Implementing Evidence-Based Practices in Mental Health & Addictions

MAY 15-17, 2017

Holiday Inn Barrie Hotel & Conference Centre
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Conference Themes
- Evidence-Based Practice
- Implementation Science
- Knowledge Translation or Mobilization
- Quality and Systems Improvement

Keynote Speakers

Nicholas Watters
Knowledge Exchange Centre
Mental Health Commission of Canada

Nadine Wathen
Centre for Research and Education on Violence Against Women and Children
Western University

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WI-FI PASSWORD: yrrca
Monday, May 15, 2017—Pre-Conference Workshops

7:45 – 8:45 am  Main Floor Hallway
Registration
Exhibitor Set-Up

8:45 – 9:00 am  Churchill Ballroom
Opening Remarks

9:00 am – 4:00 pm  Churchill Ballroom
Workshop #1
Starting conversations with First Nation youth about fentanyl and other drug use
Canadian Centre for Substance Abuse
Presented by: Lisa Di Gioacchino, Roderick Ross, Elder Keith Berens, Chief Heartley Everett

This workshop will enhance participants’ capacity to better engage with their local First Nation communities to support them in speaking to youth about fentanyl, cannabis and other drug use.

Community-based professionals serving Berens River First Nation and representatives from the Canadian Centre on Substance Abuse will share lessons learned from delivering workshops to students in Berens River First Nation and students attending the Southeast Collegiate in Manitoba.

This workshop will build upon the principles of CCSA’s Competencies for the Youth Substance Use Prevention Workforce and will discuss child and youth development, health promotion and prevention knowledge and evidence-informed resources to support participants in starting conversations with youth about drug use and related harms.

10:00 – 10:15 am  Break and Exhibitor Viewing

12:15 – 1:15 pm  Lunch - Buffet  Hallway/Churchill Ballroom

2:45 – 3:00 pm  Break and Exhibitor Viewing
Feather Carriers: Leadership for Life
Deborah Wilson Danard, John Rice, Cliff Sharpe

In 2015, Feather Carriers: Leadership for Life was developed to bridge the gap reflected in the Truth and Reconciliation Commission of Canada: Calls to Action (2015) as a culturally reflective training, combined with a community mobilization strategy by a team which included, Dr. Ed Connors (Haudenosaunee), Elder/Healer John Rice (Anishinaabe) and Debby Wilson Danard PhD, MEd. (Anishinaabe).

Since 2015, the Feather Carriers: Leadership for Life has advanced local community cultural knowledge for new and existing training in multiple sectors shifting to a paradigm of Life Promotion. As a community-directed traditional knowledge and culture-based education approach it speaks to the heart and minds of the people working with individuals and families who are at risk of premature death; as well as loss survivors.

The traditional knowledge contexts of the Feather Carriers: Leadership for Life experiential education approach is shared through stories and teachings, that connect participants expertise through applied knowledge in a safe environment.

With a focus on Life Promotion, the Feather Carriers: Leadership for Life aligns with cultural safety strategies to mobilize cross-sectoral stakeholders from traditional knowledge cultural competency contexts to traditional knowledge cultural safety practices.

This one-day approach to Feather Carrier training as an alternative/enhancement to the cultural awareness and was piloted to the CMHA management team (Simcoe) and is currently being presented to CMHA staff by CMHA FNIM personnel.

The cultural concepts of Feather Carriers: Leadership for Life is currently part of a project that involves engaging cultural safety and determining institutional factors that support a sustainable cultural safety education intervention at Waypoint.
Tuesday, May 16, 2017

**7:45 – 8:45 am**
Main Floor Hallway
Registration
Exhibitor Set-Up

**8:45 – 9:00 am**
Churchill Ballroom
Opening Remarks

**9:00 – 10:00 am**
Churchill Ballroom
**Keynote**

*Innovation to Implementation: Accelerating Change in the Mental Health System*

*Nicholas Watters*

Research has established that there is a substantial gap from the time new knowledge is created to when it is put into practice. Nicholas will highlight a practical tool developed by the MHCC, the Innovation to Implementation Guide (I2I), and how it can decrease the time for innovations to create change within the mental health system. The I2I is built around the concept of innovation: products, actions, services or relationships that have the potential to enhance health outcomes. By using programmatic examples of the MHCC’s work, Nicholas will walk participants through the seven stages of the I2I, including a particular focus on evaluating knowledge translation initiatives.

Nicholas Watters is currently the Director of the Knowledge Exchange Centre at the Mental Health Commission of Canada (MHCC). In this role, Nicholas is responsible for knowledge exchange training and strategies, policy and research activities, program evaluation, national indicators, the development and execution of projects to promote the uptake of the Mental Health Strategy for Canada, while also playing a significant role in stakeholder relations.

Prior to joining the Commission Nicholas served as the Senior Advisor Communications and Knowledge Transfer at the Chronic Disease Prevention Alliance of Canada. In this role, Nicholas championed a national network of networks, facilitated and maintained inter-sectoral partnerships, and developed, implemented and evaluated knowledge exchange, and communications strategies for all projects.

Nicholas has served on, and currently sits on multiple pan-Canadian and international networks aimed at increasing collaboration, and mobilizing best and promising practices.

**10:00 – 10:15 am**
Break and Exhibitor Viewing
Oral Paper Session—Quality & Systems Improvement
Using Stakeholder Consultation in the Context of an Environmental Scan to Inform Research and KT Priorities
Anneliese Poetz

Kids Brain Health Network (KBHN formerly NeuroDevNet) is a Federally funded Network Centre of Excellence (NCE) focused on early diagnosis and treatment for children and families affected by neurodevelopmental conditions such as Autism Spectrum Disorders, Cerebral Palsy and Fetal Alcohol Spectrum Disorders. Knowledge Translation (KT) is important for helping to move research based interventions and discoveries into practice and policy, for improving the lives of Canadians. KBHN's KT Core provides a suite of services to assist its researchers and trainees to maximize the impact of their work. One of the tools for maximizing impact is to engage and consult those directly or indirectly affected by the activities' outcomes throughout research and KT processes. During 2016, KBHN conducted an environmental scan with its stakeholders (parents, clinicians/frontline workers, and policymakers) across Canada in order to learn from their experiences within the 'system' of policies, programs, services and daily living as related to life with a neurodevelopmental condition. Thirty-two stakeholders were interviewed one-on-one, for an average of 88 minutes each. Trustworthiness was established through member-validation and triangulation of similar reports. An overarching or 'core' need, 9 themes, and 42 focus areas were identified which will inform future research and KT directions for KBHN. This presentation will describe: 1) the process for conducting this environmental scan, 2) findings and their relevance for improving health and other interrelated systems within Canada, 3) priority setting exercise with stakeholders, and 4) lessons learned.

Improving Value, Improving Care, Reducing Hidden Risk: Towards a Mental Health Inequity Audit
Thomas Ungar, Stephanie Knaak

Mental illness-related stigma in healthcare environments remains a hidden and largely unperceived learning need. Yet the problem of stigma, especially structural stigma, remains a key risk and barrier to quality care for patients with mental illnesses. Our presentation applies a quality of care perspective to the problem of stigma under the equity pillar and proposes the use of a mental health inequity audit as a key tool for improving value and quality care for patients with mental illnesses.

Quality of care is a structural priority. Governments, regulators, accreditors and others have established quality of care standards and processes through which to assess, measure, and improve patient-centered care. Our presentation will describe the rationale behind developing a mental health inequity audit, discuss the main components to be included, and indicate proposed measures. Our audit framework encompasses the six main dimensions of quality care – safety, effectiveness, patient-centeredness, timeliness, efficiency, and equitable care.

Our key learning outcome is to show how framing stigma as an often times hidden and structural-based quality of care concern allows us to conceptualize and measure different forms of mental health care inequity as outcome based performance and structural deficits. Implications for system change will be discussed.
Workshop
Walking the Talk: Engaging Youth in Mental Health
Nicole Sudiacal, Julia Armstrong, Charlie Carter

Youth engagement is an important aspect of effective mental health service planning, delivery and system development. This workshop will share evidence-informed models and tools to support organizations and communities to improve their engagement of young people in all aspects of mental health service delivery and planning. Specifically, we will showcase Walking the talk: A toolkit for engaging youth in mental health (www.yetoolkit.ca) which was developed by the Ontario Centre of Excellence for Child and Youth Mental Health (the Centre).

Walking the talk is a unique online toolkit that was co-developed and co-designed with young people. Informed by implementation science and the experiences of young people, the toolkit brings together research on youth engagement as well as practical resources and examples to help organizations shift towards a model of meaningful youth engagement for the benefit of the organization, young people and the community more broadly.

The content presented will focus on a theory of change for youth engagement (embedded in the toolkit), which provides a framework through which organizations can incorporate youth engagement activities. Drawing on tools and examples from the toolkit, participants will explore the four key domains of the theory of change for youth engagement: agency readiness, positive youth development, openings and possibilities, and broadening and strengthening.

Oral Paper Session—Gender & Mental Health
Pregnancy, Birth and Beyond: It Isn't Easy! -- Are we doing enough to support local families affected by perinatal mood disorders?
Jaime Charlebois

Pregnancy and postpartum is a joyous time filled with wonderful memories to last a lifetime, or so we’re told. What if this is not the case and instead days and nights are filled with anguish? One in five women and one in ten partners across North Simcoe Muskoka (NSM) are affected by perinatal mood disorders (PMD), a mental illness that manifests itself in a variety of symptoms and diagnoses. Rates of PMD across NSM are significantly higher than the provincial average. Symptoms can start anytime perinatally, between conception and one to two years postpartum. PMD is one of the most debilitating illnesses during the child bearing years and the most frequent form of maternal morbidity following childbirth. Mental illness in the perinatal period (maternal, paternal or dual) may adversely influence positive parenting practices such as bonding and attachment. As a result, children may experience cognitive, emotional and behavioural impairments increasing vulnerability at school and into adulthood.

In NSM, there is no collaborative strategy, care or referral pathway thus creating inconsistencies in how to prevent, assess, screen, and treat PMD to remission. Health care providers are challenged to find appropriate referrals for their clients and often do not know how to provide the most effective treatments.

This presentation will describe a thorough gaps analysis process in 2015/2016. Results will be
Oral Paper Session—Gender & Mental Health
Reducing the Impact of Interpersonal Trauma in the Community Through Improving Intake Screening and Referral
Elsabeth Jensen, Monica Ruitort, Shereen Rampersad, Crystal Shepherd

Violence against women affects approximately one in three women globally, is not a new issue nor are the consequences for health insignificant (World Health Organization (WHO), 2013). The decision was made in Peel Region to screen all people coming for service rather than focus on only women. Given the higher rates of women as victims, any effort to reduce the impact of violence in the community will benefit all women. Truly universal screening is also a culture changing message. A training program for screening has been developed and pilot tested by Seamless Services for Mental Health, Addictions, and Trauma Committee in Peel Region.

Training in universal screening at intake will be provided to service providers from community agencies. This will be evaluated using a program evaluation method. Record audits will look at fidelity post training. Focus groups with service providers and community service users will be conducted to also evaluate the impact of the screening. Findings will be shared with residents and disseminated widely.

Conversation Session—Suicide I
Let’s Talk About In-hospital Suicide
Candace Zylak, Lori Armour

When a person who is at risk of self-harm is hospitalized to receive mental health and/or addictions-related care, families and the health system expect the person to be closely monitored and protected from engaging in self-harm. Despite the efforts of hospital staff to ensure patient safety, a 2016 CTV media, ‘W5’, investigation has identified that approximately 300 suicides occurred in Canadian hospitals over 10 years.

There is little contextual data on inpatient suicide in Canada, making it difficult to determine predictive factors and preventative strategies. Using 10 years of comprehensive clinical data from the Ontario Mental Health Reporting System (OMHRS), 139 individuals were identified as having completed a suicide while receiving care in an adult mental health bed in Ontario. These 139 individuals were primarily male (61.9%), unmarried (72.4%), and admitted to hospital because they were considered a danger to themselves (68.4%).

This conversation session will begin with a descriptive comparison of the demographic, clinical and service use characteristics of these individuals as the foundation for a conversation in which conference participants will learn from each other’s experience and knowledge so that the predictive factors of high risk patients can be identified and successful preventative strategies be shared. The goal of this conversation would be to improve our understanding of, and encourage the adoption of, best practices to prevent in-hospital suicide.
It is a well-accepted truth that evidence is necessary but not sufficient, in and of itself, for achieving consistent adoption of evidence-based practice in health care. The body of evidence to guide high quality care continues to grow yet wide gaps persist between current practice and evidence-based care in many areas. Traditional evidence translation vehicles such as clinical practice guidelines often face challenges in gaining wide uptake due to their broad scope, their lack of orientation toward measurement or implementation, and clinician resistance to change.

In October 2016, Health Quality Ontario launched the first set of Canadian Mental Health Quality Standards—focusing on Behavioural Symptoms of Dementia, Major Depression, and Schizophrenia—to drive broad-scale adoption of evidence-based practices in high priority areas and minimize unwarranted variations in care. Informed by a similar model established in England, Health Quality Ontario’s Quality Standards are concise sets of evidence-based statements in areas with significant gaps between current practice and optimal care in Ontario. Quality Standards are intended to support health care professionals in providing the best care possible, and to help patients, caregivers and the public know and understand what kind of care they should receive. Each quality standard is accompanied by an implementation plan as well as a set of resources to support use and interpretation of the standard by the field.

This conversation session provides an overview of the mental health quality standards development and implementation process. This session allows the audience to engage in discussions about strategies for promoting uptake and adoption and measuring improvements. Delegates will also have the opportunity to learn about the upcoming Quality Standards for Dementia Care in the Community and Schizophrenia Care in the Community.
Association Between Family Factors and Illicit Polysubstance Use Amongst Methadone Maintenance Patients with Opioid Use Disorder

Hamnah Shahid, Meha Bhatt, Zena Samaan

Opioids, a class of drugs with pain relieving properties, are widely used in North America, leading to the increasing prevalence of Opioid Use Disorder (OUD). Methadone Maintenance Therapy (MMT) is one of the most widely used methods for Opioid Substitution Therapy to relieve the symptoms of opioid withdrawal, and to manage symptoms of OUD.

Despite MMT's overall effectiveness, individual patient outcomes vary, and there is little research exploring why differences in response to MMT exist. Considering the well-documented association between genetic vulnerability, including family factors, and the development of substance use disorders in general, this study investigated the relationship between family factors and patient outcomes in a sample of adult patients with OUD receiving MMT.

In this study, family factors were defined as the number of relatives with an addiction, and their degree of genetic relatedness to the proband. Patient-related outcomes were determined by measuring illicit opioid and non-opioid use during MMT. Using multivariable logistic regressions, a significant association was found between number of family members with an addiction and the proband's illicit opioid use ($p = 0.03; \text{OR} = 1.08, 95\% \text{CI} = 1.01 - 1.16$). No significant association was found between genetic relatedness and the proband's illicit opioid and non-opioid use, as well as between number of family members with an addiction and the proband's illicit non-opioid use. These results suggest that there is a role of shared familial environmental factors in OUD treatment outcomes. Based on these findings, healthcare providers should stratify their patients based on family history of addictions, and provide extra support to those with a positive one to improve MMT outcomes for patients with a family history of substance use.
Influence of Parental Status on Methadone Maintenance Treatment Outcomes in Patients with Opioid Use Disorder: A Cross-Sectional Study
Candice Luo, Laura Zielinski, Meha Bhatt, Nitika Sanger, Zena Samaan

Currently, Canada has the second highest prevalence of opioid use disorder (OUD) in the world. The most common treatment for OUD is methadone maintenance treatment (MMT). Although MMT has been shown to be effective in combating opioid addictions, the role of parental status in MMT outcomes remains unclear. The aim of this study is to investigate the influence of parental status on MMT treatment outcomes.

Data is retrieved from the larger GENOA (Genetics of Opioid Addiction) program, a prospective cohort study investigating the genetic determinants of MMT response. All participants are 18+ years old, provided informed consent, and are currently receiving MMT. We performed a multivariate logistic regression to determine the association between treatment outcomes and parental status, controlling for potential confounders and effect modifiers. We performed subgroup analyses in males, females, and individuals who had children younger than 18.

Out of 1099 participants, 707 have children. Having children was not significantly associated with positive illicit opioids in urine screens (OR 1.019, p>0.05), and there were no significant interactions between having children and the sex of the participant. In the subgroup analyses, there were no significant associations.

Our findings suggest that parental status is not associated with worse MMT outcomes compared to participants without children. This research can aid policy-makers in the implementation of child-care support for this population.
A Population Mental Health Promotion Resource Scan: Clarifying Terms, Concepts, Roles and Responsibilities for Public Health Professionals
Claire Howarth, Maureen Dobbins

The National Collaborating Centres for Public Health (NCCPH) identified a need among public health professionals for clarification of population mental health promotion (PMHP) terms and concepts, and roles and responsibilities.

In order to address this, the National Collaborating Centre for Methods and Tools in collaboration with the NCCPH conducted a scan for PMHP resources. Resources were harvested from Canadian, national-level organizations with a mental health or Indigenous health mandate. These resources were assessed for relevance and data was extracted. Relevant resources were then categorized in six categories: population, equity theme, resource type, resource format, clarification of public health roles and responsibilities and PMHP terms and concepts. A total of 123 organizations were assessed for relevance and 12 were identified as relevant. Among those 12 organizations, 231 resources were identified, of which 52 were relevant. Thirty-six of the relevant resources help clarify public health roles and responsibilities and 49 help clarify PMHP terms and concepts. The method used for the scan can be used by professionals from many fields, including knowledge brokers.

A potential next step is to examine the main messages from these resources regarding terms and concepts, roles, and responsibilities, and develop a consensus on PMHP for public health in Canada. Future work could also expand this project to include resources from provincial/territorial and international organizations. Ultimately, this scan is intended to help Canadian public health professionals take action on PMHP to improve the well-being of the populations they serve by clarifying roles and filling in knowledge gaps.
Oral Paper Session—Mental Health Promotion

Building Public Health Capacity to Integrate Mental Health Promotion for Children and Youth: The Development of a Public Health Primer

Claire Howarth, Lesley Dyck

The National Collaborating Centres for Public Health, through surveys and focus groups of public health professionals, identified the need for a knowledge translation resource to help strengthen the integration of mental health promotion for children and youth into their practice. While there are many resources available related to prevention, early identification, and treatment of mental illness, there is a significant gap around positive mental health promotion for children and youth.

The Population Mental Health Promotion for Children and Youth project produced five topical and four general resource documents after a review of academic and grey literature. This presentation will share the key findings from these documents, framed around the determinants of positive mental health, public health roles, and a settings approach. A research-focus on population approaches to positive mental health is only very recent. However, promising practices are emerging such as the increased advocacy for urban green-space, recognition of culture and heritage as a critical part of dismantling oppressive colonial structures for Indigenous peoples, the integration of mental health promotion strategies into harm reduction programs, and consideration of positive mental health as an essential outcome for healthy public policy.

Public health professionals have reported uncertainty about how to integrate mental health promotion effectively into their current practice and significant structural and operational challenges to doing so. The development of this resource is an important step in supporting public health and other mental health professionals to prioritize mental health promotion as essential for achieving population health improvements.
The Ontario Centre of Excellence for Child and Youth Mental Health (the Centre) has implemented a knowledge broker model to work collaboratively with child and youth mental health organizations in Ontario’s 33 service areas. A knowledge broker is a new role that has emerged across health care settings to promote the interaction between research and practice (Dobbins et al., 2009). At the Centre, knowledge brokers provide support in five key domains, including: program evaluation, implementation, youth engagement, family engagement and performance measurement. Given resource constraints and the changing landscape of the child and youth mental health system in Ontario, service providers may struggle to maintain momentum as they use evidence to strengthen various aspects of service delivery.

Centre knowledge brokers support agencies to implement evidence-informed practices at a program level, as well as in the context of larger organizational changes and initiatives. Centre knowledge brokers walk alongside agency implementation teams by providing tailored supports to lead agencies. Supports include facilitating sessions on implementation science and related topics, preparing the implementation team for the work ahead, supporting access to the relevant evidence including the research literature, identifying implementation drivers, supporting evaluation activities, establishing linkages with other agencies, coordinating regular team meetings and supporting knowledge mobilization activities. This oral presentation will highlight the capacity-building role of the knowledge broker in child and youth mental health agencies and will address the challenge of doing this work within a provincial context.
The Forensic Early Intervention Service at the Toronto South Detention Centre
Kiren Sandhu, Tanya Connors, Brad Tamscu

Research has identified an overrepresentation of severe mental illness (SMI) amongst individuals in the correctional system (e.g., Simpson, McMaster & Cohen, 2013). Disorders classified under the SMI umbrella are considered to be potentially treatable, yet it has been reported that less than half of persons diagnosed with SMI received mental health treatment while incarcerated (Simpson, Brinded, Fairly, Laidlaw, & Malcom, 2003). Identifying this need, the Centre for Addiction and Mental Health (CAMH) in collaboration with the Toronto South Detention Centre (TSDC) developed the Forensic Early Intervention Service (FEIS). By offering early engagement, FEIS aims to identify inmates who may have fitness to stand trial concerns or who may have the Not Criminally Responsible on account of mental disorder finding available to them. Additionally, FEIS creates an opportunity for inmates to receive timely access to mental health services within TSDC as well as in the community once released from custody.

FEIS has been operational at TSDC since January 2015, so its success is dependent on the partnership between CAMH and TSDC. This presentation will review the development of FEIS through this partnership as well. Additionally, a needs profile and program outputs will be discussed from the first two years since the inauguration of FEIS (Simpson, Patel, Sandhu, Connors, and Tamscu).

Safewards: An Evaluation of a Conflict Reduction Strategy
Alana Friedlander, Sharminy Nagulendran, Lisa Marshall

Violent incidents within mental health hospitals are a concerning phenomenon both nationally and internationally (Kynoch & Chang, 2009; Wells & Bowers, 2002). Patient violence and aggression towards healthcare workers in mental health facilities is multifaceted, thus comprehensive conflict-reduction strategies are required (Cutcliffe & Riahi, 2013). The Safewards model comprises a wide range of interventions aimed at reducing rates of conflict (violence) and containment (use of seclusion and restraint).

This study evaluated the implementation of the Safewards model within the Forensic Program at Ontario Shores. Staff and patients who volunteered to participate in the study completed questionnaires pre and post implementation of Safewards. The MAVAS was used to assess participants’ attitudes regarding the causes and management of aggression. The Perceived Stress Scale examined self-reported levels of stress and the EssenCES examined staff and patient perspectives of the overall atmosphere of the unit.

Key changes in attitudes towards violence, self-reported stress levels and perceptions of the unit climate were noted post-implementation of Safewards. In addition, post-implementation of Safewards, staff reported greater support for the use of de-escalation strategies for managing potentially violent incidents.

The introduction of Safewards impacted staff and patient perspectives of factors related to conflict and containment. Ongoing sustainability data is being collected to examine whether these changes are maintained one year post-implementation.
Little is known about hope in forensic and mental health patients. This study will explore hope and hope engendering interventions as perceived by in-patients and nurses from Forensic Services and Acute Mental Health Services at St. Joseph’s Healthcare Hamilton.

The research questions are: 1) what are the patients’ and nurses’ perceptions about hope and hope-engendering interventions in Forensic Services and Acute Mental Health Services; and 2) what knowledge about hope do individuals with mental illness and their nurses need.

A concurrent mixed method approach will collect qualitative data and generalizable quantitative data. For the qualitative strand, a purposeful sample of patients will be selected. Nurses will be invited to participate in the quantitative stand of the study. The study aims to recruit a minimum of 50 in-patients and 65 nurses.

Patients will complete the Integrative Hope Scale (IHS) and an audio recorded interview. Nurses will complete the Hope-Engendering Nurse Intervention – Nurse Version (HENI) questionnaire. Nurses and patients will complete a Short Demographic Questionnaire. Quantitative data will be analyzed using descriptive statistics. Interpretive analysis will be used for qualitative data. The quantitative strand of the study will be completed by March 2017 and will be ready to disseminate.

It is hoped that the results of the study will add to the body of knowledge about hope and hope engendering interventions for patients and nurses in forensic and acute mental health settings.
Oral Paper Session—Models of Care

Integrative Model of Care: Collaborative Mental Health Care for Underserved Patients within an Interprofessional Primary Care Setting


Facilitating access to healthcare is a growing concern, with Canadians reporting difficulties seeking primary care services (Canadian Institute for Health Information, 2009). Recommendations for improving access to healthcare in Ontario have highlighted the importance of interprofessional primary care (College of Family Physicians of Canada et al., 2007). Interprofessional settings allow for efficient use of clinical resources, improved subjective experiences, and better clinical outcomes (Kates et al., 2011). The present talk will explore experiences working as psychology students within the Department of Family and Community Medicine at St. Michael’s Hospital, a primary care practice that endorses a model of collaborative care and provides services to a diverse, underserved, high needs, population in downtown Toronto. The talk will include a discussion of the benefits of using a collaborative care model and will highlight implications for psychologists and other healthcare professionals.

Psychology students at St. Michael’s Hospital collaborate with family physicians, dieticians, social workers, lawyers, and income support services as part of the “circle of care” treatment model. All providers utilize Electronic Medical Records (EMR), which allow for efficient communication among providers. The EMR system enables providers to share important information including diagnostic clarification, patient progress, and notable effects of medications. The collaborative care model also allows providers to collaborate in running interprofessional psychotherapy groups and deciding on appropriate services for patients. Therefore, patients obtain the specialized care that many Canadians are currently lacking. With this model, access to care is improved for patients, and contributes to improved practice amongst health care professionals.
Oral Paper Session—Models of Care

Exploration and Assessment of a Unique “Psychiatric Hospitalist” Model of Care in the New Adult Schedule 1 Psychiatry Unit of a Mid-Sized Non-Urban Ontario General Hospital

R. Zacharias, S. Belcher, M. Rodway-Norman, D. Guller, A. Chawla, P. Hough, W.G. Smith

At the opening in 2006 of the Schedule One Mental Health Unit in Orillia Soldiers’ Memorial Hospital (OSMH), a unique Psychiatric Hospitalist (PH) model was established. Though guided by extent research, our model became markedly different from those described in the literature. Specifically, though our model commonly involves Family Physicians as the Most Responsible Physician (MRP), in many cases where the patient does not have a Family Physician to take on the MRP role, the PH assumes the MRP role. As ‘admission gate-keeper’, the PH maintains clinical responsibility for all medical issues and provides support for psychiatric issues. Our psychiatrists meanwhile, drive psychiatric management. Reasonable PH remuneration is supplemented by a ministry-funded On-Call stipend, insuring 24/7 coverage.

Ten years later in 2016, an updated literature review was completed using Yale MeSH Analyzer software. Administrative data were reviewed at multiple levels. Additionally, a satisfaction survey was distributed among patients and staff.

While the updated literature review suggests our model remains unique, recent accounts of similar models consistently reported favorable ratings of service, outcome and satisfaction. As our program has grown with each year (901 admissions in FY2015-16), average length of stay has always remained shorter than the provincial average. In addition, our average cost per admission has been lower than regional and provincial averages since 2012. Survey responses (n = 21 anonymous patients/doctors) expressed overwhelming support for the model.

Although our model began as a means-to-an-end around our region’s shortage of psychiatrists, we share evidence of a solution found efficient, effective and well-liked.
Oral Paper Session—Models of Care

Responses of Patients and Nursing Staff to the Implementation of a Different Model of Patient Care
Melissa Berquist, Lindsay Healey, Ken Laprade

On a secure forensic psychiatric unit, it is often difficult to balance the needs of nurses with the needs of patients and still maintain a safe, therapeutic environment. Mindful of these concerns, and wishing to improve the quality of our in-patient services, Total Patient Care (TPC), a prime nursing approach, was implemented at the Brockville Mental Health Centre, beginning in June 2016. The goal of the change was to increase the level of nurse/patient interaction on the units, thereby enhancing development of therapeutic relationships in a manner that was more congruent with a client-centered and recovery-oriented approach to nursing care.

Baseline data was collected pre-TPC and the impact on both nurses and patients was evaluated at three and nine months post-implementation. Measures of job satisfaction, burnout, engagement, perceived safety and recovery-oriented care were administered to nursing staff. In patients, measures reflecting boredom, satisfaction with care, perceived safety and recovery-oriented care were administered. Initial results reflected challenges to implementation in the sense that nursing staff actually perceived the environment to be less recovery and therapeutically inclined, than did patients, who actually reported greater satisfaction with their care, albeit in a more “boring” environment.

The final data collection revealed some surprising results, including a reversal of some of our initial seemingly contradictory findings. As time progressed, the impact of implementing the new model became clearer and more evident. The results are discussed in terms of the challenges faced, when implementing changes in the quality of patient care in a secure forensic environment.
High-powered analyses of general-population data have contributed to meaningful reductions in completed suicide around the world. Similar reductions should now be possible for the high-risk inpatient mental health patient population in Ontario, using aggregated data from the provincially-mandated Resident Assessment Instrument for Mental Health (RAI-MH). Discharge assessments from 2008-2015 of 'validated' episodes ending in suicide (N=98) show significant positive associations with expected factors such as weather variation (precipitation, p<.04), PTSD (p<.05), and multiple temporal variations (e.g., Sunday, p<.03; winter, p<.04).

Surprisingly, few suicides occurred in areas of risk commonly associated with chronic mental illness such as command hallucinations, psychosis, inadequate education and never married/separated/divorced. Instead, inpatient suicides more often occurred within a month of admission for treatment of a mood disorder, within the MH "Acute Care" program of a general hospital. Doctors and nurses were remarkably effective at admission, documenting eventual suicides having "Intent to Die" behaviour and (DSM-IV) Major Depression Disorder.

Most meaningful going forward were the previous admission histories of suicide patients. While inpatient programs in Ontario are generally noted for high levels of readmission, rates do not approach the 64% found in the year prior to admissions ending in suicide. Perhaps most crucial to recognize and resolve, over 40% of those committing suicide were admitted to more than one facility in the year prior to death. Thus, Dr. Marissa Rodway-Norman hosts a solution-focused conversation with some of her "Acute Care" peers, intending to increase hope for the many deeply-despondent patients we 'collectively' care for throughout Ontario.
Conversation Session
The Damage Caused by Workplace Bullying and What You Can Do About It: Introducing a New Canadian Not-For-Profit Organization Called Workplace Nirvana
Annaliese Poetz

There are over 18 million employees in Canada, with over 6 million in Ontario, and 577,000 in York Region. It has been estimated that approximately 40% of employees in Canada are being bullied on a weekly basis. There are no solutions for workplace bullying and harassment that are effective. Workplace Nirvana is the only organization in Canada dedicated to creating practical solutions for workplace bullying.

Workplace Nirvana is a not-for-profit organization (applying for charitable status) that is developing research and knowledge translation programs for educating organizations to be able to create contextually relevant solutions for their workplaces, building the evidence-base for policy and organizational decision-making, and providing education for the public about the health effects of workplace bullying. Not only is it the right thing to do, but creating safe workplaces is in the best interest of organizations because it fosters innovation and higher productivity. This in turn benefits Canada's overall economic competitiveness.

Workplace Nirvana accomplishes this in part, through providing process development services to interested organizations, as well as awareness-raising through public speaking about workplace bullying. This discussion session will begin with a short presentation by its Founder and Executive Director followed by an activity with participants for providing feedback to inform Workplace Nirvana's services.
Oral Paper Session—Metabolic Syndrome
The Effect of Peer Support on Knowledge and Self-Efficacy in Weight Management: A Prospective Clinical Trial in a Mental Health Setting
Claire Hibbert, Emilie Trottier, Marlie Boville

Increased body weight is common in people with serious mental illness (SMI) due to pharmacological side effects. Strategies for weight management may include group education, peer support, frequent follow up, and the use of ‘Confidence and Conviction’ (C&C) to gauge knowledge and self-efficacy. This study will evaluate the effects of a weight management program tailored to individual C&C on body mass index (BMI) and determine the relationship between the change in weight and C&C in people with SMI.

Fifteen participants (aged 51.7 ± 12.2 years; 10 (67%) female) who were unable to successfully achieve and maintain a 5% weight loss were recruited from a Metabolic and Weight Management Clinic at a mental health care facility. Weight, C&C, a Dietary Screener Questionnaire and the 36-item Short Form Survey Instrument were collected at baseline (November 2016) and will be collected at 3, 6, and 12 months. The 12-month weight management program includes bi-weekly group lifestyle education sessions facilitated by a registered dietitian and a registered nurse. Clients also attend monthly individual follow-up throughout the year.

At baseline, BMI was 44.1 ± 9.2 kg/m2, conviction was 9.3 ± 1.0, and confidence was 6.6 ± 2.1. Three-month data will be collected in February 2017 and results will be presented. It is expected that weight management programming tailored to individual C&C will result in clinically meaningful reduction in BMI and that baseline C&C will be associated with the change in weight at three months.
### Family Violence and Mental Health: Mobilizing Knowledge to Effect Change

*Nadine Wathen*

Family violence is a “wicked problem” — a social problem that is difficult (or impossible) to solve due to one or more of: knowledge gaps or contradictions, multiple stakeholders and positions, large economic burden, and the interconnected of violence with other problems, especially mental health and health inequities.

Effective knowledge mobilization (KMob) strategies are largely driven by context – what knowledge is needed? where, how and by whom will it be used? to what specific effect? Drawing on KMob experiences from multiple projects, Dr. Wathen will outline new approaches to, and “lessons learned” from, knowledge production, synthesis and sharing activities that are explicitly intersectoral, user-oriented, tailorable, and address policy and practice gaps.

Nadine Wathen, PhD has been a family violence researcher for over 15 years. As a professor in the Faculty of Information & Media Studies at Western University, founding Coordinator of its Joint Graduate Program in Health Information Science, and a Member of the College of the Royal Society of Canada, Nadine works to develop better evidence to support the health sector response to family violence. Motivated by principles of social justice, she seeks to find better ways to support women and children exposed to violence and to address the systemic and social structures that perpetuate violence.

Nadine is strongly committed to mobilizing new research evidence by developing and testing processes of knowledge translation and exchange (KTE). Her research is aligned to the health sector primarily as it is a key place where women and children can seek help.
Mental health services for prisoners have remained relatively under-developed, despite an international emphasis on equivalence with community service provision (WHO, 2001; Ogloff, 2002; Simpson et al., 2013; Fazel et al., 2016). Epidemiological studies within Canada and internationally have demonstrated psychiatric morbidity is significantly higher in correctional populations than in the general population with increasing adverse events, including suicides and violence in custody contributing to escalating public concern about this vulnerable group of people (Fazel et al., 2016; Zinger, 2016). Incarceration provides a health opportunity to engage with a group of disengaged, socially deprived individuals with very significant health needs.

The International Collaboration for Excellence and Innovation in Mental Health in Corrections (I-CEIsMIC) network has mobilized an international and interdisciplinary network of 15 international leaders in correctional mental health service (CMHS) design and delivery. We have designed an evidence-based model of CMHS that will be developed, packaged, and disseminated to provide the highest quality mental health services to inmates of correctional facilities internationally. We will do this through the promotion and development of evidence-based models of practice, with innovative staffing and training models to facilitate service improvement with significant policy and system-level impacts. Measurement of success will be a key component of the collaborating sites.

I-CEIsMIC will be led by the two major Canadian forensic mental health centres (Toronto and Vancouver), collaborating with other Canadian and international centres (Manchester, London, Connecticut, Melbourne and Auckland). We will apply implementation science in CMHS and develop a platform and network for dissemination to CMHS internationally.

We have led the development and testing of an evidence-based model of mental health care, STAIR. This model integrates the five core service requirements (Screening, Triage, Assessment, Intervention, and Reintegration) with epidemiologically-derived performance benchmarks into an integrated pathway of care. Members of I-CEIsMIC bring vital expertise in service network development and implementation science to enable effective international implementation of a STAIR-based CMHS model. We will have at least 15 participating sites internationally within 2 years, doubling in the later years of the project.

I-CEIsMIC initiatives aim to improve the health and well-being of inmates, the safety and security of institutions, promote public safety, and reduce the economic burden of crime.
Workshop
Getting Funded: Successful Research Grant Proposals
Della Saunders

Less than 5% of Canadian federal and provincial health research dollars are allocated to mental health research – much less than for many other diseases. Also, few private or community foundations fund mental health research.

Yet improved knowledge and evidence-based practices could transform mental health care and outcomes. But applying for research grants and securing funding is a challenge. Writing proposals is time-consuming. The funding environment is competitive. Funding agency criteria can be difficult to interpret. Application guidelines can be confusing.

The goal of this workshop is to explore how to navigate the funding environment and share ideas on how to write an effective proposal to improve grant success. We will:
• look at where to find funding opportunities that match your research ideas and your vision
• discuss how to clearly express your research aims and the impact of your proposed research
• consider how to position your research career to improve chances of funding

A well-written, organized and focused proposal that clearly articulates the significance, impact and outcomes of your research has a higher chance of convincing reviewers that your work should be funded. With this in mind, we will review the typical components of a grant proposal, such as, Hypothesis, Background, Goals, Methods, Results, and Challenges. We will explore where to search for funding opportunities and how to best write for these various audiences (and always a busy reviewer) to help ensure that your proposal is memorable and impactful. And, of course, is funded.
Oral Paper Session—Methadone, Part II
Risk of Relapse in Methadone Maintenance Treatment: The Case for Monitoring Social Issues?
Meha Bhatt, Laura Zielinski, Nitika Sanger, Carolyn Plater, Andrew Worster, Michael Varenbut, Jeff Daiter, Guillaume Pare, David C. Marsh, Dipika Desa, Lehana Thabane, Zainab Samaan

Methadone maintenance treatment (MMT) is a widely prescribed treatment for opioid use disorder (OUD), yet significant variability exists in treatment response. In Canada, there has been a shift in the demographic profile of MMT patients corresponding to the rise in prescription opioid abuse. Social dysfunction remains prevalent among this cohort of MMT patients and may be implicated in treatment response. This study aims to examine the association between social issues and relapse to opioid use during MMT.

We conducted a multicentre, prospective cohort study of MMT patients in Ontario, Canada. We used multivariable logistic regression analyses to determine whether interpersonal conflict, criminal activity and employment status were associated with continued illicit opioid use at study entry and three-month follow-up.

We included 1043 participants (45.8% female), with a mean age of 38.4 years. At study entry, criminal activity (odds ratio [OR]=2.61, 95% confidence interval [CI]=1.43–4.74) and interpersonal conflict with friends (OR=1.46, 95% CI=1.05–2.04) were associated with continued opioid use, while legal employment (OR=0.73, 95% CI=0.56–0.97) decreased odds of continued opioid use. At three-month follow-up, interpersonal conflict with friends remained significantly associated with continued opioid use (OR=1.54, 95% CI=1.06–2.23).

Criminal activity, employment and interpersonal conflict with friends are important factors affecting relapse to opioid use in the MMT population. Structured monitoring of social issues in clinical settings may help improve treatment response in MMT and provide tailored treatment for high-risk patient groups.
Association Between Cannabis Use and Methadone Maintenance Treatment Outcomes: An Investigation into Sex Differences
Laura Zielinski, Meha Bhatt, Nitika Sanger, Carolyn Plater, Andrew Worster, Michael Varenbut, Jeff Daiter, Guillaume Pare, David C. Marsh, Dipika Desai, James MacKillop, Meir Steiner, Stephanie McDermid Vaz, Lehana Thabane, Zainab Samaan

Methadone maintenance treatment (MMT) is a common pharmacological treatment for opioid use disorder (OUD), yet a large number of patients respond poorly and continue using illicit opioids. A large number of patients also use cannabis during treatment, but the impact of its use remains unclear. Sex differences in substance use behaviours are well established, and thus the current study aims to investigate sex differences in the association between cannabis use and illicit opioid use in a cohort of MMT patients.

This multicentre study recruited participants on MMT in Ontario, Canada. A logistic regression analysis was performed in the total sample and separately by sex to investigate the association between any cannabis use and illicit opioid use, defined as at least one positive opioid urine screen. A secondary logistic regression analysis was conducted to investigate the association using heaviness of cannabis use in men and women. We included 414 men and 363 women on MMT. Cannabis use was significantly associated with illicit opioid use in women only (OR = 1.82, 95% CI: 1.18, 2.82, p=0.007). Heaviness of cannabis use was not associated with illicit opioid use in either sex.

Cannabis use may be a sex-specific risk factor for poor response to MMT, such that women are more likely to use illicit opioids if they also use cannabis during treatment. Women may show improved treatment outcomes if cannabis use is addressed during MMT.
Breaking Down Silos: Collaborating and Co-Creating Across Sectors to Improve Ontario’s Mental Health and Addiction System

Luciana Rodrigues, Nandini Saxena, Andrea Flynn

The past three decades in Ontario have been characterized by provincial policy and advocacy highlighting the need for a more coordinated, inclusive, accessible, evidence-informed and accountable mental health and addiction system. There is also growing movement in health care toward actively engaging users in designing the programs, processes, and products that are relevant to them. Simultaneously, the field of Implementation Science has shown the critical role that effective implementation plays in the successful uptake and sustainability of relevant, evidence-informed interventions. These three parallel and complementary priorities can be enhanced by engaging diverse stakeholders in co-creating, adapting, and implementing evidence.

This presentation highlights system improvement initiatives supported by the Centre for Addiction and Mental Health’s (CAMH) Provincial System Support Program (PSSP). Acting as an intermediary organization that helps advance the goals of Ontario’s 10 year Comprehensive Mental Health and Addiction Strategy, PSSP works with partners across sectors to move evidence to action using an integrated approach involving expertise in implementation, knowledge exchange, evaluation, coaching, and health equity.

In this presentation, attendees will hear how diverse stakeholders were engaged to co-create a provincial priority evidence agenda, and will learn how stakeholders, including persons with lived experience and cross-sector service providers, were engaged to co-create, adapt, and implement evidence-informed interventions in Ontario communities. The presentation will provide the opportunity for attendees to consider how co-creation and meaningful engagement of diverse partners are integral to mental health and addiction system improvement initiatives.
Oral Paper Session—Systems
Excellence Through Quality Improvement Project (E-QIP): Enhancing a Culture of Quality in Community Mental Health and Addictions
Michael Dunn, Sandra Cunning

E-QIP is an 18-month partnership initiative (commencing March 2016) between Addictions & Mental Health Ontario (AMHO), Canadian Mental Health Association, Ontario (CMHA) & Health Quality Ontario (HQO) to promote and support quality improvement (QI) in the community mental health and addictions sector in response to self-identified needs. This initiative is the first of its kind for the community mental health and addictions sector.

The project aimed to: 1) increase understanding of QI in community mental health and addictions; 2) increase sector-wide QI learning and mentorship; 3) highlight existing cultures of quality and promising QI practices within the field; 4) build readiness within the sector for the Excellent Care for All Act (ECFAA) principles. To achieve these aims, E-QIP employed: 1) community engagement and partnership; 2) education and training; 3) collaboration and alignment; and 4) resources tailored to the sector and targeted to “readiness”.

E-QIP has provided Introduction to IDEAS training across the and has supported 30 QI projects (at varying degrees of readiness) across the province. Key resources have included a Collaborative Community of Practice - anchored in an online platform providing access to resources, education, tools and peer-to-peer support. Critical to the project have been dedicated QI and Data Coaches who have provided organizational and project support.

The objectives of the discussion are to: 1) share provincial and local outcomes of the initiative; 2) discuss resources and processes underpinning the initiative and how they can support and advance QI efforts within local settings.
In 2015, Mental Health Commission of Canada (MHCC) released the Guidelines for Recovery-Oriented Practice, a blueprint for mental health service delivery change. In its application, a recovery-oriented system takes a value-based approach and asks healthcare providers and leadership to reflect on the way we think about mental health problems and consider the implications for the relationship between leaders, mental health care providers and those who seek access to supports and services.

This workshop will discuss key principles of recovery-oriented practice geared at transforming and improving the mental health system. Presenters will provide participants with specific tools, resources and ideas for implementing recovery-based principles within their organizations.

This workshop will include the following interactive elements:

- An overview of the four guidelines addressing service and system transformation;
- A discussion of how recovery-oriented practices have been used to reduce stigma and improve outcomes of individuals seeking treatment;
- A patient first-voice perspective from a person with lived experience of a mental illness living in recovery (in keeping with the core principles of recovery-oriented practice);
- A reflective practice exercise to consider how to translate this knowledge into practice (as recovery-oriented leadership requires a greater awareness of one’s own assumptions, values, principles, strengths and limitations).
Epidemiological studies consistently reveal high rates of comorbidity between addictive disorders and other psychiatric disorders (i.e., concurrent disorders, CD). The objective of this study was to implement a standardized clinical screening battery at St. Joseph’s Hospital to aid diagnosis and treatment of individuals with CD.

Patients’ complete a computerized questionnaire battery during their intake assessment. The battery is comprised of validated screening measures for addictive behaviours and psychiatric disorders. The patient’s responses are automatically scored to generate a one-page report summarizing the patient’s mental health and addictions profile.

At present, 296 outpatients and 80 inpatients have completed the screening battery as an intake measure. We have received positive feedback from physicians that the one-page report enables earlier identification of mental health and substance use disorders, which translates into earlier care and treatment. In addition, clinicians have reported that the “readiness to change” rulers have been valuable when selecting treatment plans for their patients. Moving forward, data analysis will focus on identifying distinct clusters of symptoms for the purpose of creating care paths as well as identifying the prevalence of specific co-occurring disorders to support new program initiatives and future program direction.

The implementation of a standardized clinical screening battery offers valuable strategies for mental health programs providing care for individuals with CD. It represents a bench-to-bedside partnership between academic researchers and treatment providers that is consistent with a growing emphasis on translational research in mental health settings.
Oral Paper Session—Substance Use Treatment

Computer Based Training for Cognitive Behavioural Therapy (CBT4CBT), an Innovative New Substance Abuse Therapy for Canada

Michelle Patterson, Luke Marriott, Kathleen Carroll, Juergen Krause

Created by Dr. Kathleen Carroll at the Yale School of Medicine, CBT4CBT is a revolutionary new substance abuse treatment program that is currently being rolled out in the United States. Introductory trials conducted among urban populations in major US cities have demonstrated CBT4CBT’s effectiveness for challenging populations at moderately low cost and with lasting effects.

A recent collaboration between Dr. Carroll and Drs. Juergen Krause and Michelle Patterson of the Centre for Health and Community Research (CHCR) at UPEI will bring this innovative treatment program to Canada for the first time. CBT4CBT is currently being implemented and evaluated in sub-populations of high-need individuals as part of a CIHR funded pilot and will subsequently be rolled out across Canada.

The pilot program aims to determine the effectiveness and efficacy of this computer-based treatment option for addiction therapy within specific rural Canadian populations. CBT4CBT is offered at trial sites in PEI and New Brunswick which have been selected as representative of high-needs populations who may benefit from improved addiction treatment options and support. The trial populations include Indigenous populations, youth (age 18-24), individuals maintained on methadone, and individuals transitioning out of inpatient facilities.

A larger-scale implementation of CBT4CBT across Canada will offer an innovative and in-demand therapeutic option for individuals struggling with substance abuse. A roll-out plan for the implementation of CBT4CBT across Canada is under development, and a list of priority revisions and enhancements for future iterations the program is being established and compiled.
Oral Paper Session—Workplace Psychological Health & Safety
Putting Evidence in Context: What Works in Occupational Health and Safety
Emma Irvin, Stephen Bomstein, Kim Cullen, Amanda Butt, Dwayne Van Eerd, Leslie Johnson, Steve Passmore, Sarah Mackey, Ron Saunders

Mental health disorders and work-related injuries are burdensome for workers and employers as well as for healthcare and compensation systems. To take effective preventive action, interventions require the latest scientific evidence on what works. In addition, occupational health and safety (OHS) decision-makers need to know what will work in their geographic, jurisdictional and industrial context. Growing amounts of evidence are available but OHS decision-makers have limited time and/or capacity to locate, assess, synthesize and contextualize this literature.

Through a collaboration involving researchers and an advisory panel of OHS stakeholders in Manitoba, the Institute for Work & Health (IWH) and Memorial University’s SafetyNet Research Centre have developed and tested an innovative methodology for synthesizing current scientific knowledge and tailoring it for use in specific contexts. The methodology combines features of the "Contextualized Health Research Synthesis Program" developed at the Newfoundland and Labrador Centre for Applied Health Research with systematic review techniques and synthesis reports pioneered at IWH.

Preliminary results indicate that stakeholders report that geographic, jurisdictional and industrial contexts have an effect on the uptake and implementation of the evidence. The project focused on a knowledge synthesis on “ Managing depression in the workplace” contextualized for specific resources, capacities and challenges of Manitoba. One example was rural versus urban factors impact on service delivery.

The presentation will discuss a practical and relatively inexpensive way for OHS stakeholders to develop increased research synthesis capacity. Specifically we will discuss contextual variables and their impact on managing depression in the workplace.
Oral Paper Session—Workplace Psychological Health & Safety
Preventing Work Disability in Workers with Depression: A Systematic Review
Kim Cullen, Emma Irvin, Dwayne Van Eerd, Ron Saunders

By the year 2020, depression will be the second largest burdensome illness in developed economies. In addition to its adverse individual effects, the associated workplace effects of depression are extensive. This review is an update and re-synthesis of a 2010 review to determine effective intervention approaches to manage depression in the workplace that yield value for employers in developed economies. We ran literature searches in seven electronic databases from inception up to June 2015. Independent reviewers selected articles that met the following criteria: working age individuals with mild or moderate depression; workplace-based interventions; comparator group in the analysis; outcomes of prevention, management, work disability or sickness absence, and work functioning. Reviewers independently reviewed each article for quality and extracted data using standardized forms. The quality of evidence addressing each outcome was graded as high, moderate, low, or insufficient and synthesized using a “best evidence synthesis” approach.

The review examined 8123 titles and abstracts for relevance and found 22 RCTs and nine nRCTs from various jurisdictions evaluating a range of interventions. The review has yielded the following intervention types; psychological interventions, enhanced primary care delivered by physicians and nurses, psychiatry plus occupational therapy, enhanced occupational physician role, Integrated care management, exercise, worksite intervention. Key messages for occupational health and safety stakeholders (e.g., employers, workers, disability management professionals, labour, etc) will be presented. The results of this review will be valuable in strengthening the body of evidence for workplace parties to develop evidence-based policies and practices to manage depression in the workplace.
Oral Paper Session—Workplace Psychological Health & Safety
Workplace Practices and Policies to Accommodate Workers with Depression
Dwayne Van Eerd, Kim Cullen, Emma Irvin,

The burden associated with the effects of depression in the workplace is extensive. Workers with depression lose more health-related productive time, have higher rates of absenteeism and short-term disability, and experience higher rates of job turnover than those without depression. Our objective is to synthesize evidence from the scientific literature, practice evidence (workplace policies and practices), and workplace experiences from OHS stakeholders in Ontario and British Columbia (Occupational Health and Safety (OHS) professionals, disability managers, supervisors/managers, human resource personnel, joint health and safety committee members, labour representatives, and workers).

We are collecting evidence of practitioners’ expertise and worker experiences using a series of techniques, including a web-based survey (ongoing), focus groups, and interviews with representatives from various stakeholder groups from multiple sectors. We will use the Public Health Agency of Canada’s best practices portal to structure our data collection of workplace practices and policies to prevent productivity losses, promote stay-at-work, and support return-to-work for workers with depression. We will synthesize evidence gathered from stakeholders with that from published reviews, including a recent review our team completed. With the evidence we will co-create (with OHS stakeholders) a practical guide to help workplaces develop and implement effective practices and policies to accommodate workers with depression in the workplace.

The presentation will focus on the survey results highlighting the current policies and practices described by our workplace audiences as compared to the scientific evidence. We will discuss the synthesis of the evidence to co-create a guide to aid in accommodating workers with depression.
The Effect of Capacity to Consent to Treatment and Medication Compliance on Violence in a Maximum Secure Forensic Setting

Lauren Wright, Liam E. Marshall

In Ontario, patients deemed capable to make treatment decisions do so even in the circumstances where they may be held involuntarily, such as under the Mental Health Act or by order of court. The extant literature draws the inference that forensic patients who refuse medical treatments are more likely to require seclusion and/or restraint, may stay in hospital longer, and are at greater risk to assault others. This is usually demonstrated through studies showing a reduction in patient violence after the introduction of atypical antipsychotics and other medications (e.g., Brown et al., 2014).

The current study examines the effect of capacity to consent to treatment and medication compliance on violence and time in hospital in a maximum secure forensic setting. We reviewed the files of approximately 120 primarily psychotic (73.2%) forensic patients housed in a high secure facility in Ontario. Our results suggest that patients who are capable to consent to treatment spend less time in hospital, are no greater risk for violence, and engage in violent behavior no more frequently, than patients who are deemed incapable to make treatment decisions. Similar results were found when comparing patients who are compliant with medical treatment versus those who are not or partially compliant with prescribed medications. The only exception to this was that patients who are partially or non-compliant with prescribed medications were found to be statistically significantly less violent than compliant patients.

Although these are somewhat preliminary results, they are counterintuitive and therefore warrant further investigation. Greater details of our findings and implications for the treatment and management of maximum secure forensic patients will be discussed.

An Exploration of How Therapeutic Relationships and Shared Decision Making Influence Attitudes Toward Antipsychotic Medication: Clinician and Patient Perceptions

Karishma Jivraj, Iris Gault, Mary Chambers

Prevalence of mental illness in the United Kingdom is high, and treatment consumes a disproportionate share of health care costs. Adherence to antipsychotic treatment is centred on effective treatment planning; including therapeutic relationships, shared decision making and attitudes towards medication. Exploring these topics from both clinician and patient perspectives would allow implementation of evidence based practice and improve the effectiveness of mental health service provision in the NHS.

This mixed methods research aims to examine patient and clinician perceptions of the therapeutic relationship and how this may affect decision making and attitudes towards antipsychotic medication. 100 patients and 24 prescribing clinicians across NHS community services are being invited to complete questionnaires with standardised assessment tools and semi-structured interviews (N= 10 patients / N = 10 clinicians) in attempt to explore and fill some of the gaps across existing literature and contribute towards better patient orientated services.

Study data will be collected and subject to separate statistical and qualitative analyses and written up in a synthesis of findings in a final discussion.
In a previous study conducted at Ontario Shores, we found that 91% of all inpatients received at least one PRN medication during the three month time period examined. However, PRNs have been subject to criticism due to risks of inappropriate use, polypharmacy, dependence, and impairing skill acquisition. Furthermore, PRNs are commonly used in care for problems such as anxiety, for which non-pharmacological treatment options may be the indicated first stage treatment. The literature outlining the current practices of PRN use at inpatient psychiatric facilities is inconsistent and the conclusions are unclear; plus, poor documentation has blurred our understanding of practice. Therefore, the objective of the current study was to use both documentation and interviews with patients and staff to collect more comprehensive data about the process of administering PRN medication for anxiety, thereby addressing some of the limitations of previous research.

The project is a mixed methods, non-random, two site pilot study that uses an A-B-A design to measure the impact of examining the PRN process for anxiety with staff and patients on designated units. Data regarding PRN administration for anxiety were collected from documentation during 12 weeks in Phase 1, followed by 12 weeks of interviews during the active phase of the project (Phase 2). Data for the following 12 weeks after our interviews (Phase 3) will be collected from documentation.

Preliminary analyses of the first 12 week data period indicate that for both sites Lorazepam was the most common medication given. Several differences between sites were noted such as who initiated the PRN (nurse or patient) (55% vs. 71%), the overall number of PRNs for anxiety administered (N= 79 vs. 403), documentation of effectiveness (100% vs. 11%), and the frequency of nursing staff documenting attempts to intervene with non-pharmacological strategies prior to the administration of medication (39% vs. 20%).

Implications of these results support the need for more documented information about the effectiveness of PRNs and exploration of use of PRNs in order to make accurate treatment decisions. Furthermore, the results strongly suggest that there are barriers for nurses to use non-pharmacological interventions for anxiety.
Psychosocial rehabilitation is an approach to recovery from mental illness that promotes work-related skill development, self-determination, employment, and development of the social network. One specific type of psychosocial rehabilitation program is the clubhouse model. Clubhouses provide individuals living with severe mental illness opportunities to successfully live and work in their communities through a variety of services. Progress Place, an accredited clubhouse located in Toronto, Ontario recently undertook a two phase, mixed methods, realist evaluation to develop a theory of change which would explain outcomes, as well identify mechanisms of change that lead to recovery outcomes. In the first phase of the study, focus groups, group interviews, and questionnaires, with staff, members, and board members, were conducted to uncover and corroborate outcomes and mechanisms that occur for members. The theory designed from this study found three mechanism-outcome configurations that lead to recovery for members including a restorative model, a re-affirming model, and a re-engagement model. The second phase of the study involved validating the qualitative models using quantitative measures. Members completed a self-report questionnaire consisting of validated measures and visual analogue scales in order to measure the mechanism and outcome variables that were found in the qualitative study.

Results found that specific mechanisms were significantly associated with the qualitative outcomes of feeling better and at peace, personhood, and acquiring skills. The present study has created and refined a model of recovery that is found within a psychosocial rehabilitation program.
Advancing labour force participation of people with mental illness is a priority in Canada. However, securing meaningful employment remains a significant challenge, especially among those receiving provincial disability benefits. The structure of disability income support systems is one critical factor that can restrict efforts to find and retain paid employment.

The purpose of this research was to examine income support policy strategies for people with mental illness who are entering provincial disability income support systems, and their role in advancing employment outcomes. Using an interpretative qualitative approach, the research team conducted approximately 20-25 interviews across Ontario, British Columbia and Nova Scotia with key informants including recipients, provincial disability program staff and community mental health service providers. The data were analyzed to explore different perspectives, and outline consequences associated with different policy strategies on the experiences of recipients living with mental illness in terms of their employment pursuits.

We identify key policy strategies and system characteristics that can either support employment or act as disincentives. We will highlight issues of interest to mental health practitioners and policy leaders in this area, including the various features of each province’s systems that can optimize the work of employment service providers. The findings highlight how policy strategies can be implemented in ways that can either support or detract from efforts to improve employment outcomes. Improved understanding of systemic issues can help mental health employment service providers to improve opportunities for their clients related to employment and income security.
With current economic challenges facing the healthcare system, the demand to demonstrate improved outcomes as a result of interventions is increasing. Recreation therapists, and other clinicians, are being asked to show that they are using program resources effectively, enabling the desired outcomes for their clients, and are practicing in an evidence-based way.

This presentation will discuss a grass-roots approach initiated by recreation therapists to implement the use of the Leisure Competence Measure (LCM) within a tertiary mental health care setting. The LCM is currently the ‘gold standard,’ evidence-based outcome measurement tool for therapeutic recreation. The LCM serves as a means of categorizing and summarizing information related to a client’s leisure functioning. Working collaboratively with researchers, recreation therapists co-designed a method and strategy to test and evaluate the applicability and feasibility of the LCM for mental health, as a part of their regular TR practice.

This presentation will outline the steps taken by the team during the project initiation, implementation, and evaluation process. We will use this to provide guidelines and recommendations for others looking for TR outcome measures in mental health.
Combating mental illness-related stigma among healthcare providers is an important goal. Since 2009, Opening Minds (OM), the anti-stigma initiative of the Mental Health Commission of Canada, has conducted a large series of evaluations of anti-stigma programs targeting various healthcare provider audiences. OM partnered with organizations conducting anti-stigma interventions for the purpose of evaluating program effectiveness. Qualitative research and synthesis of quantitative data arising from these evaluations helped to identify key ingredients and best practices for programming success.

This presentation reports the results of our research on key ingredients and best practices for anti-stigma programming in health care. Findings include healthcare providers’ main learning needs for stigma reduction, the identification and validation of key content ingredients for program effectiveness, successful programming models and programs available for replication, and demonstration of select program tools.

In 2014, the Canadian Federation of Mental Health Nurses (CFMHN) conducted a scoping study to support the 4th revision of the standards of nursing practice. The CFMHN standards revision utilized Levac, Colquhoun, and OBrien’s (2010) scoping framework to guide the revision process. The CFMHN standards committee conducted an extensive review of the academic and grey literature with consultation from mental health nurse, educator, and researcher stakeholders across Canada, via surveys and focus groups. Empirical evidence and mental health nursing expertise informed standard revisions for the current issues, beliefs and values, and six indicators across 5 of the 7 standard statements. Evidence from nurse stakeholder surveys (N = 295) and focus group narratives (N = 2) confirmed grey literature (N = 10) findings that mobilize the recovery philosophy as a nursing practice standard across six indicators.

The revised indicators that direct nursing practice according to the recovery philosophy are presented with the supporting policy documents, best practice guidelines, standards of practice documents from other jurisdictions, and stakeholder surveys and narratives. Gaps in the empirical literature to direct future research are identified and knowledge mobilization strategies for the revised indicators to improve patient care and recovery are discussed.
Oral Paper Session—Medication Effectiveness & Delivery

Meaningful Limits on Effective Long-Acting Injectable Antipsychotic Use: A Retrospective Analysis Powered by Facility-Level RAI-MH Data

Bob Bruer, Marissa Rodway-Norman, Shawna Belcher

The burden of schizophrenia is extensive; challenging physical, mental, social and spiritual well-being. Early diagnosis and effective treatments are crucial to meaningful life-long recovery. Recent improvements to Long-Acting Injectable (LAI) antipsychotics, though proven effective and in common use in various countries, within Canada often remain a last resort. At our hospital, while finding evidence that our team’s LAI use had an overall positive effect on patient outcomes compared to non-use, we completed a retrospective analysis to better understand the times when LAI use failed. Thus, we linked two hospital administrative data-sets (i.e., our pharmacy records of LAI initiation and our RAI-MH data at initiation) and compared pre-post hospital service use between the ‘Intent to Treat’ (ITT) LAI group (N = 47) and a reasonable ‘Treatment as Usual’ (TAU) group (N = 42). Outcome measures included emergency room use, in-patient re-admissions, and community mental health service use.

General Inpatient care for all patients with schizophrenia led to short-term (six month) reduction in post-discharge ER visits (p<.05), but only LAI patients experienced longer-term (one year) reductions in both ER visits and readmissions (p<.05). One year hospital savings were $3,677/patient (ITT vs. TAU). LAI relapse was associated with living alone, substance use, and employment. Given the small number of cases available for our analyses, we seek collaborations with similar peer facilities to further test and refine our preliminary findings in this important area of optimal recovery.

Evidence Informed Intramuscular Injections

Helen McGee

A comprehensive educational initiative regarding intramuscular injections (IMIs) was delivered to 120 Registered Practical Nurses (RPNs) in a large, urban mental health and addictions centre from 2015-2016. Each RPN participated in a four-hour simulation session, demonstrated IMI skills according to a competency checklist using a manikin, and observed and administered two IMIs in the clinical setting, coached by another nurse. Outcome measures included successful demonstration of the skills, self-rated confidence in administering IMI injections at the ventrogluteal site, and improved documentation of clients’ immediate response to the procedure.

Following this presentation, attendees will be able to describe the teaching and evaluation strategies; name two components of intramuscular injection technique that have been well studied; identify three goals and outcomes of the initiative; and discuss problems discovered as filter needles were introduced in the mental health setting.
The overall aim of the Common Thread Initiative (CTI) is to improve the quality of life for individuals with intellectual disabilities who have behaviours associated with complex and challenging mental health needs (dual diagnosis). CTI promotes a team-based, problem solving approach to making evidence-based decisions to best support persons with challenging behaviours living in a residential program. A key goal is to improve communication between program staff and across the trans-disciplinary team, with clinicians and across organizations. Both Ministry of Community and Social Services (MCSS) and Ministry Of Health (MOHLTC) agencies have participated in CTI.

CTI is evidence-informed and was developed in consultation with individuals with experience and expertise in adult education, knowledge transfer, and behavioural analysis. The initiative was designed using a blended learning approach that integrates in-person learning, online learning and other strategies in a purposeful, thoughtful and complementary way to enhance engagement and support transfer of knowledge to practice.

The CTI program spans 10 months, includes 8 Units of learning, as well as series of CTI processes and tools. The initial pilot program was launched in May 2014 and to date, three cohorts have completed the training and a fourth will commence in September 2017. Three mental health agencies have participated to assist in supporting individuals with dual diagnosis. Two full evaluations have been done of the CTI program to date, and another evaluation is currently being completed by the Centre for Community Based Research at the University of Waterloo.

This initiative demonstrates the benefits of integrating a knowledge transfer approach to support the use of evidence within practice and service delivery as well as policy and management decision-making in organizations.