FRCPC

OTTAWA IN ACTION: NEW AND ONGOING CLINICAL PROGRAMS AT THE SHARED MENTAL HEALTH TEAM WORKING IN THE OTTAWA HOSPITAL AND BRUYERE ACADEMIC FAMILY HEALTH TEAMS

ABSTRACT #: 31

Donna Klinck, MSW, Social Worker, MSW RSW, Shared Mental Health Care TOH & Bruyere Academic FHT; **Tracy Meeker,** APN, Advanced Practice Nurse and Team Manager, Shared Care Team, TOH/Bruyere Family Health Teams; **Noella Bussieres-Butler, MA,** Adminstrative Coordinator, Shared Care Team, TOH/Bruyere Family Health Teams; **Fatiha Rochelle,** MSW RSW, Registered Social Worker, Shared Care Team, TOH/Bruyere Family Health Teams

Learning Objectives: Describe the new and ongoing programming actively underway in Ottawa over the past year, including pilot projects, works in progress and "veteran" programs, Discuss the process of striving for true collaborative practice (with FHT staff and service users) in development of new programs, Exchange knowledge and facilitate dialogue with other agencies to gain more ideas and insights in order to increase innovative future program development

Abstract: The Ottawa Shared Mental Health Care team has many active ongoing programs/groups as well as new initiatives underway. These are delivered in 4 different sites of two large Family Health Teams. This poster presentation will outline both the ongoing programs & groups currently running (some for many years), as well as introduce some new initiatives developed during 2017. The goal will be to use this poster as a unique opportunity to network with conference participants of varied disciplines, both Nationally and Internationally, to exchange ideas, knowledge, and share information. The poster will cover all of the work that the multi-disciplinary team is involved with presently, including the disciplines of Nursing, Social Work, Psychiatry, and Administrative/Management support. We will briefly outline our programs as well as share our views on challenges, successes and lessons learned. As well, some focus will be on the process of decision-making for program development, as well as how collaboration was approached with the FHT staff, members of the clinical team, and service users, in developing and carrying out both new & ongoing programs. It is our hope to bring information back to our program for future consideration and ongoing innovation and to ensure our programs are impactful, successful and appropriate

Co-Authors: Tracy Meeker, MN APN, Advanced Practice Nurse; Noella-Mae Bussieres-Butler, MA, Admin. Co-ordinator; Loanna Maidment, RN, Shared Care Team, TOH/Bruyere Family Health Teams

BREAKING STIGMA FOR STUDENTS AND FACULTIES IN ACADEMIA WITH MENTAL HEALTH PROBLEMS: A PILOT PROJECT

ABSTRACT #: 37

Yanbo Zhang, MBBS, PhD., FRCPC, Dept of Psychiatry, College of Medicine University of Saskatchewan

Learning Objectives: Be able to describe the current mental health status in academia, including students, staff, and faculty, at a medium-sized Canadian research-intensive academic institution, Be able to explain the evidence-based program designed to tackle mental health concerns in academia, Learn about the multidisciplinary and integrated knowledge translation approach to the design of the proposed program

Abstract: Poor mental health of university students, faculty, and staff is an issue in universities globally. Environmental factors (stigma, peer/faculty acceptance and support, and academic policies) have a tremendous impact on mental health outcomes. Although universities have made great efforts to provide mental health services and academic accommodations, the culture environment and supports are far from optimal. An accepting, non-stigmatising, supportive academic environment may help prevent mental health problems before they occur. This project is to design a cross-campus platform to provide necessary tools, skills, and knowledge to faculty, staff, and students regarding mental health and how to resume and build professional relationships with colleagues who suffer from mental illness. The objectives are to: 1) Gain a thorough insight into the skill set of current faculty, students, and staff relating to mental health; 2) Develop and evaluate an educational program and materials for the target audience groups (e.g. faculty, students, indigenous and international students); 3) Develop and implement a strategy for scale-up and sustainability of the program. The immediate goal of this work is to increase coordinated efforts, exposure, and capacity in providing mental health services, information, and tools to the campus community. The long-term focus is to reduce stigma and increase the ability to recognize and implement appropriate interventions for campus individuals with mental health concerns.

Co-Authors: Alana Holt MD, FRCPC, Department of Psychiatry, College of Medicine University of Saskatchewan; Murray D. Drew, PhD, Department of Animal and Poultry Science University of Saskatchewan; Peter Hedley, MA, Student Affairs and Services, University of Saskatchewan; Jocelyn Orb BScN, MA, Student Wellness Centre, University of Saskatchewan; Izabela Szelest, PhD, Department of Psychiatry, College of Medicine University of Saskatchewan

28 MONTH REVIEW: INTEGRATING GERIATRIC PSYCHIATRY SERVICES WITH A COMMUNITY SOCIAL SERVICES PROVIDER

ABSTRACT #: 40

Mark Lachmann, MD, MHSc, FCPC, FRCP, Geriatric Psychiatrist, Sinai Health System

Learning Objectives: Describe a co-design approach to development of a community based senior's mental health service, Describe the patient population supported by a community senior's mental health service, Compare a community based senior's mental health program to a hospital based memory clinic

Abstract: A 28 month co-design process is presented on integrating geriatric psychiatry services with a large community social services agency in Toronto. The co-design process involved a 16 month period of interactive sessions with geriatric psychiatrist, social workers, and community partners, eventually formalized into a monthly afternoon case conferencing session; and then a 12 month period of weekly integrated geriatric psychiatry clinics. This 12 mo. period was formally evaluated. The 45 seniors assessed and then followed in a mix of home and office visits had a high rate of major neurocognitive disorders (58%) and psychiatric illness (58%). The majority (81%) relied solely on government support. When compared to a hospital based memory clinic operating in the same area, this integrated program saw an older (72 years vs. 66 years) and a more cognitively impaired population (58 % vs 36 %).

Co-Authors: Rahim, Ashnoor. MBA. Woodgreen Community Social Services; Chao, Julia. MSW. Woodgreen Community Social Services

SURVIVING AND THRIVING THROUGH WALK-IN COUNSELING: INCLUSIVE CARE

ABSTRACT #: 49

Irina Sytcheva, M.S.W., R.S.W., WoodGreen Community Services; **Jamie Lemen,** MSW, RSW, Supervisor, Walk-In Counseling

Learning Objectives: Explain Walk-in Counselling and Single-session models of service, Outline new ways to recruit, engage and retain volunteers to enhance clinical service delivery and innovative strategies to address the challenges experienced in community settings (e.g. waitlist management), Examine capacity to start-up a Walk-in Counselling service in a local community

Abstract: The Walk-In Counselling Service (WICS) model provides The service model reduces waitlists for other services, delivers better health outcomes than traditional counselling and reaches isolated and vulnerable client populations, including youth, immigrants, and the precariously housed. A 2015 study by University of Waterloo in The Journal of Mental Health found that walk-in counselling resulted in better mental health outcomes than traditional counselling because of its immediacy. The 2016 Ontario Auditor General's report found that people on waitlists for traditional counselling experienced further mental health decline that could be mitigated by immediate, barrier-free access. WoodGreen Community Services' Walk-In Counselling Service (WICS) has provided immediate, free access to high-quality counselling services that are flexible, culturally sensitive, and respectful. WICS reduces barriers to access by being fully inclusive, with no restrictions based on age or address and with no appointment or referral required. Counsellors take a solution-focused approach to improve clients' resiliency, determine their goals, identify available resources, and decide on first steps to positive change. Since WICS's inception there has been an annual increase in the number of clients served, but the need is outpacing the resources. Building on WoodGreen's experiences and lessons learned, this presentation will provide an overview of Walk-In Counselling and how single-session model can effectively support the growing demand for low-cost, accessible, and immediate psychotherapeutic services. The presentation will also highlight the unique aspect of WoodGreen's WICS in terms of engaging, supporting volunteer therapists and subsequently enhance clinical capacity.

Co-Authors: Lemen, Jamie, M.S.W., R.S.W., WoodGreen Community Services; Ashraf, Asim, University of Toronto

TELEMEDICINE IMPACT PLUS (TIP): AN INTERDISCIPLINARY COLLABORATIVE APPROACH TO ADDRESS MEDICAL AND MENTAL HEALTH NEEDS FOR COMPLEX PATIENTS TO MAXIMIZE QUALITY OF LIFE USING SECURED VIDEO CONFERENCING

ABSTRACT #: 52

Agnes Oriade, BScN, RN, Saint Elizabeth Health Care, University Health Network; **Poonam Sehmbi,** RN, BScN, Bsc, Telemedicine Impact Plus Nurse Facilitator/University Health Network

Learning Objectives: Identify clear criteria for patient identification, Identify how an integrated and collaborative approach affects patient care, especially for those living with mental illness, Discuss opportunities to shift focus from acute care to community care in order to best support our vulnerable patient populations.

Abstract: Telemedicine Impact Plus(TIP) has been an integral partner in the development of an innovative collaborative model of care across various cultures within our health care system, to make most effective use of resources in a local geography, and maximize the impact of health-focused interventions, which are specific to patient needs. TIP uses a holistic approach focusing on the medical, mental health and social needs of the patient. This presentation will describe a model of collaborative care planning using video technology connecting patients, primary care providers, and interdisciplinary teams. The presentation will also discuss the various stakeholders who play a pivotal role in collaborative mental health care.There are currently 15 TIP teams in the Toronto sub-regions consisting of general internal medicine, psychiatry, social work, pharmacy, home and community care and other inter-professional staff as required (e.g pain/addiction specialist, dietician) TIP is being evaluated as part of a national randomized controlled trial (RCT). Preliminary results are promising with qualitative evidence that both complex patients and their GPS believe the needs of vulnerable patients are being addressed and quantitative evidence that post-TIP patients improved their ability to self-manage on four out of eight domains. This presentation will also address some of the challenges we have encountered which include: inaccessibility and limitation of resources to certain groups based on regional availability; impact of lack of access to meaningful health care records at the point of care; treatment redundancy; and results of a small study identifying challenges in engaging family physicians.

Co-Authors: Pariser,Pauline,MASc, MD CCFP FCFP, University Health Network; Shembi, Poonam, BScN,RN, University Health Network

EMENTALHEALTH.CA, A COMPREHENSIVE CANADIAN MENTAL HEALTH WEBSITE PORTAL: A MIXED METHODS ASSESSMENT

ABSTRACT #: 53

Dahn Jeong, MSc, University of Ottawa; **Dr. Michael Cheng,** MD, Psychiatrist at the Children's Hospital of Eastern Ontario (CHEO), Ottawa, Ontario, Canada; **Dr. Mireille St-Jean,** MD, Family Physician at The Ottawa Hospital

Learning Objectives: Assess the characteristics of the user population of a portal providing information and tools related to mental health, Illustrate the users' perception of the website, satisfaction, frequency of use and future intentions to use the informational website about mental health, Identify the strengths and weaknesses of an online mental health platform and discuss ways to promote engagement of the general population and healthcare professionals and to further advance collaborative mental health care

Abstract: Background: There is a great unmet need of mental health care and services in Canada. The websites eMentalHealth.ca, created for the general population, and eMentalHealth.ca/PrimaryCare, created specifically for primary care providers, aim to provide various information about mental health topics, screening tools and region-specific information about mental health services. Objectives: This project described the users of the two websites and assessed their use patterns, perception of the websites, satisfaction, frequency of use, and future intentions to use. Methods: Google Analytics was used to assess the total number of visitors. Online self-administered surveys were used to assess their perception of the websites and satisfaction regarding the websites. Results: Over two million people had visited the main website since its opening. There were more female users than male, and the majority of users were aged 35 years and older. Most users were located in Canada, and in Ottawa; French website was accessed in Montreal most frequently. About 17-20% of users identified themselves as healthcare professionals. Online surveys were completed by 370 respondents. Overall, the majority of respondents found the contents of the website helpful. Additional comments identified the content and quality as the strengths of the website; technical difficulties and the design were identified as the weaknesses. Conclusions: Many Canadians are looking for online resources to obtain information regarding mental health and access to care. Both websites have shown a great potential to be a successful tool in providing timely and easy access to Mental Health information and resources to general population and healthcare professionals.

Co-Authors: Cheng, Michael, MD, University of Ottawa and CHEO; St-Jean, Mireille, MD, University of Ottawa; Jalali, Alireza, MD, University of Ottawa

CROSSING THE CULTURE DIVIDE BETWEEN A TERTIARY CARE PSYCHIATRIC HOSPITAL AND A COMMUNITY GERIATRIC MENTAL HEALTH CLINIC

ABSTRACT #: 55

Jennifer Cavanagh, B.Sc. (Occupational Therapy), Occupational Therapist, Geriatric Psychiatry Community Services of Ottawa; **Vickie Demers,** OT Reg. (Ont.), Executive Director, Geriatric Psychiatry Community Services of Ottawa; **Adele Loncar,** BHSc., MSc., Program Evaluation Coordinator/The Royal

Learning Objectives: Summarize how the Lean process can facilitate efficient practices, Describe the benefits of a centralized intake process, Identify potential collaborative opportunities outside of your current practice which better serve the patient population

Abstract: The Royal Ottawa Mental Health Centre (The Royal) is a tertiary care psychiatric hospital with a geriatric program which provides comprehensive geriatric psychiatry services including in-patient care, out-patient and outreach services to long term care. Using a case management model with geriatric psychiatrists and allied health case managers, Geriatric Psychiatry Community Service of Ottawa (GPCSO) is a community geriatric mental health clinic which provides in home and out-patient services. With various system pressures including increasing wait times, more complex clientele, the two programs sought an innovative response that could be implemented within existing resources. It was recognized that a joint referral form, common criteria and a single point of access to services would result in delivering improved coordinated and integrated care and a more equitable access to services [1]. A Lean review and value stream mapping was done to design the ideal future state including an evaluation framework [2-4]. From there both parties entered into a memorandum of understanding to implement and deliver a geriatric psychiatry centralized intake. The new centralized intake demonstrated system improvements such as a more equitable and timely access to services, a simplified referral process for referral partners and improved system navigation. Trust and understanding was developed, communication was improved and a new way of working has emerged leading to increased collaboration between the two programs. In addressing challenges and leveraging new opportunities to deliver high quality client care, the partnership has succeeded in bridging a cultural divide between hospital-based and community-based services.

Co-Authors: Loncar Adele, M. Sc., Royal Ottawa Mental Health Centre; Demers, vickie B. Sc., Geriatric Psychiatry Community Services of Ottawa; Gobessi, Linda, MD, FRCPC, Geriatric Psychiatry Community Services of Ottawa; Lodha, Vinay MD, FRCPC, Royal Ottawa Mental Health Centre; Dr. Louise Carrier, MD, FRCPC, Geriatric Psychiatry Community Services of Ottawa

BUILDING ENGAGEMENT AND A COMMUNITY OF PRACTICE TO IMPROVE MENTAL HEALTH AND ADDICTION CARE WITHIN PRIMARY CARE: INNOVATIONS USING THE ECHO MODEL

ABSTRACT #: 56

Cheryl Pereira., MPH, Research Coordinator, ECHO Ontario Mental Health at CAMH and U of T, Centre for Addiction and Mental Health

Learning Objectives: Describe the ECHO model and the gaps in healthcare delivery it proposes to solve., Demonstrate how technology can be leveraged to increase collaboration and capacity in mental health education., Summarize how innovative approaches can be used in an online milieu to create a cohesive virtual community of practice.

Abstract: Primary care providers (PCPs) are first-line responders for individuals experiencing mental health and addictions concerns. In rural and underserved areas, where access to specialists is limited, complex mental health disorders are often managed within primary care leaving PCPs feeling under-resourced and isolated. Project Extension for Community Healthcare Outcomes (ECHO) is a 'Hub' and 'Spoke' tele-mentoring model that uses a virtual community of practice to leverage scarce healthcare resources in rural communities. PCPs connect with an inter-professional specialist team as well as providers practicing in similar settings to discuss complex real-world patients, share knowledge, and learn best practices in the management of complex chronic illness. The ECHO model has been adopted globally for the treatment of various conditions; however, its use in mental health has been limited. The Centre for Addiction and Mental Health and the University of Toronto launched the first Canadian ECHO focused on mental health care, ECHO Ontario Mental Health. In this workshop, we will describe the ECHO model, how it can be used to build specialized mental health capacity in PCPs, and how to leverage technology to increase engagement and community building in a virtual milieu. The innovative approaches described during this workshop can serve to reduce feelings of professional isolation by creating opportunities for collaboration and shared learning for PCPs. At the conclusion of the workshop, participants will have a toolkit with resources on the ECHO model, engagement considerations, and resources on innovative ways to leverage technology to build cohesive communities of practice at a distance.

Co-Authors: Sanjeev Sockalingam,, MD, FRCPC, MPHE, University of Toronto; Eva Serhal, MBA, Centre for Addiction and Mental Health

CHALLENGES AND RESPONSES TO IMMIGRANT AND REFUGEE MENTAL HEALTH CARE IN POSTMIGRATION RESETTLEMENT

ABSTRACT #: 62

Alfred Okot Ochen, CMHA, CHA,BA,BS,MA,MBA Candidate, Settlement, Community & Housing, Victoria Immigrant And Refugee Centre Society, Compassion For Life Foundation; **Angela Gallentes,** MA Human Security and Peacebuilding, Royal Roads University

Learning Objectives: To identify and classify post migration resettlement stressors on newcomer (immigrant and refugee) attitudes towards seeking primary mental health care, To explain how post migration resettlement stressors affect newcomer attitudes towards seeking primary mental health care, To examine the positive effects of settlement services in mitigating newcomers' negative attitudes towards seeking primary mental health care during post migration resettlement.

Abstract: This study focuses on newcomer (immigrant and refugee) attitudes during post migration resettlement in seeking primary mental health care in the receiving country. The challenge during this migration transition exists because of the newcomers' varied experiences in social, economic, and cultural shifts. The goal is to be able to classify and discuss newcomer challenges during post migration resettlement and examine the mitigating effects of settlement services on newcomers' negative attitudes towards primary mental health care. Various related literatures on immigrant and refugee mental health will be compiled and reviewed. The study aims to promote the importance of settlement support services institutions and their role in mitigating the newcomer populations' negative attitudes to seeking mental health care.

SURFING THROUGH TRANSITIONS: HELPING PATIENTS WITH COMPLEX MEDICAL AND MENTAL HEALTH NEEDS TRANSITION ACROSS SECTORS

ABSTRACT #: 64

Michelle Peralta, RN MN BScN, BHSc Hon., Clinical Nurse Specialist, The Hospital for Sick Children; **Ms Elaine Widgett,** MRSc, OT Reg (Ont), CHE, Executive Director, Holland Bloorview Kids Rehab; **Dr Peter Rumney,** MD, FRCP, Physician Director, Rehab and Complex Continuing Care, Holland Bloorview Rehab; **Dr Arlette Lefebvre,** MD, FRCP, DipC, OOn, CM, Staff Psychiatrist, The Hospital for Sick Children; **Hana Saab,** BScN, MEd, PhD, Implementation & Evaluation Lead, Psychiatry, The Hospital for Sick Children

Learning Objectives: Discuss how to build/implement a bidirectional integrated pathway bridging acute hospital, rehabilitation, community and educational services, Identify the barriers that exist that affect collaboration between sectors, Determine how to build capacity across systems with engaged and confident providers.

Abstract: Integrated care is seen as a solution to service fragmentation and disjointed care (Kodner, 2009). Our project was inspired by the desire to establish a seamless pathway for Paediatric patients with severe neurological dysfunction and concomitant psychiatric needs and their families. We will highlight essential components for bridging acute hospital, rehabilitation, community and educational services while ensuring patient centeredness. Our model is premised on the Chronic Care Model (CCM) (Coleman et al., 2009) which aims to improve patient outcomes through a combination of effective team care and planned interactions. Involving community partners during the acute phase of an illness is essential for establishing bi-directional pathways and partnerships, streamlining communication processes, and ensuring continuity of care thus transforming the daily care for patients with chronic illnesses "from acute and reactive to proactive and planned". Providing coordinated and integrated care for this patient population will result in better outcomes, reduced caregiver stress and enhanced quality of life. Moreover, we will highlight how a safe transition from acute care to the community ensures that patients will have access to ongoing diagnostic support, behavioral, educational and rehabilitation specialists beyond the walls of healthcare institutions.

Co-Authors: Elaine Widgett, MRSc, OT Reg (Ont), CHE, Executive Director, Holland Bloorview Kids Rehab; Peter Rumney MD, FRCP, Physician Director, Rehab and Complex Continuing Care; Marjory Phillips, PhD, Director, Integra Program at the Child Development Institute; Arlette Lefebvre MD, FRCP, DipC, OOn, CM, Staff Psychiatrist, The Hospital for Sick Children; Hana Saab BScN, MEd, PhD, Implementation & Evaluation Lead, Psychaitry, The Hospital for Sick Children

UNDERSTANDING BARRIERS AND FACILITATORS TO USE OF THE OTTAWA DEPRESSION ALGORITHM IN PRIMARY CARE

ABSTRACT #: 67

Douglas Green, MD, The Ottawa Hospital and University of Ottawa

Learning Objectives: Summarize the background to and the steps in the Ottawa Depression Algorithm, Outline the Theoretical Domains Framework and the Think-Aloud method, Identify barriers and facilitators to using the Ottawa Depression Algorithm

Abstract: Background: Depression is a common mental health issue and is most often managed in primary care [1]. The 'Ottawa Depression Algorithm' was developed to support primary care professionals in providing care for adult patients presenting with symptoms of depression. While promising, the development of the algorithm does not guarantee its use. Objective: To identify barriers and facilitators to use of the Ottawa Depression Algorithm in primary care. Methods: We conducted semi-structured interviews with primary care professionals (physicians, residents, nurse practitioners, nurses, and administrators) in the Champlain LHIN region. Participants worked through the algorithm using a written patient scenario while verbalizing their thoughts ('Think Aloud'), and responded to questions informed by the Theoretical Domains Framework (TDF), used to identify factors that may influence behaviour change [2]. Barriers and facilitators to algorithm use were identified from interview transcripts. Results: Interviews are ongoing. Barriers identified from preliminary analyses of nine transcripts include: familiarization with the extensive algorithm content requires a significant time commitment; the algorithm is difficult to use during a time-constrained consultation; it is not clear how the algorithm will be kept up-to-date in accordance with best evidence. Facilitators include: the algorithm brings together disparate resources; uptake could enhance the use of a common language across providers and agreement on roles and responsibilities of team members. Conclusions: We have identified barriers and facilitators to use of the Ottawa Depression Algorithm. Findings will be used to enhance usability and to develop an implementation strategy.

Co-Authors: Nicola McCleary, PhD, Ottawa Hospital Research Institute; and University of Ottawa; Kendall, Claire, MD, Bruyère Research Institute; and University of Ottawa; Yamada, Janet, PhD, Ryerson University; Gillis, Kathy, MD, The Ottawa Hospital; and University of Ottawa; Presseau, Justin, PhD, Ottawa Hospital Research Institute; and University of Ottawa

USING AN INTEGRATED SUITE OF ASSESSMENTS TO SUPPORT COLLABORATIVE CARE

ABSTRACT #: 68
Rim Khazall, PhD, Canadian Institute for Health Information; **Diana Ridgeway,** PhD, Canadian Institute for Health Information

Learning Objectives: Describe how the interRAI suite of assessments supports continuity of care and quality improvement, Identify the role of the Canadian Institute for Health Information (CIHI) in promoting data standards and accelerating improvements in the health system, Describe the value of an integrated suite of assessments in community mental health

Abstract: The interRAI suite of assessment instruments is designed to support collaborative, patient-centred care. The instruments were developed to address specific populations, including community mental health, child and youth mental health, inpatient mental health, home care and continuing care. The instruments share a core set of assessment items, and are designed to work together as part of an integrated health information system. The use of a "common language" facilitates the sharing of information across service providers in multiple settings, and the development of collaborative care plans. For example, the assessments would support in the continuity of care of youth transitioning from children and youth mental health services to adult mental health services. The Canadian Institute for Health Information (CIHI) is a not-for-profit organization that provides information for health system management. CIHI supports the implementation and use of comprehensive and standardized clinical assessments across the continuum of care, based on the interRAI suite of instruments. In addition to aiding practitioners in providing high quality care, these assessments provide data to inform planning and policy decisions. These results are synthesized and reported to stakeholders to help improve patient-centred care. This presentation will highlight examples of using CIHI data to inform system management and clinical care decisions in caring for individuals with mental health issues.

Co-Authors: Ridgeway, Diana, PhD., Canadian Institute for Health Information

MEDICAL COMPLEXITY AND CONCURRENT DISORDERS IN ADOLESCENTS

ABSTRACT #: 71
Trisha Tulloch, MD, FRCPC FAAP, Centre for Addiction and Mental Health, Hospital for Sick Children;

Learning Objectives: Describe the physical health issues that are often present for teens and youth with concurrent disorders, Discuss the challenges and barriers to optimal health outcomes for this group, Identify approaches to working with youth and 'service providers' across health settings to optimize health and well being

Abstract: Teens and transitional age youth with mental health and substance use disorders often have co-existing health issues that may be acute and/or chronic. Depending on the health care setting in which they seek care, aspects of these complex health needs may or may not be identified or addressed. Many do not have a primary care health provider. Some see 'specialists' for parts of their care, others access the health care system mainly through emergency rooms or walk in clinic visits. As result, their health care is often fragmented, disconnected and less than optimal. This interactive case based workshop will engage participants in discussions about the intersections of physical health, mental health and substance use in the adolescent population. Relevant literature and recent local research will be shared and discussed. Opportunities for shared problem solving and the identification of potential solutions to what is often fragmented health care for this group of young people will be provided. This session will be shaped by the experiences and ideas of the participants, along with the facilitators who have worked in the area of adolescent health in a variety of settings.

Co-Authors: Renee Logan, MD, CCFP, Centre for Addiction and Mental Health; Jenny Nicolle, MD, CCFP, St. Michael's Hospital; Karen Leslie, MD MEd FRCPC, Pediatrician/Hospital for Sick Children; Susan Rosenkranz, PhD, Psychologist/ CAMH; Corine Carlisle, MD FRCPC, Psychiatrist; Sooyoun Shin, Medical Student/ University of Toronto; Shaheem Abid, Medical Student/ University of Ottawa

PERCEPTIONS OF EDUCATIONAL NEEDS IN AN ERA OF SHIFTING MENTAL HEALTH CARE TO PRIMARY CARE: CAREGIVERS OF PATIENTS WITH MENTAL HEALTH CONDITIONS AND PRIMARY CARE PROVIDERS

ABSTRACT #: 76
Stephanie Sutherland, PhD, The Ottawa Hospital

Learning Objectives: Identify the similarities and differences in the perceptions of caregivers and primary care providers regarding barriers to shifting mental health care to primary care providers., Describe the various solutions to overcome barriers in shifting mental health care to the community level., Plan for educational materials that target the needs of both caregivers and primary care providers in bridging the gaps in perception and practice.

Abstract: Problem Mental health problems are mounting and there is currently a shortage of primary care providers that provide mental health care. For this reason, we undertook a needs assessment (NA) to understand educational needs with regard to shifting mental health care to primary care providers from two key stakeholder groups: 1) caregivers of patients with a mental health condition, 2) primary care providers. Methods Two qualitative focus groups with patient caregivers were conducted (2014, 2016). A total of 22 (2014 = 10, 2016 = 12) participants took part in each of the two focus groups. General practitioners affiliated with University of Ottawa, Faculty of Medicine were asked to participate. In turn, agreeable participants nominated colleagues who might be willing to take part in an interview. A total of 10 general practitioners took part in a 30-minute interview. Results Caregivers and general practitioners' educational needs are more similar than different. That is, both groups seek information as related to disease specific symptoms and treatment options, and access to system-level psychiatric oversight. However, potentially more serious is the attitudinal divide between the two stakeholder groups. Caregivers report a lack of ability with regard to primary care treatment of their loved one, whereas some general practitioners prefer not to treat mentally ill patients. Conclusion/Significance This needs assessment has demonstrated a clear need to better bridge the divide between caregivers of patients with mental health conditions and primary care physicians. Carefully developed educational materials, delivered in preferred formats are a start to collaborative care.

Co-Authors: Jalali, Alireza, MD, Professor, University of Ottawa; St-Jean, Mireille, MD, The Ottawa Hospital; Cheng, Michael, MD, Children's Hospital of Eastern Ontario

TEACHING ABOUT COUNSELLING AND MENTAL HEALTH TO FAMILY PRACTICE RESIDENTS

ABSTRACT #: 82
William Watson, MD, CCFP, Family Physician, St. Michael's Hospital, University of Toronto

Learning Objectives: Describe the challenges in teaching counselling around medical and psychosocial issues in family medicine training, and demonstrate new approaches to teaching, Apply a variety of innovative teaching programs and ideas that have worked at the University of Toronto, and elsewhere, Discuss and share ideas around this topic.

Abstract: While Family physicians provide the majority of mental health care in Canada, training programs in family medicine often struggle with teaching about behaviour medicine and mental health issues, especially around common clinical psychosocial problems such as depression, anxiety disorders, chronic pain, suicide and addiction. There are challenges in fitting into the already crowded curriculum, use of interdisciplinary mental health providers, and coverage of the wide breadth of mental health problems seen in Family Practice. In addition, teachers may have concerns about how best to teach behavior medicine within a busy 2-year curriculum, with questions such as why should we teach these skills, what specific information should be taught, how can a program effectively combine didactic learning with an experiential component, and how can behavioral medicine be incorporated into the already crowded family medicine curriculum; what are the specific educational needs of millennials? Using an interdisciplinary approach, this workshop will focus on how to effectively combine didactic learning in behavior medicine with an experiential component; videotaped materials and use of role play. This workshop will be of particular interest to those involved in teaching behavior medicine to family medicine residents. In the spirit of sharing information, participants will be invited to share resources and strategies that have worked in their own programs.

Co-Authors: Katie Sussman, MSW, RSW; Lindsay Watson, MA; Emelyn Bartlett, MSW, RSW; Hannah Feiner, MD, CCFP

BETTER TOGETHER: A MIXED-METHODS STUDY TO GUIDE A CONTINUING PROFESSIONAL DEVELOPMENT AND FACULTY DEVELOPMENT CURRICULUM IN INTEGRATED MENTAL HEALTH CARE

ABSTRACT #: 84

Michael Neszt, MDCM, Psychiatrist, University of Toronto; **Shelley Rohar,** PhD (candidate), Department of Educational & Counselling Psychology, McGill University, Research Coordinator, St-Michael's Hospital

Learning Objectives: Describe psychiatrists' faculty development needs to teach and assess psychiatry residents in Integrated Mental Health Care (IMHC), Describe psychiatrists' continuing professional development needs to practice IMHC in a way that helps bridge the gap between evidence-based models of IMHC and current clinical practice, List steps in curriculum development for medical education using David E. Kern's six step model relevant for the creation of IMHC faculty development and continuing professional education

Abstract: Training in Integrated Mental Health Care (IMHC) has been mandated for Canadian psychiatry residents and provides crucial preparation for team-based models of care that better meet population needs. Residents require exposure to evidence-based models of IMHC, and faculty supervisors adept in implementing and teaching about such models. However, across Canada there is a sizeable gap between evidence and practice (1), leading to deficiencies in clinical learning environments. While this problem is likely multifactorial, psychiatrists' lack of knowledge of the evidence, and how to implement it, is contributory. Despite the need, it is not known how best to prepare clinical supervisors to implement and supervise evidence-based models of IMHC (2). This poster will present preliminary results of a mixed methods study examining the learning needs and preferences of faculty psychiatrists affiliated with the University of Toronto with respect to implementing evidence-based IMHC models in primary care- and community-based training sites, and teaching and assessing residents in this important new area of training. The qualitative component involves semi-structured interviews with 12-15 faculty supervisors with varying experience with IMHC and supervision to explore their perspectives and preferences regarding past and future IMHC educational experiences. Interviews will be audio-recorded, transcribed, and thematically analyzed. Findings will be triangulated with the content analysis of PGY5 IMHC psychiatry resident written assignments that assess implementation of IMHC in their clinical setting to better understand opportunities to improve the implementation of IMHC. Study results will be used to inform design and implementation of new faculty development and continuing professional development curricula.

Co-Authors: Sunderji, Nadiya, MD, MPH, University of Toronto; Rohar, Shelley, MA, University of Toronto; Teshima, John, MD, MEd, University of Toronto; Mylopoulos, Maria, PhD, University of Toronto; Sockalingam, Sanjeev, MD, MHPE, University of Toronto

DEMOGRAPHIC ANALYSIS OF THE CAMH PARTNERS INTEGRATED CARE PROJECT

ABSTRACT #: 85

Eleni Kelly, BA, Research Analyst, Centre for Addiction and Mental Health; **Alexandra Kubica,** BSc, Centre for Addiction and Mental Health

Learning Objectives: Identify and discuss the diverse communities that are being served by integrated care projects in Ontario, Determine the unique needs of the different communities participating in this integrated care project, and if they feel adequately supported by this model, Discuss how these findings can be used to inform the design and implementation of other mental health integrated care projects in the future

Abstract: The CAMH PARTNERs Project is a randomized controlled trial that supports primary care patients with depression, anxiety, and at-risk drinking using a telephone-based integrated care model. Patients are randomized to one of two groups: Enhanced Usual Care (EUC) and intervention (INT) for 12 months. Patients in EUC receive comprehensive telephone assessments at baseline, 4, 8, and 12 months; these results are shared with their primary care providers. In addition to these assessments, INT patients will receive regular telephone support from a Mental Health Technician, who monitors symptoms, treatment adherence, and provides education on lifestyle changes. PARTNERs serves a diverse adult client base of participants from a variety of different communities, cultures, and socioeconomic statuses. The project is implemented across Ontario at 18 primary care sites with 184 physicians and nurse practitioners across rural, urban, and suburban settings. Utilizing data obtained from baseline assessments, we will present the demographic information of participants enrolled in PARTNERs. This includes age, gender, ethnicity, financial stability, perceptions of health, and housing circumstances. Satisfaction survey results obtained at the 12 month assessment will also be presented regarding participants perceptions of feeling supported in their cultural needs. This poster presentation will help illustrate the unique population of individuals participating in an integrated care model in Ontario, and indicate which groups are most represented so as to tailor future integrated care projects to better support these and other communities. With this demographic analysis, we will show that our culturally encompassing project provides further data on integrated care models.

Co-Authors: Kubica, Alexandra, BSc, Centre for Addiction and Mental Health; Perivolaris, Athina, RN, MN, Centre for Addiction and Mental Health; Rodie, David, MD, FRCPC, Centre for Addiction and Mental Health; Mulsant, Benoit, MD, MSc, FRCPC, Centre for Addiction and Mental Health

"ARE WE SUPPOSED TO DUKE IT OUT NOW?": INTERPROFESSIONAL TEAM DECISION-MAKING ABOUT PSYCHIATRY RESIDENT PERFORMANCE WHEN PILOTING A MULTISOURCE ASSESSMENT TOOL IN COLLABORATIVE MENTAL HEALTH CARE SETTINGS

ABSTRACT #: 86

Vijay Sandhu, BSc, Medical Student, University of Toronto

Learning Objectives: Review the role of multisource feedback within a broader portfolio of assessment tools in collaborative care settings, Explain factors that impede effective group communication and decision-making in interprofessional team settings, Compare and critique alternative approaches to eliciting multisource feedback in collaborative care training of psychiatry residents.

Abstract: Psychiatric education increasingly involves training in collaborative care settings where trainees learn from a diverse community of experts. Multisource feedback tools tap into this distributed expertise providing a comprehensive view of trainee performance; however, eliciting assessment data from healthcare providers of diverse backgrounds is challenging. One solution to this problem is having clinical teams work together to assess a trainee through group discussion. Studies in other contexts suggest that interprofessional interactions are influenced by professional and experience-related status differentials and differences in professional values and perspectives. We designed a program of assessment for psychiatry residents training in collaborative care, including multisource assessment by team members in the 'host' primary care or community agency setting. In this study, we piloted our tool by simulating interprofessional decision making about resident performance. Teams assigned a relative ranking for seven composite descriptions of psychiatry residents, completing the task individually and then collectively to determine a consensus relative ranking. We observed, transcribed and thematically analyzed the group discussions. Teams varied in final decision quality, extent to which divergent perspectives were heard, and strategies used to resolve differences. Based on this, we decided to solicit individual rather than group input on actual resident performance. Innovations in collaborative care education afford rich opportunities for psychiatry residents to benefit from exposure to other professional cultures as well as from a culture of interprofessionalism, but only if implemented thoughtfully. As collaborative approaches to mental health education continue to gain traction, we advise a thoughtful approach to interprofessional assessment of students.

Co-Authors: Nadiya Sunderji, MD, MPH, University of Toronto; Andrea Waddell, MD, MEd, University of Toronto; Kristina Powles, MD, University of Toronto

HEALTHY LIFESTYLES PROGRAM PILOT STUDY: COLLABORATING FOR HEALTH PROMOTION AND CHRONIC DISEASE MANAGEMENT

ABSTRACT #: 92

Elizabeth Alvarez, MD, MPH, PhD, CMCBT, Assistant Professor, McMaster University

Learning Objectives: Participants will be able to develop ways to reconceptualize patient-centered care, Participants will be able to identify relevant components of a new healthy lifestyles program, Participants will be able to evaluate the role of collaborative care for chronic conditions.

Abstract: Background: Rates of chronic conditions, such as diabetes, obesity and anxiety, are increasing throughout Canada and internationally. These chronic conditions, on their own and combined, significantly impact the quality and quantity of people's lives. General mental health is rarely addressed in the context of chronic disease management due to time limitations, payment schemes, and lack of training. Behaviour change is difficult yet lies at the crux of patient self-management. Innovative methods are needed to achieve patient-centered care and sustainable improvements in health. A new year-long healthy lifestyles program has been developed. Methods: A pragmatic mixed methods pilot study, including a randomized controlled trial and qualitative components, is being used to evaluate the program. The control arm participants meet every three months with a research assistant trained in theories of health behaviour to develop health goals and measure progress in meeting these goals. Participants in the intervention arm meet weekly for education or brainstorming group sessions and meet monthly with an integrated healthcare team including a family physician, dietician and physical therapist to also address the "how to" implement lifestyle changes. The program is evaluated through administrative data, participant surveys, qualitative interviews with program staff and participants' healthcare providers, and family focus groups. In addition, multiple aspects of a person's health are measured, including physical and mental well-being. Cost-effectiveness will also be evaluated. Results: Preliminary findings on the implementation of the program and participant outcomes will be presented.

Co-Authors: Qutob, Majdi, MD, MSc, MBA, Innovation Science and Medicine

BUILDING A COLLABORATIVE CARE NETWORK IN THE PROVINCE OF ONTARIO: BRIDGING PRIVATELY- AND PUBLICLY-FUNDED PROFESSIONAL CULTURES IN MENTAL HEALTH CARE

ABSTRACT #: 93
Zainab Mohamed, McMaster University (MD Candidate 2018)

Learning Objectives: Explain Network Theory as it Relates to Collaborative Care Efforts, Compare and Contrast Collaborative Care Hierarchies with Collaborative Care Networks, Recommend Ways to Evaluate Quality of Care in One Network Model of Mental Health Collaboration

Abstract: Across the globe, public-private partnerships in mental health care are not a new innovation. In Canada, public-private partnerships are ubiquitous in funding models keeping hospitals and other health care services operational. Public-private partnerships offer a potential opportunity to improve standards of collaborative care in mental health. Risks and benefits emerge from such a partnership. An innovative model of collaborative care, utilizing privately-funded psychotherapists trained to provide case-management in collaboration with publicly-funded psychiatrists, has been operating in Ontario, Canada, since 2015. Cultural strengths of the public and private entities are utilized within this model creating unexpected positive results. Process and outcome results will be presented. Questions about sustainability and scalability arise when considering ways to optimize positive impact the model has on mental health care. How stakeholders supporting the innovation stay flexible in adapting to technological challenges, limitations in information technology, and unique needs of local targeted populations within the province, will determine future strategic objectives for this unique model of collaborative mental health care.

Co-Authors: Vicky P. K. H. Nguyen, MD, PhD, Post Graduate Trainee in Psychiatry Year 4, Northern Ontario School of Medicine; Allan Steingart, MD, FRCP(C), University of Toronto, Assistant Professor of Psychiatry

ENGAGEMENT OF PRIMARY CARE PROVIDERS IN THE CAMH PARTNERS PROJECT

ABSTRACT #: 95
Alexandra Kubica, Honours Bachelor of Science, The Centre for Addiction and Mental Health; **Eleni Kelly,** BA, Centre for Addiction and Mental Health

Learning Objectives: Describe factors for successful implementation of an integrated care project for depression, anxiety, and at-risk drinking., Compare the engagement of primary care providers in Ontario in an integrated care model for depression, anxiety, and at-risk drinking, Utilize data presented in this poster to inform the design and implementation of future mental health integrated care projects.

Abstract: The CAMH PARTNERs Project is a randomized controlled trial that supports adult primary care patients with depression, anxiety, and at-risk drinking using a telephone-based integrated care model. Patients are randomized to one of two groups: Enhanced Usual Care (EUC) and intervention (INT) for 12 months. Patients in EUC receive comprehensive telephone assessments at baseline 4, 8, and 12 month intervals, the results are shared with their primary care providers (PCPs). Additionally, patients in the intervention receive regular telephone support from Mental Health Technicians (MHTs), who monitor symptoms, treatment adherence, and provide education on lifestyle changes. PARTNERs has been implemented at family health clinics, and solo physician practices across Ontario: currently, 184 physicians, nurse practitioners, and social workers are participating. The data explored will compare engagement across project sites and assess factors for successful implementation as demonstrated by PARTNERs. Factors will be measured in the following: referral source (PCP vs inter-professional team member) type of family practice clinic (FHT, FHO, or solo provider) as well as the quality of these referrals. Quality will be measured by matching problems identified by physician to baseline assessment scores (PHQ-9, GAD-7, Timeline Follow Back), and rates of ineligibility at baseline. Furthermore, trends in patient engagement will be assessed via ability to establish contact with participants after being referred and ease of enrolment. Physician collaboration and ongoing engagement is integral to successful implementation of integrated care models for improving access to mental health services, project success, and the quality of care that participants receive from PARTNERs.

Co-Authors: Kelly, Eleni, BA, Centre for Addiction and Mental Health; Perivolaris, Athina, RN, MN, Centre for Addiction and Mental Health; Rodie, David, MD, FRCPC, Centre for Addiction and Mental Health; Mulsant, Benoit, MD, MSc, FRCPC, Centre for Addiction and Mental Health

SET FOR HEALTH: TRANSLATING SELF-MANAGEMENT SUPPORT INTO INTERDISCIPLINARY MENTAL HEALTH CASE MANAGEMENT SERVICES

Abstract #: 123
Susan Strong, PhD, OT Reg.(Ont), (C), School of Rehabilitation Science, McMaster University, SCIS, St. Joseph's Healthcare Hamilton (SJHH)

Learning Objectives: Identify how a model of self-management support embedded in transitional case management community services (SET for Health) was adapted and operationalized in the context of specialized mental health services delivered by interdisciplinary teams for individuals and families living with schizophrenia / psychotic disorders and various co-morbidities; Summarize the participatory approach employed to prepare and support case managers to make the necessary shifts in client-provider roles, providers' client views, and focus of interventions in order to deliver self-management support; Examine the challenges encountered and strategies used to facilitate client-provider engagement, collaboration and shared decision-making for clients actively taking charge of their health, learning about self and health through goal-setting, problem-solving and review

Abstract: Individuals/families living with schizophrenia are often insufficiently involved in the treatment process. Core features of schizophrenia, including poor insight and negative symptoms often lead to disengagement, medication nonadherence, relapse and rehospitalisations. Providers are challenged to build relationships with someone who, as a result of the condition itself, may not believe they have an illness. Self-management support is advocated as a feasible, effective intervention for engagement and building capacity within individuals and their families/supports to actively manage the impact of illness and live fuller, healthier lives. In a mixed methods feasibility study, 'SET for Health' is being evaluated regarding extent: a) adds value from clients'/families' and providers' perspectives; and b) influences individuals' engagement in treatment, participation in self-management, symptom distress, sense of hope and quality of life. Procedures and facilitation tools tailor and operationalize the intervention's four main components derived from common elements of standardized self-management programs. 10 interdisciplinary case managers (registered nurses, social workers, occupational therapists) are offering the intervention to 42 individuals (120 expected). Initial findings revealed: expanded spaces for client participation; self-management discussions of illness and health; and provider recovery orientation. Providers experienced challenges changing habits and traditional practices, particularly regarding client directed goal-setting, problem-solving and review. These results can be understood in the context of a new complex practice being delivered by a variety of health disciplines, for some of whom goal-setting is not previously an integral part of practice. The process continues to contribute to a culture of self-reflection, learning and the resetting of expectations.

Co-Authors: Heather McNeely, PhD, C. Psych, Department of Psychiatry & Behavioural Neurosciences, McMaster University, 2SCIS, St. Joseph's Healthcare Hamilton (SJHH); Mary-Lou Martin, MScN, MEd, RN, School of Nursing, McMaster University, Forensic Psychiatry Program, SJHH; Alycia Gillespie, SCIS, St. Joseph's Healthcare Hamilton (SJHH)

RETHINKING THE 'EXPERT APPROACH' OF MODERN HEALTHCARE: THE ROLE OF THE PATIENT ADVOCATE IN COLLABORATIVE MENTAL HEALTH CARE

Abstract #: 124

Montana Skurka, Bachelor of Arts (Hons.), Queen's University, Ontario; Master of Teaching, Ontario Institute for Studies in Education of the University of Toronto, OCT-qualified teacher (Intermediate and Senior Divisions, History and English; Special Education); Certified Health and Wellness Coach (Wellcoaches) and yoga teacher (Ahimsa 300h Yogayama), Montana Skurka Patient Advocacy

Learning Objectives: Evaluate the current power dynamics inherent in the patient-medical professional relationship and whether this adequately serves the needs of patients; Prioritize integrating physical and mental health care, particularly for complex patients; Demonstrate the positive impact a patient advocate can have within the collaborative mental health care framework

Abstract: Our healthcare system was built to manage acute medical conditions and emergencies. Individuals who live with chronic illness are often plagued by fear, guilt and isolation. The emotional and psychological impact of disease is often overlooked. Each patient deserves to be treated as a whole being: mind, body and spirit. The word patient comes from the Latin verb pati (to suffer), from which we also get the word passive. When one is going through a health crisis, it is reasonable to be a passive recipient of care. However, it can be detrimental if a complex care patient adopts the label 'patient' as part of his or her identity. This poster explores how the medical professional and patient relationship can exacerbate mental health concerns for patients with complex health issues. In my personal experience as a complex care patient, I became over-reliant on medical experts to make decisions for me. I lacked a sense of control and autonomy over my own life. This greatly exacerbated my mental health concerns of depression and anxiety throughout my life. I believe that patient advocacy is an exciting avenue to help patients overcome the barriers of the deficit model of healthcare. It is not sustainable for patients to solely rely on 'experts' to 'fix us'. We must learn how to care for one another and build a society that nurtures. The word compassion comes from the same Latin verb as patient, 'pati', plus the addition of 'com', which means together with. This is true healing.

OFF- ROADING IN THE RIGHT DIRECTION: TRANSFORMING TRANSITIONS FOR ALC CLIENTS WITH MENTAL HEALTH ADDICTIONS AND CHALLENGES

Abstract #: 125

Debra Walko, LOFT Community Services

Learning Objectives: How to assume a strong role in transition planning and execution; Establishing the importance of adapting to changing needs by remaining fluid and flexible; Provide an overview of the principles followed around quality transitions in care

Abstract: There is a critical need to accelerate change toward better supporting individuals living with mental health and addiction challenges, designated Alternate Level of Care (ALC). With a lack of appropriate care settings or an integrated person centered approach to transitions, significant pressure is placed on providers to find quick solutions. LOFT will relate our experiences on moving towards fluid person centered approaches and processes. To demonstrate that in order to recognize and meet the needs of clients with complex challenges by nature require a different level of care and a greater appetite for innovative thinking. LOFT will engage and speak to how we use an integrated approach to care transitions across community and hospital sites (collaborating across cultures), using principles developed to strengthen a client centered approach. How the principles were applied and outcomes will be shared.

STIGMA TOWARD PEOPLE WITH MENTAL ILLNESS AND/OR ADDICTION AMONG PRIMARY CARE PROFESSIONALS: PRELIMINARY RESULTS OF A NATIONAL SURVEY STUDY IN CHILE

Abstract #: 126

Jaime C. Sapag, MD MPH PhD, Associate Professor, Departments of Public Health and Family Medicine, School of Medicine, Pontificia Universidad Católica de Chile (Santiago, Chile) / Associate Professor, Dalla Lana School of Public Health, University of Toronto / Project Scientist, Office of Transformative Global Health, Centre for Addiction and Mental Health, Ontario, Canada

Learning Objectives: Describe the main differences of stigma toward people with mental illness and/or addiction among primary care professionals in Chile; Identify key potential factors affecting stigma toward people with mental illness and/or addiction among primary care professionals in Chile; Appraise some differences regarding Collaborative Mental Health Care between Chile and other countries and how they may affect stigma and strategies to effectively prevent it

Abstract: Introduction & Purpose: Stigma toward people with mental illness (MI) and/or addiction (AD) is a significant barrier to accessing good quality of care. Chile is implementing a Community Mental Health Model with a strong role of primary health care (PHC). The overall objective of this study is to examine the differences in the levels of stigma towards MI and AD found in a sample of PHC professionals in Chile. Methods: A cross sectional survey study was conducted with health professionals in 34 PHC centres of the public health system across Chile. Socio-demographic and other key variables were assessed. The self-administered questionnaire included previously adapted international scales: the Modified Bogardus Social Distance Scale (Link et al., 1987) and the Recovery Assessment Scale (RAS) (Corrigan et al., 2004) for both MI and AD, among others. The analysis included: Student's t-test, ANOVA test, and chi-squared tests. General linear models were run to determine independent factors associated with stigma scores, and to account for possible confounders. Appropriate statistical tests to examine differences of stigma between MI and AD were performed. Results: 842 PHC workers from different disciplines participated in the study. We observed that there is stigma toward people with MI and AD among PHC providers in the Chilean public health system. Some differences among MI and AD were identified. Conclusions: This is the first National study to explore MI and AD stigma among PHC professionals in Chile. There are potential collaborative care opportunities to prevent or mitigate stigma and its negative effects.

Co-Authors: Jaime C. Sapag; Paola R. Velasco; Rubén Alvarado; Claudia Parra; Luis Villarroel; Samantha Anríquez; Ana Jofré; Cinthia Álvarez; Andrés Díaz; Jorge Revuelta; Daniela Barrios; Jocelyn Mesías; Viviana Ulloa

READINESS FOR PATIENT ENGAGEMENT IN ONTARIO'S PRIMARY CARE TEAMS

Abstract #: 127

Vincent Tang, MD Candidate, Medical Student, Faculty of Medicine, University of Toronto; **Nadiya Sunderji,** MD, MPH, FRCPC, St. Michael's Hospital, University of Toronto; **Allyson Ion**, PhD Candidate, MSc, McMaster University

Learning Objectives: Identify tools to measure patient engagement and readiness for patient engagement in primary care settings; Describe common strengths and challenges in Ontario's primary care organizations' readiness for patient engagement; Begin to consider what supporting structures and processes may be needed to support patient engagement

Abstract: The majority of Canadians who receive mental health care do so in primary care settings, where implementation of collaborative mental health care models improves access to care. Current programs of research seek to improve the implementation and evaluation of collaborative mental health care models in primary care in Canada, including by engaging patients in collaborative care program development, evaluation, and quality improvement. However, despite its proposed benefits, it is not known if and the extent to which primary care teams are ready and equipped for meaningful patient engagement in mental health-related quality improvement in primary care. This study aims to describe perceived readiness for patient engagement among organized primary care teams in Ontario. A total of 283 Family Health Teams, Community Health Centres, Nurse Practitioner-Led Clinics, and Aboriginal Health Access Centres in Ontario, Canada was surveyed using a 49-item online survey, including items from the Measuring Organizational Readiness for Engagement (MORE) and Public and Patient Engagement Evaluation Tool (PPEET). This research is in progress, with recruitment occurring March 23 - May 25, 2018. To date, 134 teams have responded, for an interim participation rate of 47%. While the importance of patient inclusion in research and quality improvement is increasingly recognized, little is known about the readiness of primary care teams to undertake such endeavours. The results of this study will shed light on the current readiness in, arguably, the most well-resourced primary care teams in Canada, and can help to guide further efforts to promote meaningful patient engagement.

Co-Authors: Rayner, Jennifer, PhD, Association of Ontario Health Centres (AOHC); Mulder, Carol, MSc, DVM, DBA, CUTL, Association of Family Health Teams of Ontario (AFHTO)

ADDRESSING GENDER AND MINORITY STRESS IN ADDICTIONS CARE

Abstract #: 128

Jacqueline Vincent, BSc (Hons) Neuroscience, MA Gender, Feminist & Women's Studies, Medical Student, McMaster University

Learning Objectives: Explain how understanding and applying knowledge about the issues covered in the poster will improve care; Explain and analyze at least two unique issues faced by a minority population of women (e.g. transgender or sexual minority women) when experiencing and recovering from addictions; Identify at least one area of change they are capable of working on in their role to improve addiction care access for minority women

Abstract: This poster reviews how systems of oppression affect access to care and treatment outcomes for women with substance use disorders, with particular attention given to issues affecting Indigenous and LGBTQ+ women in Canada. The poster explores sociocultural and physiological issues that shape women's experiences of substance use and addiction, analyzes particular barriers that affect some groups of women more than others (e.g. domestic violence, poverty, comorbid HIV/Hep C), and draws connections between discriminatory incarceration and criminalization, trauma, addiction, and the minority stress experienced by different groups of women. Ultimately the goal of this research is to provide a multifaceted perspective on gender and addictions - combining data and narratives from medicine, social work, epidemiology, nursing, and lived experiences - to help make collaborative change possible for both large-scale interventions and individual provider-client relationships.

ARE MENTAL HEALTH SERVICES ABLE TO KEEP UP WITH THE RECENT INCREASE IN STUDENT MENTAL HEALTH AWARENESS AND EDUCATION? AN UNIVERSITY-WIDE STUDENT SURVEY STUDY

Abstract #: 129

Dan Huynh, MD, PGY-1 Psychiatry, University of Saskatchewan

Learning Objectives: To summarize the University of Saskatchewan NCHA mental health survey data results between 2013 and 2016; To illustrate the significant increase in student mental health awareness and education and importance for increased resources for student mental health services; To formulate discussion for novel strategies to optimize student mental health services

Abstract: University students are more likely to develop mental health conditions compared to the general population (Ibrahim et. al, 2013), especially those from ethnic minorities (Lee et al., 2014). Recently, the number of mental health initiatives for university students have dramatically increased and many of the resources have been directed towards education and awareness. The University of Saskatchewan provides students with the ACHA-National College Health Assessment - a mandatory and comprehensive survey that includes numerous questions regarding mental health. The objective of our study was to compare differences in student mental health care at the University of Saskatchewan between 2013 and 2016. There were no significant differences between students self-reporting depressive symptoms in 2013 compared to 2016. However, of these students, there was a significant increase in the percentage of them interested in obtaining more information regarding mental health resources and seeking mental health services in 2016 compared to 2013. Mental health service use at the University of Saskatchewan has tripled in last 3 years despite stable self-reported mental health symptomatology. Our study demonstrates that interest in mental health awareness and education has increased, as well as the percentage of students seeking mental health services. The largest barrier for students to receive mental health care has shifted from education and awareness to them being able to access mental health services. An increased amount of resources needs to be directed towards supporting multicultural student mental health services in order to account for the increase in student mental health awareness and education.

Co-Authors: Yanbo Zhang, MD, PhD, FRCPC; Rani Ojah, MD; Molly Trecker, PhD; Alana Holt, MD, FRCPC; Murray Drew, PhD; Jocelyn Orb; Peter Hedley; Rita Hanoski

'BE WELL' - A PROPOSAL TO EVALUATE THE UNIVERSITY OF SASKATCHEWAN STUDENT MENTAL HEALTH STRATEGY

Abstract #: 130

Rani Ojah, MB, BCh, BAO; MSc. Kinesiology; BSc. Biology, PGY-1 Psychiatry University of Saskatchewan, Saskatoon, University of Saskatchewan, College of Medicine; **Dr. Dan Huynh, Dr. Yanbo Zhang**

Learning Objectives: To summarize the existing University of Saskatchewan student services framework that guides those seeking mental health support on campus; To highlight existing successful promising practices supported by other higher education institutions; To propose an approach to evaluating the accessibility, utility, and efficiency of the University of Saskatchewan Be Well strategy

Abstract: Post-secondary student mental health is flagged as a cornerstone that defines Canadian higher education institution (HEI) campuses. According to the 2016 National College Health Assessment (NCHA) Survey, 46, 65, and 14% of HEI students report symptoms of depression, anxiety, and suicidal thoughts, respectively, precipitated by academic related stress. Well known triggers such as pressure to perform and financial strain persist. However, novel stressors have emerged. With improved inclusivity and accessibility toward "non-traditional" students such as of various ethnic backgrounds; with disabilities; and with pre-existing psychiatric diagnoses, campuses across Canada have launched dynamic mental wellness strategies. Unfortunately, due to the magnitude of the student mental health crisis, the bulk of existing services were created reactively rather than proactively (DeSomma et al. 2017). Resultantly, there remains a paucity of data critically analyzing the effectiveness of such policies. Since practice has preceded research, HEIs have only formulated 'promising practices' rather than concrete evidence-based generalizable best practices (Eisenberg et al. 2012). Currently, University of Saskatchewan employs the 'Be Well' framework that aims to establish a healthy ecosystem of health promotion, prevention, and intervention among students, faculty, and staff. All members of the campus community have blanket access to a multi-faceted network of resources including workshops, counsellors, faith representatives, physicians, and online support. For those in crisis, an outreach facilitator triages cases and then acts at an interventional level to support students at risk. While the Be Well Strategy is evidently holistic, we propose that a formal evaluation of its accessibility, efficiency, and utility will ensure the maximization of this valuable resource.

Co-Authors: Ojah, R.; Huynh, D.; Holt, A.; Drew, M.; Orb, J.; Hedley, P.; Hanoski, R.; Szelest, I.; Zhang, Y.

RETHINKING SUCCESSFUL OUTCOMES: HOW INTER PROFESSIONAL TEAMS AT ONTARIO COMMUNITY HEALTH CENTRES CHALLENGE UNDERSTANDINGS OF EFFECTIVE MENTAL HEALTH INTERVENTIONS

Abstract #: 131

Dariya Gusovsky, BA (hons); MSc, Program Evaluation and Policy Analyst, Ontario Association of Health Centres

Learning Objectives: Change perspectives on what constitutes mental health treatment within a collaborative interprofessional team environment; Create a dialogue on the role that determinants of health should play in mental health treatment; Improve our understanding of what kind of service professionals can provide mental health treatment

Abstract: Ontario's Community Health Centres (CHCs) serve an important role in the provincial primary care sector. By making use of integrated inter-professional teams, these organizations are able to provide holistic health services to populations who regularly face barriers in access to care. A number of CHCs have signed off on the Model of Health and Well Being, which is a primary care model describing a set of attributes to be prioritized when serving such populations (Rayner et al 2018). A focus of the model is on determinants of health and integrated inter professional care. CHCs regularly serve clients with serious mental illness, who also face a multitude of social issues that impact their overall health. (Ahmad et al 2016) This work seeks to understand how the inter professional teams at CHCs address a magnitude of medical and social barriers faced by clients and subsequently how this influences what is considered a successful outcome. Does addressing social barriers faced by clients become a successful mental health outcome? Preliminary data will be provided demonstrating the high degree of overlap between the determinants of health and mental illness. In addition, service interactions will be described that will highlight the breadth and depth of interprofessional care. Through a series of quantitative analyses and qualitative interviews this project will describe the number of service providers seen by complex mental health clients, and also try to understand how service providers define positive outcomes for a complex clients.

Co-Authors: Dr. Jennifer Rayner, PhD, Director of Research and Evaluation, Ontario Association of Health Centres

IMPROVING THE MENTAL HEALTH OF EMERGING ADULTS

Abstract #: 132

Kam Tello, BSc, BA, MSc, Knowledge Broker, Mental Health Commission of Canada

Learning Objectives: Describe emerging adulthood and the unique mental health risks that emerging adults face; Describe the actions that you can take to ensure the continuity of mental health care for emerging adults; Determine how you can build relationships with emerging adults as experts in their own health care

Abstract: Emerging Adulthood: Emerging adulthood is a developmental stage of life between the ages 14 to 25 years of age. This critical developmental stage can be a period of great volatility, marked by exploration and experimentation with new identities and roles. Issue: Research shows that 75% of mental health problems begin in childhood, adolescence or young adulthood (MHCC:2015). Young people are being overlooked. Emerging adults find themselves 'aging out' of child and youth system when they reach the age of 18 or 19 years. Research shows that 45% of youth stop receiving services after they reach 18 or 19 years of age and at a time when they need them the most (MHCC:2015). There is an urgent need to transform organizational culture and develop policies and programs that are based on need instead of categorizing them by age. Consensus Statement on the Mental Health of Emerging Adults: In November 2015, the MHCC convened the first Canadian consensus conference on the mental health of emerging adults. The resulting principles and recommendations for a transformed mental health care system are outlined in the Consensus Statement on the Mental Health of Emerging Adults: Making Transitions a Priority in Canada. Call to action: Build policies, programs and services based on emerging adults' needs and not their age. Build relationships with emerging adults as experts in their own mental health care. They can define outcomes and decide which services meet their needs. Remove barriers for services and sectors so that they can collaborate and integrate. This helps mental health care to be continuous. Dedicate time and funds to improve evaluation, data collection, research and knowledge exchange in emerging adult mental health.

Co-Authors: Schick, Lynette, MSW, MA, Mental Health Commission of Canada

ENGAGING INDIVIDUALS WITH SEVERE MENTAL DISORDERS IN PHYSICAL ACTIVITY: AN EVALUATIVE CASE STUDY OF AN INTERVENTION IN THE FRANCO-ONTARIAN COMMUNITY

Abstract #: 133
Eva Guérin, PhD, Biostatistician, Hôpital Montfort; Institut du Savoir Montfort; **Jean-Pierre Dupuis**, RN, Hôpital Montfort

Learning Objectives: Raise awareness regarding the benefits of physical activity in individuals with severe mental disorders; Identify the benefits of an individualized physical activity intervention delivered in the community from the perspective of patients and health professionals; Document key intervention characteristics in order to successfully engage this population in physical activity change

Abstract: Adults suffering from severe mental disorders have a higher risk of obesity and associated physical health problems. Physical activity has the potential to enhance the quality of life of these individuals by improving cardiometabolic parameters and reducing psychiatric and social problems. Affiliated with Hôpital Montfort in Ottawa Ontario, the Assertive Community Treatment (ACT) Team-Ottawa is a multi-disciplinary team of health professionals that offers specialized, person-centered services that target Francophone individuals with severe mental disorders living in the community. In response to troubling rates of cardiometabolic ailments and sedentary behaviour, the team launched an individualized intervention to increase activity levels, improve metabolic profiles, and counter an underlying mental health stigma. The objectives of this case study were threefold: to document the health benefits of the intervention, to understand the determinants of adoption by participants, and to identify characteristics of the intervention. Using a mixed-methods approach, 14 francophone participants were followed over a 9-month period. Semi-structured interviews were conducted with participants and staff. Results revealed significant improvements in weight over the study period. Participants reported improvements in self-esteem and other health behaviours and staff members noted positive effects on participant goal setting, autonomy, and socialisation outcomes. Key intervention characteristics included building the therapeutic alliance, eliminating participant barriers, and ongoing commitment of the staff. Future work is needed to develop an implementation and evaluation framework for this type of intervention for broader implementation and to build awareness regarding the health benefits of physical activity for individuals living with severe mental disorders.

Co-Authors: Prud'homme, Denis, MD/MSc, Institut du Savoir Montfort, University of Ottawa

NEW INITIATIVE – INNOVATION, COLLABORATION IN MENTAL HEALTH BY TELEMEDICINE/NOUVELLE INITIATIVE – INNOVATION, COLLABORATION EN SANTÉ MENTALE PAR LA TÉLÉMÉDECINE

Abstract #: 134
SoSonia Myre, MA, PA/RP,CCC; psychothérapeute, Hôpital Montfort, **Sylvie Faulkner**, MSW, ICADC, travailleuse sociale, Hôpital Montfort

Learning Objectives: Understand the lack of mental health services available in French in rural areas; Learn about the new mental health initiative between Hôpital Montfort and Hearst Family Health Center; Understand the benefits of telemedicine in mental health knowledge transfer / Comprendre le manque de service de santé mentale disponible en français en région rurale; Connaître la nouvelle initiative en santé mentale entre hôpital Montfort et le centre de santé familiale de Hearst; Comprendre les avantages de la télémédecine dans le transfert des connaissances en santé mentale

Abstract: Hôpital Montfort located in Ottawa provides person-centered care to 1.2 million residents from eastern Ontario in both official languages. In 2013, Hôpital Montfort received its designation as an academic hospital and has a mandate to work with professional organizations and physicians across Ontario to provide telemedicine services to Francophone patients and education. It is recognized that patients in rural areas are experiencing particular health challenges, including mental health, such as a higher rate of addiction and suicide. Unfortunately, by the very fact of being in an isolated area, these patients have fewer resources at their disposal. A request for mental health service was made to answer the lack of service in French Mental Health. A new initiative was put in place that allows the Hôpital Montfort mental health team to offer practical and recognized interventions - in this case in anxiety management - to Francophones in Northern Ontario who would not normally have access. In addition, it is an opportunity for mental health workers in the region, who accompany these patients, to obtain training on this subject without having to travel. This represents a first phase in the expansion of services offered remotely in French by a multidisciplinary team highly qualified in mental health. We hope to share with you our innovative telemedicine collaboration experience. Available in both languages English and French. / L'hôpital Montfort, située à Ottawa, offre des soins centrés sur la personne à 1.2 million de résidents provenant de l'est de l'Ontario, dans les deux langues officielles. En 2013, l'hôpital Montfort a reçu sa désignation comme hôpital académique et a un mandat d'assumer une collaboration avec des organismes professionnels et des médecins partout en Ontario pour donner des services par la télémédecine aux patients francophones. Il est reconnu que les patients en milieux ruraux vivent des difficultés particulières de santé, incluant la santé mentale, tel un taux davantage élevé d'addiction et de suicide. Malheureusement, par le fait même d'être en région isolée, ces patients ont moins de ressources à leur disposition. Une demande de service en santé mentale nous a été faite afin de répondre au manque de service en français. C'est ainsi qu'une nouvelle initiative fut mise sur place qui permet à l'équipe de santé mentale de l'Hôpital Montfort d'offrir des intervenions pratiques et reconnues – dans ce cas en gestion de l'anxiété – à des francophones du Nord Ontarien qui n'y auraient pas normalement accès. De plus, c'est l'occasion pour les intervenantes en santé mentale de la région, qui accompagnent ces patients, d'obtenir de la formation sur ce sujet sans devoir se déplacer. Ceci représente une première phase dans l'expansion des services offerts à distance en français par une équipe multidisciplinaire hautement qualifiée en santé mentale. Nous espérons pouvoir partager avec vous notre expérience de collaboration innovatrice par télémédecine. Available in French and English.

Co-Authors: Judith Boileau, BSc inf, DESS Androgogie / BSc nursing, DESS Adult Teaching, IA / RN, Hôpital Montfort

ADVERSE CHILDHOOD EXPERIENCES: IDENTIFICATION AND STRATEGIES FOR INTERVENTION

Abstract #: 136
William Watson, MD, FCFP, Staff Physician, St. Michael's Hospital, Associate Professor, DFCM, University of Toronto; **Seema Bhandarkar,** NP, St. Michael's Hospital, **Katie Sussman,** MSW, St. Michael's Hospital

Learning Objectives: Interpret the evidence about the effects of adverse childhood experiences (ACE) on health; Apply how knowledge of adverse childhood experiences in our patients can be used in family practice; Explore strategies to provide trauma-informed care and specific interventions for individuals with high ACE scores

Abstract: There is a compelling body of evidence that suggests that the impact of childhood trauma, adverse childhood experiences (ACE's) , can have negative health consequences in adult life, both physical and mental.(Felliti, 1998). ACEs which include stressful childhood experiences such as abuse, neglect, witnessing domestic violence or growing up with alcohol/substance abuse, mental illness, parental discord or crime in the home, are a common pathway to social, emotional and cognitive, and even medical impairments in later life. These negative experiences can lead to unhealthy behaviors, school drop-out, depression, suicide, violence, disease, disability and premature mortality. In short, the ACEs are correlated with the social determinants of health which have a long term impact on health outcomes and health care utilization of our patients. (Glowa, 2016). Many physicians are unaware of the impact of ACEs , and what interventions might be available individuals with high ACE scores. Previous studies have developed the ACE survey which consists of 10 questions relating to childhood trauma. (see appendix) An ACE score of greater than 4score is associated with a significantly higher risk of health problems later in life, including obesity, smoking, depression, suicide attempts, illicit drug use, heart disease and cancer. The ACE score can help family physicians identify and facilitate conversations with their patients about adverse childhood experiences, and help provide 'trauma –informed care'. One study (Glowa, 2016) concluded: 'Incorporation of ACE screening during routine care is feasible and merits further study. ACE screening offers clinicians a more complete picture of important social determinants of health. Primary care–specific interventions that incorporate treatment of early life trauma are needed.' Through the use of case scenarios and interactive discussion, this poster will focus on risk assessment in the family practice setting using the ACE tool and explore possible interventions.

Co-Authors: King, Ashley, MSW, St. Michael's Hospital; Katie Sussman, MSW, St. Michael's Hospital

ADVANCING INTEGRATED CARE THROUGH PSYCHIATRIC WORKFORCE DEVELOPMENT: A SYSTEMATIC REVIEW OF EDUCATIONAL INTERVENTIONS TO TRAIN PSYCHIATRISTS IN INTEGRATED CARE

Abstract #: 137
Dan Huynh, MD, Department of Psychiatry, University of Saskatchewan

Learning Objectives: Summarize collaborative care education initiatives by USA and Canadian Psychiatry Residency Programs, Illustrate the need for further formal evaluations of collaborative care educational interventions at the residency level, promote discussion regarding implementing novel collaborative care education strategies

Abstract: Integrated or collaborative care is a well-evidenced and widely practiced approach to improve access to high-quality mental health care in primary care and other settings. Psychiatrists require preparation for this emerging type of practice, and such training is now mandatory for Canadian psychiatry residents. However, it is not known how best to mount such training, and in the absence of such knowledge, the quality of training across Canada has suffered. To guide integrated care education nationally, we conducted a systematic review of published and unpublished training programs. We searched journal databases and web-based 'grey' literature and contacted all North American psychiatry residency programs known to provide integrated care training. We included educational interventions targeting practicing psychiatrists or psychiatry residents as learners. We critically appraised literature using the Medical Education Research Study Quality Instrument (MERSQI). We described the goals, content, and format of training, as well as outcomes categorized according to Kirkpatrick level of impact. We included 9 published and 5 unpublished educational interventions. Studies were of low to moderate quality and reflected possible publication bias toward favourable outcomes. Programs commonly involved longitudinal clinical experiences for residents, mentoring networks for practicing physicians, or brief didactic experiences and were rarely oriented toward the most empirically supported models of integrated care. Implementation challenges were widespread. Similar to integrated care clinical interventions, integrated care training is important yet difficult to achieve. Educational initiatives could benefit from faculty development, quality improvement to synergistically improve care and training, and stronger evaluation.

Co-Authors: Nadiya Sunderji, MD, MPH, FRCPC; Allyson Ion, MSc, PhD(c); Paul Benassi, MD, MSc, FRCPC; Abbas Ghavam-Rassoul, MD, MHSc, CCFP, FCFP; Adriana Carvahal, MD, PhD, FRCPC

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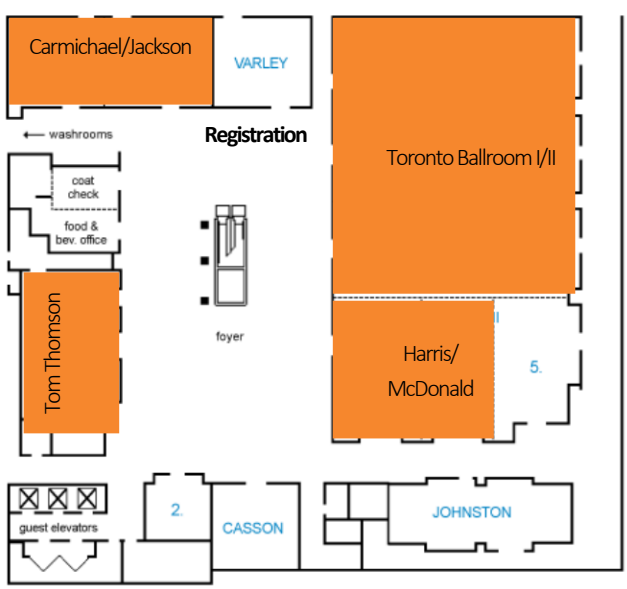

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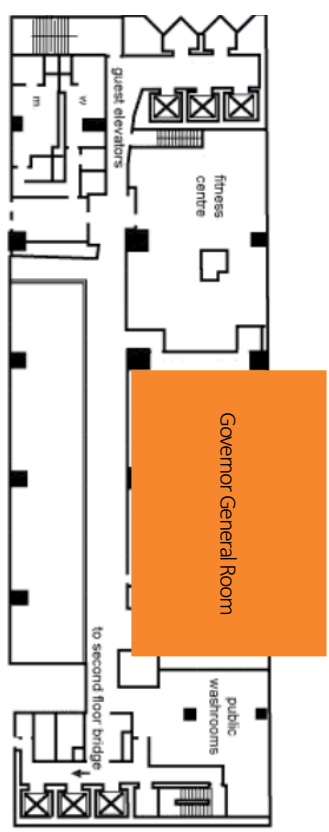

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