# 2024 Paula Goering Collaborative Research and Knowledge Translation Award

June 5, 2025
12 – 1 PM (ET)

camh

camh FOUNDATION

Psychiatry
UNIVERSITY OF TORONTO

This webinar will be recorded and will be posted on **eenet.ca** after the presentation.

# Land acknowledgement

CAMH is situated on lands that have been occupied by First Nations for millennia; lands rich in civilizations with knowledge of medicine, architecture, technology and extensive trade routes throughout the Americas. In 1860, the site of CAMH appeared in the Colonial Records Office of the British Crown as the council grounds of the Mississaugas of the New Credit, as they were known at the time. Today, Toronto is covered by the Toronto Purchase, Treaty No. 13 of 1805 with the Mississaugas of the Credit. Toronto is now home to a vast diversity of First Nations, Inuit and Métis who enrich this city.

CAMH is committed to reconciliation. We will honour the land through programs and places that reflect and respect its heritage. We will embrace the healing traditions of the Ancestors, and weave them into our caring practices. We will create new relationships and partnerships with First Nations, Inuit and Métis – share the land and protect it for future generations.

Reference: https://www.camh.ca/en/driving-change/building-the-mental-health-facility-of-the-future

# About Paula Goering

*“Paula was always bold and fearless in her commitment to helping those in need”*

*Paula led the Health Systems Research and Consulting Unit at the Clarke Institute/CAMH for 20 years, conducting stakeholder driven, policy relevant research*

*She was awarded a 10 year Health Services Research Chair in 2000, with a focus on IKT, the first of its kind in Canada.*

*Led five-year, five-city, multimillion dollar study of the homeless mentally ill in Canada - "At Home/Chez Soi“. Guided by stakeholders at every stage, it showed the importance of putting "Housing First" in any successful strategy of treating the homeless mentally ill.*

*“She was the best friend and the best colleague that many of us have ever known”.*

# Paula Goering IKT award recipients

The PG IKT award is given bi annually to projects that demonstrate an innovative partnership between researchers and knowledge users and value to the field. This year, among many excellent submissions, three were selected to receive the award:

**Mental Health Outcomes and Needs of Birthing Parents with Disabilities:** Resources to support the well-being of birthing parents with disabilities during and after pregnancy.

**Supporting Alternate Level of Care Patients with a Dual Diagnosis to Transition from Hospital to Home:** Practice guidance

**Brain Connections:** A self-guided, web-based program explaining difficult concepts and motivating people to reduce gambling and gaming harms.

# Mental Health Outcomes and Needs of Birthing Parents with Disabilities: From Evidence to Action

Presented by:

**Dr. Hilary K. Brown, PhD**
Associate Professor, University of Toronto

# Today’s objectives

1. Describe a community-engaged research study that examined the perinatal mental health outcomes and care of women with disabilities;
2. Highlight a series of resources that were created to support perinatal wellbeing among people with disabilities and disability-affirming care by their providers; and
3. Identify the processes of successful community engagement in this project, including co-creation of knowledge with peer researchers with disabilities

# Rationale for the study

15%

# Overview of approach

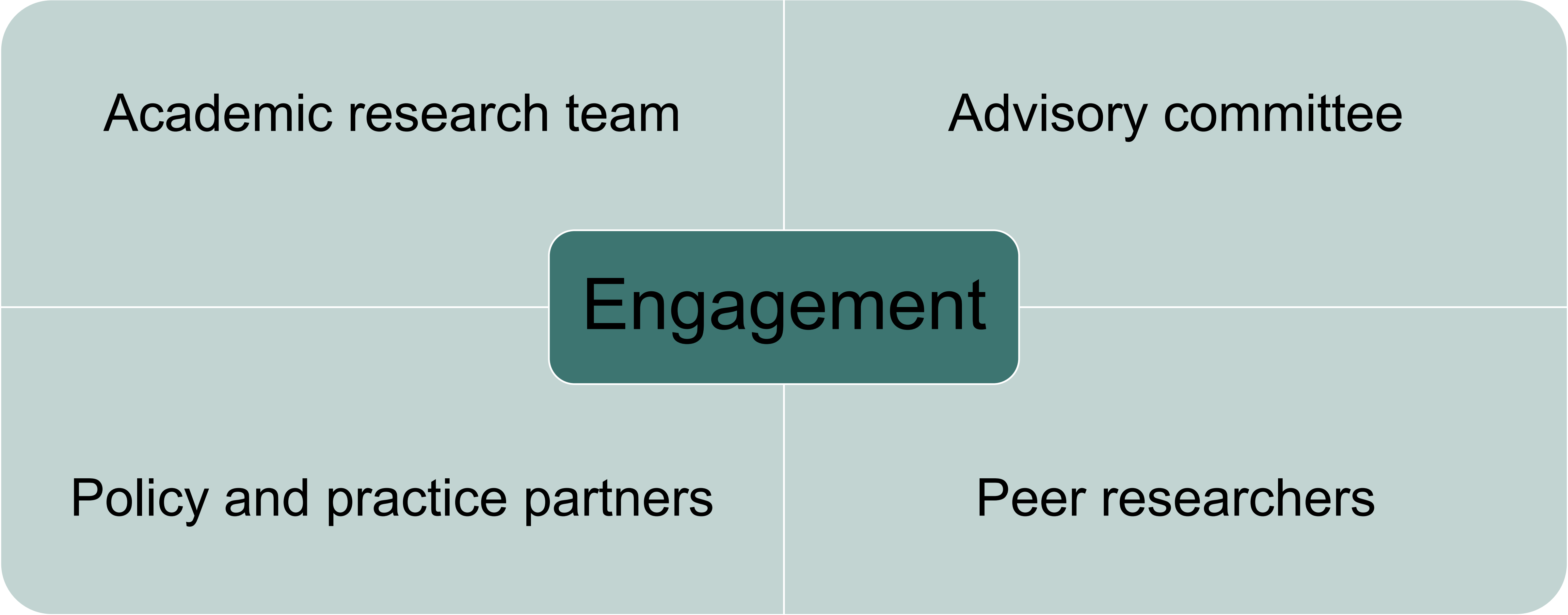
## Population-based data

Linked ICES health administrative data for all 15 to 49-year-old females in Ontario (cross-sectional data on n=532,716 females and longitudinal data on n=147,622 births)

## Qualitative study

In-depth qualitative interviews with 31 people with disabilities and 31 service-providers and decision-makers in Ontario

# Our approach to engagement



Academic research team

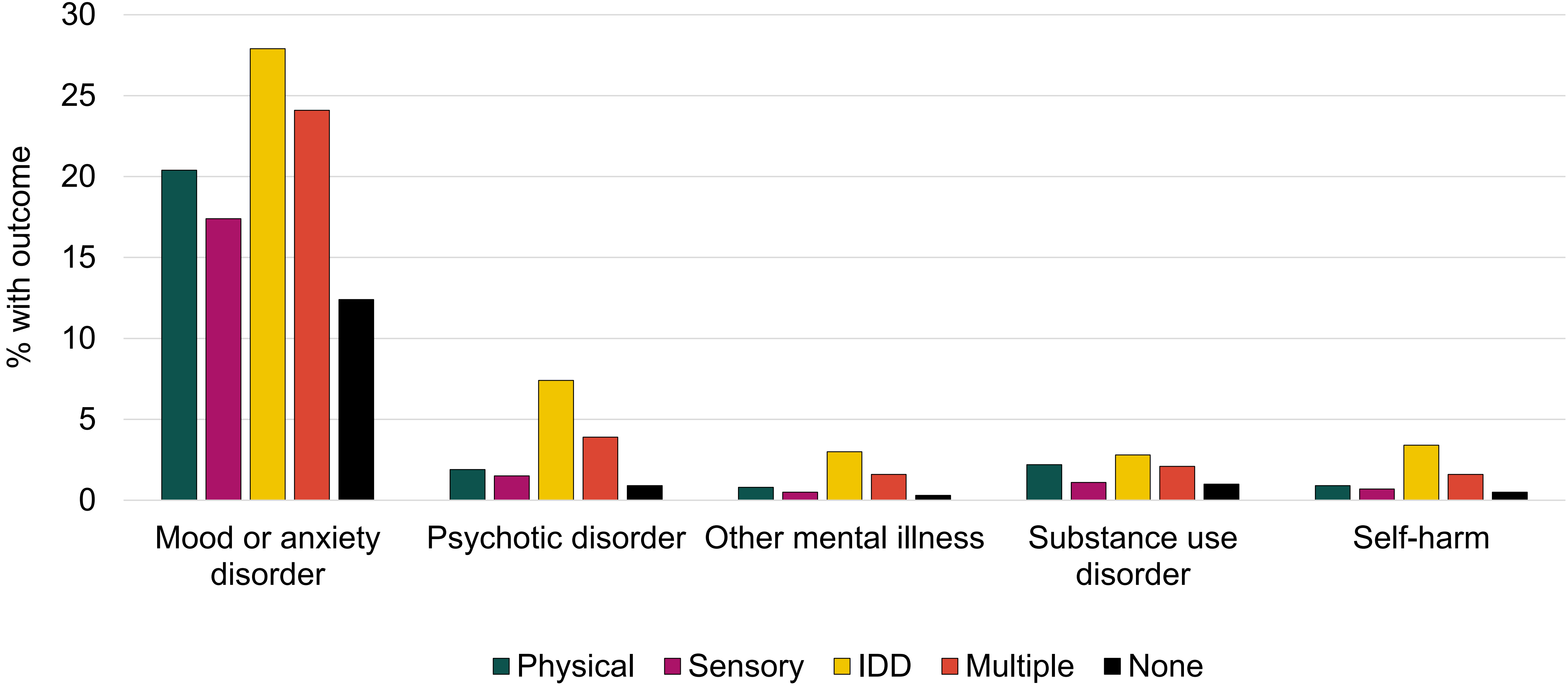
Advisory committee

Engagement

Policy and practice partners

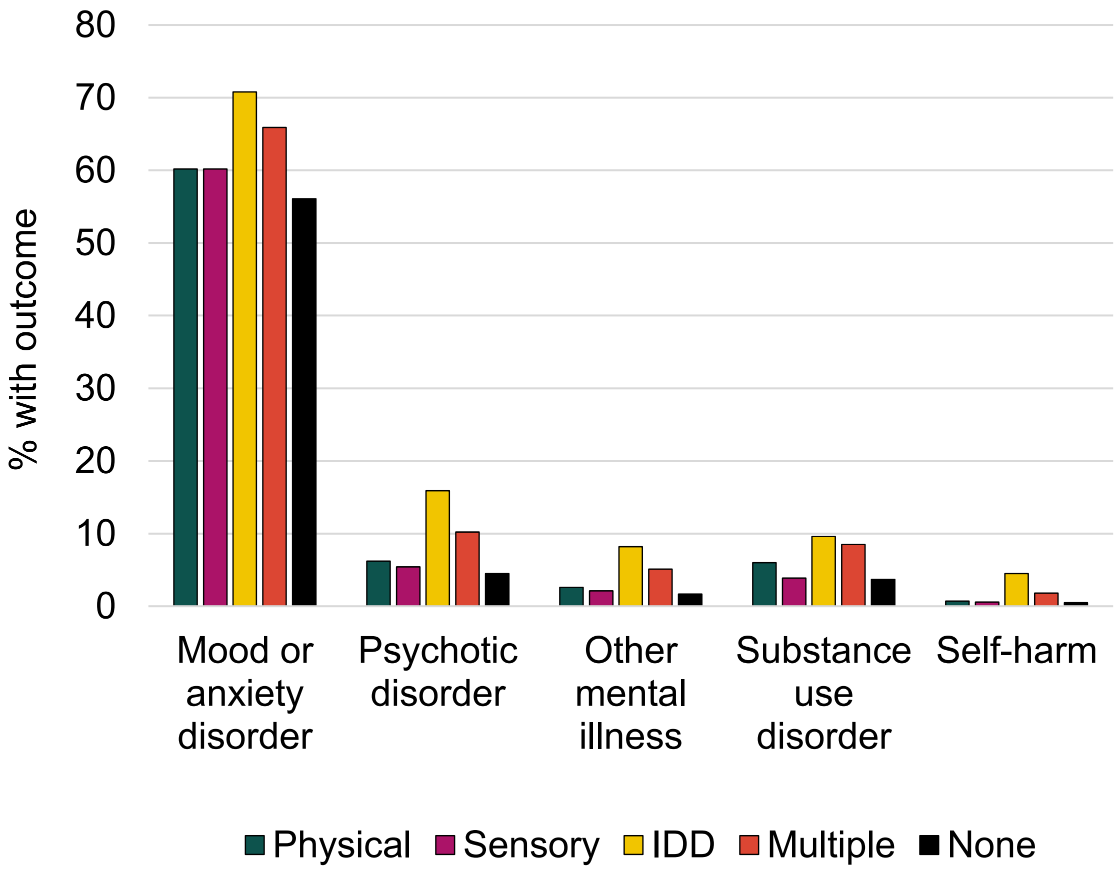
Peer researchers

# Preconception mental health

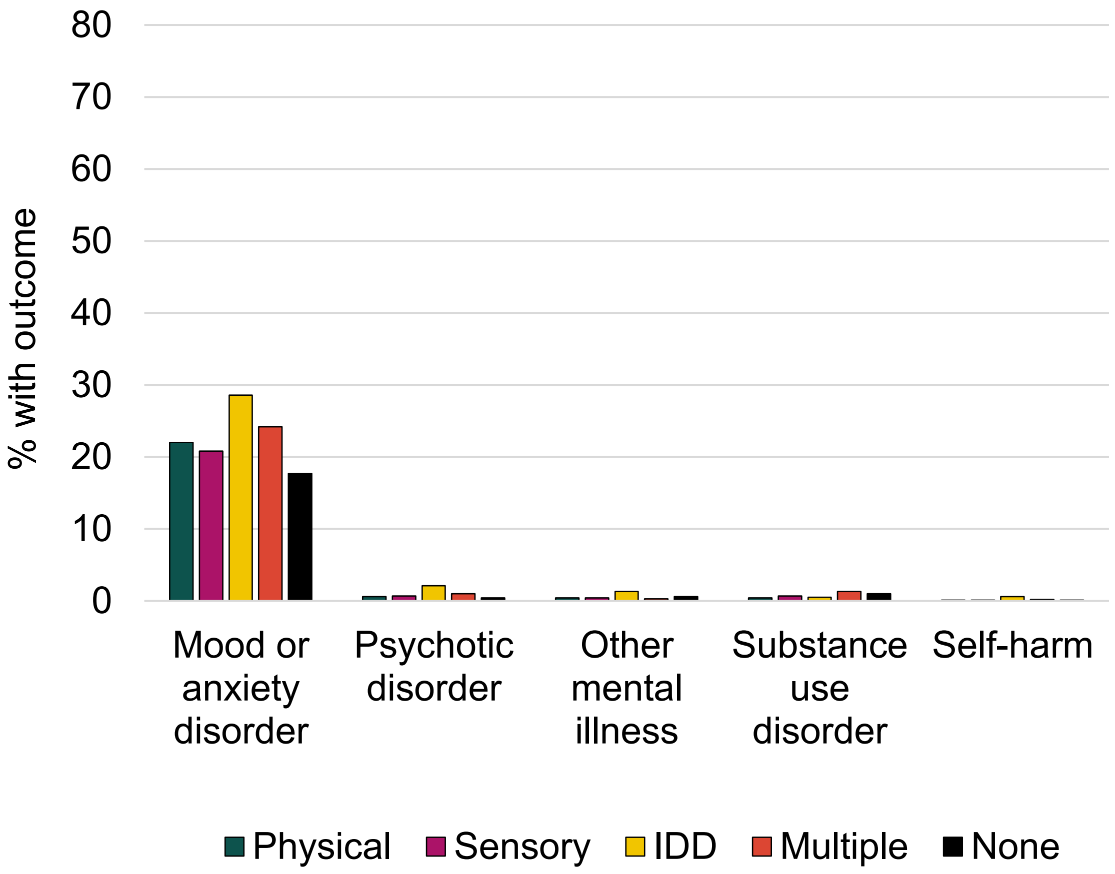


# Perinatal mental health

## With mental illness history



## Without a mental illness history



# Other factors contributing to wellbeing

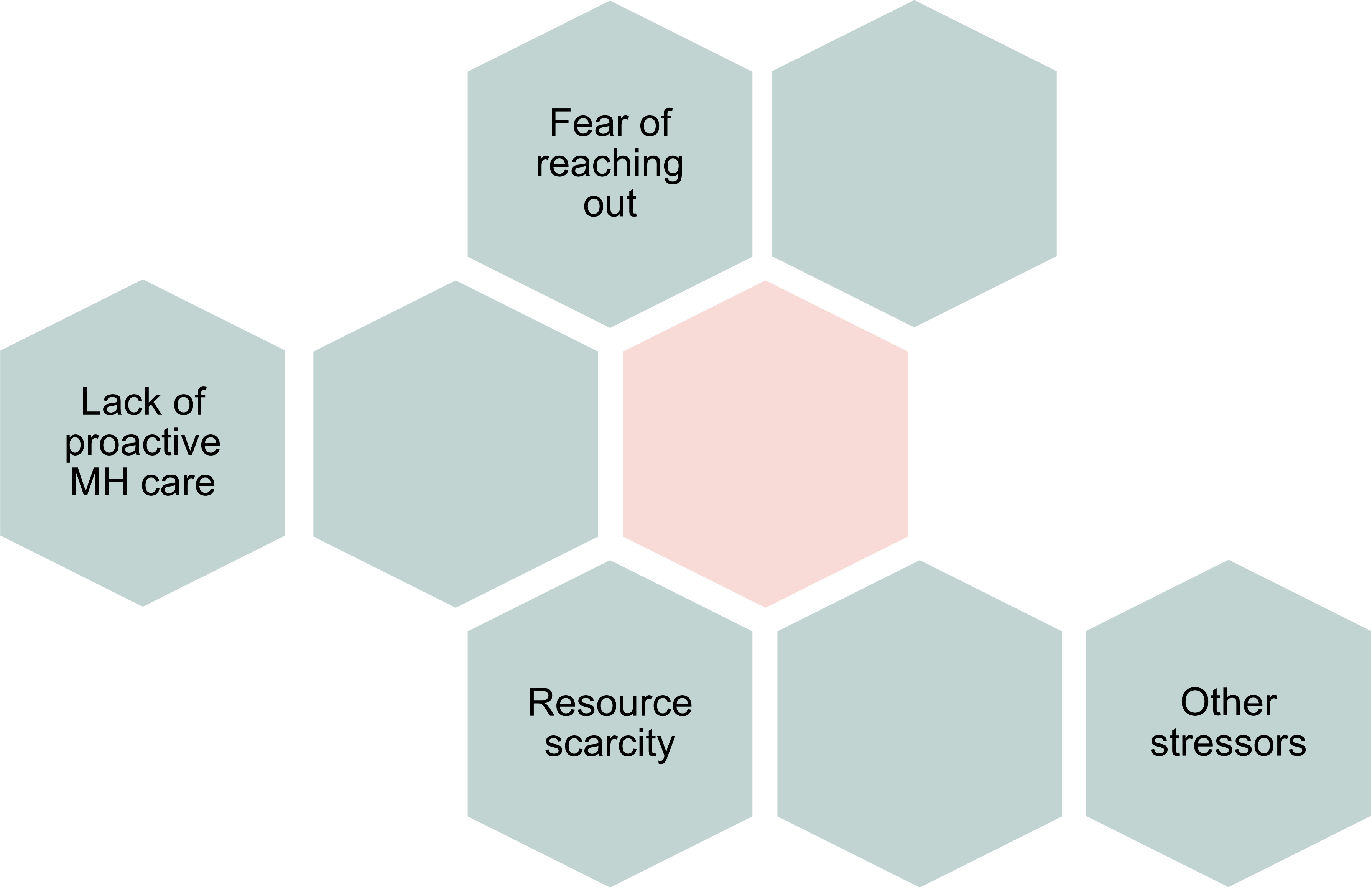
Higher rates of **medical complications** in pregnancy and postpartum

Higher rates of **preterm birth** and **NICU admission** among newborns

More instances **of interpersonal violence** resulting in ED visits perinatally

Reduced access to **breastfeeding initiation** and **support**

# Interviews



Fear of reaching out

Lack of proactive MH care

Resource scarcity

Other stressors

# Fear of reaching out

“I remember **feeling very isolated** and all the people I was seeing, they didn’t get it. And I was **wary of appearing to struggle too much**. So, if there was a way to have a safe person to share what you’re struggling with… Maybe someone who actually sat you down and said, ‘I know this is an issue with disability, I’m aware of it. These are the only instances that I would call child welfare.’ **I would have more trust if** I knew the person was aware of that or were disabled themselves.” [parent]

# Lack of proactive MH care

“I think that [mental health] was brushed off and it’s so dangerous. If you have a mom with a high risk of postpartum depression, who has heavy, hardcore painkillers at home, I think that’s a deadly combination… I was almost suicidal… I was disappointed... **I definitely wish that there was some sort of mental health support**. And something that you can probably **get started towards the end of the pregnancy and continue on**, not just do it until the baby comes and see if you’re going to develop postpartum depression.” [parent]

# Scarcity of resources

“I think it’s just a lot of the issues are accessing things, right? Like accessing programs out there, even funding for things. A lot of moms are on social assistance, **it’s barely enough to cover what they need** and then if you have a disability you’re at higher risk of having all of these other issues. The mental health piece and issues in home … And we do see that those struggles are there and unfortunately **there aren’t enough services out there** to provide the support that parents need, when they have a disability.” [provider]

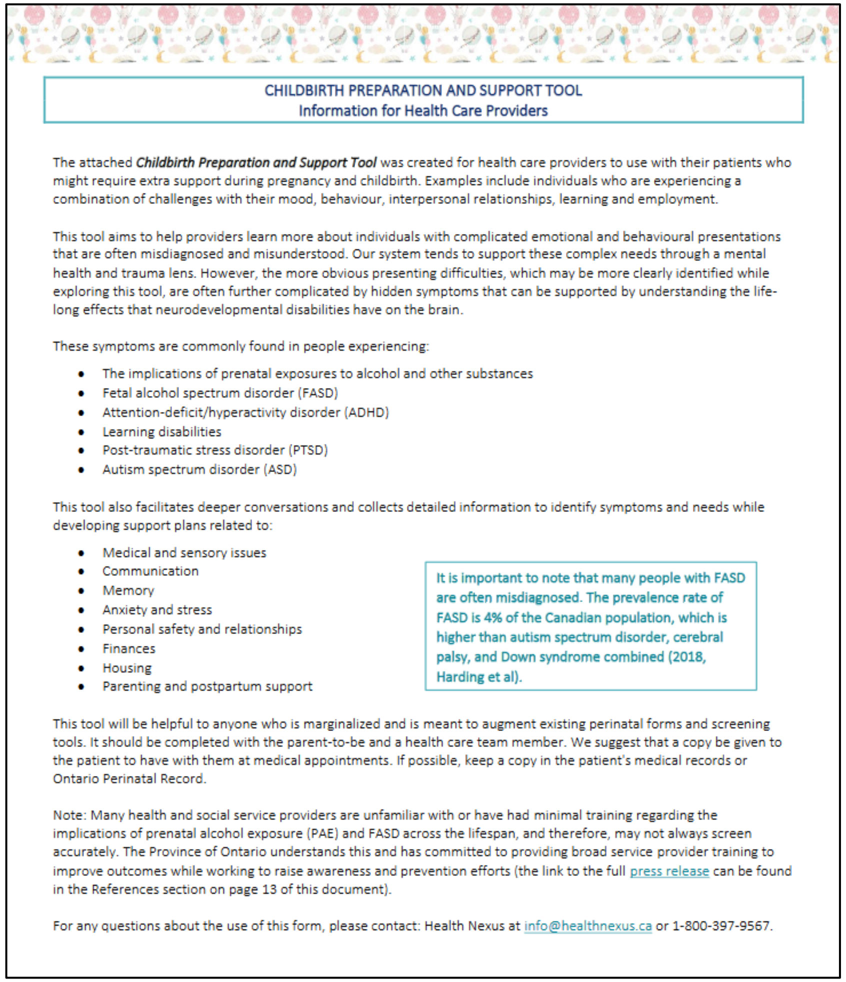
# Other stressors

“They were not equipped; **they were not accessible by any means** so the only way I was weighed was because my husband picked me up and we’d be weighed together and then he’d be weighed and he’d put me up on the exam table.” [parent]

“I met him [doctor] for the first time when I went in to confirm the pregnancy. He was like ‘What brings you here?’ ‘Oh, I just found out that I’m pregnant.’ And **he looked down at my wheelchair for a second, and he looked at me, and he said, ‘Are you here to get an abortion?’** And I was absolutely stunned. ‘No, we’ve been trying for a year and we’re really excited,’ and that was a really weird and terrible experience.” [parent]

# Recommendations

# Resource 1: Health Nexus



## CHILDBIRTH PREPARATION AND SUPPORT TOOL
### Information for Health Care Providers

The attached ***Childbirth Preparation and Support Tool*** was created for health care providers to use with their patients who might require extra support during pregnancy and childbirth. Examples include individuals who are experiencing a combination of challenges with their mood, behaviour, interpersonal relationships, learning and employment.

This tool aims to help providers learn more about individuals with complicated emotional and behavioural presentations that are often misdiagnosed and misunderstood. Our system tends to support these complex needs through a mental health and trauma lens. However, the more obvious presenting difficulties, which may be more clearly identified while exploring this tool, are often further complicated by hidden symptoms that can be supported by understanding the life-long effects that neurodevelopmental disabilities have on the brain.

These symptoms are commonly found in people experiencing:

- The implications of prenatal exposures to alcohol and other substances
- Fetal alcohol spectrum disorder (FASD)
- Attention-deficit/hyperactivity disorder (ADHD)
- Learning disabilities
- Post-traumatic stress disorder (PTSD)
- Autism spectrum disorder (ASD)

This tool also facilitates deeper conversations and collects detailed information to identify symptoms and needs while developing support plans related to:

- Medical and sensory issues
- Communication
- Memory
- Anxiety and stress
- Personal safety and relationships
- Finances
- Housing
- Parenting and postpartum support

**It is important to note that many people with FASD are often misdiagnosed. The prevalence rate of FASD is 4% of the Canadian population, which is higher than autism spectrum disorder, cerebral palsy, and Down syndrome combined (2018, Harding et al).**

This tool will be helpful to anyone who is marginalized and is meant to augment existing perinatal forms and screening tools. It should be completed with the parent-to-be and a health care team member. We suggest that a copy be given to the patient to have with them at medical appointments. If possible, keep a copy in the patient's medical records or Ontario Perinatal Record.

Note: Many health and social service providers are unfamiliar with or have had minimal training regarding the implications of prenatal alcohol exposure (PAE) and FASD across the lifespan, and therefore, may not always screen accurately. The Province of Ontario understands this and has committed to providing broad service provider training to improve outcomes while working to raise awareness and prevention efforts (the link to the full press release can be found in the References section on page 13 of this document).

For any questions about the use of this form, please contact: Health Nexus at info@healthnexus.ca or 1-800-397-9567.

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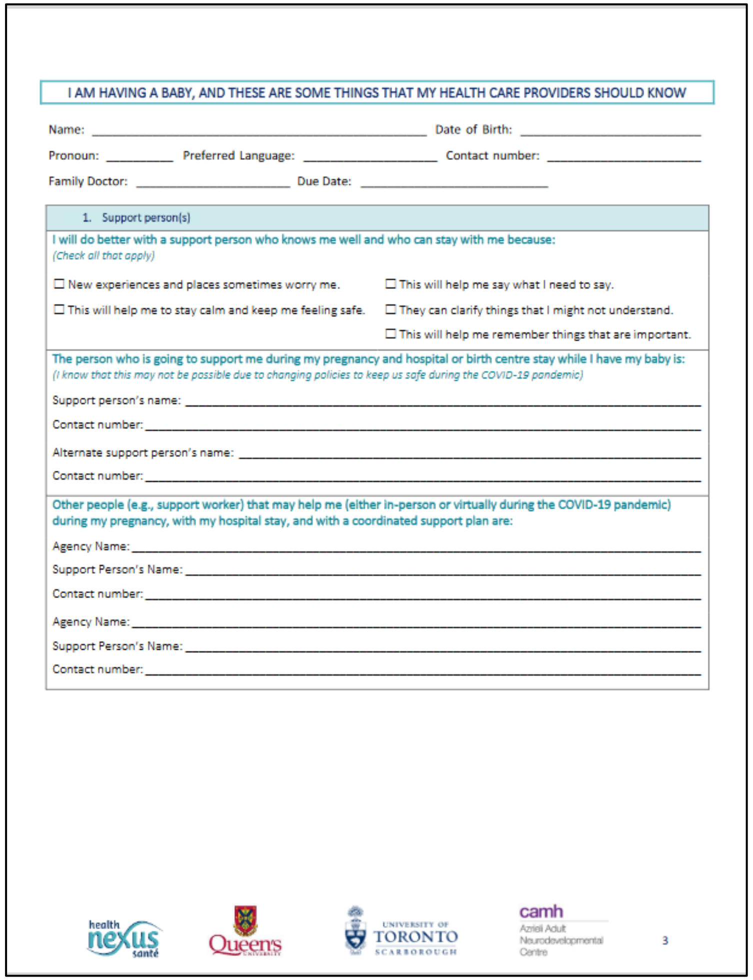

## I AM HAVING A BABY, AND THESE ARE SOME THINGS THAT MY HEALTH CARE PROVIDERS SHOULD KNOW

Name: ______________________ Date of Birth: ______________
Pronoun: ________ Preferred Language: ____________ Contact number: ______________
Family Doctor: ______________ Due Date: ________________

### 1. Support person(s)

**I will do better with a support person who knows me well and who can stay with me because:**
*(Check all that apply)*

☐ New experiences and places sometimes worry me.
☐ This will help me to stay calm and keep me feeling safe.
☐ This will help me say what I need to say.
☐ They can clarify things that I might not understand.
☐ This will help me remember things that are important.

**The person who is going to support me during my pregnancy and hospital or birth centre stay while I have my baby is:**
*(I know that this may not be possible due to changing policies to keep us safe during the COVID-19 pandemic)*

Support person's name: ______________________
Contact number: ______________________
Alternate support person's name: ______________________
Contact number: ______________________

**Other people (e.g., support worker) that may help me (either in-person or virtually during the COVID-19 pandemic) during my pregnancy, with my hospital stay, and with a coordinated support plan are:**

Agency Name: ______________________
Support Person's Name: ______________________
Contact number: ______________________
Agency Name: ______________________
Support Person's Name: ______________________
Contact number: ______________________

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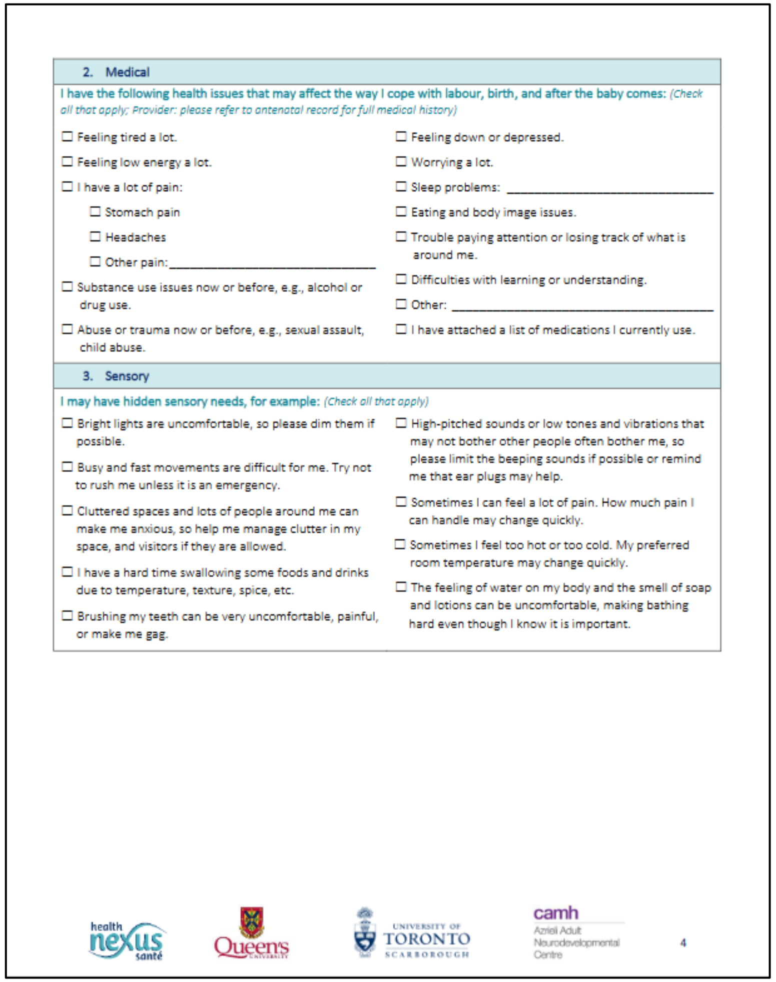


### 2. Medical

**I have the following health issues that may affect the way I cope with labour, birth, and after the baby comes:** *(Check all that apply; Provider: please refer to antenatal record for full medical history)*

☐ Feeling tired a lot.
☐ Feeling low energy a lot.
☐ I have a lot of pain:
  ☐ Stomach pain
  ☐ Headaches
  ☐ Other pain: ______________
☐ Substance use issues now or before, e.g., alcohol or drug use.
☐ Abuse or trauma now or before, e.g., sexual assault, child abuse.
☐ Feeling down or depressed.
☐ Worrying a lot.
☐ Sleep problems: ______________
☐ Eating and body image issues.
☐ Trouble paying attention or losing track of what is around me.
☐ Difficulties with learning or understanding.
☐ Other: ______________
☐ I have attached a list of medications I currently use.

### 3. Sensory

**I may have hidden sensory needs, for example:** *(Check all that apply)*

☐ Bright lights are uncomfortable, so please dim them if possible.
☐ Busy and fast movements are difficult for me. Try not to rush me unless it is an emergency.
☐ Cluttered spaces and lots of people around me can make me anxious, so help me manage clutter in my space, and visitors if they are allowed.
☐ I have a hard time swallowing some foods and drinks due to temperature, texture, spice, etc.
☐ Brushing my teeth can be very uncomfortable, painful, or make me gag.
☐ High-pitched sounds or low tones and vibrations that may not bother other people often bother me, so please limit the beeping sounds if possible or remind me that ear plugs may help.
☐ Sometimes I can feel a lot of pain. How much pain I can handle may change quickly.
☐ Sometimes I feel too hot or too cold. My preferred room temperature may change quickly.
☐ The feeling of water on my body and the smell of soap and lotions can be uncomfortable, making bathing hard even though I know it is important.

# Resource 2: PHN-PREP

PHN-PREP
Public Health Nursing Practice,
Research & Education Program

PHN-PREP
Public Health Nursing Practice,
Research & Education Program

Professional Resource

## Supporting People with Disabilities in Pregnancy, Labour and Delivery, and Postpartum: Resources for Public Health Nurses

This resource provides current evidence about the perinatal health and health care experiences of people with physical, sensory, and intellectual/developmental disabilities and guidance on supporting them during the perinatal period.

Disability is common, impacting nearly 15% of reproductive-aged people.[1] The World Health Organization defines disability by the interaction between a person's health condition and environmental barriers to full participation in society.[2] Disabilities can be physical, impacting mobility; sensory, impacting vision or hearing; and intellectual or developmental, impacting learning, practical or social skills, or communication.

Disability impacts nearly
15%
of reproductive-aged people[1]

1 in 8
pregnancies in 2017 were people with a disability[4]

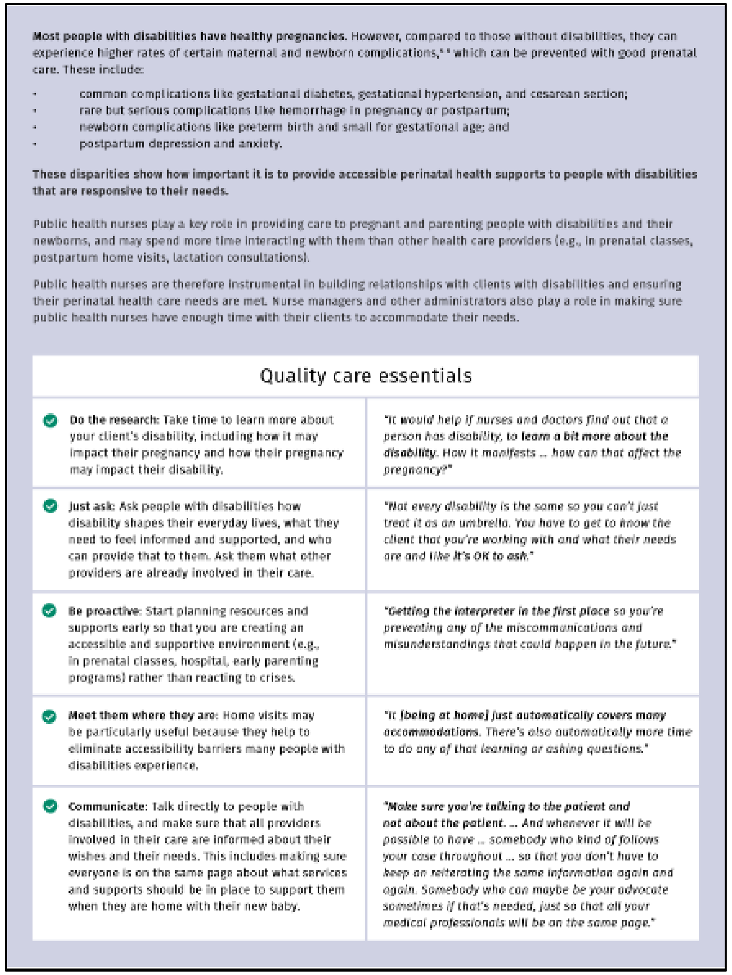
The pregnancy-related needs of people with disabilities have often been overlooked, in part because of negative societal assumptions about disability, sexuality, and parenting. The 2006 United Nations Convention on the Rights of Persons with Disabilities protects the rights of people with disabilities to decide the number and spacing of their children and to found a family.[3] Data from Ontario suggests that **one in eight pregnancies in 2017 were people with a disability.**[4]

To support people with disabilities in pregnancy it is important to keep in mind that reproductive-aged people with disabilities are more likely than those without disabilities to experience preconception health disparities,[5] including:

- poverty;
- chronic medical conditions, such as diabetes, hypertension, asthma, and depression;
- prescribed medications that are potentially teratogenic;
- history of assault; and
- barriers to accessing health care and negative health care experiences.

These disparities are known risk factors for maternal and newborn complications and need to be addressed before and during pregnancy.

Developed: November 2021 www.phnprep.ca 1



**Most people with disabilities have healthy pregnancies.** However, compared to those without disabilities, they can experience higher rates of certain maternal and newborn complications,[6,7] which can be prevented with good prenatal care. These include:

- common complications like gestational diabetes, gestational hypertension, and cesarean section;
- rare but serious complications like hemorrhage in pregnancy or postpartum;
- newborn complications like preterm birth and small for gestational age; and
- postpartum depression and anxiety.

**These disparities show how important it is to provide accessible perinatal health supports to people with disabilities that are responsive to their needs.**

Public health nurses play a key role in providing care to pregnant and parenting people with disabilities and their newborns, and may spend more time interacting with them than other health care providers (e.g., in prenatal classes, postpartum home visits, lactation consultations).

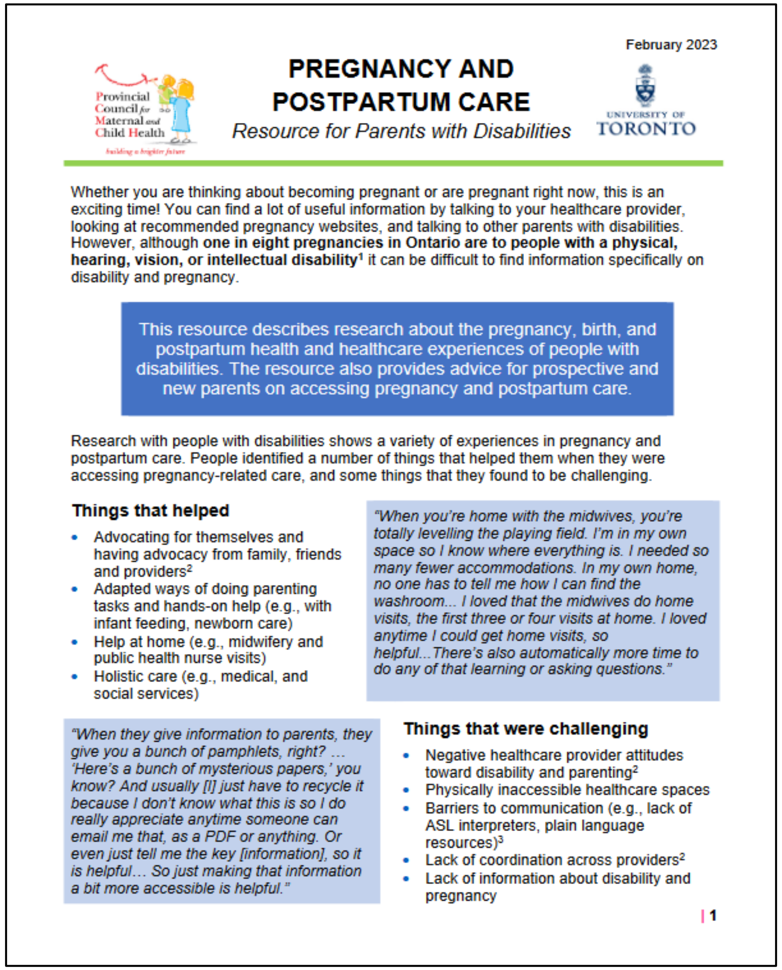
Public health nurses are therefore instrumental in building relationships with clients with disabilities and ensuring their perinatal health care needs are met. Nurse managers and other administrators also play a role in making sure public health nurses have enough time with their clients to accommodate their needs.

### Quality care essentials

| | |
|---|---|
| ✓ **Do the research:** Take time to learn more about your client's disability, including how it may impact their pregnancy and how their pregnancy may impact their disability. | *"It would help if nurses and doctors find out that a person has disability, to* ***learn a bit more about the disability****. How it manifests … how can that affect the pregnancy?"* |
| ✓ **Just ask:** Ask people with disabilities how disability shapes their everyday lives, what they need to feel informed and supported, and who can provide that to them. Ask them what other providers are already involved in their care. | *"Not every disability is the same so you can't just treat it as an umbrella. You have to get to know the client that you're working with and what their needs are and like* ***it's OK to ask****."* |
| ✓ **Be proactive:** Start planning resources and supports early so that you are creating an accessible and supportive environment (e.g., in prenatal classes, hospital, early parenting programs) rather than reacting to crises. | *"****Getting the interpreter in the first place*** *so you're preventing any of the miscommunications and misunderstandings that could happen in the future."* |
| ✓ **Meet them where they are:** Home visits may be particularly useful because they help to eliminate accessibility barriers many people with disabilities experience. | *"It* ***[being at home] just automatically covers many accommodations****. There's also automatically more time to do any of that learning or asking questions."* |
| ✓ **Communicate:** Talk directly to people with disabilities, and make sure that all providers involved in their care are informed about their wishes and their needs. This includes making sure everyone is on the same page about what services and supports should be in place to support them when they are home with their new baby. | *"****Make sure you're talking to the patient and not about the patient.*** *… And whenever it will be possible to have … somebody who kind of follows your case throughout … so that you don't have to keep on reiterating the same information again and again. Somebody who can maybe be your advocate sometimes if that's needed, just so that all your medical professionals will be on the same page."* |

| | |
|---|---|
| ✓ **Get creative:** Consider what adaptations and accommodations are needed to meet clients' physical, sensory, and learning needs related to pregnancy and newborn care (e.g., wheelchair-accessible spaces, hoyer lifts, accessible cribs, different breastfeeding positions, tactile resources, ASL interpreters, visual aids, avoiding medical jargon). | *"Just to be aware of how welcoming it [the office] is to a disabled person. Even just little things like in the waiting room,* ***is there a place to wait with a wheelchair****. … When people actually listen, you'll hear them say, 'Oh, I'm glad you said that because now it's so much easier to transfer you this way,' or whatever it was."* |
| ✓ **Think outside the health care box:** Work with people with disabilities, their partners or families, and other providers to ensure that resources and services related to the disability and other life circumstances, such as those related to the social determinants of health, are in place. This might include working with disability community agencies, accessible transportation services, financial aid, housing services, child protection, occupational therapy, and nurturing assistance | *"****Access to the supports is huge****. … Listen to the people [with disabilities] about what their particular needs are. … There may have been supports available to me and I didn't know about them."*<br>*"They [health care providers] should be oriented to work with the society, the community, … so* ***they should be also working with the [disability] community*** *so that they can know about these things [resources]."* |
| ✓ **It takes a team:** Ask people with disabilities what care they are receiving from other providers, especially if they have multiple disabilities or chronic medical conditions like diabetes. It may be helpful to connect with other providers involved in their care by writing a note to communicate care needs. | *"I just wish there was a* ***true multidisciplinary team*** *… a truly cohesive circle of care, that if this person is pregnant and she has a chronic illness or disability, 'Okay I'm going to send her to this person, this person, that person,' and they would all kind of know about you."* |
| ✓ **Take the time:** Provide more frequent and/or longer visits or sessions (e.g., during home visits, lactation consultations) to facilitate delivering the aspects of support above. | *"Be more open. Listen to the client. It's not easy to have a disability nor is it easy to go in it and facing it alone. …* ***more support, someone to talk to and not so rushy-rushy.****"* |

# Resource 3: PCMCH



February 2023

## PREGNANCY AND POSTPARTUM CARE

*Resource for Parents with Disabilities*

Whether you are thinking about becoming pregnant or are pregnant right now, this is an exciting time! You can find a lot of useful information by talking to your healthcare provider, looking at recommended pregnancy websites, and talking to other parents with disabilities. However, although **one in eight pregnancies in Ontario are to people with a physical, hearing, vision, or intellectual disability**[1] it can be difficult to find information specifically on disability and pregnancy.

This resource describes research about the pregnancy, birth, and postpartum health and healthcare experiences of people with disabilities. The resource also provides advice for prospective and new parents on accessing pregnancy and postpartum care.

Research with people with disabilities shows a variety of experiences in pregnancy and postpartum care. People identified a number of things that helped them when they were accessing pregnancy-related care, and some things that they found to be challenging.

### Things that helped

- Advocating for themselves and having advocacy from family, friends and providers[2]
- Adapted ways of doing parenting tasks and hands-on help (e.g., with infant feeding, newborn care)
- Help at home (e.g., midwifery and public health nurse visits)
- Holistic care (e.g., medical, and social services)

> *"When you're home with the midwives, you're totally levelling the playing field. I'm in my own space so I know where everything is. I needed so many fewer accommodations. In my own home, no one has to tell me how I can find the washroom... I loved that the midwives do home visits, the first three or four visits at home. I loved anytime I could get home visits, so helpful...There's also automatically more time to do any of that learning or asking questions."*

> *"When they give information to parents, they give you a bunch of pamphlets, right? … 'Here's a bunch of mysterious papers,' you know? And usually [I] just have to recycle it because I don't know what this is so I do really appreciate anytime someone can email me that, as a PDF or anything. Or even just tell me the key [information], so it is helpful… So just making that information a bit more accessible is helpful."*

### Things that were challenging

- Negative healthcare provider attitudes toward disability and parenting[2]
- Physically inaccessible healthcare spaces
- Barriers to communication (e.g., lack of ASL interpreters, plain language resources)[3]
- Lack of coordination across providers[2]
- Lack of information about disability and pregnancy

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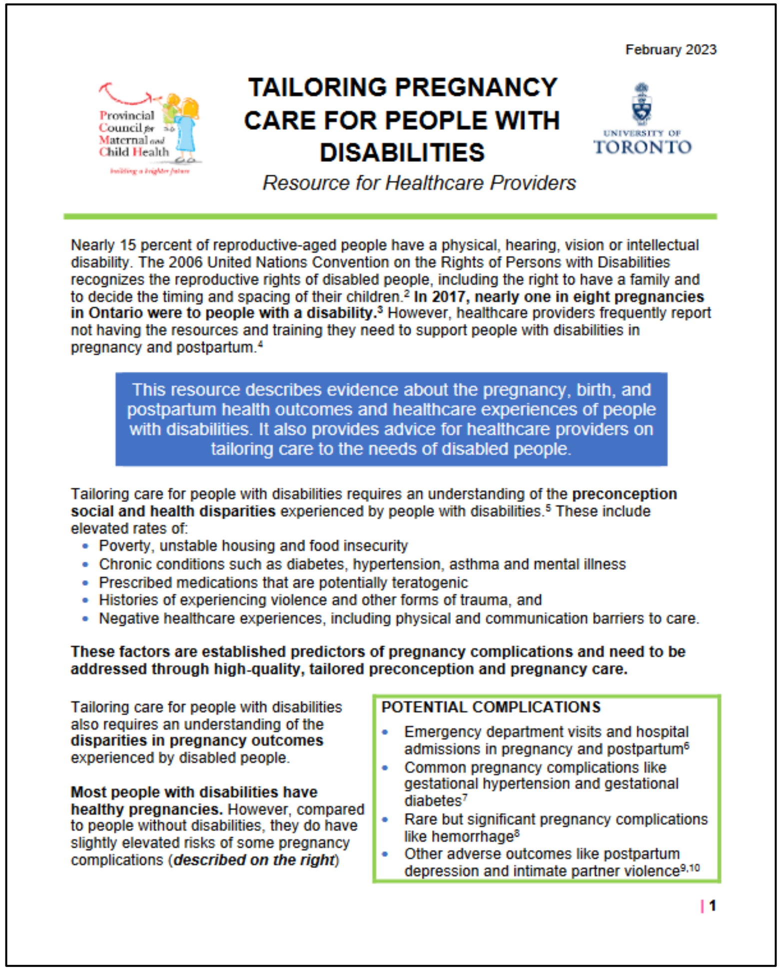

February 2023

## TAILORING PREGNANCY CARE FOR PEOPLE WITH DISABILITIES

*Resource for Healthcare Providers*

Nearly 15 percent of reproductive-aged people have a physical, hearing, vision or intellectual disability. The 2006 United Nations Convention on the Rights of Persons with Disabilities recognizes the reproductive rights of disabled people, including the right to have a family and to decide the timing and spacing of their children.[2] **In 2017, nearly one in eight pregnancies in Ontario were to people with a disability.**[3] However, healthcare providers frequently report not having the resources and training they need to support people with disabilities in pregnancy and postpartum.[4]

This resource describes evidence about the pregnancy, birth, and postpartum health outcomes and healthcare experiences of people with disabilities. It also provides advice for healthcare providers on tailoring care to the needs of disabled people.

Tailoring care for people with disabilities requires an understanding of the **preconception social and health disparities** experienced by people with disabilities.[5] These include elevated rates of:

- Poverty, unstable housing and food insecurity
- Chronic conditions such as diabetes, hypertension, asthma and mental illness
- Prescribed medications that are potentially teratogenic
- Histories of experiencing violence and other forms of trauma, and
- Negative healthcare experiences, including physical and communication barriers to care.

**These factors are established predictors of pregnancy complications and need to be addressed through high-quality, tailored preconception and pregnancy care.**

Tailoring care for people with disabilities also requires an understanding of the **disparities in pregnancy outcomes** experienced by disabled people.

**Most people with disabilities have healthy pregnancies.** However, compared to people without disabilities, they do have slightly elevated risks of some pregnancy complications (***described on the right***)

**POTENTIAL COMPLICATIONS**

- Emergency department visits and hospital admissions in pregnancy and postpartum[6]
- Common pregnancy complications like gestational hypertension and gestational diabetes[7]
- Rare but significant pregnancy complications like hemorrhage[8]
- Other adverse outcomes like postpartum depression and intimate partner violence[9,10]

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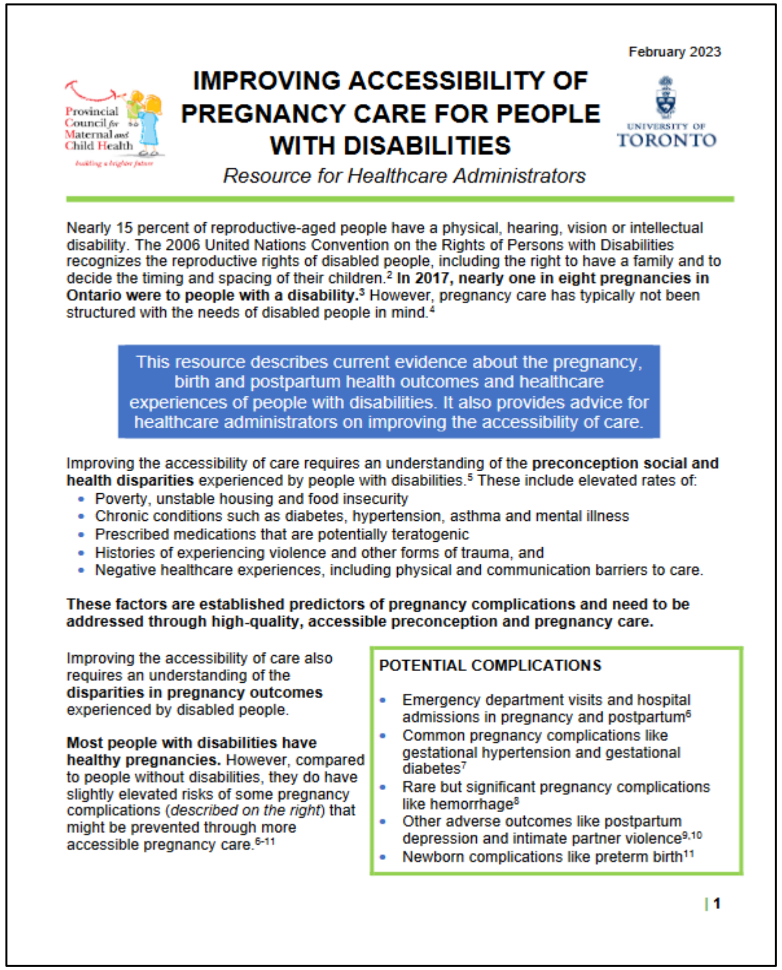

February 2023

## IMPROVING ACCESSIBILITY OF PREGNANCY CARE FOR PEOPLE WITH DISABILITIES

*Resource for Healthcare Administrators*

Nearly 15 percent of reproductive-aged people have a physical, hearing, vision or intellectual disability. The 2006 United Nations Convention on the Rights of Persons with Disabilities recognizes the reproductive rights of disabled people, including the right to have a family and to decide the timing and spacing of their children.[2] **In 2017, nearly one in eight pregnancies in Ontario were to people with a disability.**[3] However, pregnancy care has typically not been structured with the needs of disabled people in mind.[4]

This resource describes current evidence about the pregnancy, birth and postpartum health outcomes and healthcare experiences of people with disabilities. It also provides advice for healthcare administrators on improving the accessibility of care.

Improving the accessibility of care requires an understanding of the **preconception social and health disparities** experienced by people with disabilities.[5] These include elevated rates of:

- Poverty, unstable housing and food insecurity
- Chronic conditions such as diabetes, hypertension, asthma and mental illness
- Prescribed medications that are potentially teratogenic
- Histories of experiencing violence and other forms of trauma, and
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**These factors are established predictors of pregnancy complications and need to be addressed through high-quality, accessible preconception and pregnancy care.**

Improving the accessibility of care also requires an understanding of the **disparities in pregnancy outcomes** experienced by disabled people.

**Most people with disabilities have healthy pregnancies.** However, compared to people without disabilities, they do have slightly elevated risks of some pregnancy complications (*described on the right*) that might be prevented through more accessible pregnancy care.[6-11]

**POTENTIAL COMPLICATIONS**

- Emergency department visits and hospital admissions in pregnancy and postpartum[6]
- Common pregnancy complications like gestational hypertension and gestational diabetes[7]
- Rare but significant pregnancy complications like hemorrhage[8]
- Other adverse outcomes like postpartum depression and intimate partner violence[9,10]
- Newborn complications like preterm birth[11]

# Lessons learned

- Build meaningful engagement and co-leadership, not just tokenistic participation
- Support peer researchers by building capacity through training
- Create safe environment for feedback by building relationships and actively listening

**Requires researchers to step out of their typical academic roles**

# Thank you!

Email: hk.brown@utoronto.ca

UNIVERSITY OF TORONTO

DEFY GRAVITY

# Supporting Alternate Level of Care Patients with a Dual Diagnosis to Transition from Hospital to Home

**Avra Selick**, CAMH, and **Dianna Cochrane**, Ontario Ministry of Health

HCARDD Health Care Access Research and Developmental Disabilities

Ontario

camh

# It takes a team!

A huge thank you to our other team members who were integral to this project – Yona Lunsky (CAMH), Ryan Hodgson (Ministry of Health), Tiziana Volpe (CAMH), Susan Morris (consultant), Michelle Chin (CAMH), Sandy Stemp (Reena), Melonie Hopkins (CAMH), Sue Gosselin (caregiver), Judy Wiener (caregiver), our expert review panel and the many individuals across Ontario who provided input and shared their stories and experiences for this project.

# Today

1. Why we started this work and what we have developed together
2. How we worked together as a team and engaged with diverse groups
3. Creative knowledge translation strategies to promote awareness and utilization of research among diverse knowledge users including clinicians, families, people with disabilities, and policy makers.

# How did we get here?

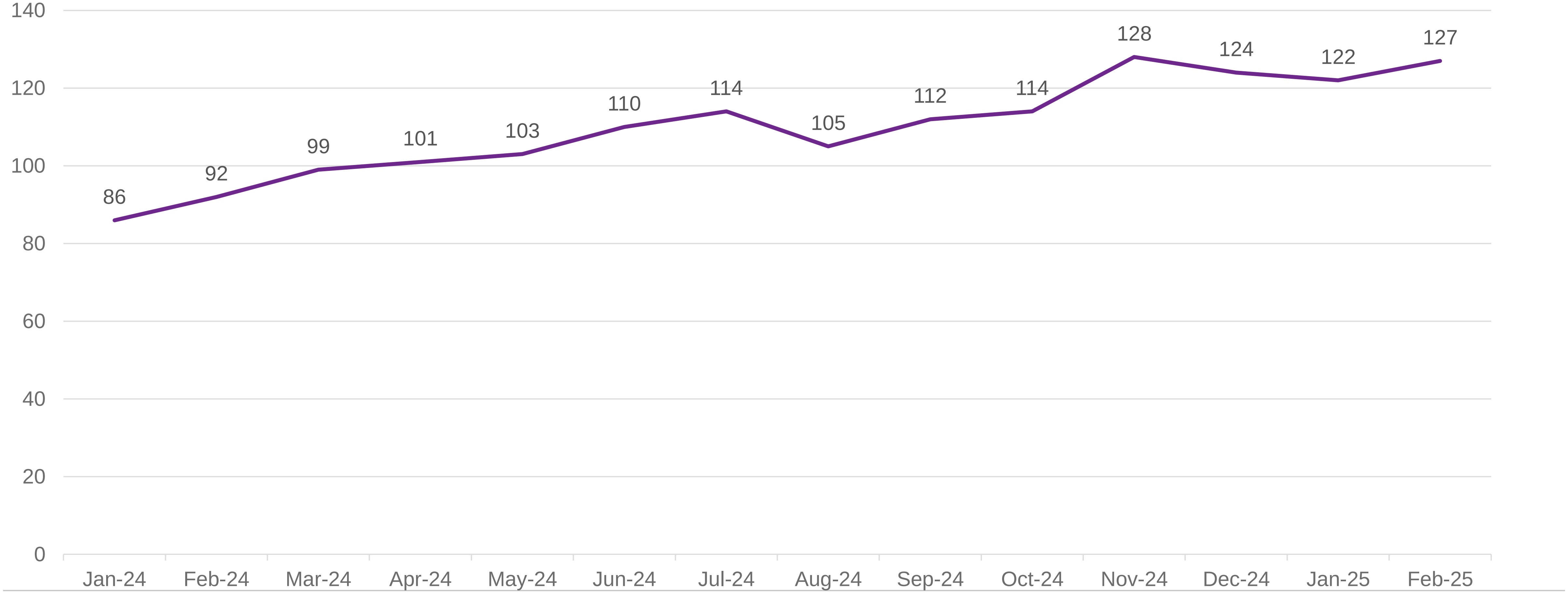
# What is Alternate Level of Care (ALC)?

- ALC designation is given when a patient in hospital no longer requires hospital care but cannot be discharged.
- Often this is because no appropriate setting in the community.
- In some cases, ALC patients spend several years in hospital.
- This can lead to negative outcomes for the ALC patient and treatment delays for other patients who require hospital care.

Rojas-García et al. (2018) Impact and experiences of delayed discharge: A mixed-studies systematic review. Health Expectations.
Everall et al. (2019) Patient and caregiver experience with delayed discharge from a hospital setting: A scoping review. Health Expectations.

# Alternate Level of Care

Ontario Health ALC Data for Patients with Dual Diagnosis waiting for an Alternate Living Arrangement



# Alternate level of care and dual diagnosis

Adults with developmental disability and a mental illness (i.e., dual diagnosis) are at higher risk of having a delayed discharge

**9 x** **more likely to have a delayed discharge, compared with individuals without IDD**

**1 in 4 patients who have been in a mental health bed more than 1 year**

Most delayed discharge initiatives focus on older adults but this group has different needs (e.g., younger, disability sector involvement).

Lin et al. (2019). Addressing Gaps in the Health Care Services Used by Adults with Developmental Disabilities in Ontario. Institute for Clinical Evaluative Sciences.
H-CARDD and ICES (2025) H-CARDD Snapshot: Long-Stay Patients in Ontario Mental Health Beds with Developmental Disabilities.

# Barriers to transitions

- Many barriers to successful transitions
  - Insufficient funding and community living options
  - Shortage of trained health care providers
  - Siloed health and social services sectors
  - Unclear discharge processes
  - Inconsistent resource availability across the province
  - Lack of data to inform planning
- Most ALC initiatives focus on older adults but this group has different needs (e.g., younger, disability sector involvement)

# Hospital to Home- speaking our language

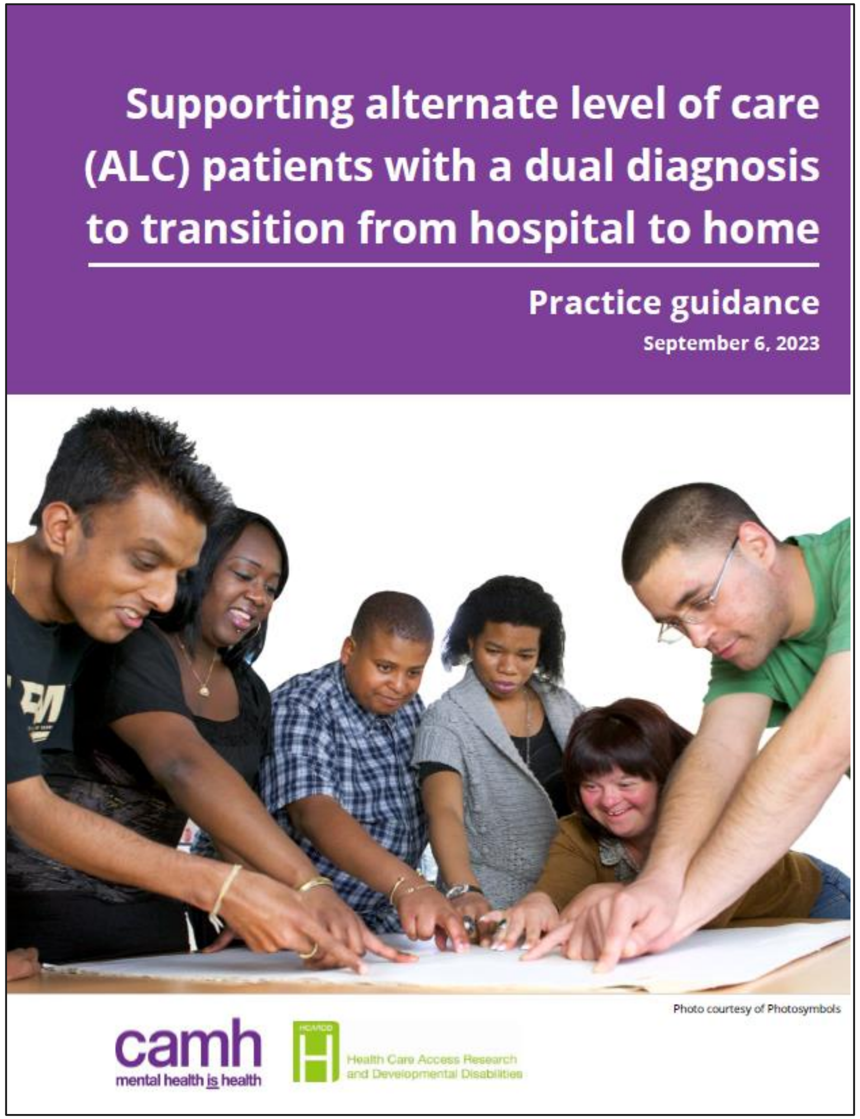
**Ministry of Health** ? **Ministry of Community and Social Services**

**Hospitals** ↔ **Supported Living**

# What did we do?

# Practice Guidance

- 10 core components
- Identifies roles and responsibilities for:
  - Hospital teams
  - Developmental service providers
  - Community healthcare providers
  - Health and developmental service planners
  - Patients and families



Supporting alternate level of care (ALC) patients with a dual diagnosis to transition from hospital to home

Practice guidance

September 6, 2023

Photo courtesy of Photosymbols

camh
mental health is health

Health Care Access Research and Developmental Disabilities

BUT we don’t want our guidance to gather dust on a shelf!!

# Working together to ensure relevance, comprehensiveness and engage knowledge users

**1** Bi-weekly meetings with CAMH + MOH

**2** Consultations with over 100 Ontario stakeholders

- Psychiatric specialty hospitals
- Acute care hospitals
- Developmental services agencies
- Community mental health
- Researchers
- People with a dual diagnosis who have been ALC and their families

**3** Review by multi-sectoral expert panel

# Speak their language

**For health care providers-**

- Instead of creating something new, adapted the existing Ontario Health Quality Standard *Transitions Between Hospital and Home*
- In partnership with Ontario Health, we developed a *Quality Standards Placemat* (summarizing key points for healthcare providers)

QUALITY STANDARDS

Placemat for Supporting High-Quality Transitions Between Hospital and Home for Alternate Level of Care Patients With a Dual Diagnosis

This document is a resource for health care providers and offers guidance on how the Transitions Between Hospital and Home quality standard can be applied in supporting alternate level of care patients with a dual diagnosis to transition out of hospital. See the complete adapted guidance for this population: Supporting Alternate Level of Care Patients With a Dual Diagnosis to Transition From Hospital to Home: Practice Guidance.

Information-Sharing and Assessment

Quality Statement (QS) 1: Information-Sharing on Admission

When a person is admitted to hospital, the hospital shares information about the admission with their primary care and home and community care providers, as well as any relevant specialist physicians, soon after admission via real-time electronic notification. These providers in the community then share all relevant information with the admitting team in a timely manner.

Ensure that when a person is admitted to hospital, their community health and developmental service providers are notified of the person's admission, diagnoses, and predicted discharge date.

Ensure that community health providers and developmental service providers share relevant information with the hospital team as soon as possible.

Support regular communication with everyone involved in the transition throughout the person's hospital stay and during the transition period. This includes the patient, their family, the hospital

QS 2: Comprehensive Assessment

People receive a comprehensive assessment of their current and evolving health care and social support needs. This assessment is started early upon admission, and updated regularly throughout the hospital stay, to inform the transition plan and optimize the transition process.

Initiate a comprehensive assessment of the patient's current and evolving health care and developmental services needs at admission to hospital. Update the assessment regularly.

Ensure that the assessment uses a strengths-based, culturally relevant, developmentally informed, trauma-informed approach. Providers with expertise in dual diagnosis may be needed to conduct some assessments.

Work with Developmental Services Ontario to see if the patient is eligible for provincial developmental services.

Identify risk factors for a complex or delayed transition.

Obtain collateral input from family members and

## For people with disabilities

camh | Azrieli Adult Neurodevelopmental Centre

**Easy Read Summary:**

**Things that will help people to leave the hospital**

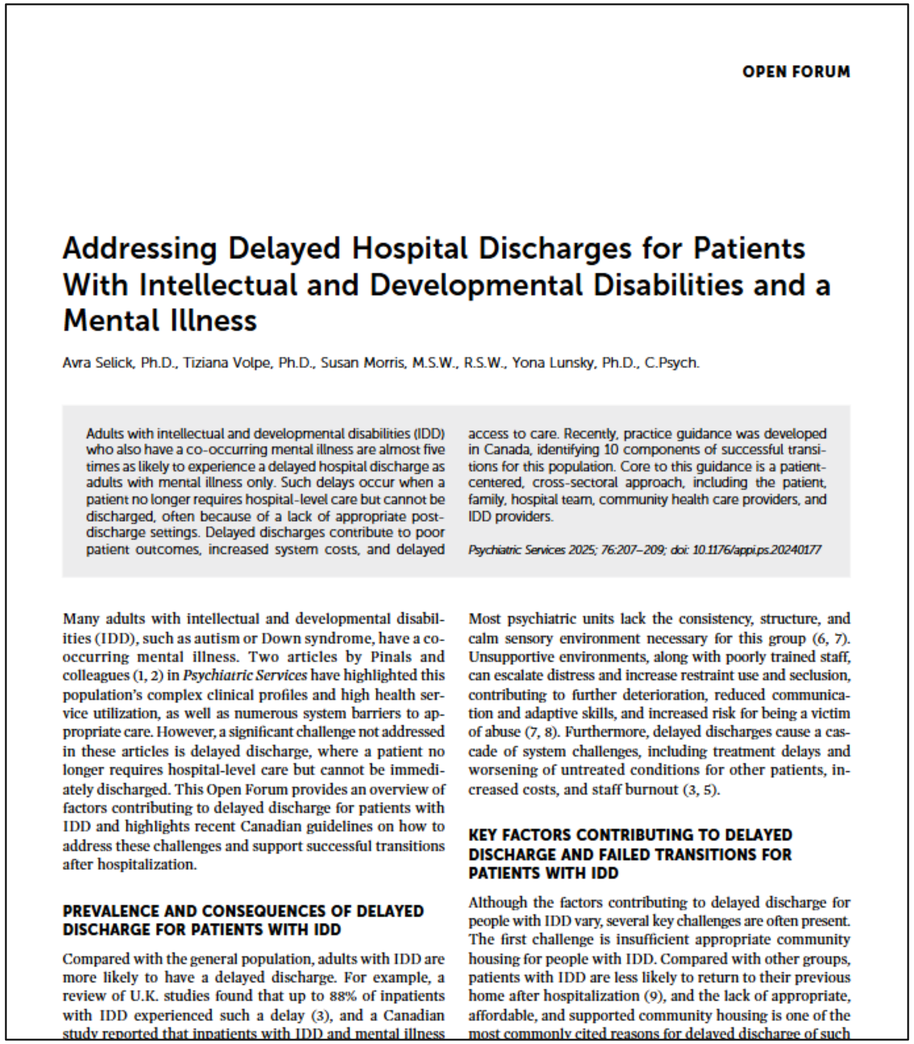
**This is an Easy Read of a report called: Supporting Alternate Level of Care (ALC) Patients with a Dual Diagnosis to Transition from Hospital to Home: Practice Guidance**

What do we recommend to help a person leave hospital?

10 steps we think are
rtant. These are called
**tion Components".**

will go through each
component.

## For researchers



**OPEN FORUM**

### Addressing Delayed Hospital Discharges for Patients With Intellectual and Developmental Disabilities and a Mental Illness

Avra Selick, Ph.D., Tiziana Volpe, Ph.D., Susan Morris, M.S.W., R.S.W., Yona Lunsky, Ph.D., C.Psych.

Adults with intellectual and developmental disabilities (IDD) who also have a co-occurring mental illness are almost five times as likely to experience a delayed hospital discharge as adults with mental illness only. Such delays occur when a patient no longer requires hospital-level care but cannot be discharged, often because of a lack of appropriate post-discharge settings. Delayed discharges contribute to poor patient outcomes, increased system costs, and delayed access to care. Recently, practice guidance was developed in Canada, identifying 10 components of successful transitions for this population. Core to this guidance is a patient-centered, cross-sectoral approach, including the patient, family, hospital team, community health care providers, and IDD providers.

*Psychiatric Services 2025; 76:207–209; doi: 10.1176/appi.ps.20240177*

Many adults with intellectual and developmental disabilities (IDD), such as autism or Down syndrome, have a co-occurring mental illness. Two articles by Pinals and colleagues (1, 2) in *Psychiatric Services* have highlighted this population's complex clinical profiles and high health service utilization, as well as numerous system barriers to appropriate care. However, a significant challenge not addressed in these articles is delayed discharge, where a patient no longer requires hospital-level care but cannot be immediately discharged. This Open Forum provides an overview of factors contributing to delayed discharge for patients with IDD and highlights recent Canadian guidelines on how to address these challenges and support successful transitions after hospitalization.

#### PREVALENCE AND CONSEQUENCES OF DELAYED DISCHARGE FOR PATIENTS WITH IDD

Compared with the general population, adults with IDD are more likely to have a delayed discharge. For example, a review of U.K. studies found that up to 88% of inpatients with IDD experienced such a delay (3), and a Canadian study reported that inpatients with IDD and mental illness

Most psychiatric units lack the consistency, structure, and calm sensory environment necessary for this group (6, 7). Unsupportive environments, along with poorly trained staff, can escalate distress and increase restraint use and seclusion, contributing to further deterioration, reduced communication and adaptive skills, and increased risk for being a victim of abuse (7, 8). Furthermore, delayed discharges cause a cascade of system challenges, including treatment delays and worsening of untreated conditions for other patients, increased costs, and staff burnout (3, 5).

#### KEY FACTORS CONTRIBUTING TO DELAYED DISCHARGE AND FAILED TRANSITIONS FOR PATIENTS WITH IDD

Although the factors contributing to delayed discharge for people with IDD vary, several key challenges are often present. The first challenge is insufficient appropriate community housing for people with IDD. Compared with other groups, patients with IDD are less likely to return to their previous home after hospitalization (9), and the lack of appropriate, affordable, and supported community housing is one of the most commonly cited reasons for delayed discharge of such

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# The power of stories

## Meet Monique

> *" You need to believe in yourself that you can do it. Have confidence in yourself. Because it is really hard."*
>
> *- Monique*

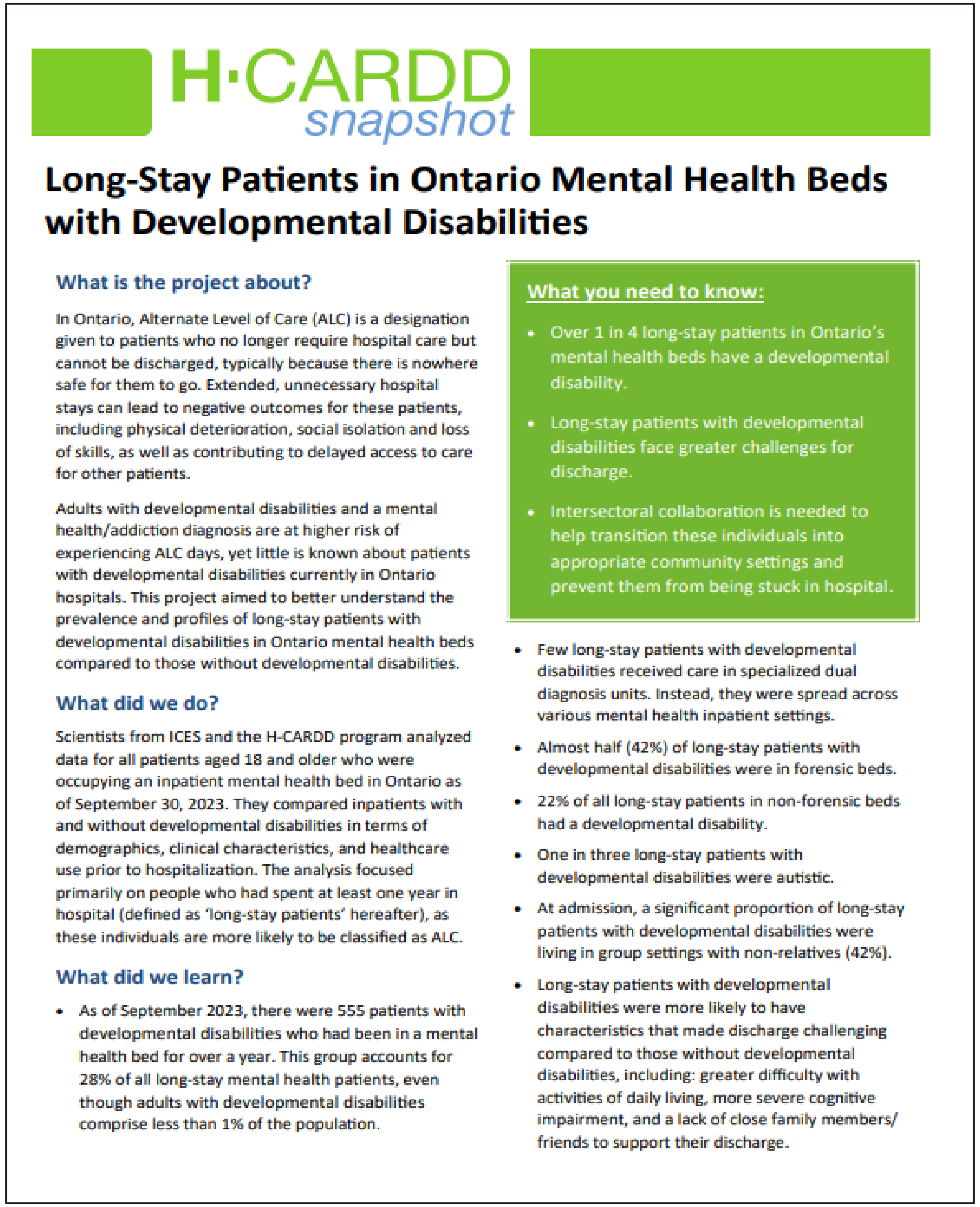
## Meet Amanda

> *"It took more than a year for Amanda to finally move into her apartment. The barriers we faced included insufficient expertise in developmental disabilities within the hospital staff, lack of a centralized process to find housing, and delays getting the budget approved."*
>
> *- Sarah, Amanda's stepmom*

## Meet Taydon

> *"We were fortunate to have a lot of angels in our corner surrounding us with what I wanted to see for my son and setting him up for success. Not the norm, but it is his norm."*
>
> *– Denise, Taydon's mother*

# The power of numbers



H·CARDD snapshot

## Long-Stay Patients in Ontario Mental Health Beds with Developmental Disabilities

### What is the project about?

In Ontario, Alternate Level of Care (ALC) is a designation given to patients who no longer require hospital care but cannot be discharged, typically because there is nowhere safe for them to go. Extended, unnecessary hospital stays can lead to negative outcomes for these patients, including physical deterioration, social isolation and loss of skills, as well as contributing to delayed access to care for other patients.

Adults with developmental disabilities and a mental health/addiction diagnosis are at higher risk of experiencing ALC days, yet little is known about patients with developmental disabilities currently in Ontario hospitals. This project aimed to better understand the prevalence and profiles of long-stay patients with developmental disabilities in Ontario mental health beds compared to those without developmental disabilities.

### What did we do?

Scientists from ICES and the H-CARDD program analyzed data for all patients aged 18 and older who were occupying an inpatient mental health bed in Ontario as of September 30, 2023. They compared inpatients with and without developmental disabilities in terms of demographics, clinical characteristics, and healthcare use prior to hospitalization. The analysis focused primarily on people who had spent at least one year in hospital (defined as 'long-stay patients' hereafter), as these individuals are more likely to be classified as ALC.

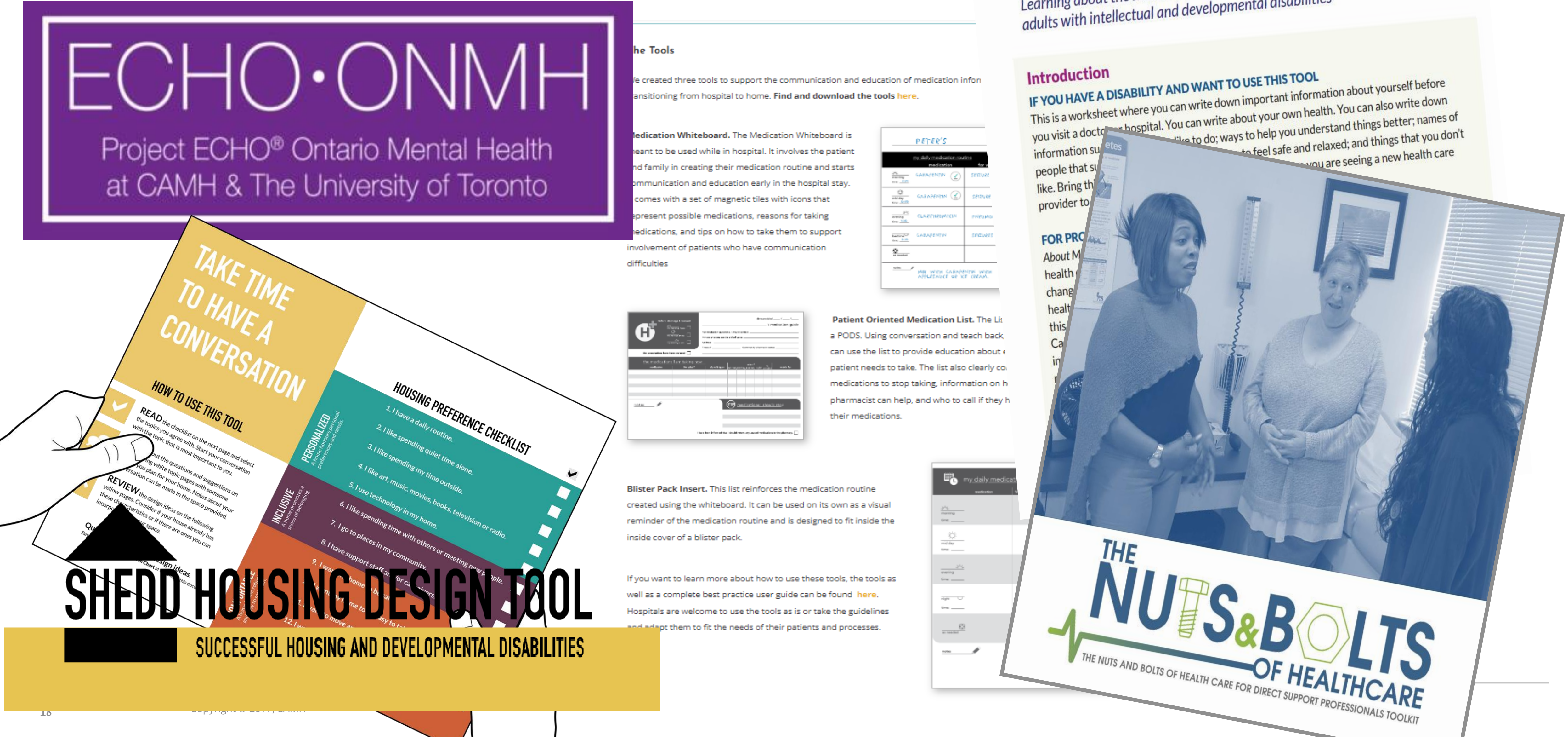
### What did we learn?

- As of September 2023, there were 555 patients with developmental disabilities who had been in a mental health bed for over a year. This group accounts for 28% of all long-stay mental health patients, even though adults with developmental disabilities comprise less than 1% of the population.
- Few long-stay patients with developmental disabilities received care in specialized dual diagnosis units. Instead, they were spread across various mental health inpatient settings.
- Almost half (42%) of long-stay patients with developmental disabilities were in forensic beds.
- 22% of all long-stay patients in non-forensic beds had a developmental disability.
- One in three long-stay patients with developmental disabilities were autistic.
- At admission, a significant proportion of long-stay patients with developmental disabilities were living in group settings with non-relatives (42%).
- Long-stay patients with developmental disabilities were more likely to have characteristics that made discharge challenging compared to those without developmental disabilities, including: greater difficulty with activities of daily living, more severe cognitive impairment, and a lack of close family members/ friends to support their discharge.

**What you need to know:**

- Over 1 in 4 long-stay patients in Ontario's mental health beds have a developmental disability.
- Long-stay patients with developmental disabilities face greater challenges for discharge.
- Intersectoral collaboration is needed to help transition these individuals into appropriate community settings and prevent them from being stuck in hospital.

# Highlighting existing tools and resources



ECHO·ONMH

Project ECHO® Ontario Mental Health
at CAMH & The University of Toronto

TAKE TIME
TO HAVE A
CONVERSATION

HOW TO USE THIS TOOL

**READ** the checklist on the next page and select the topics you agree with. Start your conversation with the topic that is most important to you.

…out the questions and suggestions on …ing white topic pages with someone …you plan for your home. Notes about your …ersation can be made in the space provided.

**REVIEW** the design ideas on the following yellow pages. Consider if your house already has these characteristics or if there are ones you can incorpo… …ur space.

HOUSING PREFERENCE CHECKLIST

PERSONALIZED
A home honours personal preferences and needs.

1. I have a daily routine. ☐
2. I like spending quiet time alone. ☐
3. I like spending my time outside. ☐
4. I like art, music, movies, books, television or radio. ☐
5. I use technology in my home. ☐

INCLUSIVE
A home promotes a sense of belonging.

6. I like spending time with others or meeting new people. ☐
7. I go to places in my community. ☐
8. I have support staff and/or caregivers. ☐

9. I wa… home … ☐

12. I w…

SHEDD HOUSING DESIGN TOOL

SUCCESSFUL HOUSING AND DEVELOPMENTAL DISABILITIES

he Tools

e created three tools to support the communication and education of medication infor ansitioning from hospital to home. **Find and download the tools here.**

**ledication Whiteboard.** The Medication Whiteboard is eant to be used while in hospital. It involves the patient nd family in creating their medication routine and starts ommunication and education early in the hospital stay. comes with a set of magnetic tiles with icons that epresent possible medications, reasons for taking edications, and tips on how to take them to support involvement of patients who have communication difficulties

PETER'S

my daily medication routine

| medication | for w |
|---|---|
| GABAPENTIN ✓ | SEIZURE |
| GABAPENTIN ✓ | SEIZURE |
| CLARITHROMYCIN | PNEUMO |
| GABAPENTIN | SEIZURE |

MIX WITH GABAPENTIN WITH APPLESAUCE OR ICE CREAM.

**Patient Oriented Medication List.** The Lis a PODS. Using conversation and teach back can use the list to provide education about e patient needs to take. The list also clearly co medications to stop taking, information on h pharmacist can help, and who to call if they h their medications.

**Blister Pack Insert.** This list reinforces the medication routine created using the whiteboard. It can be used on its own as a visual reminder of the medication routine and is designed to fit inside the inside cover of a blister pack.

If you want to learn more about how to use these tools, the tools as well as a complete best practice user guide can be found here. Hospitals are welcome to use the tools as is or take the guidelines and adapt them to fit the needs of their patients and processes.

my daily medicat

Developmental Disabilities
Primary Care Program

SURREY PLACE

About My Health

*Learning about the healthcare and communication needs of adults with intellectual and developmental disabilities*

Introduction

IF YOU HAVE A DISABILITY AND WANT TO USE THIS TOOL

This is a worksheet where you can write down important information about yourself before you visit a docto… hospital. You can write about your own health. You can also write down information su… …like to do; ways to help you understand things better; names of people that su… …to feel safe and relaxed; and things that you don't like. Bring th… …you are seeing a new health care provider to…

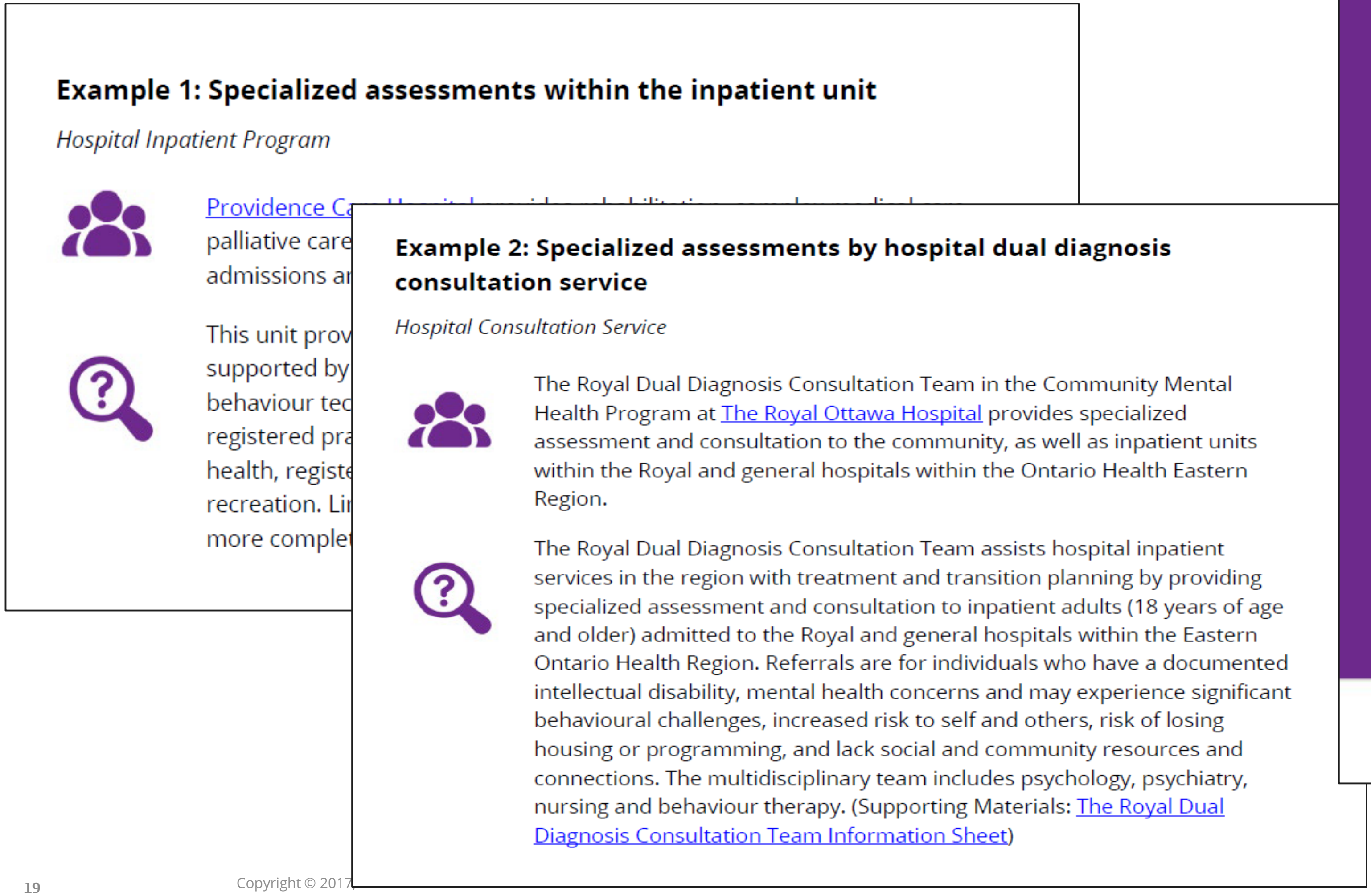
FOR PRO…

About M… health … chang… healt… this… Ca… in…

THE NUTS & BOLTS OF HEALTHCARE

THE NUTS AND BOLTS OF HEALTH CARE FOR DIRECT SUPPORT PROFESSIONALS TOOLKIT

# Facilitating spread of innovative practices



**Example 1: Specialized assessments within the inpatient unit**

*Hospital Inpatient Program*

Providence Ca
palliative care
admissions ar

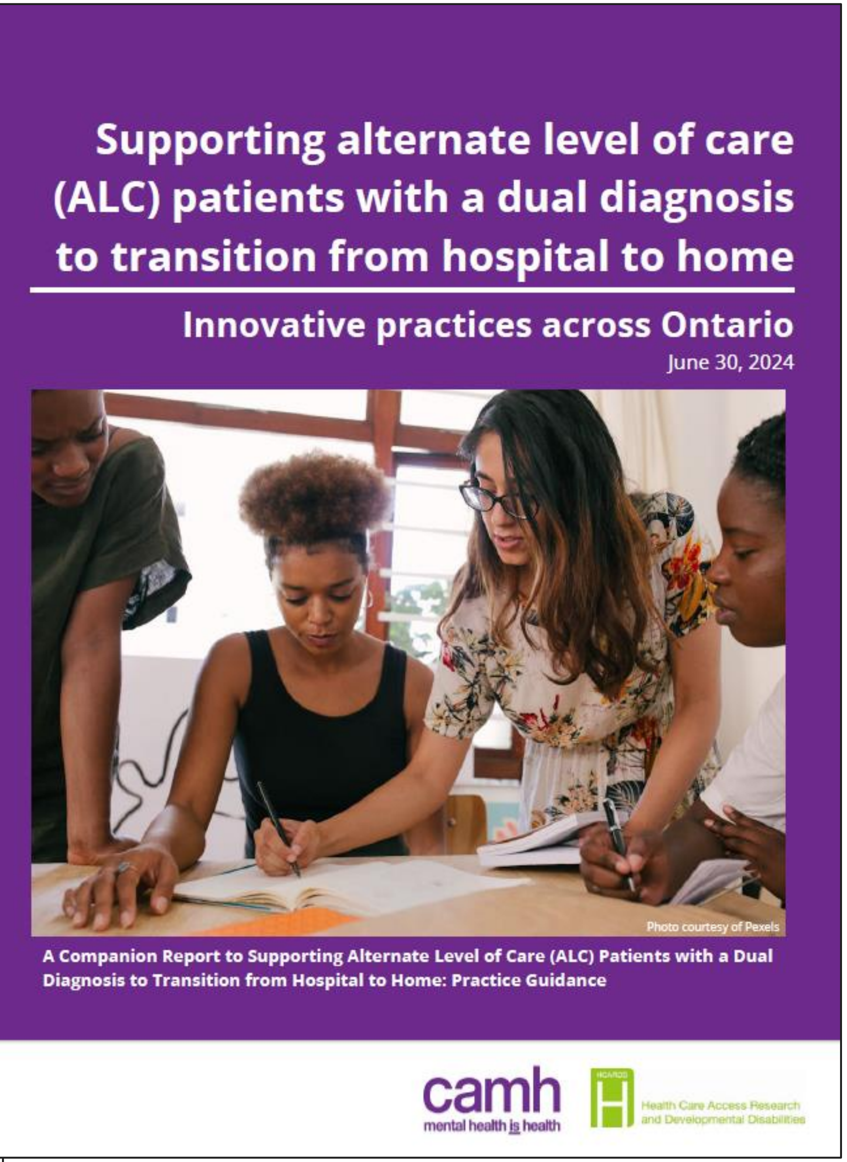
This unit prov
supported by
behaviour tec
registered pra
health, registe
recreation. Li
more comple

**Example 2: Specialized assessments by hospital dual diagnosis consultation service**

*Hospital Consultation Service*

The Royal Dual Diagnosis Consultation Team in the Community Mental Health Program at The Royal Ottawa Hospital provides specialized assessment and consultation to the community, as well as inpatient units within the Royal and general hospitals within the Ontario Health Eastern Region.

The Royal Dual Diagnosis Consultation Team assists hospital inpatient services in the region with treatment and transition planning by providing specialized assessment and consultation to inpatient adults (18 years of age and older) admitted to the Royal and general hospitals within the Eastern Ontario Health Region. Referrals are for individuals who have a documented intellectual disability, mental health concerns and may experience significant behavioural challenges, increased risk to self and others, risk of losing housing or programming, and lack social and community resources and connections. The multidisciplinary team includes psychology, psychiatry, nursing and behaviour therapy. (Supporting Materials: The Royal Dual Diagnosis Consultation Team Information Sheet)



**Supporting alternate level of care (ALC) patients with a dual diagnosis to transition from hospital to home**

**Innovative practices across Ontario**

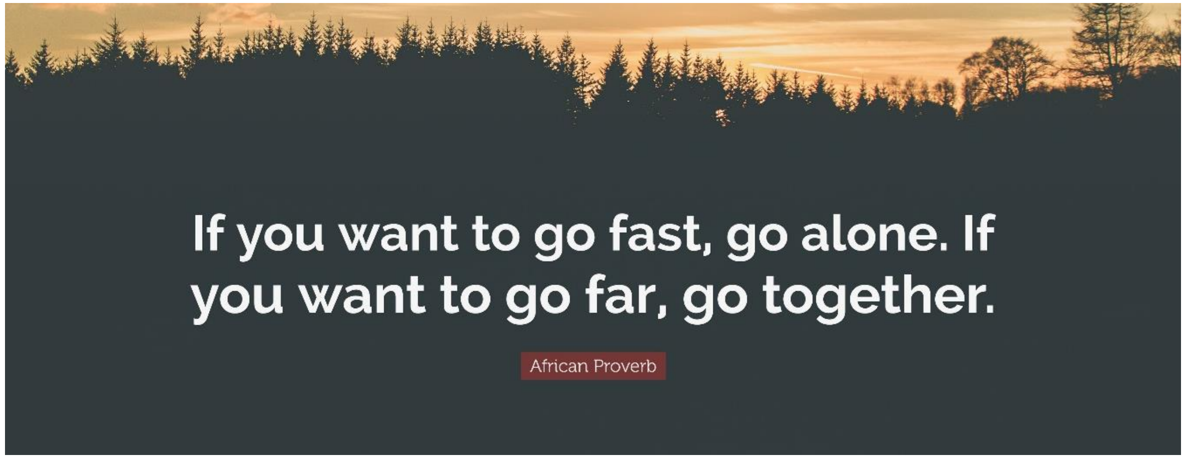
June 30, 2024

Photo courtesy of Pexels

**A Companion Report to Supporting Alternate Level of Care (ALC) Patients with a Dual Diagnosis to Transition from Hospital to Home: Practice Guidance**

# Reflections

- There is power in partnerships
- Knowledge translation is critical but takes time and resources
- One strategy, or even two or three, are not enough- everyone learns differently and speaks a different language!



# Thank you! Questions?

For the full report, summaries (EN and FR), easy read, patient stories, innovative practices- https://www.hcardd.ca

Contact: Avra Selick (avra.selick@camh.ca)

HCARDD Health Care Access Research and Developmental Disabilities

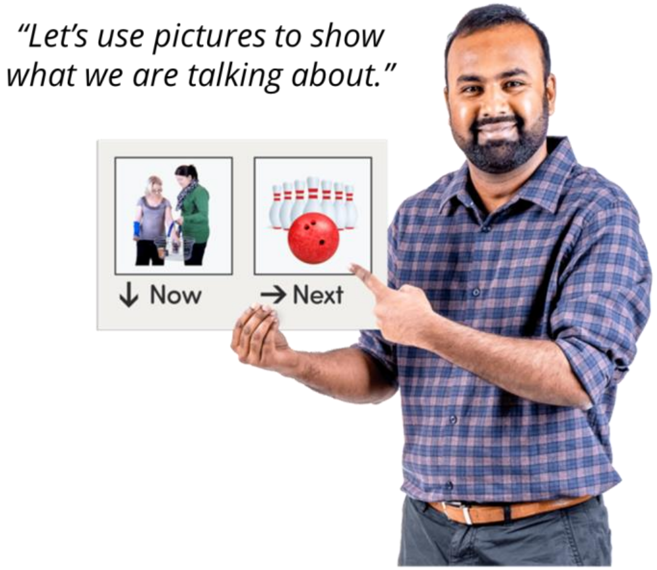
camh

# Transition Principles

- **A hospital is not a person’s home**.
- Adults with a dual diagnosis have the same rights as other Ontarians to be **treated with dignity and respect and to receive high quality care.**
- A successful transition is a **process not an event**.
- Transition planning should be p**erson-centred, culturally sensitive and trauma informed**.
- A successful transition requires **clear, consistent communication** with everyone involved.
- **Health equity, anti-racism and anti-oppression** should be foundational to all aspects of care, including transitions.
- A successful transition **should not rely on patient, family or staff advocacy**.

# Transition Components

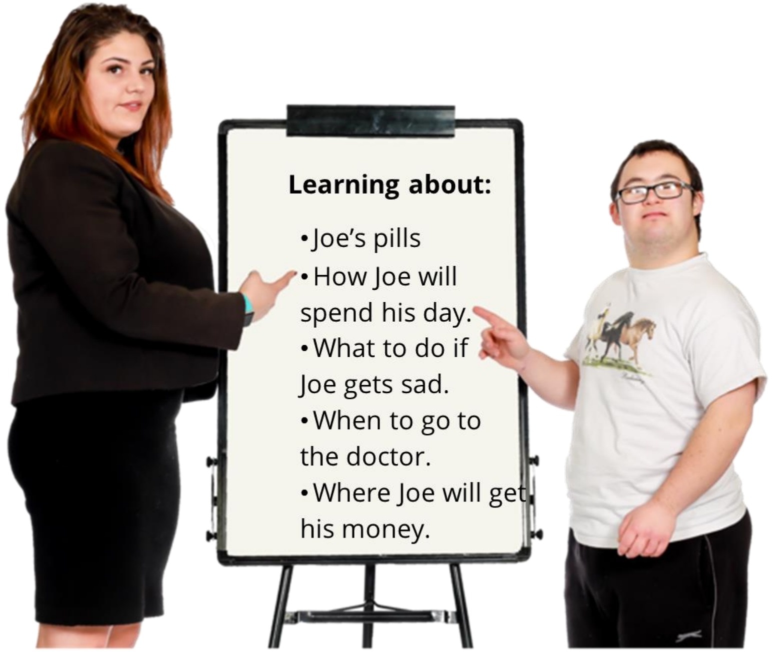
1. Ongoing Information Sharing
2. Comprehensive assessment
3. Patient and family involvement



*"I would like to speak next about an idea I have"*

# Transition Components

## 4. Patient, family and community provider training



## 5. Transition and Community Support Plan

## 6. Graduated, overlapping and coordinated transition

# Transition Components

7. Medication review and support

8. Coordinated follow-up medical and clinical care

# Transition Components

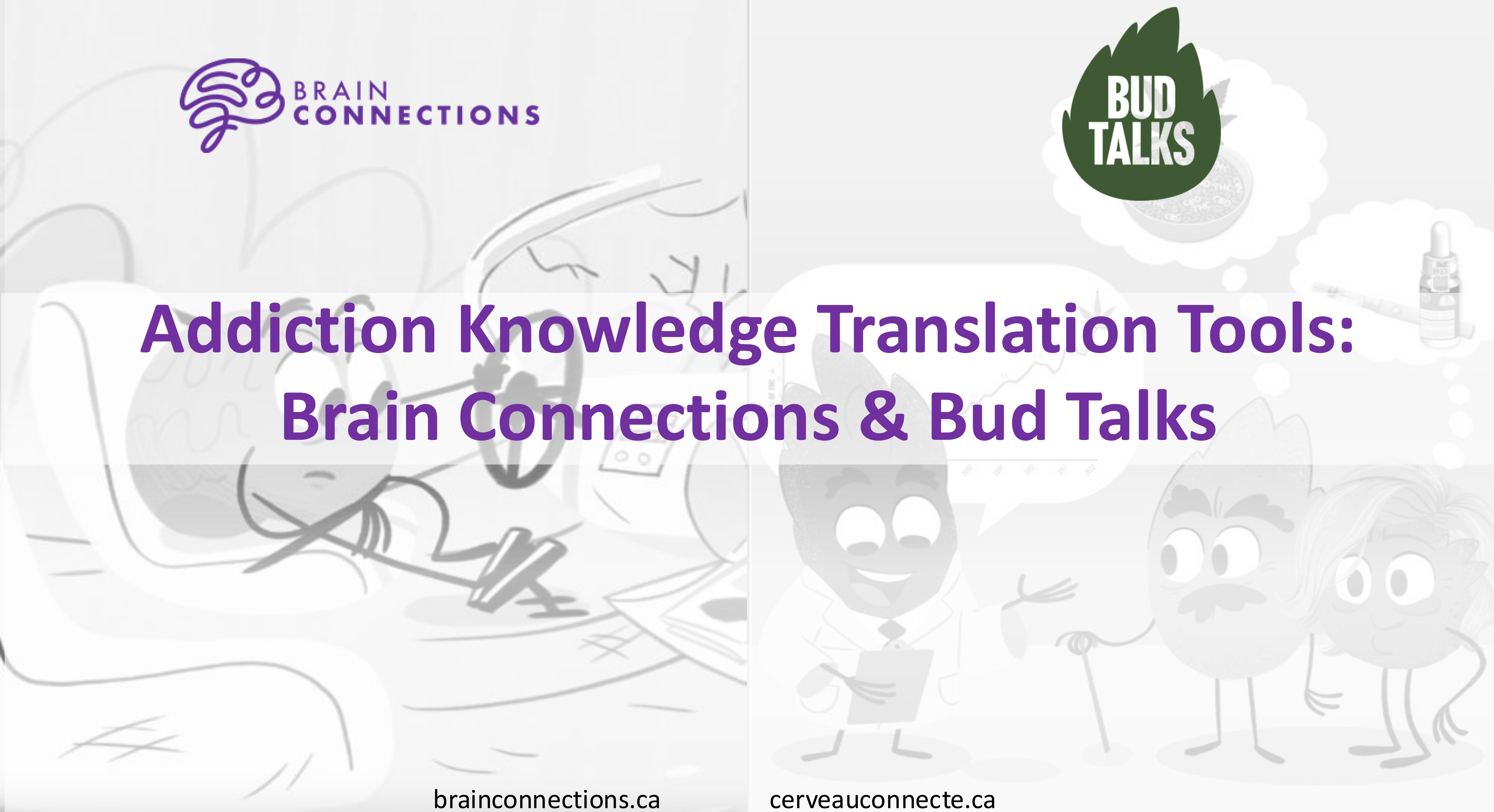
9. Appropriate and timely housing and community support

10. Sufficient and flexible funding

*“The government needs to arrange payment for things.”*

# Initial Impact

- As of December 2024, the ALC page on our website has been viewed 3,326 times by 1,633 unique users
- We have presented on this work in numerous local, national and international forums
- Findings have been shared with the Ontario Ombudsman as part of their ongoing investigation into the plight of adults with developmental disabilities inappropriately housed in hospital
- The ALC resources have been incorporated into work conducted by the Link Centre, a US organization working to bridge the IDD and mental health sectors, and Cincinnati Children's Hospital has expressed interest in adapting some of the tools and resources for youth who are ALC



# Addiction Knowledge Translation Tools: Brain Connections & Bud Talks

brainconnections.ca cerveauconnecte.ca

budtalks.ca

# The Team

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McMaster University

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Susan Boyd

Vidhi Patel

Val Cole

Zoe Smith

Will deLieveseley

Sarah Brassard

Luke Barkovich

Nikki Pangborn

Claudia Meneguzzi

Emily Dye

**Deirdre Querney, MSW**

Registered Social Worker
Canadian Certified Addiction Counsellor &
Canadian Certified Problem Gambling Counsellor
City of Hamilton’s
Alcohol, Drug & Gambling Services

# Knowledge Translation (KT)

Bridging The Gap

# Our Partnership

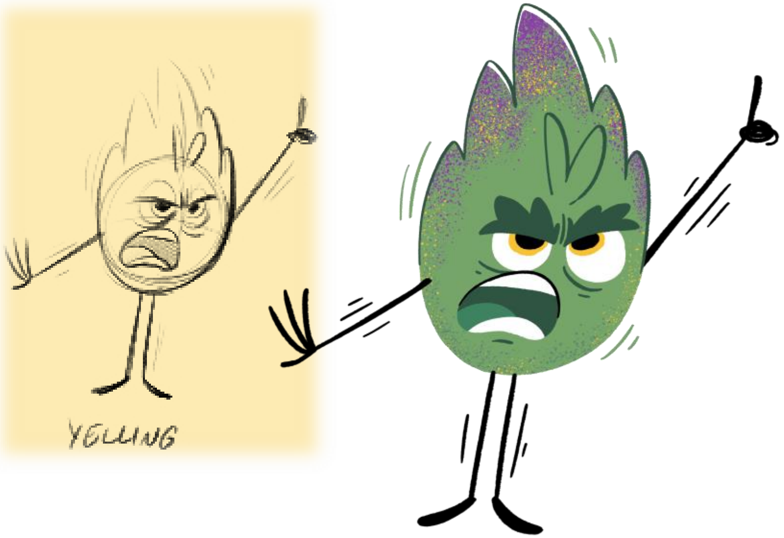
- Merging experience
- Back-and-forth dialogue
- Momentum

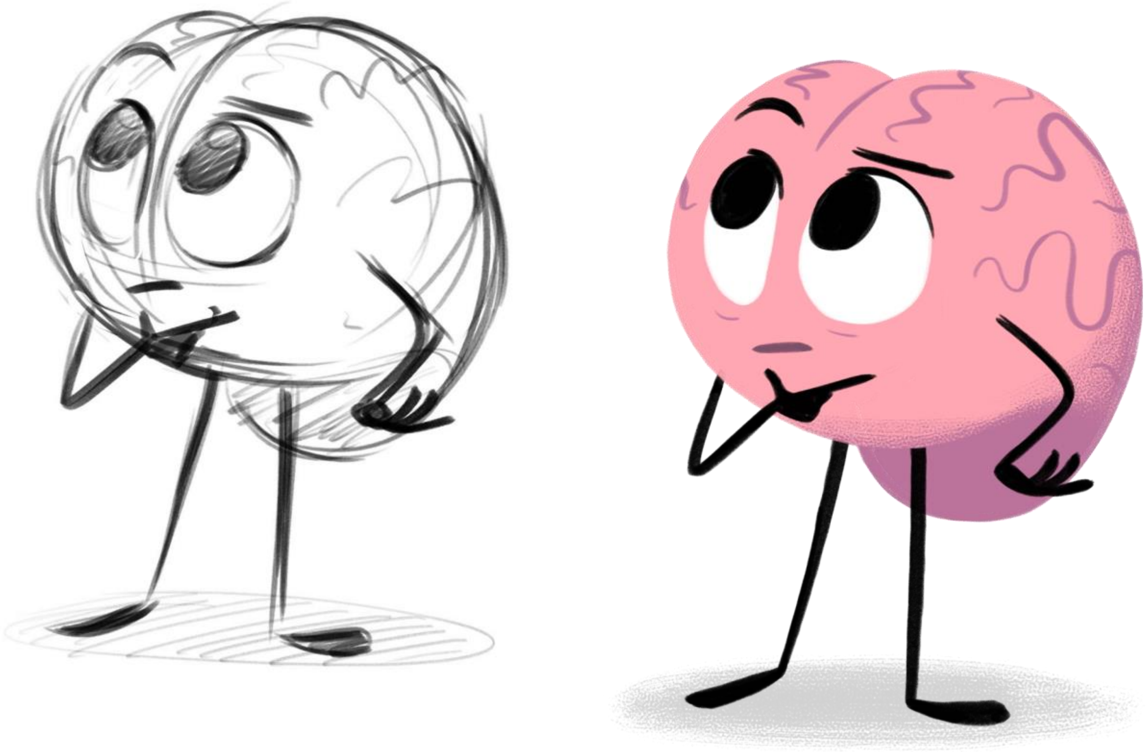
# Challenges

- Funding
- Meaningful, Accessible Content
- Stigma & Shame

## Content

- Person-friendly
- Engaging
- Accessible
- Evidence-Based



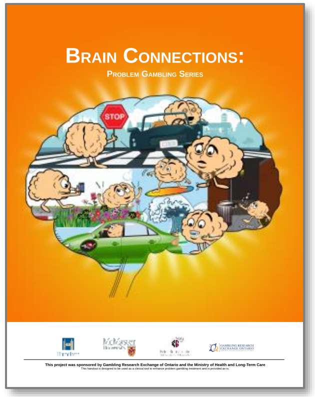


# BRAIN CONNECTIONS

www.brainconnections.ca

## BE Briefs

## Clinical Handouts



## Resources

BRAIN CONNECTIONS
Understanding Addiction and the Brain

Educational Tools about Gambling and the Brain

RG Resources

Video

Website

Clinical Handouts

www.brainconnections.ca

Researcher – Clinician Collaboration

## Bilingual Translations

BRAIN CONNECTIONS

BBC NEWS فارسی

Lotería de la Ciudad

the agenda
with Steve Paikin

ALLY
addiction consulting

ILLINOIS COUNCIL ON PROBLEM GAMBLING

marketplace

greo

CENTRE DE RÉFÉRENCE DU GRAND MONTRÉAL

DROGUE AIDE ET RÉFÉRENCE

JEU AIDE ET RÉFÉRENCE

ALL IN
THE ADDICTED GAMBLER'S PODCAST
A CONVERSATION ABOUT GAMBLING ADDICTION

The Massachusetts Council on GAMING AND HEALTH

ICRG
INTERNATIONAL CENTER FOR RESPONSIBLE GAMING

Fold em
HELP FOR GAMBLING PROBLEMS

ASU
Arizona State University

NEW HORIZONS
IN SAFER GAMBLING

CFMWS SBMFC

Canadian Centre on Substance Use and Addiction

GambleAware

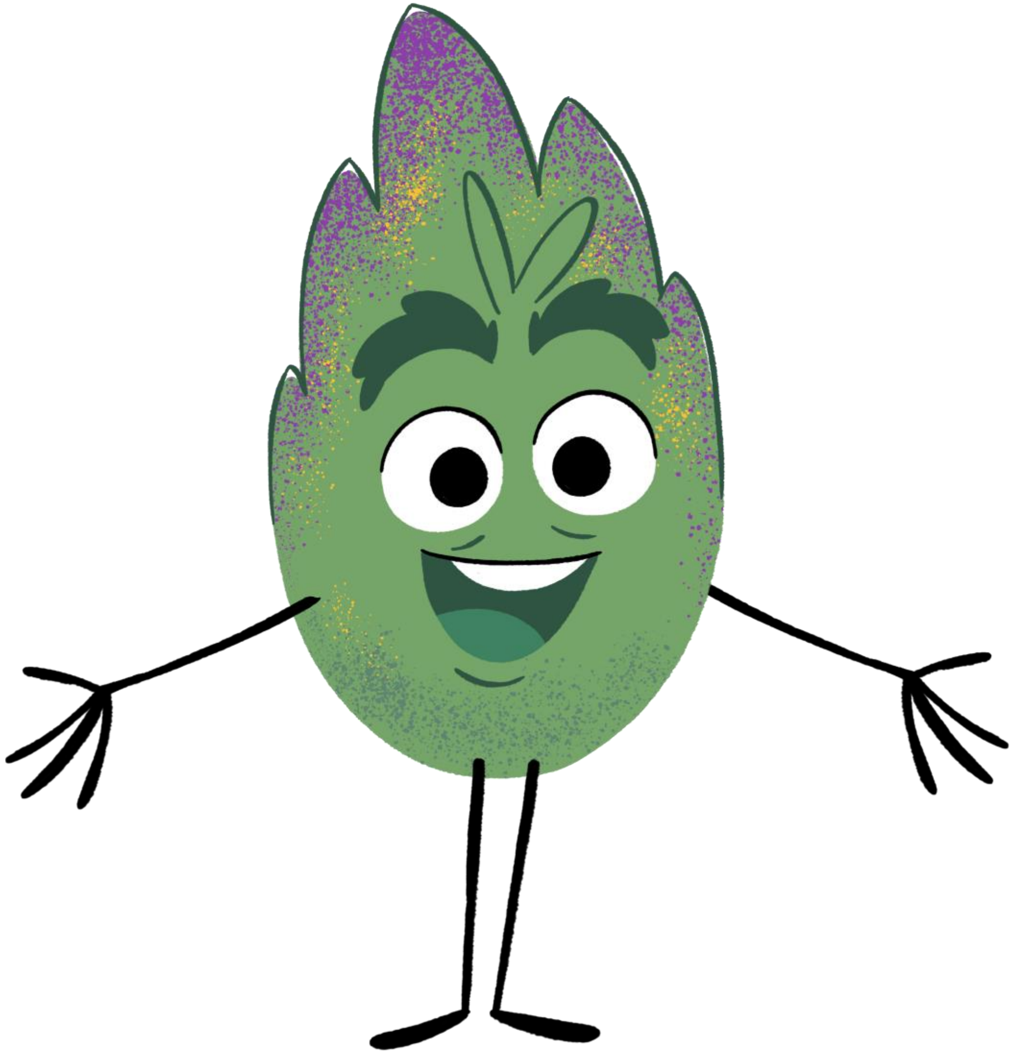
Chronic Pain Centre of Excellence for Canadian Veterans

BRAIN CONNECTIONS

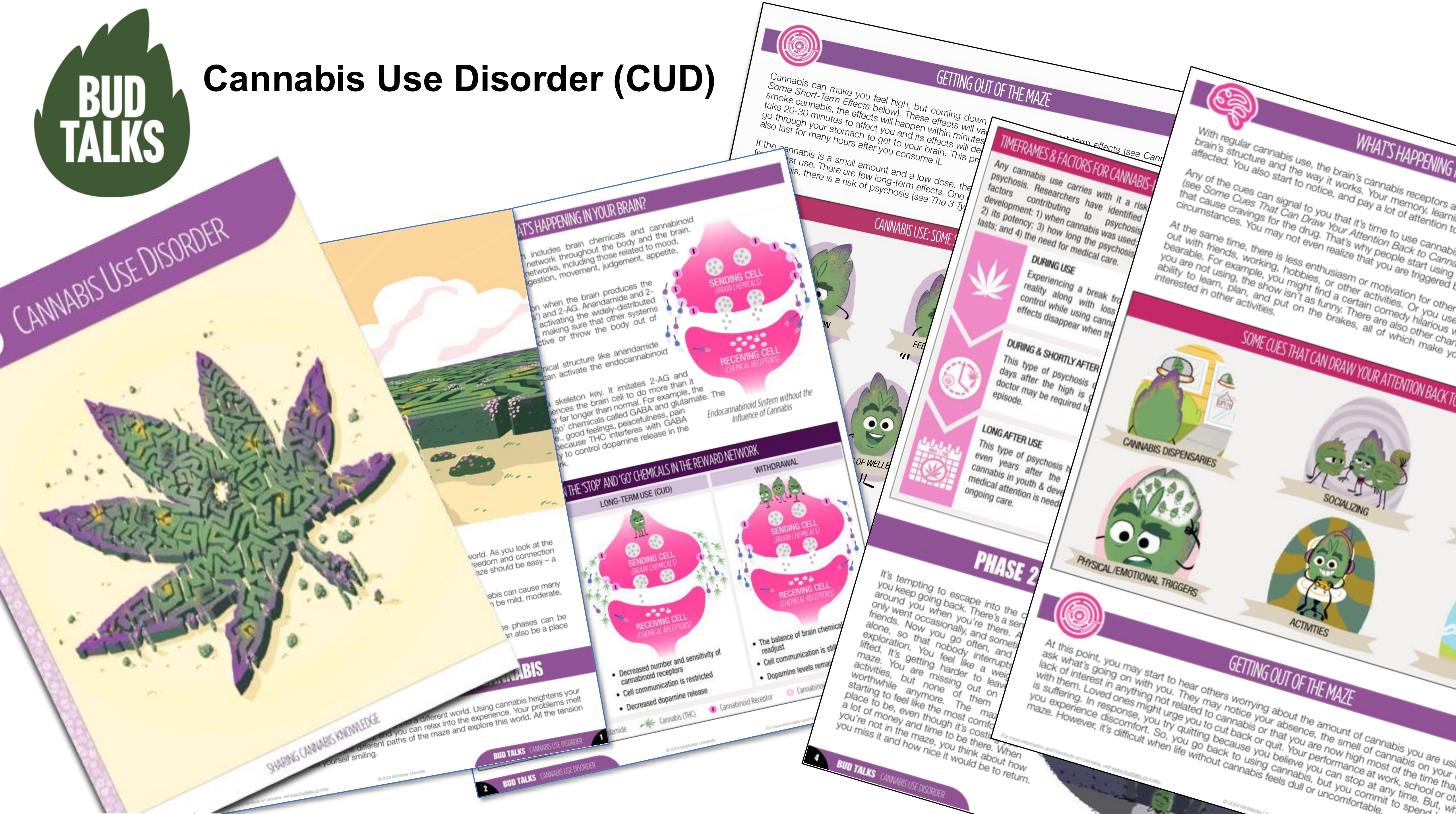
# The International Center for Responsible Gaming Scientific Achievement Award 2023

BUD TALKS

www.budtalks.ca



# Cannabis Use Disorder (CUD)



CANNABIS USE DISORDER

SHARING CANNABIS KNOWLEDGE

world. As you look at the
reedom and connection
aze should be easy – a

abis can cause many
be mild, moderate,

e phases can be
n also be a place

ABIS

a different world. Using cannabis heightens your
and you can relax into the experience. Your problems melt
different paths of the maze and explore this world. All the tension
yourself smiling.

BUD TALKS CANNABIS USE DISORDER 1

AT'S HAPPENING IN YOUR BRAIN?

n includes brain chemicals and cannabinoid
network throughout the body and the brain.
networks, including those related to mood,
gestion, movement, judgement, appetite,

on when the brain produces the
s') and 2-AG. Anandamide and 2-
activating the widely-distributed
making sure that other systems
ctive or throw the body out of

nical structure like anandamide
can activate the endocannabinoid

skeleton key. It imitates 2-AG and
ences the brain cell to do more than it
or far longer than normal. For example, the
go' chemicals called GABA and glutamate. The
., good feelings, peacefulness, pain
ecause THC interferes with GABA
y to control dopamine release in the
rk.

SENDING CELL (BRAIN CHEMICALS)

RECEIVING CELL (CHEMICAL RECEPTORS)

*Endocannabinoid System without the Influence of Cannabis*

THE 'STOP' AND 'GO' CHEMICALS IN THE REWARD NETWORK

LONG-TERM USE (CUD)

- Decreased number and sensitivity of cannabinoid receptors
- Cell communication is restricted
- Decreased dopamine release

WITHDRAWAL

- The balance of brain chemical readjust
- Cell communication is sti
- Dopamine levels remai

damide Cannabis (THC) Cannabinoid Receptor Cannabino

BUD TALKS CANNABIS USE DISORDER 2

GETTING OUT OF THE MAZE

Cannabis can make you feel high, but coming down
Some Short-Term Effects below). These effects will va
smoke cannabis, the effects will happen within minutes
take 20-30 minutes to affect you and its effects will de
go through your stomach to get to your brain. This pr
also last for many hours after you consume it.

If the cannabis is a small amount and a low dose, the
st use. There are few long-term effects. One
is, there is a risk of psychosis (see The 3 Ty

CANNABIS USE: SOME S

OF WELLB

TIMEFRAMES & FACTORS FOR CANNABIS-

Any cannabis use carries with it a risk
psychosis. Researchers have identified
factors contributing to psychosis
development: 1) when cannabis was used;
2) its potency; 3) how long the psychosis
lasts; and 4) the need for medical care.

DURING USE

Experiencing a break fro
reality along with loss
control while using canna
effects disappear when th

DURING & SHORTLY AFTER

This type of psychosis o
days after the high is g
doctor may be required t
episode.

LONG AFTER USE

This type of psychosis h
even years after the
cannabis in youth & deve
medical attention is need
ongoing care.

PHASE 2

It's tempting to escape into the c
you keep going back. There's a sen
around you when you're there. A
only went occasionally, and someti
friends. Now you go often, and
alone, so that nobody interrupts
exploration. You feel like a wei
lifted. It's getting harder to leav
maze. You are missing out on
activities, but none of them
worthwhile anymore. The maz
starting to feel like the most comfo
place to be, even though it's costi
a lot of money and time to be there. When
you're not in the maze, you think about how
you miss it and how nice it would be to return.

BUD TALKS CANNABIS USE DISORDER 4

WHAT'S HAPPENING

With regular cannabis use, the brain's cannabis receptors a
brain's structure and the way it works. Your memory, learni
affected. You also start to notice, and pay a lot of attention t

Any of the cues can signal to you that it's time to use cannabi
(see Some Cues That Can Draw Your Attention Back to Canna
that cause cravings for the drug. That's why people start using
circumstances. You may not even realize that you are triggered b

At the same time, there is less enthusiasm or motivation for other
out with friends, working, hobbies, or other activities. Or you use
bearable. For example, you might find a certain comedy hilarious w
you are not using, the show isn't as funny. There are also other chan
ability to learn, plan, and put on the brakes, all of which make y
interested in other activities.

SOME CUES THAT CAN DRAW YOUR ATTENTION BACK TO

CANNABIS DISPENSARIES

SOCIALIZING

PHYSICAL/EMOTIONAL TRIGGERS

ACTIVITIES

GETTING OUT OF THE MAZE

At this point, you may start to hear others worrying about the amount of cannabis you are usi
ask what's going on with you. They may notice your absence, the smell of cannabis on your
lack of interest in anything not related to cannabis or that you are now high most of the time tha
with them. Loved ones might urge you to cut back or quit. Your performance at work, school or
is suffering. In response, you try quitting because you believe you can stop at any time. But, w
you experience discomfort. So, you go back to using cannabis, but you commit to spend
maze. However, it's difficult when life without cannabis feels dull or uncomfortable.

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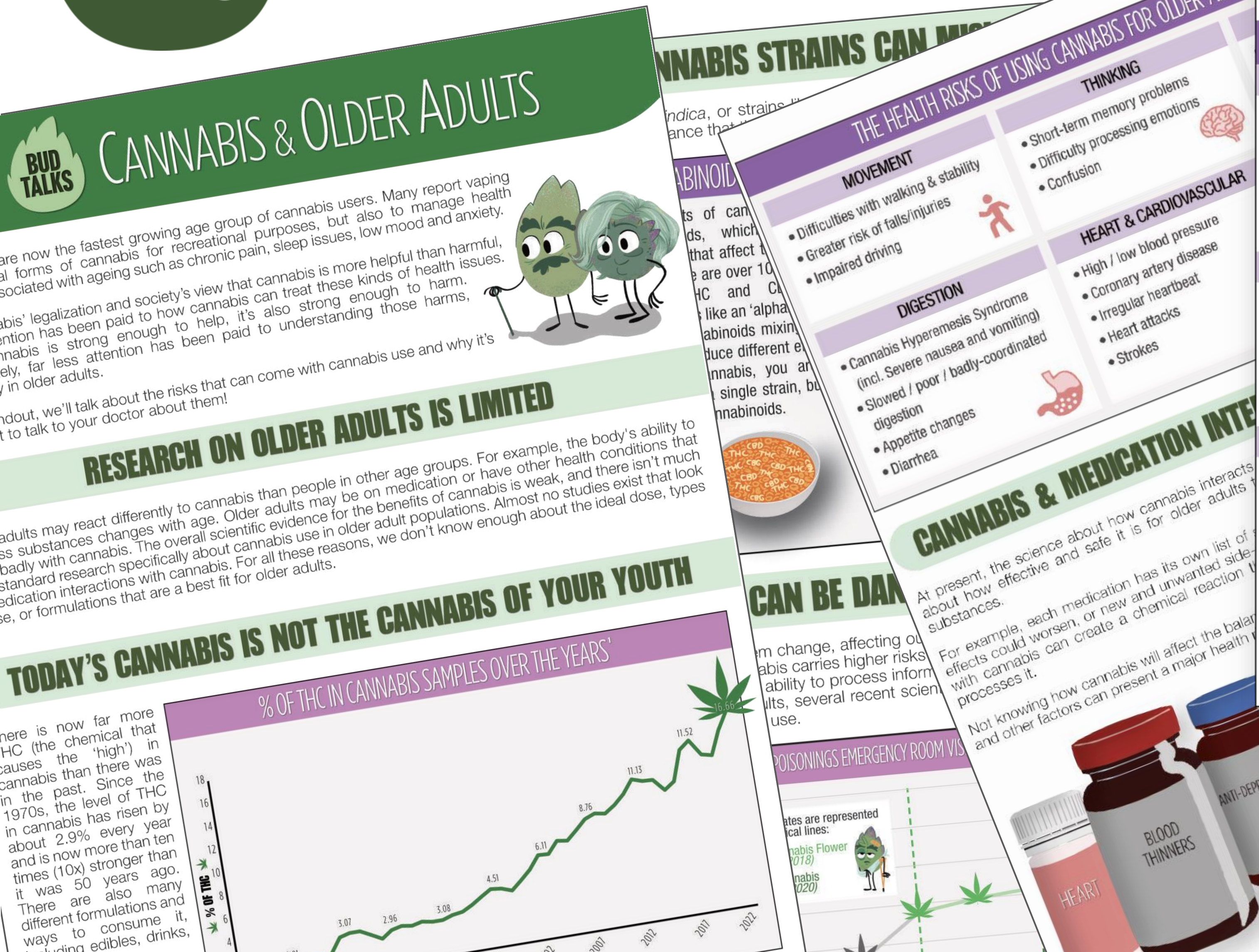
# Cannabis and Older Adults



## CANNABIS & OLDER ADULTS

are now the fastest growing age group of cannabis users. Many report vaping
al forms of cannabis for recreational purposes, but also to manage health
sociated with ageing such as chronic pain, sleep issues, low mood and anxiety.

abis' legalization and society's view that cannabis is more helpful than harmful,
ention has been paid to how cannabis can treat these kinds of health issues.
nnabis is strong enough to help, it's also strong enough to harm.
ely, far less attention has been paid to understanding those harms,
y in older adults.

ndout, we'll talk about the risks that can come with cannabis use and why it's
t to talk to your doctor about them!

## RESEARCH ON OLDER ADULTS IS LIMITED

adults may react differently to cannabis than people in other age groups. For example, the body's ability to
ss substances changes with age. Older adults may be on medication or have other health conditions that
badly with cannabis. The overall scientific evidence for the benefits of cannabis is weak, and there isn't much
standard research specifically about cannabis use in older adult populations. Almost no studies exist that look
edication interactions with cannabis. For all these reasons, we don't know enough about the ideal dose, types
se, or formulations that are a best fit for older adults.

## TODAY'S CANNABIS IS NOT THE CANNABIS OF YOUR YOUTH

here is now far more
HC (the chemical that
causes the 'high') in
cannabis than there was
in the past. Since the
1970s, the level of THC
in cannabis has risen by
about 2.9% every year
and is now more than ten
times (10x) stronger than
it was 50 years ago.
There are also many
different formulations and
ways to consume it,
including edibles, drinks,

% OF THC IN CANNABIS SAMPLES OVER THE YEARS'

## NNABIS STRAINS CAN MI

ndica, or strains
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ABINOID

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that affect t
e are over 10
HC and C
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single strain, bu
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## CAN BE DAN

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use.

POISONINGS EMERGENCY ROOM VIS

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## THE HEALTH RISKS OF USING CANNABIS FOR OLDER ADULTS

### MOVEMENT

- Difficulties with walking & stability
- Greater risk of falls/injuries
- Impaired driving

### THINKING

- Short-term memory problems
- Difficulty processing emotions
- Confusion

### DIGESTION

- Cannabis Hyperemesis Syndrome (incl. Severe nausea and vomiting)
- Slowed / poor / badly-coordinated digestion
- Appetite changes
- Diarrhea

### HEART & CARDIOVASCULAR

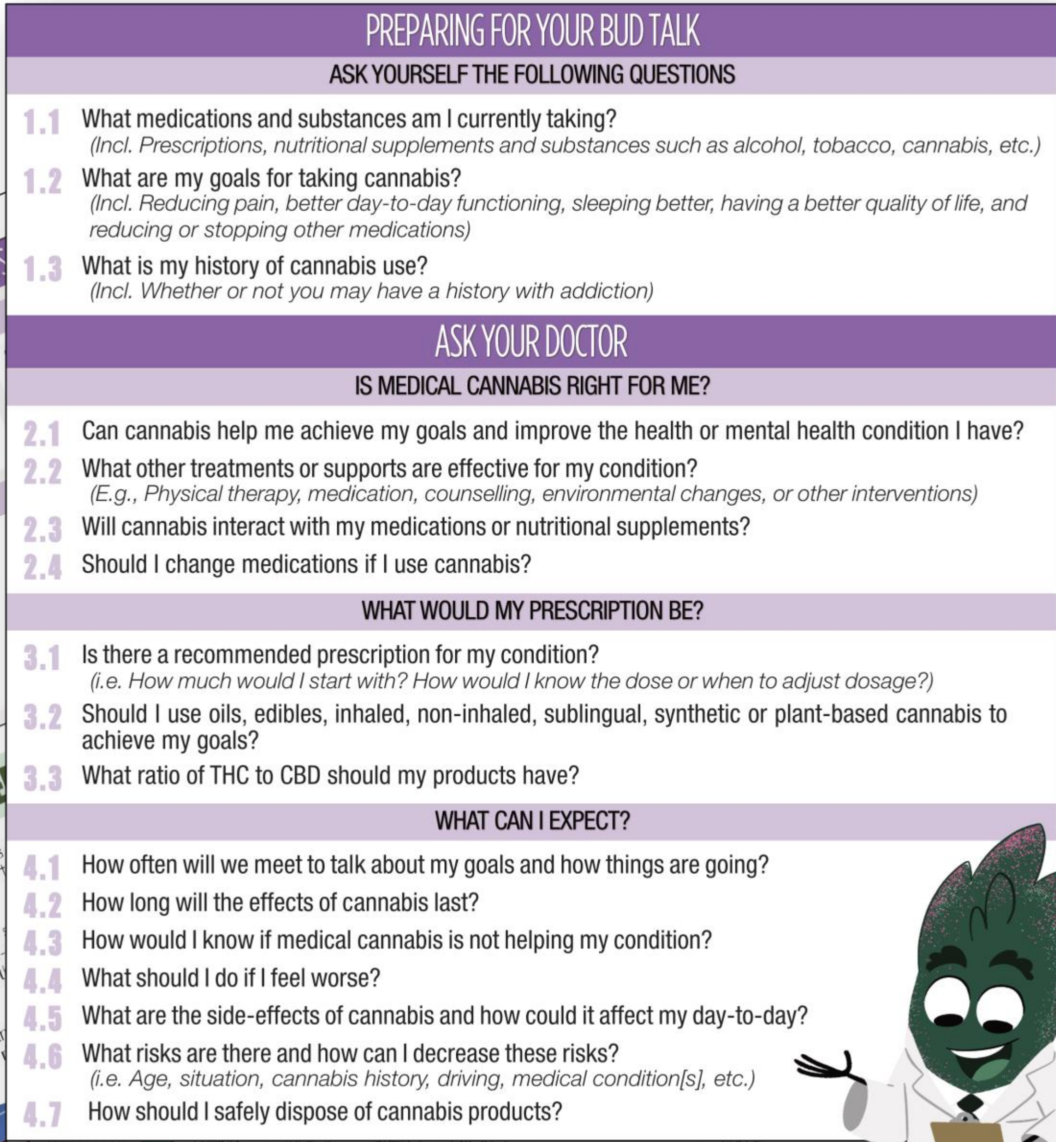
- High / low blood pressure
- Coronary artery disease
- Irregular heartbeat
- Heart attacks
- Strokes

## CANNABIS & MEDICATION INTE

At present, the science about how cannabis interacts
about how effective and safe it is for older adults
substances.

For example, each medication has its own list of
effects could worsen, or new and unwanted side-
with cannabis can create a chemical reaction
processes it.

Not knowing how cannabis will affect the balan
and other factors can present a major health



## PREPARING FOR YOUR BUD TALK

### ASK YOURSELF THE FOLLOWING QUESTIONS

1.1 What medications and substances am I currently taking?
*(Incl. Prescriptions, nutritional supplements and substances such as alcohol, tobacco, cannabis, etc.)*

1.2 What are my goals for taking cannabis?
*(Incl. Reducing pain, better day-to-day functioning, sleeping better, having a better quality of life, and reducing or stopping other medications)*

1.3 What is my history of cannabis use?
*(Incl. Whether or not you may have a history with addiction)*

## ASK YOUR DOCTOR

### IS MEDICAL CANNABIS RIGHT FOR ME?

2.1 Can cannabis help me achieve my goals and improve the health or mental health condition I have?

2.2 What other treatments or supports are effective for my condition?
*(E.g., Physical therapy, medication, counselling, environmental changes, or other interventions)*

2.3 Will cannabis interact with my medications or nutritional supplements?

2.4 Should I change medications if I use cannabis?

### WHAT WOULD MY PRESCRIPTION BE?

3.1 Is there a recommended prescription for my condition?
*(i.e. How much would I start with? How would I know the dose or when to adjust dosage?)*

3.2 Should I use oils, edibles, inhaled, non-inhaled, sublingual, synthetic or plant-based cannabis to achieve my goals?

3.3 What ratio of THC to CBD should my products have?

### WHAT CAN I EXPECT?

4.1 How often will we meet to talk about my goals and how things are going?

4.2 How long will the effects of cannabis last?

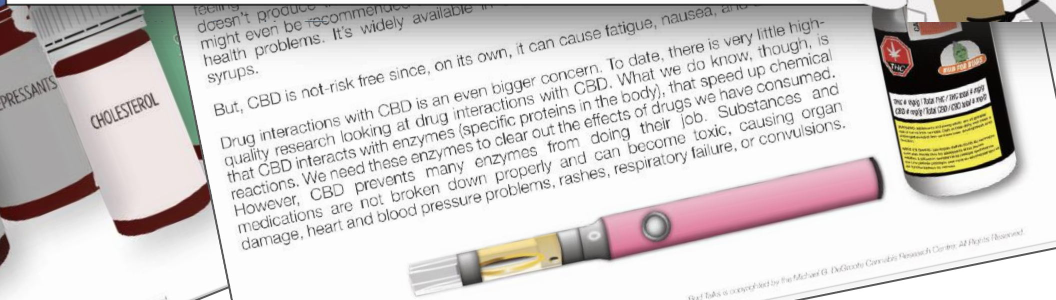
4.3 How would I know if medical cannabis is not helping my condition?

4.4 What should I do if I feel worse?

4.5 What are the side-effects of cannabis and how could it affect my day-to-day?

4.6 What risks are there and how can I decrease these risks?
*(i.e. Age, situation, cannabis history, driving, medical condition[s], etc.)*

4.7 How should I safely dispose of cannabis products?



feeling
doesn't produce
might even be recommended
health problems. It's widely available in
syrups.

But, CBD is not-risk free since, on its own, it can cause fatigue, nausea, and

Drug interactions with CBD is an even bigger concern. To date, there is very little high-quality research looking at drug interactions with CBD. What we do know, though, is that CBD interacts with enzymes (specific proteins in the body), that speed up chemical reactions. We need these enzymes to clear out the effects of drugs we have consumed. However, CBD prevents many enzymes from doing their job. Substances and medications are not broken down properly and can become toxic, causing organ damage, heart and blood pressure problems, rashes, respiratory failure, or convulsions.

BUD TALKS

# Have a **_Bud Talk_** with your doctor!

## PREPARING FOR YOUR BUD TALK

### ASK YOURSELF THE FOLLOWING QUESTIONS

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*(incl. prescriptions, nutritional supplements and substances such as alcohol, tobacco, cannabis, etc.)*

1.2 What are my goals for taking cannabis?
*(incl. reducing pain, better day-to-day functioning, sleeping better, having a better quality of life, enjoyment/recreation/relaxation, and reducing or stopping other medications)*

1.3 What is my history of cannabis use?
*(incl. whether or not you may have a history with addiction)*

## ASK YOUR DOCTOR

### IS CANNABIS RIGHT FOR ME?

2.1 Can cannabis help me achieve my goals and/or improve the health condition I have?

2.2 What other resources, treatments or supports could help me?
*(e.g. physical therapy, medication, counselling, recreation, environmental changes, etc.)*

2.3 Will cannabis interact with my medications or nutritional supplements?

2.4 Should I change medications if I use cannabis?

2.5 Is there a recommended prescription for my condition?
*(i.e. how much would I start with? How would I know the dose or when to adjust dosage?)*

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# Youth Gaming and Gambling

**Clinical Handout**

GAMING'S EFFECTS ON YOUNG BRAINS

RISK FACTORS & VIDEO GAME DESIGN

Video gaming is the most popular leisure activity in the world. Billions of gamers enjoy the entertainment, challenge, and reward of video games.

Video games are used to teach skills such as math, reading, and problem-solving, and so youth are often exposed to them early in their development. Most youth continue to game into adolescence and early adulthood.

WHY DO OUR BRAINS RESPOND SO STRONGLY TO VIDEO GAMES?

While most people enjoy video games, they are particularly attractive to youth and emerging adults. When you're young, your brain is programmed to seek out new experiences.

Gaming draws you in because it's new and exciting. Games allow you to explore different environments, create new identities, and try things you could never do in real life. For some, video games are a main pathway to social connection, skill building and self-confidence. Certain gamers can even get money and fame by hosting their own social media channels or competing in e-sports (e.g., on Twitch or YouTube).

The reward network of the brain lights up for winning experiences including seeing your name on the leaderboard or getting 'followers' on your social media channel. It's like the rush of riding down a hill fast or flooring the gas pedal of a car.

WHAT TYPES OF VIDEO GAMES ARE THERE?

Though Tetris and Minecraft are still some of the best-selling video games of all time*, there are many types of games on the market, including:

*For more details on the types of games and references, see the Brain Connections Gaming Primer on our website.

**BE Brief**

SIGNS OF A GAMING PROBLEM

By the time gaming becomes a problem, it's like you're in a cave – never looking out. The longer you're in the cave, the scarier the outside world can feel.

You lose perspective and skills for day-to-day living. Your urge to game is strong. You feel low or depressed when you aren't gaming. Even when you are gaming, your mood can suffer if you are losing in the game or being harassed by other gamers.

*These are the signs of a gaming problem:*

WHAT CAN I DO IF MY GAMING'S A PROBLEM?

When gaming becomes a problem, some people quit altogether, while others may cut back or make changes to reduce the harm. If gaming is grinding your gears:

- TALK TO FAMILY, FRIENDS, A COUNSELLOR OR HEALTHCARE PROVIDER ABOUT YOUR CONCERNS
- SET YOUR PRIORITIES & LIMITS BEFORE GAMING, INCL. PLAYTIME & PURCHASE LIMITS
- TURN OFF DEVICES AT NIGHT
- FOCUS ON SELF-CARE LIKE EATING HEALTHY, HYGIENE, AND REST/SLEEP
- ENJOY OFFLINE ACTIVITIES
- PLAY GAMES THAT AREN'T A PROBLEM FOR YOU
- JOURNAL THOUGHTS AND FEELINGS ABOUT HOW YOUR GAMING AFFECTS YOU

CONNECT WITH THE WORLD OUTSIDE

The good news is that the brain is always changing as it takes shape with different experiences. It helps to get out of the cave, explore, and connect with the world around you. When you take regular breaks and stay away from games that cause you problems, you can build the strength and ability to walk away from gaming when you need to.

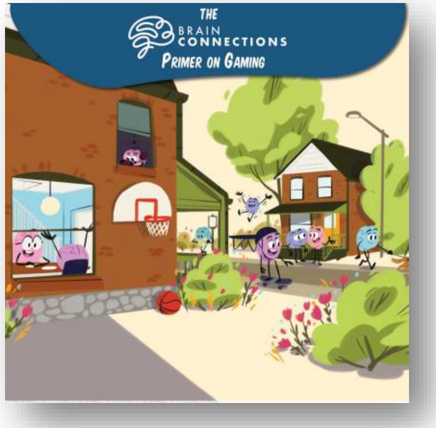
For more info & resources on youth gaming and gambling, visit:

BRAIN CONNECTIONS.CA

BRAIN CONNECTIONS PRESENTS

YOUNG BRAINS & VIDEO GAMES

**Gaming Primer**



THE BRAIN CONNECTIONS PRIMER ON GAMING

**Video**

Peter Boris Centre
FOR ADDICTIONS RESEARCH

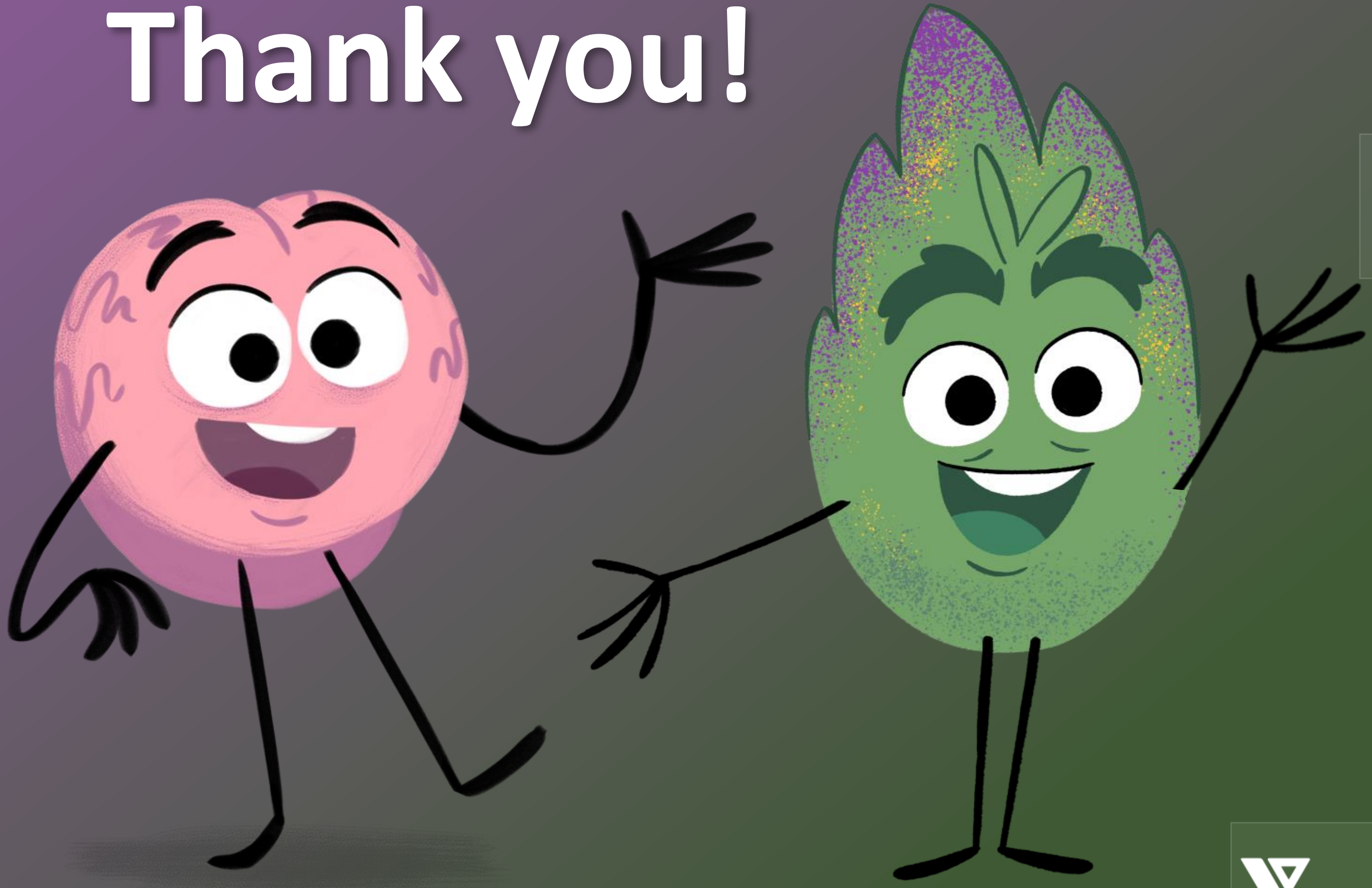
McMaster University

Hamilton

# Thank you!

CIHR IRSC
Canadian Institutes of Health Research Instituts de recherche en santé du Canada

Michael G. DeGroote Centre for Medicinal Cannabis Research



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YMCA
Youth Gambling Awareness Program (YGAP)