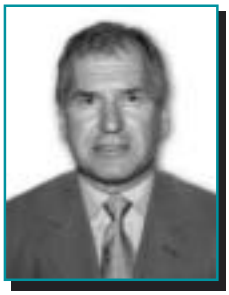
Ontario Psychiatric Association
DIALOGUE
THE NEWSLETTER OF THE ONTARIO PSYCHIATRIC ASSOCIATION/UNE PUBLICATION DE L'ASSOCIATION DES PSYCHIATRES DE L'ONTARIO
DECEMBER
2003



MESSAGE FROM THE PRESIDENT

The OPA has remained active on many fronts to represent psychiatry. We have worked hard with the Coalition of Ontario Psychiatrists to represent your interests. Dr. Doug Weir provides a very useful summary of the Coalition's activities in this issue. We are hopeful that in the new year we will have positive information to share with you about mental heath reform and the government's plans to provide better and more accessible services to those with mental illness.

During 2003 we worked to solidify an already excellent working relationship with the Canadian Psychiatric Association by ensuring that Ontario representatives were OPA Council members who could keep OPA informed on a regular basis about CPA activities and CPA informed on OPA activities. In addition to myself, Dr. Keith Anderson, Roumen Milev, Andrew Moulden, Derek Puddester and Bob Swenson are CPA committee members. The OPA also provides the CPA with biannual reports on important Ontario issues which helps us to work together as needed. The OPA also participated in meetings to create a national mental health policy in conjunction with the CPA and other national and provincial groups.

During the year, OPA Council welcomed Dr. Karen Hand as a Council member to replace Dr. Clare Pain who was unable to complete her term of office for personal reasons. Dr. Hand had been a Council member many years ago so we were pleased that she could join us.

OPA Standing Committees tackled important topics under discussion at Council. The Member Services Committee worked on reviewing member needs, based on survey results and comments from members. The Communications Committee discussed topics related to the newsletter and has developed a plan for a website which will be reviewed in the coming year. The Advocacy Committee has been active with issues related to the Consent and Capacity Board as well as reviewing inquest information and other advocacy topics.

We are looking forward to January and the Annual Meeting. Dr. Ann Thomas and the Continuing Education Committee have put together a high quality program according to the theme of destigmatizing mental illness. Special attention was paid to encouraging residents and students to attend by extending to them a much reduced registration rate. In addition, a one-day workshop, just prior to the meeting, is available to round out the educational opportunities. Please review your programme and make sure you can attend the three-day meeting as well as the OPA Annual General Meeting on Friday January 30th at 8:30 a.m. The OPA buffet Dinner/Dance promises to be as great as last year.

A recent survey of OPA members indicated that the OPA should: continue with the good job that is being done; continue to focus on professional development activities; advocate for psychiatry, psychiatrists, psychiatric resident positions and mental health with government and others; advocate for patients by educating the public about mental health and mental illness, and, continue to nurture and educate members and residents.

These survey results, and the work of your Association, should be uppermost in your mind as you review your membership renewal package. Please keep in mind that the OPA needs your support so that we can continue to work on your behalf. Speak to your colleagues and encourage them to renew or join, as the case may be, so that psychiatry can be well represented and your Association can continue with the work we are doing and our plans for the future. In 2004, I will be continuing to serve on OPA Council as Past President and will welcome Dr. Doug Wilkins in his new role as President. A new group of Council members will be joining us as well, after the elections in January.

I would like to thank all the OPA Council members, Elizabeth Leach, Director Policy and Planning and Lorraine Taylor, Executive Assistant for their dedication and support to me in my role as President.

Robert Buckingham, MD, FRCPC
2003 OPA President

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Ontario Psychiatric Association Executive and Council

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President-elect
Dr. Doug Wilkins

Past President
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Dr. Andrew Moulden

No Picture Available

Dr. Leo Murphy

Dr. Derek Puddester

Dr. Ann Thomas

Dr. Bob Swenson

Council Members can be contacted through the OPA Head Office.

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From THE EDITOR

This last issue of *Dialogue* for 2003 continues to provide you with up to date information on mental health and psychiatric topics and issues – news about what the Consent and Capacity Board is planning, information on services available in Ontario, a guest article promoting families as part of the care team, as well as a summary of the results of the recent OPA survey to full members. In this issue, Dr. Andrew Moulden discusses malingering in the first of a two part series and Dr. Doug Weir, a regular contributor to *Dialogue*, has penned an article that provides a summary of the past, present and future activities of the Coalition of Ontario Psychiatrists.

Articles related to mental health and aging and mental health and developmental disabilities have been included as a bit of a lead-in to the OPA Annual Meeting in January, since both topics are being covered in the programme.

While exploring OPA's history, I discovered an interesting summary of Dr. Hoaken's comments from his Presidential Address back in 1981, on the topic of what is now called developmental disabilities:

"1981 is the Year of the Disabled. Psychiatry's role with the disabled has changed in recent years. The chronically mentally ill and the mentally retarded live in increasing numbers in the community and fewer disabled are under direct psychiatric care. The retarded in the community have a well-organized and quite comprehensive support systems available to them. A much less-organized support system exists for the chronically mentally disabled. Research today is finding large numbers of persons living in total isolation from mental health services and this raises a question of psychiatric responsibility in relationship to these persons. For the mentally retarded, psychiatric services are sometimes difficult to obtain; perhaps, since they are seen to be the responsibility of a Ministry other than Health, they may at times be denied access to psychiatric services. Retarded persons, wherever they live, have at least the same need for psychiatric intervention. They, as a group, represent a particular challenge because the recognition of psychiatric illness and emotional problems is frequently complicated by their poor communication skills. A psychiatrist is the best person to recognize underlying psychiatric illness and provide direct treatment as well as providing guidance and advice to caretakers who are confused by their difficult-to-understand behaviour."

Plans for *Dialogue* in 2004 are underway to provide you with information about the Mental Health Implementation Task Forces, Mental Health Reform, Consent and Capacity Board Rules of Practice and Practice Guidelines, workplace issues, legal issues and community services for people with mental health problems. The next issue (in March 2004) will include an article entitled "Partial Hospitalization Programs for Mental Health Patients".

Are there topics that you would like to see covered in Dialogue ?

Your contributions – articles, comments, opinions, criticisms or suggestions – are welcome.

If you have the time to be more involved you may find that you will get more value out of your OPA membership. Consider becoming an active participant on any of the volunteer-based committees. By volunteering, you enhance your learning in key areas.

Best wishes for the holiday season and for the New Year.

Elizabeth Leach
Editor

CALENDAR OF EVENTS

Members! Contact the OPA with the details on upcoming educational events and we will do our best to include them in the *Dialogue*. Additional information on these events can be obtained from the OPA Head Office.

Brief Therapy with Families, Couples and Individuals

September 2003 – June 2004
Brief and Narrative Therapy Extern Program
(Level 1) A Year-Long Intensive Training Program
Advanced Brief & Narrative Therapy Extern Program (Level 2) An Advanced Level Year-Long Training and Research Project. These two intensive brief therapy extern programs offer a comprehensive training experience in the latest, up-to-date theory and practice of brief therapies in supportive and encouraging learning environments. Contact information: The Hincks-Dellcrest Centre, 114 Maitland Street, Toronto, Ontario, M4Y 1E1, tel: 416-972-1935 ex. 3341, Fax: 416-924-9808, email: enerlich@hincksdellcrest.org

Introduction to Borderline Personality Disorder

January 14, 2004
This course covers basic topics in understanding and managing clients with BPD. Contact information: Centre for Addiction and Mental Health, 33 Russell St., Toronto, ON, M5S 2S1, 416-595-6020, ets@camh.net, www.camh.net

Motivational Interviewing

January 20 & 21, 2004
This workshop examines motivation as an interactive process between client and counsellor, providing a variety of practice tools to address key issues in therapy. Learning activities include lectures, clinical demonstrations and small group discussions. Contact information: Centre for Addiction and Mental Health, 33 Russell St., Toronto, ON, M5S 2S1, 416-595-6020, ets@camh.net, www.camh.net

The Alliance for Continuing Medical Education 29th Annual Conference Translating Professional Competence into Practice

January 21 - 24, 2004
Hilton Atlanta, Atlanta, GA
Contact information: www.acme-assn.org

Fundamental Concepts in Mental Health

January 27 – 29, 2004
This course offers an overview of major mental illness affecting Canadians today, exploring risk and protective factors related to these conditions. Also included are client-centred methods of assessing and treating mood disorders, anxiety disorders, psychotic disorders, trauma and schizophrenia, with a focus on client rehabilitation within the community.
Contact information: Centre for Addiction and Mental Health, 33 Russell St., Toronto, ON, M5S 2S1, 416-595-6020, ets@camh.net, www.camh.net

Ontario Psychiatric Association Council Meeting

Wednesday, January 28, 2004
5:00 p.m. - Toronto Marriott Eaton Centre Hotel, Toronto
Contact information: phone: 905-827-4659, email: opa@bellnet.ca

The Ontario Psychiatric Association and Collaborative Mental Health Care Network in conjunction with the Ontario College of Family Physicians present: Cognitive Therapy for Panic Disorder

January 28, 2004
Toronto Marriott Eaton Centre Hotel, 525 Bay St., Toronto
Presenter: Christine Padesky, PhD.
Participants in this workshop will observe and practice the three clears stages of treatment in which therapist and patient collaboratively: 1) identify the sensations, thoughts/images, and catastrophic misinterpretations associated with a recent panic attack, 2) induce sensations that closely mimic a panic attack, and 3) compare catastrophic and non-catastrophic explanations for panic-related sensations.
Contact information: Ontario Psychiatric Association, phone: (905) 827-4659, email: opa@bellnet.ca

The OMA Section on Ontario Psychiatric Hospitals and Hospital Schools and Ontario Physicians and Dentists in Public Service is hosting a Hospital Contract Consultation Meeting

January 29, 2003
Toronto Marriott Eaton Centre Hotel, 525 Bay St., York A Room, 6:00 p.m.
Dr. Greg Flynn, OMA Board of Directors member is the guest speaker.
Contact information: Please RSVP to - Nancy Sarino – 1-800-268-7215 ext. 2941, 416-340-2941 or Nancy_Sarino@oma.org

Ontario Psychiatric Association 84th Annual Meeting - Destigmatizing Mental Illness

January 29, 30 and 31, 2004
Toronto Marriott Eaton Centre Hotel, Toronto
Contact information: phone: 905-827-4659, email: opa@bellnet.ca
(see article on page 7 for detailed information)

Ontario Psychiatric Association Annual General Meeting

Friday, January 30, 2004
8:30 am - Toronto Marriott Eaton Centre Hotel, Toronto
If you are unable to attend, please utilize a Proxy form included in this issue of *Dialogue*. Contact information: phone: 905-827-4659, email: opa@bellnet.ca

3rd National Summit on Reform of Canada's Drug Review System - Moving Words to Action

January 29, 2004 & January 30, 2004
Chateau Cartier Hotel, Gatineau, Quebec
Organizer: Best Medicines Coalition
Contact information: Jane Hamilton, 905-337-2606, www.bestmedicines.ca

Adolescent Self-Destruction

January 30 & 31, 2004
Boston Park Plaza Hotel, 64 Arlington Street, Boston, MA
Director: Pamela C Cantor, PhD, Judy Reiner Platt, EdD, Nancy Rappaport, M.D.
Offered by: Cambridge Hospital, Department of Psychiatry
Participants should be able to increase their clinical competency to assess risks and to develop treatment strategies for self-destructive behaviors. Faculty will present clinical findings on biological, psychological, and cultural factors influencing treatment. Key developmental aspects of self-destructive behaviors will be presented as well as how to effectively address these risk factors in therapy. The program is designed for mental health clinicians, educators, researchers and others interested in responding effectively to those adolescents who are vulnerable to self-harm. Contact information: Harvard MED-CME, P.O. Box 825, Boston, MA 02117-0825 Phone: (617) 384-8600, fax: (617) 384-8686 email: hms-cme@hms.harvard.edu or register online at www.cme.hms.harvard.edu

Anxiety and Co-occurring Depression

February 10, 2004
Centre for Addiction and Mental Health, 33 Russell Street, Meeting Centre (Rm 2029), 2nd Fl, Toronto
Anxiety is a common and normal emotion experienced by everyone when faced with a dangerous or stressful situation. However, when anxious feelings persist and begin to interfere with normal everyday functioning in situations where there is no

actual threat or danger it is an indication that something else is going on. Anxiety often co-occurs with other mental health concerns and physical disorders and when left untreated can cause significant distress. This forum will explore what anxiety is, its links to depression and treatment approaches, both medical and non-medical, for addressing anxiety and co-occurring depression.
Contact information: Centre for Addiction and Mental Health, Phone: 416-535-8501 ext. 4553, www.camh.net

The Eleventh Annual Florida Symposia
February 16 – 20, 2004
This conference provides psychologists, psychiatrists, psychiatric social workers, psychiatric nurses, and allied mental health professionals with an outstanding opportunity to combine a stimulating symposium with a relaxing sunny winter vacation. Distinguished faculty, who are leaders in their fields, will present three different week-long symposia. Each symposium will convene at The Hilton Marco Island Beach Resort on Marco Island, Florida, from 9:00 a.m. until 12:15 p.m., Monday through Friday.
Contact information: Telephone: 413-499-1489 Fax: 413-499-6584, email: educate@neei.org, www.neei.org

Harvard Medical School, Department of Continuing Education Winter Seminars
Longboat Key, Florida
Week 1: Feb. 16 -20, 2004
Week long seminars taught by distinguished faculty, the Winter Seminars allow participants an opportunity to combine learning and relaxation at a spectacular 5-star beach resort on the coast of Florida. The areas tropical climate and refined lifestyle attract visitors from all over the world, supporting a wealth of activities including championship golf, tennis, opera, theater, sport fishing, Everglades excursions, and baseball spring training.
Cognitive-Behavioral Therapy and Dialectical Behavior Therapy: A Clinical Update, 2004; A Clinician's Approach to Neuroscience: What We Should Do and Why We Should Be Doing It; Psychopharmacology in the Trenches: A Comprehensive Practical Review of the Safety, Efficacy, and Use of Pharmaceuticals with Natural Therapies.
Contact information: Harvard MED-CME, P.O. Box 825, Boston, MA 02117-0825 Phone: (617) 384-8600, fax: (617) 384-8686 email: hms-cme@hms.harvard.edu or register online at www.cme.hms.harvard.edu

6th Annual Canadian Society of Physician Executives Conference
Beyond Survival: Leading with Confidence
21-22 February 2004
Sheraton Centre, Toronto
Plus a pre-conference workshop by the Physician Manager Institute (PMI)
February 19-20 "Communication for Physician Leaders"
Contact information: Canadian Society of Physician Executives, 1559 Alta Vista Dr., PO box 59005, Ottawa, ON, K1G 5T7, phone: 613-731-8610 X2254 website: www.espexecs.com

15th Annual Meeting of the American Neuropsychiatric Association
February 21 – 24, 2004
Sheraton Bal Harbour Beach Resort
Bal Harbour, Florida
Contact information: www.neuropsychiatry.com/ANPA/annual_meeting.html

9th International Conference on Continuing Professional Development, Canadian Psychiatric Association Clinical and Professional Challenges
February 23 – 27, 3004
Punta Cana, Dominican Republic
Contact information: Phone: (613) 234-2815, www.cpa-apc.org/Cpd/ICPD/ICPD2004/site.asp

7th Annual Winter Seminars
Harvard Medical School, Department of Continuing Education
Longboat Key, Florida
Week 2: Feb. 23-27, 2004
Week long seminars taught by distinguished faculty, the Winter Seminars allow participants an opportunity to combine learning and relaxation at a spectacular 5-star beach resort on the coast of Florida. The areas tropical climate and refined lifestyle attract visitors from all over the world, supporting a wealth of activities including championship golf, tennis, opera, theater, sport fishing, Everglades excursions, and baseball spring training.
Psychotherapy of Patients with Personality Disorders; Advances In the Understanding and Treatment of Psychological Trauma: An Overview and Update; The Curative Factors in the Psychotherapeutic Process.
Contact information: Harvard MED-CME, P.O. Box 825, Boston, MA 02117-0825 Phone: (617) 384-8600, fax: (617) 384-8686 email: hms-cme@hms.harvard.edu or register online at www.cme.hms.harvard.edu

9th Annual CAPL/Forensic Section Winter Meeting
February 28 – March 3, 2004
Fairmont Chateau Lake Louise, Alberta
Paper and poster submission deadline: January 15, 2004
Contact information: Dominique Bourget, ph: 613-722-6521 ext. 6366, fax: 613-595-8971, email: thira@sympatico.ca

Harvard Medical School, Department of Continuing Education Winter Seminars
Longboat Key, Florida
Week 3: March 1 - 5, 2004
Week long seminars taught by distinguished faculty, the Winter Seminars allow participants an opportunity to combine learning and relaxation at a spectacular 5-star beach resort on the coast of Florida. The areas tropical climate and refined lifestyle attract visitors from all over the world, supporting a wealth of activities including championship golf, tennis, opera, theater, sport fishing, Everglades excursions, and baseball spring training.
Psychopharmacology Across the Life Cycle: From Pediatrics to Geriatrics; Psychodynamic/Systemic Couple Therapy; The Psychiatrist as Expert Witness: Beginning and Developing Your Forensic Practice.
Contact information: Harvard MED-CME, P.O. Box 825, Boston, MA 02117-0825 Phone: (617) 384-8600, fax: (617) 384-8686 email: hms-cme@hms.harvard.edu or register online at www.cme.hms.harvard.edu

Child and Adolescent Psychopharmacology
March 5 – 7, 2004
The Westin Copley Place, 10 Huntington Avenue, Boston, MA 02116
Director: Joseph Biederman, MD, Stephen V. Faraone, PhD, John B Herman, MD, Jerrold F Rosenbaum, MD, Thomas J. Spencer, MD, Timothy E. Wilens, MD
Offered by: Massachusetts General Hospital, Department of Psychiatry
This course intends to educate psychiatrists, pediatricians, general and family practitioners, psychologists, nurses, social workers and interested school based clinicians in the presentation, diagnosis and current treatment options available in pediatric psychopharmacology.Contact information: Harvard MED-CME, P.O. Box 825, Boston, MA 02117-0825 Phone: (617) 384-8600, fax: (617) 384-8686 email: hms-cme@hms.harvard.edu or register online at www.cme.hms.harvard.edu

Treating the Addictions
The Addictions: Treating Approaches
March 5 & 6, 2004
Boston Park Plaza Hotel, 64 Arlington Street, Boston, MA
Director: Janice F. Kauffman, RN, MPH, CAS, Edward J. Khantzian, MD, Judy Reiner Platt, EdD, Howard J. Shaffer, PhD,CAS
Offered by: Cambridge Hospital, Department of Psychiatry
At the conclusion of the 27th Annual Addictions Conference participants will be able to describe and identify addictive behaviors as well as delineate recent advances in addiction treatment. Faculty will examine the biological, psychological, and sociological influences and consequences of addictive behaviors for both adolescents and adults. The main emphasis will be on what clinical approaches work, when, why, and for whom. In addition to different assessment and treatment approaches, the influence of shame and attachment will be considered. The course is intended for all mental health clinicians, addiction treatment specialists, and others interested in the prevention and treatment of addictive disorders.
Contact information: Harvard MED-CME, P.O. Box 825, Boston, MA 02117-0825 Phone: (617) 384-8600, fax: (617) 384-8686 email: hms-cme@hms.harvard.edu or register online at www.cme.hms.harvard.edu

Harvard Medical School, Department of Continuing Education Winter Seminars
Longboat Key, Florida
Week 4: March 8 -12, 2004
Week long seminars taught by distinguished faculty, the Winter Seminars allow

participants an opportunity to combine learning and relaxation at a spectacular 5-star beach resort on the coast of Florida. The areas tropical climate and refined lifestyle attract visitors from all over the world, supporting a wealth of activities including championship golf, tennis, opera, theater, sport fishing, Everglades excursions, and baseball spring training.
Enhancement of Peak Performance State of the Therapist: A Way of Being with Patients; Essential Psychopharmacology, 2004; Trauma, Consciousness and the Body
Contact information: Harvard MED-CME, P.O. Box 825, Boston, MA 02117-0825 Phone: (617) 384-8600, fax: (617) 384-8686 email: hms-cme@hms.harvard.edu or register online at www.cme.hms.harvard.edu

Fundamental Concepts in Addiction
March 9 & 10, 2004
This two-day course introduces substance use and its treatment: alcohol and other substance use, the problems associated with their use, and treatment and prevention options.
Contact information: Centre for Addiction and Mental Health, 33 Russell St., Toronto, ON, M5S 2S1, 416-595-6020, ets@camh.net, www.camh.net

14th Annual Rotman Research Institute Conference
Traumatic Brain Injury: From Molecule to Family Systems
March 14-16, 2004
The Sheraton Centre, Toronto, Ontario, Canada
The 14th annual Rotman Research Institute conference will assemble international leaders for two days of talks and discussion on traumatic brain injury. The speakers will cover topics ranging from intracellular neuropathological processes to milieu-based rehabilitation, including findings from the latest neuroimaging technologies. This conference will provide a unique forum for both clinicians and researchers interested in traumatic brain injury and neuroscience research.
Contact information: E-mail: registration@rotman-baycrest.on.ca, Phone: 416-785-2500 ext.2363, Fax: 416-785-4215

Intensive Diagnostic Interviewing
March 18 & 19, 2004
Mass Mental Health Center, 74 Fenwood Road, Boston, MA 02115
Director: Lawrence E Lifson, MD
Offered by: Massachusetts Mental Health Center, Psychiatry
The objectives of the Two-Day Course are to upgrade interview skills and to improve techniques for concise summary, presentation, and discussion of clinical data.
Contact information: Harvard MED-CME, P.O. Box 825, Boston, MA 02117-0825 Phone: (617) 384-8600, fax: (617) 384-8686 email: hms-cme@hms.harvard.edu or register online at www.cme.hms.harvard.edu

Clinical Training in Mind/Body Medicine
March 21 – 25, 2004
The Inn at Longwood Medical, 342 Longwood Avenue, Boston, MA
Director: Peg Baim, MS, NP, Herbert Benson, MD, Eva Selhub, MD
Offered by: Beth Israel Deaconess Medical Center, Department of Medicine
Contact information: Phone: (617) 384-8600, fax: (617) 384-8686
email: hms-cme@hms.harvard.edu

First Stage Trauma Treatment: A Gender-Sensitive Approach for Women
March 24 & 25, 2004
This course teaches you about trauma and its treatment, the basic components of first-stage trauma treatment, and specific tools and concrete strategies to use in beginning this work.
Contact information: Centre for Addiction and Mental Health, 33 Russell St., Toronto, ON, M5S 2S1, 416-595-6020, ets@camh.net, www.camh.net

Assessing and Treating Depression
March 31, 2004
This workshop offers an overview of depression for health care professionals. Through presentations, small and large group discussions and case scenarios, the course explores how to assess and treat the various types of depressive disorders, including major depression, dysthymic disorder, and atypical depression.
Contact information: Centre for Addiction and Mental Health, 33 Russell St., Toronto, ON, M5S 2S1, 416-595-6020, ets@camh.net, www.camh.net
http://www.camh.net

Working with Youth with Mental Health Substance Abuse Problems
April 22 & 23, 2004
This skill-based training explores the theories that underlie responses to concurrent mental health and substance use disorders in youth. Over two days, participants will take part in discussion, small group activities and case reviews.
Contact information: Centre for Addiction and Mental Health, 33 Russell St., Toronto, ON, M5S 2S1, 416-595-6020, ets@camh.net, www.camh.net

ASIST: Applied Suicide Intervention Skills Training
April 29 & 30, 2004
CMHA Halton Region Branch, 55 Ontario St., S., 2nd flr., Suite 25, Milton, ON
This worldwide recognized LivingWorks program provides practical training for caregivers seeking to prevent the immediate risk of suicide. The emphasis is on suicide first aid, or helping a person at risk stay safe and seek further help. Participants receive a manual and certificate upon completion.
Contact information: CMHA Halton Region Branch, (905) 693-4270, www.ontario.cmha.ca

2004 APA Annual Meeting – Psychotherapy and Psychopharmacology: Dissolving the Mind-Brain Barrier
May 1-6, 2004
New York, N.Y.
Contact information: http://psych.org/sched_events/ann_mtg_04/index.cfm

Interventions in Psychosocial Oncology & Palliative Care: from Research to Clinical Practice
May 6 – 8, 2004
Delta Chelsea Inn, 33 Gerrard St. W.,Toronto, ON
Toronto will be the site of the Annual Conference of the Canadian Association of Psychosocial Oncology from May 6-8, 2004. The conference, hosted by the Department of Psychosocial Oncology & Palliative Care, Princess Margaret Hospital/University Health Network, will feature internationally renowned speakers, symposia, and paper presentations on a wide range of subjects in psychosocial oncology. Contact information: www.capo.ca/conference2004.cfm

Couple and Family Therapy
May 12, 2004
This interactive workshop gives addiction and mental health professionals the knowledge and tools they need to work with couples and families who present with substance use problems or concurrent disorders.
Contact information: Centre for Addiction and Mental Health, 33 Russell St., Toronto, ON, M5S 2S1, 416-595-6020, ets@camh.net, www.camh.net

Marital Therapy: A Research-Based Approach
May 13 & 14, 2004
National Gallery of Canada 380 Sussex Drive, Ottawa, Ontario
Presented by; Ottawa Couple & Family Institute in collaboration with Children's Hospital of Eastern Ontario, The Faculty of Social Sciences at the University of Ottawa & Leading Edge Seminars Inc.Led by John Gottman
This therapy focuses on shared meaning, purpose, mission, and legacy in couples' lives. The workshop teaches diagnostic and intervention techniques and specific exercises that empower clinicians to start applying these methods immediately. Participants not only learn about concepts and theories, but also about assessment, interventions, new skills, strategies, and perspectives.
Contact information: Leading Edge Seminars Inc., 88 Major Street, Toronto, ON, M5S 2L1, www.leadingedgeseminars.org

Mental Health Services at the Interface of Mental Disorder, Addiction and Crime International Association of Forensic Mental Health Services (IAFMHS) 4th Annual Conference
June 6 – 9, 2004
Stockholm, Sweden
Contact information: www.iafmhs.org/iafmhs.asp?pg=conference

Attention OPA Members

Are you aware of the OPA Sections and what they are doing? The six Sections are:

Child & Adolescent Section - Dr. Derek Puddester, Chair; Community Section - Dr. Karen Hand, Chair; Consultation-Liaison Section - Vacant, Geriatric Section - Dr. Rosemary Meier, Chair; Psychotherapy Section - Dr. Cinda Dyer, Chair, Resident Section - Dr. Krishna Balachandra, Chair.

The OPA Sections need your input. We also need a Chair for the Consultation-Liaison Section. Please plan on attending the Annual OPA Sections meetings on Thursday, January 29, 2004 at the Toronto Marriott Eaton Centre Hotel from 4:15 p.m. - 5:15 pm.

Please contact Dr. Margaret Steele, OPA Section Liaison, at: Margaret.Steele@lhsc.on.ca , or call her office at (519) 667-6671 if you require any further information.

AGENDA OPA Council

September 5, 2003

1.0 Remarks from the President
- i) Approval of Agenda
- ii) Appointment of new Council Member – Dr. Karen Hand (to replace Dr. Clare Pain)

2.0 Approval of Minutes of June 20, 2003

3.0 Business Arising
- 3.1 Mental Health Implementation Task Forces/Authorities
- 3.2 Review of OPA Liaison - update re: nominations for CPA positions/awards
- 3.3 Child Psychiatry Task Force
- 3.4 Review of document: "The Role of Psychiatrists in Mental Health Reform"
- 3.5 Sunrise/Sunset and Changes in Scopes of Practice Criteria Review: An HRPAC Discussion Paper (available for review at www.hprac.org)

4.0 Treasurer's Report

5.0 Reports of Task Forces and Committees
- 5.1 Advocacy Committee
- 5.2 Communications Committee
- 5.3 Continuing Education Committee
- 5.4 Finance/Audit Committee
- 5.5 Member Services Committee

6.0 Standing Reports
- 6.1 OMA Tariff/RBRVS
- 6.2 CPA Report
- 6.3 Working Group on Mental Health Services
- 6.4 Coalition
- 6.5 Council of Provinces
- 6.6 Alliance for Mental Health Services
- 6.7 CPA Standing Committee on Education
- 6.8 Section Reports

7.0 New Business
- 7.1 Strategic Planning and Governance
- 7.2 Review of Role Descriptions
- 7.3 Elections to OPA Council
- 7.4 Guest: Mr. Dennis Helm, Director, Mental Health & Addictions Branch, Ministry of Health

Call for Volunteers for the OPA Advocacy Committee

The OPA Advocacy Committee is seeking interested members, in a voluntary capacity, to participate on the Committee in 2004/2005.

The Mandate of the Committee is to provide advice and recommendations to Council regarding advocacy for the mentally ill and their families, and advocacy in the best interests of the members of the association in their relationships with government and non-governmental organizations, the media and the public at large.

The Objectives of the Committee are:
To develop and maintain relationships with other associations which advocate for the mentally ill and their families, in order to further common interests;
To seek out and respond to those advocacy issues which are of importance to the association;
To engage in analysis, review and provide recommendations on advocacy issues;
To take a leadership role in the promotion of prevention and treatment for persons with mental illness;
To develop annual strategic plans with specific goals for advocacy.

It is anticipated that the Committee will be addressing the following items during 2004:
1) matters related to findings of the Coroner's Inquests,
2) Consent and Capacity Board rules of practice and practice guidelines,
3) Mental Health Implementation Task Force reports and recommendations,
4) Mental Health Reform - review and implementation,
5) three year review of the mental health legislation (including CTOs),
6) other advocacy issues that may surface.

The Committee meets three to four times per year by telephone for approximately 1 to 2 hours each meeting.

For additional information please contact Dr. Doug Wilkins, Chair, OPA Advocacy Committee at dwilkins@qch.on.ca ; day time phone: (613) 721-4708

THE ONTARIO PSYCHIATRIC ASSOCIATION IS PLEASED TO WELCOME

the following new members up to November 14, 2003

Lana M. Benedek • Deborah Elliott • Alexa Veresezan

Report of the Continuing Education Committee: OPA Annual Meeting

By: Ann Thomas, MD, FRCPC

The OPA 84th Annual Meeting, Destigmatizing Mental Illness is fast approaching. Have you received your Preliminary Programme in the mail? If not, call our office and we'll rush your copy to you.

Our Theme Speaker this year is Dr. Donald L. Nathanson of the Silvan S. Tomkins Institute and Clinical Professor of Psychiatry at Jefferson Medical College in Pennsylvania. His address entitled "Stigma and the Compass of Shame" as well as a workshop entitled "When Stigma Explodes: Managing Shame to Prevent Violence" are sure to be outstanding. Dr. S. Charles Schulz of the University of Minnesota, will present "The Use of Atypical Antipsychotic Agents in Disease States Other Than Schizophrenia"; Dr. Michael Robinson of Queen's University presents "Delirium: A Bona Fide Diagnosis Deserving Separate Treatment and Management"; Dr. Susan Abbey of Toronto General Hospital presents "Fibromyalgia and Chronic Fatigue: An update focusing on how psychiatrists can help" and Dr. Mamta Gautam presents "Stigma in the Culture of Medicine". Spaces are limited for a course by Dr. William Molloy entitled "The Care of Patients with Mild to Moderate Dementia", so be sure to reserve your spot early.

Luncheon topics include: "Bipolar Depression – An Overview and Update on Management " with Dr. Roumen Milev, Dr. Diane K. Whitney and Dr. Lawrence Martin; "Current Concepts on Chronic Pain" with Dr. Doug Gourlay, Dr. Peter I.M. Moran and Dr. Harvey Moldofsky and; "Anxiety and the Cinema" with Dr. Kevin Kjernisted.

Dr. Bryan H. King, M.D. will present " Psychopharmacological Issues in Developmental Disabilities". Dr. King received his medical degree from the Medical College of Wisconsin. He subsequently did post-graduate training in Internal Medicine, Psychiatry, and Child and Adolescent Psychiatry at the UCLA Center for Health Sciences and the UCLA Neuropsychiatric Institute. Thereafter he joined the faculty at UCLA where he directed the Child Psychiatry Inpatient Service, and the Developmental Neuropsychiatry Laboratory. He also co-founded the Behavioral Neurogenetics Clinics. He is currently Professor of Psychiatry and Pediatrics and Director of Child and Adolescent Psychiatry at Dartmouth Medical School, and Medical Director for the New Hampshire Division of Developmental Services, Professor of Psychiatry and Pediatrics and Director of Child and Adolescent Psychiatry at Dartmouth Medical School. Dr. King will highlight some of the relatively unique behavioral problems that occur in the context of developmental disabilities, and the rationale for selection of specific medication interventions.

The OPA Annual General Meeting and buffet breakfast, will be held on Friday, January 30, 2004 beginning at 8:30 am. All OPA Members are invited to attend, free of charge. If you are unable to attend, please complete the Proxy included in this issue of Dialogue and return it to the OPA Office.

The OPA Sections will meet on Thursday, January 29, 2004 at 4:15 p.m. and a Wine & Cheese Reception/Meet the Exhibitors will follow at 5:15 p.m.

The OPA Dinner/Dance, Mental Illness Unmasked, on Friday, January 30, 2004, will feature a buffet dinner and live band. Best Poster and Best Paper Awards will be presented and there are always great door prizes to be won. The 2004 President, Dr. Doug Wilkins will be inducted. The T.A. Sweet Award, presented annually to individuals who have made a major contribution to the understanding of mental illness and its impact on individuals in our society, will be presented to Mr. Ron Ellis. Mr. Ellis has spoken publicly about his own experiences regarding the impact of mental illness, specifically depression.

New this year! The OPA and Collaborative Mental Health Care Network in conjunction with the Ontario College of Family Physicians offer you a Pre-conference, one-day workshop entitled "Cognitive Therapy for Panic Disorder" with Christine Padesky, PhD of the Centre for Cognitive Therapy in Huntington Beach, California on Wednesday, January 28, 2004. Be sure to register early, space is limited!

The OPA is pleased to thank Eli Lilly Canada Inc., Wyeth Pharmaceuticals, Eli Lilly Canada Inc., Lundbeck Canada Inc., AstraZeneca Canada Inc., GlaxoSmithKline, Pfizer Canada, and Janssen-Ortho Inc. for providing Unrestricted Educational Grants.

Thanks again to the Continuing Education Committee; OPA Council Members - Dr. Krishna Balachandra, Dr. Bob Buckingham, Dr. Jane Howard, Dr. Roumen Milev, Dr. Rosemary Meier and Dr. Leo Murphy; Dr. Michael Paré, G.P. and Elizabeth Leach, OPA Director of Policy & Planning. Thank you also to Dr. Rahul Manchanda and Dr. Verinder Sharma for their expertise in reviewing the abstracts.

I look forward to seeing everyone in January!

Call for Chair, Continuing Education Committee

OPA Council is seeking an interested member to be Chair, Continuing Education Committee in 2005. This Committee is a Standing Committee of Council and reports to Council. Dr. Ann Thomas, 2004 Chair, Continuing Education Committee, will assist the 2005 Chair to prepare to be Chair during 2004. It is expected that the 2005 Chair will be an active member of the Committee in 2004, has experience organizing CME events, is familiar with the maintenance of competency certification and has a positive working relationship with pharmaceutical company representatives.

The Mandate of the Continuing Education Committee is to develop and implement a program of education which will assist members to achieve an optimal level of professional development and practice and to exchange scientific and other relevant information.

The Objectives of the Committee are:

To create an annual conference that contributes to the maintenance and advancement of the OPA – intellectually, academically and financially;

To provide learning opportunities that are consistent with maintenance of certification requirements, the professional goals of the membership;

To disseminate educational information, including information regarding changes in the mental health system;

To administer the T.A. Sweet Award and other related educational awards as they occur.

To assist Council regarding professional practice and academic issues.

The Continuing Education Committee meets at least four times each year for approximately one to two hours per meeting. Applicants should expect to commit about 100 hours per year to this position. A small honorarium is provided.

For additional information please contact Dr. Ann Thomas, Chair, Continuing Education Committee at: athomas2@uwo.ca, daytime phone: (519) 633-8382 or Dr. Bob Buckingham, 2003 President at opa@bellnet.ca

Ontario
Psychiatric Association

Association des
Psychiatres de l'Ontario

I PROXY ELIGIBILITY:

Full Members, Life Members and Members-in-Training who are in good standing are entitled to vote at the OPA's Annual General Meeting. If you are unable to attend the meeting, you may request another person to represent you and your vote.

II VOTING CARD

Voting card(s) will be issued to each voting member on January 30, 2004 just prior to the meeting

III SUBMISSION OF PROXIES:

All those who will be exercising a proxy for a member must hand in a completed proxy form. One voting card per proxy will be issued at the OPA Annual General Meeting registration desk..

IV CONSULTATION WITH THE PERSON EXERCISING YOUR PROXY.

Voting members should inform their proxy of their preferred stand on each-topic under consideration.

Ontario Psychiatric Association
Annual General Meeting
Friday January 30, 2004

PROXY

I,_____

(please print your name)

will be unable to attend the January 30, 2004 Annual General Meeting of the Ontario Psychiatric Association, and hereby designate,

_____

(name of proxy)

OR

☐ OPA Secretary

to act at this meeting with the same power as if I personally attended.

Signature _____

Date _____

1141 South Service Road West, Oakville, Ontario L6L 6K4 Tel: (905) 827-4659 Fax: (905) 469-8697 Email: opa@bellnet.ca

AGENDA OPA Council

November 14, 2003

3.0 Remarks from the President
i) Approval of Agenda
4.0 Approval of Minutes of September 5, 2003
3.0 Business Arising
3.1 Mental Health Implementation Task Forces/Authorities
3.2 Review of OPA Liaison
- update re: nomination for Provincial Director
3.3 Child Psychiatry Task Force
3.4 Fact Sheets for Political Lobbying
3.5 "New Governance Models for Mental Health Services" – Feb. 04, Conference
3.6 Elections to OPA Council
3.7 Review of Role Descriptions
4.0 Treasurer's Report
5.0 Reports of Task Forces and Committees
5.1 Advocacy Committee
5.2 Communications Committee
5.3 Continuing Education Committee
5.4 Finance/Audit Committee
5.5 Member Services Committee
6.0 Standing Reports
6.1 OMA Tariff/RBRVS
6.2 CPA Report
6.3 Working Group on Mental Health Services
6.4 Coalition
6.5 Council of Provinces
6.6 Alliance for Mental Health Services
6.7 CPA Standing Committee on Education
6.8 Section Reports
7.0 New Business
7.1 Strategic Planning and Governance
7.2 Guest: R. John Harper, Chair & CEO of Consent & Capacity Board
7.3 Date and Guest for January Council meeting
7.4 OPA Annual General Meeting & Preparation of Annual Report
7.5 Review/clarification of Bylaw # 6.4.1 Qualifications for Full Membership
7.6 Implementation of the Personal Information Protection and Electronic Documents Act (PIPEDA)
7.7 Bridging the Solitudes: Integrating Hospital and Community Mental Health Services
7.8 Travel problems

Dear OPA Member,

This is your official notice of the Annual General Meeting (AGM) of the Ontario Psychiatric Association, which will be held at 8:30 a.m. on Friday, January 30, 2004 at the Toronto Marriott Eaton Centre Hotel, 525 Bay St., Toronto. A buffet breakfast will be provided to all who attend.

All OPA members are welcome to attend, although voting is restricted to Full Members, Life Members and Members-in-Training.

If you are unable to attend, please utilize a proxy form. Proxy forms are available in this issue of *Dialogue* or you may receive one by email, mail or fax by contacting the OPA Office. The Proxy form will assist the OPA in terms of ensuring that a sufficient number of members or their proxies are present for voting purposes. Please return the proxy by fax, mail or email to the OPA Office no later than Monday, January 19, 2004. Proxy forms may also be given to your designate who will attend the AGM.

The financial statements for the fiscal year ending December 31, 2003, will be included in the Annual Report, available at the Annual General Meeting and can be requested by contacting the OPA Office. The Annual Report will be published in the March 2004 issue of *Dialogue*.

I look forward to your attendance as well as your participation at the OPA 2004 Annual General Meeting.

Sincerely,
Robert Buckingham, M.D., FRCPC
OPA 2003 President

AGENDA OPA ANNUAL GENERAL MEETING

Friday, January 30, 2004 – 8:30 am

Toronto Marriott Eaton Centre Hotel, Salon C/D

1. Call to Order and Introduction of Guests– B. Buckingham
2. Approval of Agenda
3. Approval of Minutes of the January 31, 2003 Annual General Meeting
4. OPA President's Report – B. Buckingham
5. OPA Treasurer's Report – J. Howard
6. Appointment of Auditor
7. OPA President's Address – B. Buckingham
8. Presentation of 2004 Budget – D. Wilkins
9. Election Results for 2004 Council – M. Steele
10. Other Business
11. Adjournment

A BRIEF HISTORY OF MENTAL HEALTH REFORM IN ONTARIO

Allen G. Prowse *Lyn E. Carpenter†

Since the 1960s, Ontario, like other jurisdictions, has striven to develop a more balanced mental health system that would rely more on community treatment resources than on long-term inpatient care.

In the recent past, starting with *The Graham Report* (1988), Ontario has attempted to shift human and financial resource investments in the mental health system away from institutions and towards community-based treatment venues. The significant difference between these initiatives and their predecessors has been that they included clear, measurable commitments to monitor progress toward the desired results. These results are at the heart of determining whether and to what extent Ontario's reform efforts have met their goals.

Key Initiatives and Directions

The history of the most recent reform efforts in Ontario includes the following reports by the province's Ministry of Health and Long-Term Care ("Ministry"):[1]

Building Community Support for People: A Plan for Mental Health in Ontario (1988)
Also known as *The Graham Report*, this document provided an action plan intended to lead to the development of a community-focused, integrated mental health care system in Ontario. A major goal of this plan was to stimulate action to help people with serious mental health problems participate more fully in community life by providing care and support as close to home as possible. It envisioned District Health Councils (DHCs) as the vehicle for bringing together the respective interests of hospitals, community-based services, consumers and their families. With its 19 recommendations, *The Graham Report* helped launch what proved to be a multi-year provincial process to improve mental health services and supports by funding community-based initiatives such as case management, 24-hour crisis intervention, housing and consumer/survivor and family-run supports. This initial contemporary reform report was followed five years later by a blueprint report designed to advance both the cause and the pace of mental health reform.

Putting People First (1993)
In 1993, the Ontario Ministry of Health published *Putting People First: The Reform of Mental Health Services in Ontario*. This blueprint for mental health reform provided a policy framework that helped launch the transformation of the province's mental health services through a planned ten-year mental health reform. This policy framework builds on *The Graham Report* of 1988. *Putting People First* helped guide the initiation of a coordinated system of mental health services and supports in Ontario by recognizing fundamental determinants of mental health such as housing, income maintenance, and employment.

Putting People First made the following observations about establishing measurable targets and timelines for mental health reform.

> To ensure this strategy works, and the system does change, the Ministry of Health has set a number of targets – or critical success factors – that will be used to monitor shifts in service. The targets are tools to assess progress toward the goals.[1]

This policy framework further noted that:

> According to experience in other provinces, setting multiple targets – rather than a single one – and looking at a range of different measures was more just and effective.[2]

With this overall approach, Ontario established targets for spending, inpatient bed capacity and hospital utilization. The intention was to achieve the following:

1) ***Fiscal Shifts***: "By 2001, Ontario will be spending 40% of its budget on institutional care and 60% on community services."[1] To this end, Ontario was to set benchmarks for years one, four, seven, and ten. For the purpose of comparison, approximately 80% of Ontario's mental health budget was spent on institutional services and only 20% on community-based programs in fiscal 1992-1993.
2) ***Bed Ratios***: "By 2001, Ontario will maintain a bed ratio of 30 psychiatric beds for every 100,000 people in the province."[3] In 1992-1993, Ontario maintained an average of 58 psychiatric beds for every 100,000 people, which represented a ratio that was "considerably higher than that in other jurisdictions."[4] The Health Services Restructuring Commission later recommended an interim ratio for adults of 35 beds per 100,000 people. The Ministry of Health and Long-Term Care approved this revised ratio as a target bed ratio and has proceeded with the implementation of these bed targets.
3) ***Hospitalization Rates***: If community service enhancements are effective, the hospitalization rate should drop. At the time of printing *Putting People First*, targets for changes in hospitalization rates were in the process of being developed. The establishment of these targets was overtaken by other events and, to date, no target rates for hospitalization have been established.

The intent of these key service ratios and performance measures was to allow government to assess the mix of services, confirm that all key services were being provided and ensure that the right people were getting the services they needed.

In its conclusion, *Putting People First* recognized that "plans, policies and directions [would need to] be developed and refined over the next 10 years"[5] in order to make Ontario's mental health services stronger and more effective.

Implementation Planning Guidelines for Mental Health Reform (1994)
This document was one of a series that flowed from the release of *Putting People First*. It focused on the District Health Councils (DHCs) because DHCs were expected to lead the implementation planning process at the district and regional levels. DHCs were seen as an important link with key stakeholders such as consumers, family members, service providers, and interested community members. DHCs were asked to meet the challenge of planning for a mental health system that would put the consumer at the centre of the system. These guidelines were intended to provide the framework within which stakeholders would plan for mental health reform. The guidelines included principles for implementation planning, the roles and responsibilities of the Ministry and the DHCs, and the structures, processes, and resources required to plan for implementation. Several subsequent documents issued by the Ministry in 1995 and early 1996, including *Mental Health Reform Implementation Guidelines for Housing and Support Services* (1996), also supported the DHCs' efforts in developing implementation plans for mental health reform.

Rural and Northern Health Care Framework (1997)
This Ministry document confirmed the government's vision for health care as meaning "patients getting the right care, in the right place, at the right time."[6] Although there is only one specific reference to mental health programs in this document, it reinforced the basic theme of providing care closer to home.

Making It Happen (1999)
The most recently approved policy document designed to provide a structure and approach to guide mental health reform efforts, *Making It Happen*, was published in 1999. This two-part publication (operational framework for services and implementation plan) was to serve as the next step in ensuring that the reformed mental health system would provide integrated and coordinated services that would work effectively for people and were based on best practices. *Making It Happen* offered a strategy to increase service capacity by proposing both an operational framework and an implementation plan that would result in a continuum of care that included providing community alternatives wherever possible. This plan was also intended to guide "strategic reinvestments" to support the implementation of key service delivery changes by 2002-2003. The intent was that "the reformed mental health system would make reinvestment decisions strategically instead of on a program by program basis. Program funding [was to] be directly tied to program performance so that reliance on inpatient services [would be] decreased and the continuum of community and inpatient services [would be] sufficiently funded to meet a diverse range of client needs."[7]

Making It Happen: Operational Framework for the Delivery of Mental Health Services and Supports outlines three approaches or areas of focus to support effective service delivery:

- service/system accountability;
- shared service models; and
- improved access.

For example, to help address the issue of service system fragmentation (i.e., many separate agencies and many access points), guidelines for common assessment tools and a template for service agreements were proposed. Access improvement would require "each local system of mental health services to develop:

- centralized information and referral functions;
- fewer points of entry;
- consultation services provided by psychiatrists ...be facilitated; and
- minimal assessments"[8] – a service system which minimized duplicate assessments.

Making It Happen identified implementation priorities for the Ministry over three years (i.e., 1999-2002). These included:

- tools to facilitate better access – a common assessment tool and a template for service agreements;
- a policy on housing and access to housing;
- an accountability framework; and
- policy frameworks for Schedule 1 general hospitals and physician services.

Making It Happen views consumer need as the key driver towards clear system/service responsibility and accountability. In the implementation plan document, under "Processes/Tools," the need for an accountability framework to focus on consumer need and service provision is "to be developed." Ideas on how accountability in consumer service delivery was to be achieved included:

- a minimum data set for performance monitoring;
- negotiated and approved operating plans;
- standardized data-gathering tools (Psycho Social Rehabilitation Toolkit);
- service agreements;
- program standards (such as Assertive Community Treatment Team standards); and
- monitoring and evaluation of reinvestments.

When referring to system management/service delivery responsibility and accountability, the *Implementation Plan* notes: "Measures of success will include wellness and quality of life indicators, not just symptom reduction. Linking funding to system and program performance is a critical element of system change."[9] In short, evaluating reform initiatives had stepped beyond broad system targets and was to be achieved by linking funding to outcomes/performance.

Making It Happen committed the Ministry of Health

and Long-Term Care to reviewing the *Implementation Plans* in 2002 and revising implementation strategies and program funding priorities as necessary. In addition, the Ministry's Mental Health and Rehabilitation Reform Branch committed itself to developing a mental health accountability framework consistent with the direction in *Making It Happen*. The Mental Health Accountability Framework has been developed and is expected to be released in 2003.

The creation of the Health Services Restructuring Commission resulted in further recommendations for reform. In its February 1999 report *Advice to the Minister of Health on Building a Community Mental Health System in Ontario*, the Commission recommended that nine Mental Health Implementation Task Forces (MHITFs) be established throughout the province.

The MHITFs were to be responsible for making recommendations to the Ministry of Health regarding the completion of implementation of mental health reform. The nine MHITFs and the Provincial Forum of the MHITFs were established in 2000 and have completed their work, submitting their final reports to the Minister in December 2002. The delivery of these reports sets the stage for the next phase of mental health reform.

Challenges to the Pace of Reform

A number of factors have challenged the pace of mental health reform. There have been both achievements and challenges in its rollout over the last ten years.

Achievements

Since 1996, over $381 million has been invested to advance mental health reform and increase the availability and capacity of services. Among the initiatives undertaken to support the directional change outlined in subsequent Ontario policy commitments such as *Making It Happen* (1993) and *The Newman Report* (1998) are a range of actions including: the legislative reforms contained in Bill 68 (Mental Health Reform 2000); expanded access to rights advice; a major homelessness initiative; the funding and establishment of 61 full and partial Assertive Community Treatment Teams (ACTTs); the divestment of six provincial psychiatric hospitals; significant funding for case management and crisis intervention services; and the development of accountability tools, including a specialized transfer payment agreement with the Ministry. Of the total $381 million, over $212 million has been invested in community-based as opposed to institutionally based services. Mental health expenditures in 2001-2002 represented a spending ratio of 56% institutional and 44% community.

Challenges

Events challenge even the best of plans. It has been said that life is what happens when you are making other plans. The following represent key events and time frames which have challenged the pace of reform, have required re-thinking and re-commitment, or have coincided with reduced growth in the community investments needed to complete mental health reform.

- The severe economic downturn of the early and mid-1990s resulted in reduced budget allocations, as government sought to contain expenditure growth.
- The change in government in June 1995 resulted in a re-evaluation of current government directions, including mental health reform. This review ultimately confirmed government's commitment to continue reform as outlined in *The Newman Report* (1998).
- Government's ongoing efforts to reduce and eliminate deficits resulted in controlled allocations and a rate of growth in investment which matched the growth in government revenues. The growth in new community mental health investments matches closely the periods of strong economic growth in the province. The economic downturn and threat of recession in 2001 caused the pace of investment to decline.

These events affected the pace of reform, and serve as an important backdrop for appreciating fully the achievements, which represent significant new investment.

The Next Steps

Ontario has made progress in achieving its reform objectives. The dominant community-based mental health system envisioned in *Making It Happen* has not been fully achieved. The completion of the work of the nine Mental Health Implementation Task Forces, the Provincial Forum of Mental Health Implementation Task Forces, and the Forensic Mental Health Expert Advisory Panel, sets the stage for a new wave of reforms and a new strategy for action.

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[1] Unless otherwise stated, all reports are published in Toronto by the Queen's Printer for Ontario.
[2] *Putting People First: The Reform of Mental Health Services in Ontario* (at 28).
[3] *Ibid.*
[4] *Ibid.*
[5] *Ibid.*, at 26.
[6] *Ibid.*, at 28.
[7] *Ibid.*, at 30.
[8] *Rural and Northern Health Care Framework*
[9] *Making It Happen* (Implementation Plan, at 41).
[10] *Making It Happen* (Operational Framework, at 23).
[11] *Making It Happen* (Implementation Plan., at 41).

At the time of writing, Allen G. Prowse, was the Manager, Mental Health Program, Health Care Programs Division, Ontario Ministry of Health and Long-Term Care.
†Lyn E. Carpenter, Senior Policy Analyst, Resources Management Office, Integrated Policy and Planning Division, Ontario Ministry of Health and Long-Term Care.

MENTAL HEALTH AND AGING

Dean Johnson*

Statistics Canada reports that 12% of the population in 1996 were over the age of 65. This is expected to rise to 25% by 2021.[1]

The 85+ group is the fastest growing segment of the population, therefore, many seniors may live with activity limitations for more than 20 years. As the population ages, the need for mental health services for older adults will increase.

There will be a need for a continuum of services, from community based to institutional, including services to seniors in good mental health, through outreach and preventative education programs.

Substance abuse and misuse, gambling addictions, ethnic and racial diversity, and the abuse and neglect of older adults are added variables that must be addressed. The larger number and greater diversity will present an important challenge to the design and delivery of mental health services to this specialized population.

Overview of Mental Health Issues

The major mental health problems facing older adults include anxiety disorders, depression and dementias, such as Alzheimer's Disease. The complexity of needs (psychiatric, medical, and social) requires specialized mental health services. Some mental illnesses are unique to seniors, e.g., types of dementia, while others are complicated by pre-existing conditions and/or co-existing problems.

Depression is not a normal part of aging. It is a treatable medical illness which may be a relapse of an earlier depression or triggered by other illnesses, hospitalization, or specific stressors, such as loss or grief. Most older adults are able to adapt and maintain health. Some are, however, unable to maintain a sense of balance when confronted by feelings of persistent grief. Losses could include spouse, friends, job, home, mobility, sensory changes, and health.

Serious illness is the most common cause of depression in the elderly, affecting about 25% of those with chronic illness and as many as 50% of long-term care (LTC) residents, according to the American Association for Geriatric Psychiatry. Serious depression among the elderly can lead to a vicious cycle if not detected and treated: it can cause other illnesses to worsen, leading to deeper depression, which can end in premature death or suicide. Because depression among the elderly occurs within the complexities of various physical, mental, and social problems, it can be difficult to identify. Co-existing medical disorders may also cause some of these symptoms.

Symptoms may include persistent complaints of pain, headaches, fatigue, insomnia, weight loss, and withdrawal from regular activities. Complaints of a lack of energy, unspecified ill feelings and self-neglect (e.g., appearance, eating) are not uncommon. This can be complicated by the difficulty that many seniors have in expressing feelings of depression. The present cohort group of seniors did not grow up when depression was known to be a medical illness, so they fear being seen as "crazy" or having a character weakness. They may think of it as something that they can "snap out of" rather than an illness to be diagnosed and treated by a trained professional.

Alzheimer's Disease is often associated with severe behaviour management problems. As it progresses, the individual may experience agitation, aggression, difficulty with activities of daily living, insomnia, and wandering. These problems may also be the result of a treatable problem such as pain, infection, or discomfort. This again points to the importance of being able to access specialized geriatric services.

Addictions may be lifelong or late-onset problems. As is the case with depression, stressful life events may exacerbate problems.

Suicide rates among seniors is higher than in other age groups. Studies have found that many have visited a family physician close to the time of suicide, therefore, physicians must be trained to identify the signs and symptoms of depression in the elderly.

Ageism: Why Does it Matter?

Societal values suggest that decline in aging is to be expected and that nothing can be done to improve one's health once it has begun to deteriorate. This pervasive view can be seen in family members, professionals, and older adults themselves. Expectations affect the vigour with which treatment is sought.

Primary care physicians may have negative attitudes toward the treatment of older people, which undermines the effectiveness and shape of the approach taken. A study by Zylstra and Steitz[2] found that those with the lowest negative biases toward older persons had greater knowledge of late-life depression and were more likely to provide proactive follow-up treatment. Many physicians believe depression is "understandable" or part of normal aging: "What do you expect at your age?" This can lead to inadequate diagnosis and treatment of mental illnesses among the elderly.

Systemic ageism impacts on the priority given to issues affecting older adults and the political will to fund services to address them. In-home counselling services, for example, can be more expensive on the surface but can

save future health care dollars that will be needed for costly hospitalizations. It is too easy to be "penny wise and pound foolish."

Treatment

Standard treatments for mental illnesses among older adults include psychotherapy and pharmacology. But a complete physical is the first step – depression may be a side effect of a medical condition or of medications. Understanding the complexity of problems seen in older adults can help to avoid the cyclical nature of the interactions, i.e., a medical condition leads to mental health/behavioural problems which, if not treated, lead to increased functional disability.

Comprehensive assessment and diagnosis, treatment and management are essential to the mental health of older adults. It is crucial to have access to trained professionals such as a geriatric psychiatrist, to provide optimal care to this population. A specialized geriatric assessment program can ensure access and continuity of optimum resources and liaison with primary partners. It can also help families understand the illnesses and link them to community supports, where needed. Multidisciplinary teams can help with pooling limited resources and discussing referrals.

Health promotion has been shown to be an effective accompaniment to other psychotherapies. Educating older adults about how to increase control over and improve health in a variety of areas (nutrition, physical activity, alcohol and substance reduction, tobacco use, stress management) helps maintain their independence and feeling of well-being.[3] Education can also provide a link to appropriate resources.

Other treatments geared toward supporting older adults include peer counselling and "life review" programs.

Peer counselling/self-help programs are generally offered in senior's centres, where older adults feel safer and more comfortable, and which are more acceptable to them than formal treatment sites. These programs can include telephone reassurance, shopping excursions, friendly visiting, and problem-solving opportunities.

"Life review" activities can help to reframe and integrate life periods and events. A study by Haight et al.[4] found significantly less depression and hopelessness and greater life satisfaction reported following involvement in a "life review" program.

Outreach programs help to keep older adults in the community with "tailor-made" services (e.g., counselling, medication monitoring, visiting nursing), rather than trying to fit a "square peg into a round hole."

Access/Barriers to Service

Some studies suggest that only half of older adults who acknowledge mental health problems receive treatment, and only a fraction receive specialized mental health services. There may be many reasons for this.

1) Older adults may fear the stigma, deny the problem or are reluctant to self-refer.
2) Diagnosis and treatment are often received first by the family physician, who may have inadequate training and may inappropriately prescribe psychotropic medications. Mental illness among older adults is thought, therefore, to be underreported.[5]
3) There may be a failure by professionals to identify signs and symptoms of mental illness in older adults.[6]
4) The physical environment (e.g., heavy doors, uncomfortable chairs, lack of facility for hearing impairments) is not accessible to some older adults.
5) There is a lack of understanding of multiethnic and linguistic issues.
6) There is a lack of coordination between agencies and systems (e.g., mental health, medical, and community seniors organizations).

Work force issues which act as barriers to service include:

- a shortage of mental health professionals trained in aging and aging professionals trained in mental health;
- community mental health organizations lacking staff trained in addressing non-mental health medical needs;
- the shortage of family physicians in some areas, which creates a reliance on clinics and a subsequent loss of continuity;
- the high incidence of mental illness (particularly depression) in long term care (LTC) facilities, with inadequate treatment available;
- a lack of knowledge and inadequate training of LTC staff about mental health issues;
- difficulty accessing psychiatric services and other mental health professionals in LTC because of limited resources;
- the need to incorporate mental health care as a basic component of LTC; and
- the need for paraprofessional staff/volunteer training, e.g., LTC staff trained and monitored by mental health professionals.

Conclusion

Aging baby boomers will put a further strain on an already underserviced area. There are steps that we can and must take to prepare.

1) The Mental Health Service needs for an aging population must start with increasing specialty training programs in geriatric mental health, and integrating aging and mental health content into the curriculum of professional degree programs.
2) Paraprofessionals and volunteers in LTC and senior centres should also be targeted for training, emphasizing the importance of interdisciplinary practice.
3) Encouraging collaboration can help to assure access to a comprehensive range of mental health care.
4) Work must be done, through public education, to change attitudes and behaviour about mental illness and older adults.
5) The involvement of consumers and family, of all ethnicities, by recruiting, training, and employing practitioners knowledgeable about these populations should be encouraged.

By working together across services, systems, and disciplines, creative solutions can be found to help avert the crisis.

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[6] Cooper-Patrick L, Crum RM, Ford DE. Identifying suicidal ideation in general practice. Journal of the American Medical Association 1994;272:1757-1762.

*Dean Johnson, Executive Director, Council on Aging, Windsor-Essex County.

CAMH OPENS INFORMATION STOREFRONT FOR THE GENERAL PUBLIC

The Centre for Addiction and Mental Health (CAMH) in Toronto recently opened the R. Samuel McLaughlin Addiction and Mental Health Information Centre, a walk-in storefront where the general public can pick up printed materials about mental health and addiction issues. The resource centre is located at 219 Dufferin Street, Suite 3B, on a major public transit route near the intersection of King West and Dufferin.

The centre offers publications in 16 languages and works in partnership with CAMH's Cultural Interpretation Services to provide service in languages beyond English and French. The centre is funded by a gift from the R. Samuel McLaughlin Foundation.

The McLaughlin Centre also provides a telephone support line staffed by trained volunteers and a 24-hour recorded message line (416-595-6111 or toll-free at 1-800-463-6273), as well as a website at www.camh.net/mclaughlin.

Increased access to addiction and Mental Health services in Hamilton

On November 7, 2003 the Ontario government announced an additional $2.4 million in capital funding to St. Joseph's Healthcare Hamilton for the purpose of increasing access to treatment for women with addictions and people with a mental illness who have come in contact with the criminal justice system. The funding includes $1.4 million for the construction of 18 interim forensic mental health beds at the Centre for Mountain Health Services site. The government is covering the full cost of the $3.9 million project. St. Joseph's Healthcare currently operates 18 minimum-secure beds at this site. An additional $1 million in funding will go towards the renovation of a building that will become a 24-bed women's addiction treatment facility. The new facility will be operating under a new program, Womankind, which the Centre for Mountain Health Services created through the merger of its addictions program and Mary Ellis House.

CONSENT AND CAPACITY BOARD Task Force on the Implementation of Rules of Practice

On September 29, 2003, Mr. R. John Harper, Chair and Chief Executive Officer of the Consent and Capacity Board sent a memorandum to stakeholders to announce the creation of the Task Force on the Implementation of Rules of Practice. Lawyer member of the Board, The Honourable Doug Lewis, will chair the Task Force. The other members are:
Susan Opler, Lawyer member, Toronto, Dr.
Rajiv Bhatla, Psychiatrist member, Ottawa,
Patricia Muldowney-Brooks, Community member, Hamilton
Erin Rankin-Nash, Community member, London

A summary of the committee's mandate is as follows:
1. To integrate the 2002 Draft Rules with the previous consultation and input received to the 2002 request for comments;
2. To provide an up-to-date draft set of Rules, having regard to previously received submissions;
3. To submit the 2003 Draft Rules to all Board members and stakeholders to allow for their update, review with previous submissions, and further submissions;
4. To allow for written and oral submissions to the Task Force in a manner and time line to be set and published by the Task Force;
5. To produce a final set of Rules of Practice and Practice Guidelines by January 1, 2004.

The 2003 Draft Rules are available on the Consent and Capacity Board website at www.ccboard.on.ca. A hard copy or electronic copy of the Rules can be obtained directly from Margaret James at (416) 327-4704, toll-free at 1-888-219-8349 or margaret.james@moh.gov.on.ca

A Notice of Public Forum to hear oral submissions was provided to the OPA on November 6, 2003 which included a list of tentative dates for the forums to be held throughout the province during the month of November, as well as December 1, 2003, with a request to RSVP no later than one week prior to the meeting .

The OPA provided a written submission on April 15, 2002 on the 2002 draft Rules of Practice to the former Chair and Chief Executive Officer, Consent and Capacity Board. This submission queried whether it was the intention of the Consent and Capacity Board to evaluate the way in which the Rules of Practice are used by the different boards and if the Rules would be reviewed on a regular basis. It was suggested also that because the commentary provided along with the rules would be of assistance to those using the rules, that a more English language approach be utilized, such as the development of a document similar to the Roles and Responsibilities document that was published as a guide with the Mental Health Act.

On October 31, 2003, the OPA provided a written submission to the Chair, Task Force on the Implementation of Rules of Practice; this submission included the comments in the previous submission as well as expressing the belief that it is essential that psychiatrists are educated on the Rules of Practice and that the OPA would be interested in working with the Task Force on the development and dissemination of the Rules of Practice and Practice Guidelines.

On November 3, 2003, the OPA was provided with a list of those stakeholders who had made a submission to the Consent and Capacity Board Task Force on the Implementation of Rules of Practice by October 31, 2003. Those stakeholders were as follows:

1. Dr. Luc Bourgon **2.** Children's Lawyer **3.** Centre for Addiction and Mental Health **4.** Wm. Mark Dresser **5.** Empowerment Council **6.** Grey Bruce Health Services **7.** David G. Hoff **8.** Legal Aid Ontario **9.** Legal Services Branch – Ministry of Health and Long-Term Care **10.** Michael A. McCue **11.** Mental Health Legal Committee **12.** Theodore Nemetz **13.** Ontario Psychiatric Association **14.** Swadron Associates

Mr. R. John Harper, Chair and Chief Executive Officer, Consent and Capacity Board presented to the OPA Council at their meeting on November 14, 2003 and provided an opportunity for questions and discussion. The OPA is currently in the process of reviewing the issues for discussion with the Task Force and the Board. For additional information please contact Dr. Doug Wilkins, Chair, OPA Advocacy Committee (and OPA President-Elect) at: dwilkins@qch.on.ca or office phone: (613) 721-4708.

In future issues of *Dialogue*, notices regarding "Positions Available/Practices for Sale/Persons Seeking Employment/Positions Sought" will be published for OPA Members free of charge. Non-Members will be charged a fee.
Please email your notice to: opa@bellnet.ca fax: 905-469-8697 or mail to OPA,
1141 South Service Rd. W., Oakville, ON, L6L 6K4

Geriatric Psychiatry Services Directory for Toronto

The Toronto District Health Council (TDHC) has recently published the Geriatric Psychiatry Services Directory for Toronto – January 2003 (Revised June 2003). This document provides a listing of geriatric psychiatry services across all health sectors in Toronto. It was developed in response to requests from consumers, providers and caregivers for a resource of this kind. The directory was developed by the TDHC in conjunction with the development of a report on Medical, Psychiatric and Rehabilitation Services for the Elderly in Toronto. That report provides the context and describes the current issues and trends in the provision of geriatric psychiatry in Toronto.

The TDHC has taken an inclusive approach in compiling the directory because it recognizes that there is a scarcity of geriatric psychiatrists in Toronto. The report used the following definitions to guide the inclusion of services in the directory:

Geriatric Psychiatry: the study and treatment of mental disorders – of both organic and functional origins – that occur in the elderly.

Geriatric psychiatry resources: resources in Toronto that are specific, specialized, professional services which assess, treat and/or maintain seniors with mental health needs (including cognitive impairments).

The 134 page directory contains an overview and brief description of various types of services by defined program type (community (including adult day programs, caregiver support programs, client intervention and assistance, social work, respite care, and supportive housing services); in-patient care; out-patient care; outreach services and special programs) and three appendices (geriatric psychiatry services by program type; geriatric psychiatry services by geographical location (based on CCAC Catchment Area) and Selected Community Support Services provided by CSS agencies in Toronto).

The directory is available from the TDHC website at www.tdhc.org or from the OPA office. For more information visit the TDHC website or call the TDHC offices at: (416) 222-6522

Guest Column: Families as Partners in Care

By Len Wall, Family Member and President of the Schizophrenia Society of Ontario

The Canadian Clinical Practice Guidelines for the Treatment of Schizophrenia[1] recognize the important role that families play in the treatment, care and recovery of people with schizophrenia. The Guidelines also speak to the importance of the professional-family relationship and the need to involve families in the treatment plans of their clients. Although direct involvement and interaction between families and professional caregivers has increased dramatically in recent years, due to the shift to community care, misunderstandings continue to exist between families and mental health professionals.

The Schizophrenia Society of Ontario is a family based organization representing families living with schizophrenia in Ontario. We have first hand experience navigating the middle road between mental health professionals and the clients who are our sons and daughters, brothers and sisters, partners and spouses, fathers and mothers, friends and relatives. Our hope is to strengthen cooperation and understanding between mental health professionals and families to ensure the best possible outcomes for our loved ones.

The Schizophrenia Society of Ontario (SSO) views "family" in the broadest sense, including biological family members, close friends, caring neighbours, co-workers etc.

Family members are usually the core support system for people with mental illness. Over 60% of people suffering from severe mental illness live in the community under the care of their family[2]. Families are involved in virtually all aspects of care and recovery of people with schizophrenia, even in cases where an individual does not live with his or her family. Families provide stability and the necessities of life for their ill relatives. They monitor symptoms, administer medication, plan recreation activities, and provide housing, financial aid, companionship and emotional support.

Due to the lack of community resources, families become the caseworker, the nurse, the crisis worker, the system navigator – too often, families are the system.

A diagnosis of schizophrenia of a family member creates a crisis that affects all family members and leaves them in a state of shock and disbelief. Family members experience a range of emotions including grief, denial, bewilderment, fear, anger and despair. Many families feel isolated and they may blame themselves or other family members as the source of the illness. The chronic stress that family members experience in their role as caregivers often undermines their own health, financial resources and ability to cope. The negative impact on the family can also hinder the stabilization and rehabilitation of the ill person.

Research has shown that with proper acceptance, involvement and education, families can be real assets in the treatment and care of people with schizophrenia. For example, when treatment plans involve families, families can provide important feedback to the professional treatment team. They can advise on the progress of the family member, the effectiveness of the treatment plan, and they can let professionals know if they see any slippage or warning signs of a possible relapse.

To be effective partners in care, families need education and support. Psycho-education programs offered to families, as part of client treatment plans, have been shown to reduce relapse rates and psychotic symptoms[3,4]. Family support or self-help strategies have been shown to increase the understanding of mental illness, improve family coping, reduce caregiver burden, and improve relations with, and support provided to, the ill relative[5,6].

Supporting and respecting the role of families also makes good economic sense. The National Schizophrenia Fellowship in the UK estimates that caregivers save the British government approximately three billion pounds each year.

Families, through organizations like SSO, are becoming more vocal; asking that their role as caregivers be recognized and respected. SSO is working with mental health professionals in Ontario to recognize the program entitled, "Families as Partners in Care"[7]. As respected partners in care, families deserve to have their role recognized. Families deserve:

- A family centred approach to treatment and support
- Access to family support organizations – education, support and services – funded by health care dollars
- To be treated with understanding and respect
- To be taken seriously when expressing concerns about changes in a person's behaviour
- General information about mental illness, treatment and coping strategies (This need not break confidentiality between professional caregivers and clients.)
- The opportunity to provide relevant information about a family member's history in confidence
- To be included in care planning, implementation and review
- To be provided with the names and contact information for members of the care team
- Rapid response in all situations, but especially in emergencies
- To be consulted about a family member's discharge plan
- A second opinion regarding diagnosis and treatment
- Culturally acceptable treatment options
- Access to mechanisms of complaint and redress

SSO understands that some clients prefer not to involve their families, or certain members of the family, in their treatment plans. We are not asking mental health professionals to disregard the wishes of their clients or to break professional-client confidences. However, mental health professionals can foster positive involvement of families by building personal trust with clients and creating an environment that encourages family involvement. For example, suggestions like, "you don't mind if we bring your parents in on this one?" or "I think your sister could be a great help here, don't you?" and other caring suggestions help to show the patient that the family can be of assistance.

Our main goal is to ensure that our loved ones receive the best possible treatment and care to facilitate optimal recovery. Professional health care providers come and go, but the majority of people with severe mental illness rely on their families for a lifetime. A positive family role is important in facilitating recovery.

For more information about the Schizophrenia Society of Ontario please visit our website www.schizophrenia.on.ca. If you would like to have SSO speak with your team, please do not hesitate to contact Len Wall, President at lwall@storm.ca, or Ursula Lipski, Policy and Research Coordinator at (416) 449-6830 or ulipski@schizophrenia.on.ca

1Canadian Psychiatric Association (1998). Canadian Clinical Practice Guidelines for the Treatment of Schizophrenia, Canadian Journal of Psychiatry. Vol. 43, Supplement 2 (revised), pp. 25S-40S.

2 Seeman, M. (1988). The Family and Schizophrenia, Human Medicine, 4(2) pp. 96-100.

3 Barton, R. (1999). Psychosocial Rehabilitation Services in Community Support Systems: A Review of Outcomes and Policy Recommendations, Psychiatric Services. 50 (4): 525-534.

4 Lauriello, J., Bustillo, J. and S.J. Keith (1999). A Critical Review of Research on Psychosocial Treatment of Schizophrenia, Society of Biological Psychiatry. 46: 1409-1417.

5 Dixon, L. et. al. (2001). Evidence-Based Practices for Services to Families of People with Psychiatric Disabilities, Psychiatric Services. 52: 903-910.

6 Pickett-Schenk, S.A., Cook, J.A. and A. Laris (2000). Journey of Hope Program Outcomes, Community Mental Health Journal. 36 (4): 413-424.

7 Families as Partners in Care is a program developed by the World Fellowship for Schizophrenia and Allied Disorders in 1998. The program includes a set of principles to guide mental health professionals in working with families.

OPA Full Member **SURVEY RESULTS**

Earlier this year, the OPA sent a 2 page survey to Full Members to find out why members join, which activities the OPA should engage in, and the challenging issues and practice changes that members anticipate within the next three to five years. An excellent response (17%) was received from both men (69%) and women (31%), most of whom were in full time practice. Of those who responded to the survey, 31% were under the age of 50 and 69% were over the age of 50. Most respondents were from Toronto (41%) although surveys were received also from members in Hamilton (14%), Ottawa (12%) and London (7%) as well as Grey Bruce, Guelph, Kingston, Mississauga, Newmarket, Oakville, Sarnia and Waterloo. Approximately one-third of respondents practiced in each of the academic, private and hospital settings, with some individuals practicing in more than one setting.

Members indicated that they joined the OPA because they believed it was important to belong to a professional association (97%), OPA represents psychiatrists (94%), they supported OPA's objectives (76%) and they wanted to receive OPA's quarterly newsletter, Dialogue (53%). Member comments indicated that representation of the profession, being kept informed of issues, peer networking and continuing education opportunities were also important reasons to join the OPA.

Question 2 of the survey incorporated some of the OPA's objectives articulated in the Association's by-laws. Survey respondents indicated that they wanted the OPA to continue to abide by Association objectives by:

- representing members to government and universities (100%);
- promoting an optimal level of professional development (89%);
- promoting an optimal level of professional practice (89%);
- advocating for persons with mental illness and their families (88%);
- promoting the prevention of mental disorders in Ontario (85%), and,
- representing members to medical/non-medical associations (79%).

Question 2 of the survey also asked members about information that they wanted to receive and if the OPA should provide this information in new ways. Ninety-seven per cent of members wanted the OPA to keep them current/informed on important issues. Eighty- four per cent of respondents wanted the OPA to provide a mechanism for members outside of Toronto to more fully participate in OPA activities, 72% of members wanted the OPA to publish a member directory and 43% wanted the OPA to implement a web based discussion group.

Major Practice Changes in the Next Three to Five Years

Members were asked what, if any, major changes they expected to see in their practice in the next three to five years.

Members foresaw more people reliant on disability, because the system does not encourage entrance into the work force, further eligibility restrictions for government benefits, decreased government funding and increased government intrusion in their practice. Members anticipate poor community and institutional resources, unavailability of community psychiatrists, increased movement of patients from the hospital to the community and an increased need to liaise with community agencies and provide consultation.

Concerns were expressed regarding the inability to cope with the increasing workload and with the increased numbers of severe non-psychiatric traumatized patients and people with personality disorders, mood disorders, depression and anxiety. An increase in the acuity/severity of patients, with a focus on pathology, rather than on dynamics, and more medications were predicted. One hospital-based psychiatrist suggested that there would be more defensiveness from litigation, more paperwork, on behalf of patients, and increased expectations, as a result of shortages. Another member commented on an increase in negative references from pharmaceutical companies.

Some members felt that they personally would face an increased workload while others were looking forward to a decreased workload due to retirement or a shift to part-time practice. Members anticipated a change in their role or shift in focus, for example, to an ACT team, taking a year overseas or moving to a hospital based practice. Other members were considering joining an AFP, being more selective in terms of the patients that they saw, for example, no longer seeing the violent homeless or moving away from a primary care role. It was predicted that there would be a decreased tolerance for psychotherapy and further erosion of funding for psychotherapy. One member commented on a future that held the promise of new treatment modalities, greater acceptance of mental illness as medical illness, and doctors having more autonomy and a greater voice on how to run their practices.

Challenging Issues for Psychiatrists in the Next Three to Five Years

Members were asked for their opinion on what the challenging issues for psychiatrists would be in the next 3 to 5 years.
Members felt that the public perception of mental disorders needed to be changed, that the public needed to be aware of and recognize the severe impact of mental illness, especially depression, and more work was needed to decrease the myths regarding mental illness and medications. Members reflected on a system that was falling further behind and did not currently provide adequate hospital or community programs or services. Members noted that there were more severe cases in the community, due to the downsizing of provincial psychiatric hospitals and decreased numbers of mental health hospital beds. There is a real need to develop more effective community-based programs and address post discharge patient management. Members expressed concern regarding government interference with treatment decisions and the reluctance of psychiatrists to use the Mental Health Act (competency to consult families).
Members felt challenged as to how to provide optimal mental health care to the mentally ill in a timely manner, given the financial constraints, limited patient services (both in the hospitals and the community), and the need to meet bureaucratic/administrative pressures. Members want to continue to advocate for their patients and to be involved in mental health reform. They are feeling challenged with respect to dealing with severely ill patients in the hospital and how to deal with the lack of success of the atypical anti-psychotic medications, treatment resistant mental disorders, dual diagnosis, substance abuse and axis I. They want to know how to avoid burnout, keep up to date, incorporate the use of computer software in their practices and upgrade their skills and training, while resisting pharmaceutical company influences. One member commented on the need to move from clinical practice guidelines to evidence-based practice. Another member wondered how to ensure that insurance companies respected the psychiatrist's reports.

Members commented on the current and future shortages of psychiatrists, increasing workload, underserviced areas and difficulties providing back-up, consultation to family MDs, on call duties and services to inpatients. Shortages of generalists, subspecialists, child psychiatrists, dual diagnosis and addiction services were noted. Members commented on the stigma of psychiatry as a career and the need to attract medical students into psychiatry. One member noted the need to decrease discouragement with the system so that new MDs will want to go into this specialty. Another member commented on the recent changes in how medical students choose a specialty and that the difficulty in changing a specialty contributes to shortages. There were also comments suggesting the need to clarify the relationship of psychiatrists to non-medical therapists and the need to defend turf from other professional groups seeking to take over the psychiatrists' role due to shortages, such as prescribing by psychologists and nurses.

There were many comments regarding the need for fee equity, better remuneration, alternate payment plans and adequate payment for psychotherapy. One member noted the need for increased fees for treating severely mentally ill

patients as an incentive since current fees do not distinguish between dealing with stable and unstable patients. Members commented on the need to promote non-MD psychotherapists, re-defining a role for psychiatrists in psychotherapy and encouraging new psychiatrists to value psychotherapy instead of medication.

OPA members were asked for their suggestions on how the OPA could best meet their needs. Five themes emerged:

1. continue with the good job that is being done;
2. continue to focus on professional development activities;
3. advocate for psychiatry, psychiatrists, psychiatric resident positions, and mental health with government and others;
4. advocate for patients by educating the public about mental health and mental illness, and;
5. continue to nurture and educate members and residents

In conclusion, OPA Council thanks those members who took the time to complete the Full Member survey. Council will continue to work to address issues that were raised in the survey and will continue to seek member feedback as suggested. A full transcript of the survey results and comments is available upon request.

Saint Elizabeth Health Care's Mental Health Services

By: Krysia Tomsic, BComm, BScN, RN CPMHN (C)

The Mental Health and Addictions Program at Saint Elizabeth Health Care (SEHC) is dedicated to providing a continuum of high quality, cost-effective services covering the entire lifespan. The Program is designed to help individuals with mental health issues, who may concurrently have addiction issues, achieve their optimal level of independence and wellness in their home or work environment. The program provides integrated, accessible supports, education and advocacy, while working in partnership with other health care organizations. The goals for our Mental Health and Addictions Program are:

- To support clients in their own environment to the highest degree possible.
- To provide healthy and supportive community alternatives to hospitalization and bridge the hospital and community sectors.
- To assist clients and families in achieving and maintaining optimal levels of independence, integration and wellness.
- To provide holistic treatment and support, recognizing the biopsychosocial and psychosocial nature of serious mental illness.
- To advocate for clients and their families.
- To incorporate innovative delivery approaches.
- To support integrated health care service delivery through partnerships with other services and organizations.
- To provide consultation, participate in research, and provide education to the community.

A Multidisciplinary Team Approach

Our multidisciplinary team of Registered Nurses, Registered Practical Nurses, Personal Support Workers and Rehabilitation Therapists are expert providers of a broad range of services to people of all ages and diagnoses in the comfort and convenience of their own home, workplace or community setting. The wealth of knowledge and experience of our highly skilled multidisciplinary staff enables SEHC to provide a comprehensive range of mental health services.

Clients can access our care and services in their location of choice, 24 hours a day, 365 days a year. Our organization presently provides services to clients of over half of the 43 publicly funded Community Care Access Centres (CCACs) in Ontario, as well as in select hospitals, long term care facilities and community health care clinics.

A psychiatrist may refer clients to SEHC for any of our services, specifically mental health, by contacting their local CCAC.

A Typical Patient

Mrs. K. Smith, 75 years of age, lives alone in an apartment and has recently become widowed. She has no other family supports, but has a neighbour who visits daily. She was referred to Saint Elizabeth Health Care after a four-week history of insomnia, fatigue, tearfulness, difficulty concentrating, and weight loss. Her doctor has prescribed Paxil and the mental health nurse assigned to her care ensures medication compliance. The nurse visits regularly, providing ongoing assessment and emotional support, while communicating the client's progress with the doctor as needed. The SEHC nurse was able to refer and connect her to a bereavement group, as well as provide linkages to Meals on Wheels and a community drop-in center for seniors. The client's mental health improved with medication compliance as well as the added emotional supports provided.

Other Services within the Mental Health and Addictions Program

Non-Intrusive In-Home Support and Treatment

Intensive home support and treatment is an alternative to hospitalization. It was designed specifically for people experiencing severe and persistent mental health challenges, who may also have addiction issues, and require acute and/or long-term mental health care.

Psychogeriatric Services

Integrated with our Long Term Care and Gerontology Program, our psychogeriatric services are designed to help prevent the early hospitalization of elderly individuals experiencing depression, Alzheimer's disease and other mental health issues. This service also provides education and support to caregivers.

Integrated Mobile Crisis Services

Saint Elizabeth Health Care's mobile crisis services are built on networks of community linkages and partnerships to offer timely crisis response to adults with serious mental illness. Services are multidisciplinary and include:

- 24 hour telephone access
- Timely mobile crisis response
- Pre-crisis support
- Linkages to mental health and community services
- Respite housing
- Intensive follow-up home treatment/support
- Medical psychiatric back-up and hospital services

SEHC also provides customized online health education, information and care that is accessible any time of the day or night through an innovative web-based service called @YourSide™. Clients can seek advice and guidance from their care providers and other experts, as well as access monitoring tools that allow them to track their overall health and well being.

Krysia Tomsic is the Clinical Consultant for Mental Health services at SEHC. Her career as a Mental Health Nurse has mainly been in the community, working with homeless men, women and youth in various shelters in Toronto, Canada and Auckland, New Zealand. Much of her nursing has focused predominantly on mental health wellness and promotion, client advocacy, addictions, harm reduction, crisis intervention and community treatment orders. At SEHC, her role

as the Clinical Consultant is:

- To support service provision through program design and development, including research, standards of practice, outcome indicators and measures.
- To promote excellence in care delivery as a knowledge broker.
- To support care providers via clinical discussion and collaborative decision-making, educational programs, clinical tools and processes.
- To influence mental health programs and services as a member of community committees and activities.

For more information please contact: Krysia Tomsic, Clinical Consultant, Mental Health at Tel: 905-940-9655 ext. 2215, ktomsic@saintelizabeth.com

To find out more about Saint Elizabeth Health Care and the health services that are provided, available consulting services, or the interactive@YourSide™ solutions, please visit www.saintelizabeth.com.

MEMBERS ON THE *MOVE*

Dr. Adrian Hynes, previously with the Lakehead Psychiatric Hospital, Thunder Bay was appointed to Physician Leader, Concurrent Disorders Program, Regional Mental Health Care, London effective September 15, 2003. Dr. Hynes can be reached at (519) 455-5110 or by email at hynesafm@sympatico.ca.

To get your new appointment in "Members on the Move", send us the following information – your name, position, date of appointment, the organization you were with and the new organization (if applicable), your email, phone number and address. We will run these announcements as we receive them, and as space in the *Dialogue* allows. Please forward your items in writing to the OPA Office, 1141 South Service Rd. W., Oakville, ON, L6L 6K4, by email to: opa@bellnet.ca or by fax to: (905) 469-8697.

Meet A Council Member

An Interview with Elizabeth Esmond, MB, BS, FRCP(C), FRANZCP

OPA: What is your current position on the OPA Council and on what committees do you serve?
Elizabeth: I am a Council member, and serve on the Member Services Committee.

OPA: Tell us a bit about your background.
Elizabeth: I was born and raised in Australia. My medical degree is from the University of Queensland. My internship was in Christchurch, New Zealand where I worked with Dr. Ken Adam. I was impressed by his approach to the mentally ill and decided to come to Canada to study. In Ottawa I did a residency, including child psychiatry training, married a Canadian and had three children, who are now 23, 19 and 16 years of age.

OPA: When did you join OPA and why?
Elizabeth: I was not a member for many years. However, after speaking with colleagues about issues in psychiatry, I became interested in advocacy on behalf of both colleagues and patients so I joined up. For some years I was not a member - mainly because I was involved with so many other associations and was paying fees to all of them. I decided to rejoin the OPA after reviewing my own objectives and setting priorities and deciding that because I practice psychiatry in Ontario, it was important that I understood the social, legal and political realities that my patients and I have to deal with. It is important to me also that I have access to others who have the knowledge and ability to advocate for patients and psychiatrists. After making the decision to rejoin the OPA, I gained an unexpected bonus – the chance to meet regularly with dynamic and interesting people who are on OPA Council. I am also on the Member Services Committee, which is a Standing Committee of the OPA Council.

OPA: What has been your most valuable experience as an OPA member?
Elizabeth: The Annual Meeting in January. The high quality of the presentations, the opportunity to meet (or meet again) colleagues from around the province and the excellent social event.

OPA: In what ways have you seen the OPA change over the last 10 years?
Elizabeth: I have been impressed by the dynamic, passionate attitude of my colleagues on Council and their political and social awareness.

OPA: What do you think is important to psychiatrists to be aware of in the 21st century?
Elizabeth: There are threats to our role in the treatment of our patients. There are those who would have us be consultants and prescribers only, rather than therapists and healers. We should not be apathetic about this issue.

OPA: If you were not a psychiatrist, what other professional endeavour would you be pursuing?
Elizabeth: The Arts. I am over-subscribed in my spare time to choirs, voice lessons, and dance classes. I would like to be involved in musical theatre. As a compromise, I have taken courses in dance and movement therapy.

OPA: If you had one wish for yourself, what would it be?
Elizabeth: To go somewhere with Medecins Sans Frontieres for a while.

OPA: What are your wishes for the profession of psychiatry?
Elizabeth: 1)That we would remain passionate advocates for the mentally ill.
2) That we would continue to see ourselves as therapists and healers in a direct sense.
3) That we would be sensitive to and receptive to the networks our patients are already connected with, such as their families; too often we shut them out.

The Coalition of Ontario Psychiatrists: History and Update

By Douglas C. Weir M.D. F.R.C.P.(C), Chair, OMA Section on Psychiatry

I am often asked what is the Coalition of Ontario Psychiatrists? What is the relationship between the Coalition, the Ontario Medical Association Section on Psychiatry and the Ontario Psychiatric Association? What does a psychiatrist gain from paying $250 to the OMA-OPA Coalition Action Fund? I will answer these and other questions in this article.

History of the Coalition of Ontario Psychiatrists

Prior to 1996, psychiatrists were often working on the same issues but in an uncoordinated fashion. In 1996, several psychiatrists joined together to discuss the establishment of a coalition which would serve to represent Ontario Psychiatrists by speaking with a united voice. The Coalition of Ontario Psychiatrists (Coalition) is made up of representatives of the Ontario Psychiatric Association (OPA) and the OMA Section on Psychiatry (the Section), but has always worked in conjunction with the Association of General Hospital Psychiatric Service (AGHPS), the Association of Ontario Physicians and Dentists in Public Service (OPDPS) and many other organizations to ensure that the Coalition speaks for all Ontario Psychiatrists.

Psychiatrists representing the OPA and the Section worked together but without a formal agreement between 1996 to 1998. Then in 1998 a formal memorandum of agreement was drafted and endorsed by the Section and the OPA. The Coalition has by laws that have been endorsed by both organizations. The Coalition is the partnership between these two organizations. The Directors of the Coalition of Ontario Psychiatrists come from the two organizations, currently they are the Chair, Past-Chair and Vice-Chair of the OMA Section on Psychiatry, currently Dr. Douglas Weir, Gerry McNestry and Michael O'Mahony; the President, Past President and President Elect of the OPA, currently Dr. Robert Buckingham, Margaret Steele and Doug Wilkins; and a Coordinator, Dr. Barry Gilbert.

What is the Coalition of Ontario Psychiatrists?

The OPA and the Section share many of the same goals. Both groups strive to represent Ontario psychiatrists in their relationships with governments at all levels, universities, other medical associations, other associations that relate to psychiatrists such as the Ontario Hospital Association and other stakeholders involved in mental health care in Ontario. The Coalition allows these two organizations to coordinate their efforts on these fronts. In addition each organization has distinct objectives and tasks they are trying to achieve.

The OPA is the liaison to the Canadian Psychiatric Association. The OPA puts on a very successful Annual Meeting with a three day scientific program that is varied and stimulating while providing Maintenance of Certification credits. Through the OPA Sections, subspecialty groups such as Child and Adolescent Psychiatry, Psychogeriatrics and Psychotherapy have a forum to put forward their issues. The Newsletter for the OPA, *Dialogue*, that is published four times per year, is where the OPA and the Section can communicate what they are doing and inform OPA members of a variety of topics that are of interest to psychiatrists.

The Section focuses on representing Ontario psychiatrists in negotiations regarding remuneration of psychiatrists within the OMA and those that are part of the negotiations between the OMA and the MOHLTC. The Section, as part of the OMA, represents psychiatrists in a number of other issues that affect all physicians. The Executive of the Section networks with other medical colleagues at the OMA.

Dr. Buckingham, Derek Puddester, Adrian Hynes and Federico Allodi are on the OPA Council and the Executive of the Section. The Section Executive in part consists of representatives from the various other organizations, Dr. Allodi represents the OPDPS; Dr. Tyrone Turner represents the AGHPS; Dr. Buckingham represents the OPA; Dr. Gilbert represents Ontario psychoanalysts; and Dr. Puddester represents the Academy of Child Psychiatry. There are monthly teleconference calls with participation by the Directors of the Coalition, representatives from the OPDPS, the AGHPS and Dr. Sonu Gaind, who is the Tariff Chair on the OMA Section Executive. In addition, representatives from other organizations representing psychiatrists or individual psychiatrists join in the monthly Coalition teleconference calls. As you can see, there are plenty of opportunities to make sure that we coordinate our efforts on behalf of Ontario psychiatrists.

Other organizations that the Coalition works with focus on more specific issues. The Association of Ontario Physicians and Dentists in Public Service (OPDPS) and the OMA Section of Ontario Psychiatric Hospitals and Hospital Schools represents the interests of psychiatrists who work in Ontario Provincial Psychiatric Hospitals. Although the majority of their members are psychiatrists, other physicians and dentists in public service are also represented by the OPDPS. As a result of divestment of the Provincial Psychiatric Hospitals, the number of psychiatrists in the OPDPS has decreased considerably over the last 10 years. Currently Dr. Ruth Kajander, President of the OPDPS, is invited to participate in the monthly Coalition teleconference calls to represent the OPDPS.

The Association of General Hospital Psychiatric Services (AGHPS) was established in 1982 in recognition of the major role of general hospital services in providing psychiatric care in Ontario. The mission of the AGHPS is to promote the continuing development of optimal psychiatric services in Ontario. The members are general hospitals and Schedule 1 facilities. AGHPS represents approximately 50 hospitals. Their Board of Directors is comprised of 22 Chiefs of Psychiatry and Directors of Mental Health Programs throughout Ontario. Currently Dr. Turner, AGHPS President, is invited to participate in the monthly Coalition teleconference calls to represent the AGHPS.

When the Coalition was founded, the AGHPS and the OPDPS were involved in the discussions but were not part of the formal partnership because these organizations represent not just psychiatrists but hospitals and other professionals. The objectives of the AGHPS and the OPDPS are generally shared with the OPA and the Section and so the Coalition endeavors to coordinate the efforts of all four organizations.

There are other organizations that represent not only psychiatrists but also other professionals. For example, the majority of the members in the Toronto Psychoanalytic Society, the Ottawa Psychoanalytic Society and the South Western Ontario Psychoanalytic Society are psychiatrists and the Coalition works with members of those organizations on issues of mutual interest such as the CPSO proposed psychotherapy guidelines.

The Association of Ontario ACT Psychiatrists (AOAP) approached the Coalition to help address issues related to the way in which ACT psychiatrists are reimbursed. The Coalition has been working with the AOAP to address their concerns.

Because of RAND, all psychiatrists must pay OMA dues. OMA dues pay for the excellent support staff at the OMA and honorarium for psychiatrists and other physicians representing our common interests to attend OMA meetings or bilateral OMA/MOHLTC meetings. The voluntary dues of the OPA support the valuable work of the OPA. The voluntary payment to the OMA-OPA Coalition Action Fund provides money to pay for the administrative support the Coalition uses, for example to pay

for the monthly teleconference calls. It also gives the Coalition money to pay outside experts and honorarium to psychiatrists who are doing work on behalf of the Coalition. In the next year, the Coalition has budgeted to spend about $200,000; 15% of this will be for administrative costs, 42% will be to pay various experts and 43% will be to pay psychiatrists to do the work necessary to properly represent Ontario psychiatrists.

COALITION INITIATIVES

1. Mental Health Services Delivery

The Coalition has worked to coordinate the efforts of psychiatrists dealing with government attempts to reform mental health care delivery. The Coalition hired experts and developed the document Continuing To Meet The Challenge: Facilitating Recovery: Integration Framework for Mental Health Services For Adults With Severe and Persistent Mental Illness 2001. The Coalition also used these same experts to better understand other proposals that were being put forward such as the suggestion that there be regional mental health authorities.

2. Remuneration of Ontario Psychiatrists

Sessional Fees

In 1993 the NDP government unilaterally cut sessional funds by 25%. The total funds available were cut while the rate stayed the same. Various unsuccessful efforts were made to engage the MOH and the government to reinstate those funds. Then in 2000, as a result of lobbying by the Coalition and as part of the OMA/MOHLTC negotiations, the current government restored the sessional funds back to their 1993 level. That represented a $4.2 million increase to sessional funds.

On November 6, 2002, sessional fee rates in Provincial Psychiatric Hospitals increased 15%, as a result of the settlement reached between Management Board and the OPDPS. In November, Dr. Buckingham, Turner and Weir, representing the Coalition, met with staff from the MOHLTC and the Health Minister's Office to advocate that all sessional rates should increase by 15%. In 2001/02 Community Mental Health Agencies, Children Mental Health Institutional Programs and General Hospital Psychiatric Departments received more than $20 million in sessional funds.

The former Minister of Health Tony Clement sent out a letter in July 2003 announcing that the Ministry of Health and Long-Term Care would be extending this increase to all agencies that receive a psychiatric sessional fee allocation. This 15% increase was retroactive to November 2002 and increased the sessional pool by $3 million annually. The new rate for a Psychiatrist increased from $311 to $358, for a minimum of three hours and a maximum of four hours.

CTC and RBRVS

In 1997, the Coalition started paying psychiatrists to represent us in remuneration discussions. The Ministry of Health and Long Term Care spends a great deal of money on psychiatric services through OHIP and sessional funds (about $270 million in 2002-2003); thus, it is important that psychiatrists are both prepared and well represented in remuneration discussions and negotiations. Outside experts have been employed and funded by the Coalition so that psychiatry was able to develop a reputation for being a force to be reckoned with.

Dr. Weir represented us in discussions related to addressing fee inequities through the Resource-Based Relative Value Schedule Commission of Ontario (RBRVS) and Dr. Sonu Gaind represented us at the OMA Central Tariff Committee (CTC). The time Dr. Weir and Gaind spent preparing for those discussions were paid for by the Coalition.

Psychiatric services were identified in the Final RBRVS Report as being inadequately compensated. The CTC recommended increasing the fees for many psychiatric K codes. Despite these two positive outcomes it was not clear these recommendations would translate into money in psychiatrists' pockets.

At the November 2001 OMA General Council meeting Dr Weir and Gaind put forward two resolutions that were passed: "That the OMA recognize that across-the-board fee increases to the Schedule of Benefits perpetuate existing fee inequities, and that fee increases must be allocated in a more equitable fashion." And "That the OMA make it a priority to implement the outstanding CTC recommendations from the CTC 2000 & 2001 Reports when it considers fee increases for April 1, 2003 or sooner if additional funding becomes available."

Prior to the November 2002 OMA General Council meeting we asked Ontario Psychiatrists to write the OMA President urging him to make sure those resolutions were not ignored. Over 450 Ontario Psychiatrists wrote letters and the meeting reconfirmed its recommendation to implement the CTC recommendations and to address fee inequities.

In April of this year the OMA and the Government of Ontario signed a Memorandum of Agreement for 2003-2004. The new arrangement stemmed from the provision contained in our current Master Agreement, which allowed for both parties to revisit the allocated two per cent fee increase to be applied in the final year of the Agreement. Ontario physicians were entitled to $90 million (annualized), if we had only received a 2% fee increase. The OMA was able to negotiate another $90 million to address fee inequities (rebalancing). The total change as a result of implementing CTC recommendations and rebalancing was $180 million (annualized) or an increase of over 4% to professional fees. In addition to increases to the fee-for-service pool other money was obtained for Primary Care Reform, the Hospital-on-Call program and other non-fee-for-service payments to physicians.

Psychiatrists, as a result of the implementation of CTC recommendations, effective April 1, 2003 gained an additional $9.6 million. As a result of rebalancing, the fee increases that took effect August 1, 2003, psychiatrists gained an additional $7 million (annualized), a total increase of $16.6 million (annualized) or an overall increase of 6.64% was realized.

There have been other financial benefits that resulted from the Coalition advocating on behalf of Ontario Psychiatrists. The 2000 OMA/MOHLTC Agreement introduced money for Hospital-on-Call. In 2002-2003 almost 600 psychiatrists received on-call money, for a total of over $3.8 million.

In 2001 the fee for ECT was $30.70. In 2002 ECT was divided into two new codes, G478 inpatient Electroconvulsive Therapy, $54.15 and G479 outpatient Electroconvulsive Therapy, $59.80. This increase benefited about 200 psychiatrists who received an additional $337,000 in 2002-2003 as a result of this change.

Added together all of the above increases amount to $28 million.

3. ACT Team Psychiatrists

We have also worked with the Association of Ontario ACT Psychiatrists to assist them in their efforts to get better and fairer remuneration for ACT team psychiatrists.

4. Other issues

The Coalition has canvassed widely on a number of policy issues in order to ensure that the majority of Ontario psychiatrists support the positions we present. The Medical Review Committee of the College of Physicians and Surgeons, the development of guidelines for psychotherapy at the College of Physicians and Surgeons, guidelines for psychotherapy published by the OMA/MOHLTC Guideline

Advisor Committee and the role of Nurse Practitioners prescribing antidepressants are some of the issues we have been dealing with in the last few years.

2004: The Year Ahead

What follows are the important issues the profession faces in 2004.

Negotiations

The next round of bargaining for a new Master Agreement will start in January 2004. The OMA Board of Directors appointed the Negotiations Committee whose membership includes: Dr. Stewart Kennedy, Chair a family doctor from Thunder Bay; Dr. Ray Dawes, a family doctor from Barrys Bay; Dr. Chris McKibbon, a Rheumatologist from Sudbury; Dr. Tim Nicholas a family doctor from Aurora; Dr. Wayne Tanner, a vascular surgeon from Toronto; Dr. Michael Toth, a family doctor from Aylmer, Dr. Janice Willett, an Obstetrician Gynecologist from Sault Ste Marie; and Dr. Douglas Weir, a psychiatrist from Toronto (Chair of the OMA Section on Psychiatry and one of the Directors of the Coalition of Ontario Psychiatrists).

Dr. Weir was asked to apply to the OMA Negotiations Committee and his application was successful in recognition of work he had done that was supported by the Coalition.

The next Comprehensive Agreement in 2004 gives us an opportunity to build on the "re-opener" for fiscal 2003-2004. The Coalition has identified the following priorities for the upcoming negotiations:

1) Even after getting a significant net fee increase in 2003 the average psychiatrist's net income is still 35% below the average for all specialists or 17% below the average standardized net @ 2200 hours/year for all specialists. Negotiating significant new money for relativity and continuing to address fee inequities must be a priority.

2) Fees in other provinces are significantly higher than in Ontario. For example, in BC an outpatient psychiatric consultation pays $186.95, in Ontario OHIP, as of August 2003 pays $125.00, the fee is almost 50% higher in BC. Similarly in BC a half-hour of outpatient psychotherapy pays $79.46, in Ontario OHIP, as of August 2003 pays $58.40, the fee is 36% higher in BC. Significant new money will have to be added to the OHIP Globe to correct the disparity between fees paid to Ontario physicians when compared to the fees paid in the majority of other provinces

3) The Coalition supports pursuing multiple avenues to address problems in remunerating physicians. We support additional money for academic health centers and for the hospital-on-call payment program. At the same time the OMA should seek new money for new initiatives such as pensions and paying for continuing education.

4) In this round of negotiations we would like to see the number of mental health sessions increased and a further increase to the rate. As a minimum we want an increase to the sessional rate parallel to any increase to K198 – the Psychiatric Care Fee Code.

5) We support exploring other ways of paying psychiatrists for in-direct services. Currently in-direct services are not paid for in a variety of settings and this discourages psychiatrists from working in such settings. Sessional funds is only one way to pay for such services and the Coalition would like to work with the MOHLTC to find other methods especially for settings that are currently not receiving sessional funds or are not eligible for sessional funds.

6) The top issue for psychiatrists in Ontario is the shortage of psychiatrists in all communities, large and small. Further, the average age of Ontario psychiatrists is 56. As older psychiatrists retire the shortages are going to get worse if the province fails to remunerate psychiatrists so we can attract psychiatrists from other jurisdictions, attract medical school graduates to enter psychiatry residencies and retain the psychiatrists presently working in Ontario. At the same time the province must create more re-entry psychiatric residency positions.

Mental Health Reform and the New Liberal Provincial Government

In addition to representing Ontario Psychiatrists in discussions about remuneration, the Coalition has been active in Mental Health Reform and monitoring the Mental Health Implementation Task Forces. Nothing has been heard from the MOHLTC on this since the Task Forces reported in December 2002. We expect that the new Liberal provincial government will address mental health reform. The Coalition will meet as soon as possible with the Honorable George Smitherman (Toronto Centre-Rosedale), Minister of Health and Long-Term Care or his staff to discuss mental health issues.

Although Health care ranks at the very top of the government priorities, mental health was not a big part of the Liberal platform. It is not clear in what direction they will move regarding mental health reform, so we have an opportunity to meet with them early and influence their policy decisions.

ACT Team Psychiatrists, MRC, Privacy, Psychotherapy Guidelines

ACT Team Psychiatrists should be receiving a survey that will gather information on remuneration, workload, and practice satisfaction of psychiatrists who are currently or who were previously engaged as ACT team psychiatrists. The Coalition continues to monitor issues related to MRC, privacy legislation, psychotherapy guidelines and other issues of concern to all psychiatrists.

Psychiatry Billing and Practice Guide

In the recent past the Coalition sensed the need to develop and circulate a customized billing and practice Guide. Under the direction of Dr. Gaind the Coalition has undertaken to develop such a guide that will be ready early in 2004. The intended audience of this publication would be Royal College certified physicians practicing the specialty of psychiatry in the province of Ontario. The intent of this Guide is to answer some of the most common questions heard from Ontario psychiatrists. These questions range from the more rudimentary billing questions to the more complex medical legal issues.
Clearly it is impossible to address all psychiatrists' questions; the Coalition's efforts have concentrated on those encountered most frequently by psychiatrists as well as areas where communicating better with our patients can help avoid unnecessary legal and clinical inquiries from our regulatory body (CPSO).

The Coalition will sponsor a workshop entitled How to Bill, 2:45 p.m., Friday, January 30, 2004 at the OPA Annual Meeting. The Coalition will have a draft version of the Billing Guide for those who participate in the workshop. Some of the topics to be discussed will be Block Fees, Underused Codes, and other topics of interest to psychiatrists about billing matters.

The Ministry of Health and Long-Term Care Organizational Chart, October 2003, can be found at http://www.health.gov.on.ca/english/public/ministry/orgchart.pdf .
If you wish to have a copy mailed to you, please contact the OPA Office at (905) 827-4659.

MENTAL HEALTH ISSUES FOR PERSONS WITH A DUAL DIAGNOSIS: A FAMILY PERSPECTIVE

Jim and Elgi Johnston*

Families who have an adult child with a dual diagnosis (an intellectual disability and mental health needs) struggle to access services or even to know what services are available that would help them support the individual. There are two major systems to navigate – mental health and developmental services. Supports are not keeping up to demand. There are over 600 individuals with a dual diagnosis waiting for residential services in Toronto alone. Any family dealing with an adult child with an intellectual disability is under great stress, and adding mental health issues is often enough to break down the family unit. Since current estimates are that upwards of 30% of those with an intellectual disability have mental health needs, the problem is acute and growing.

The family can be the most powerful positive influence in the support of an individual who has a dual diagnosis. In fact, the family is often the only one that is able to find and coordinate the services that the individual needs. To ensure that this happens, the family needs information and support from experts in the field. All too often, these experts focus on the individual through the paradigm of their own specialty, and ignore the potential of strengthening and informing the family.

An intellectual disability makes the diagnosis and treatment of mental health problems much more difficult than in the general population. This population is normally not able to articulate their symptoms clearly, or to independently follow treatment plans (e.g., following a medication regimen).

Mental health problems often develop as the individual reaches maturity. Sometimes, in fact, these problems are attributable to the stress of having to cope with the loneliness and rejection that impacts those who have an intellectual disability, and the lack of meaningful day program opportunities.

The mental health symptoms may be mistakenly seen as related to the intellectual disability. That is, if the family member is impulsive, withdrawn, or irritable, symptoms may be attributed to the disability, and an assumption made that there is little that can be done to reverse them. In fact, there may be an underlying physical illness, a life crisis, a psychiatric illness, or a stressful environment.

Normally, support for the individual with a dual diagnosis, if available, will come from the developmental sector in the form of day programs or residential placements. Workers in that sector do not have the specialized training to recognize mental health issues and to effectively counsel the family concerning them. In fact, the low pay scales for these workers and the resultant lack of capable young men and women who want to enter the field is alarming.

Families are also concerned with a lack of flexibility in the system. Many programs are not designed for the individual, but rather try to force-fit the individual to the program. Families will deal with one agency, but that agency is often unaware of what programs other agencies have to offer. As a consequence, a family will not be aware of other programs that could meet the needs of their adult child much more effectively. Even if the parent becomes aware of a better program there is no process for the family to evaluate the program and to transfer to another funded agency. Many families are looking for practical training that will help the adult child cope in society. Training in cooking, laundry, or personal hygiene, for example, may not be available from the agency supporting the individual.

Some families want to design an individualized program themselves which will fit their child's needs. The Government of Ontario has experimented with individualized funding where families apply to have the government fund certain specialized services that are otherwise unavailable and that the family would supervise. Although the pilot has been extremely successful for the families that participated, and is as cost effective as many agency-run programs, the government has not moved to expand the concept.

Support for assessment and diagnosis is difficult to find. The developmental agencies are not equipped to deal with a significant mental health problem, and the community mental health agencies will usually refer the individual back to the developmental sector. The linkage between developmental services and mental health services must be strengthened so families can receive a full range of supports regardless of the service the family accesses. The agency that the family deals with must be able to understand and access a wide range of services for that family.

Unfortunately, there are very few psychiatrists in the province who are competent in the field of dual diagnosis. Education for psychiatrists in the field of intellectual disabilities is sadly lacking. Medication often becomes the panacea.

In many cases, families are not informed adequately about the possible side effects of the medication, or what alternatives exist. Attempts are made to reduce symptoms by an increase in dosage instead of a more thorough assessment. Many families resort to reducing the dosage or discontinuing the medication on their own to determine what will work for their adult child.

The family needs access to a coordinated assessment of the individual, where medical, developmental, and mental health factors are all assessed and integrated so that an effective plan can be created. Very few families are able to get a good assessment. Instead, they get incomplete input from various sources (family doctor, developmental agency, etc.) and then struggle to make sense of the input.

Families do not see ongoing coordinated support from medical, developmental, and mental health professionals. Symptoms are often seen as behavioural problems and dealt with by behavioural management tools. In most cases the family does not know how to navigate the mental health system. Possible medical conditions which may be affecting the individual may not be discovered. For example:

- An individual slapped her abdomen over a period of time. It was seen as a nervous habit or attention seeking and efforts were made to stop her slapping. The woman had an ulcer.
- An individual raised his hand over and over, and was told to keep his hand down. He was having a heart attack.
- An individual seemed unresponsive and uninterested in tasks he was capable of doing. He had a sleep disorder.

As this population ages, diagnosing mental health and medical issues will become even more critical.

Inevitably, an incorrect diagnosis, and therefore the wrong interventions, will lead to a crisis. This will put extreme pressures on the family unit. The ongoing stress of supporting the adult child impacts all the members of the family, and without support the family itself is in danger of not being able to support the individual. The family must receive support to recognize impending crises, intervention to prevent them and information about what resources are available to help should crises develop. The "safe bed" initiative is a great help to families who find their child in crises, but it is a short-term solution and does not help to prevent such occurrences.

From the family's point of view, the "system" seems fragmented and often unable to provide assistance. They need help to make sense of the system and to find the appropriate supports. Case management can be helpful, but only if the case manager has a broad understanding of both the developmental and mental health sectors.

Funding from "Special Services at Home" is one way for families to access workers who may be used for respite or for particular skills development. Recently, headway has been made in creating a respite system that will help families to locate these workers. Finding workers who are competent to deal with an individual with a dual diagnosis, however, continues to be a significant problem for families.

Since there are few standards of quality for agencies in the developmental field and no requirement for certification, the quality of programs varies considerably from agency to agency. Parents often recognize this lack of quality, but may not know where to turn or may feel that there will be repercussions from complaining. There needs to be certification for agencies that deal with this most vulnerable population. In addition, there should be a clear way for a family to escalate their concerns beyond the agency with assurances that no repercussions will occur. Agencies all feel that their programs are excellent, but with no objective independent measurements, each agency is left to evaluate their own program, and only improve it if they see fit. The provincial government should take a leadership role in setting clear standards, and ensuring families understand how to escalate their complaints.

In summary, families need:

- To be able to access coordinated assessments.
- To have government recognize the value of trained workers in this field, and make their pay competitive.
- To have accreditation of agencies so that families will have some guide as to the quality of the agency.
- To have flexibility in the support of their adult child, including individualized funding and the ability to move to alternate programs if required.
- To have access to knowledgeable case managers who can help them navigate both the developmental and mental health systems.
- Assurances that proper support will be available when they can no longer support their adult child.
- To have the medical profession and medical schools recognize the lack of psychiatric and medical expertise in this field, and provide the necessary education.

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OLDER ADULTS' MENTAL HEALTH: The Importance of Prevention and Health Promotion for Successful Aging

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As many as one half of North Americans will experience a mental disorder in their lifetimes and nearly one third will have had a diagnosable mental illness in the past year (Howard et al., 1996). In addition, certain mental health problems, such as depression, are becoming increasingly prevalent, such that more recent birth cohorts are at increased risk (Cross-National Collaborative Group, 1992). Given the striking prevalence of mental health problems and evidence that prevalence rates are increasing, mental health professionals face a difficult and growing challenge.

Traditionally, mental health professionals have addressed this challenge using a model of care which focuses on diagnosis and treatment (Cole, 2002). Despite the obvious importance and necessity of treatment in improving mental health, its impact is limited in several ways. The most striking limitation is that between 70% and 80% of individuals with diagnosable mental health problems do not receive professional help (Howard et. al, 1996; Lin, Goering, Offord, Campbell, & Boyle, 1996). Older adults are especially unlikely to seek mental health services, even when differing rates of mental illness are taken into consideration (Swartz et al., 1998). The second way in which our treatment-focused model of care is limited is that for those individuals who do seek mental health services, psychological and pharmacological therapies are not 100% effective ("Mental Health," 1995).

The limitations of a treatment-focused model of care have long been recognized in the physical health field. In 1959, Debos wrote that "no major disease in the history of mankind has been conquered by therapists and rehabilitation methods alone, but ultimately only through prevention." This sentiment is echoed by the World Health Organization (2003), who define health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." Recognition of the limitations of treatment has led to a more holistic model of health care, where treatment is supplemented with efforts to prevent problems among those at risk and to promote better health among the general population. People are becoming increasingly health conscious due, in part, to large government-funded initiatives such as Health Canada's "Participaction" and "Canada's Food Guide." The explicit purpose of these programs is to prevent health-related problems and promote healthier living by educating the public about the importance of exercise and nutrition.

A similar holistic model of mental health care would consist of services to treat mental disorders, as well as initiatives to prevent the development or worsening of mental illness, and programs aimed at promoting mental health and well being. Unfortunately, efforts to develop a holistic model of mental health care lag behind such efforts in the health care field for three reasons. First, psychiatrists, psychologists, and other mental health professionals are not trained to develop and implement prevention and promotion programs. Second, it is difficult and potentially stigmatizing to identify and screen "at-risk" groups who would receive prevention programs. Third, health promotion efforts are hampered by confusion regarding what exactly healthy mental functioning is and, as a result, what mental health promotion programs would target.

Despite these difficulties, mental health prevention and promotion initiatives are beginning to emerge, although they have tended to focus on child and family issues such as learning disabilities, growing up in high-risk environments, and school violence. Examples of emerging early-intervention and prevention efforts for adult and elderly populations include the National Screening Days for mood, anxiety, and eating disorders in the United States (Screening for Mental Health, 2003), and new models of primary care designed to enhance older adults' mental health by integrating services by on-site mental health professionals (Speer & Schneider, 2003). In order to expand upon efforts such as these, Rowe & Kahn's (1998) theory of successful aging provides a conceptual framework that could be used to guide the development of mental health prevention and promotion programs for older adults. The theory of successful aging is based on a large body of research funded by the MacArthur Foundation aimed at identifying biological, psychological, and social factors responsible for healthy aging. Physical health and mental health are viewed as interrelated rather than separate and independent. According to the theory, successful aging requires three key components:

1. Avoiding Disease. Although disease is not entirely under one's control, there are risk factors and warning signs for disease that are controllable, such as blood pressure, body weight, and blood sugar. If factors such as these are monitored, significant health problems such as heart disease, stroke, and diabetes can be effectively managed or prevented. It is not surprising, therefore, that individuals who age successfully tend to watch their diet, exercise, get regular medical check-ups, and abstain from smoking.

2. Remaining Cognitively and Physically Active. Although maintaining cognitive interests and physical activity are essential aspects of successful aging, research does not suggest that older adults need to read Nietche or to start training for marathons. With respect to physical functioning, moderate physical activity such as leisurely walking or gardening is as effective as more strenuous activity in predicting later physical ability. With respect to cognitive functioning, staying socially active, maintaining hobbies and interests, and having beliefs in one's mental abilities are important. Research from the MacArthur study highlights two encouraging facts regarding physical and cognitive activity. First, fears concerning mental and physical losses with age are exaggerated. Second, many functional losses can be prevented or regained.

3. Maintaining Active Engagement with Life. The MacArthur research clearly demonstrates that individuals who age successfully are active participants in life rather than passive bystanders; they remain actively engaged with life in three important ways. First, they remain involved in activities they find meaningful and purposeful. Second, they maintain strong social connections that provide both emotional and instrumental support. Third, they continue to take part in productive activities, that are either paid or unpaid, that create goods and services of value.

It is becoming increasingly apparent that in order to meet the mental health needs of adults and the growing number of older adults, our treatment-focused model of mental health care will need to be supported by efforts to prevent problems before they occur or worsen, and to promote and enhance mental health among those who are psychologically healthy (Waters, 1995). The theory of successful aging suggests several potential pathways to achieve these goals, including enhancing older adults' social supports, increasing their opportunities for meaningful paid and unpaid work, and promoting their physical and cognitive activity.

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CTC and Tariffs: Background and Recent Developments

By: Dr. K. Sonu Gaind, Tariff Chair, OMA Section on Psychiatry

Each year, OMA Sections have an opportunity to submit proposals for revisions and new fee codes to the OMA Central Tariff Committee (CTC) during the CTC Marathon sessions. The OMA CTC is the committee responsible for suggesting adjustments to the OMA Schedule of Fees (although it has no authority to set the OHIP Schedule of Benefits). And, while there is no legally binding obligation for the Ministry of Health and Long Term Care to synchronize changes in the OHIP Schedule of Benefits with those in the OMA Schedule of Fees, this is usually done, when requested to do so by the OMA. Typically, the rates in the OHIP Schedule of Benefits are approximately 60% of the rates in the OMA Schedule of Fees.

None of the CTC recommendations from 1998, 1999, 2000, or 2001 were implemented by OHIP because OMA General Council had voted for several years to request across-the-board increases to all fees in the OHIP Schedule of Benefits, leaving no money available for implementation of CTC recommendations. Not only did this result in CTC recommendations remaining unimplemented, but it also maintained existing fee disparities in the Schedule of Benefits. In fact, these across-the-board percentage increases magnified the absolute dollar disparities.

At the November 2001 OMA General Council, the Section on Psychiatry was successful in passing two precedent setting motions, which shifted OMA policy away from across-the-board fee increases, and set the stage for ensuring that outstanding CTC recommendations would be implemented by 2003. Of particular importance to psychiatrists were the CTC recommendations that identified significant increases to psychiatric time-based fees. In spite of the recommendations, the Executive of the Section felt that there was a possibility that the OMA might revert to its previous practices. As a result, a letter writing campaign was mounted which resulted in over 450 psychiatrists writing to the OMA President urging him to insure that the CTC recommendations were implemented. The November 2002 General Council meeting resulted in the OMA agreeing to forward the outstanding CTC recommendations to the Ministry for implementation by OHIP.

2003 Changes

The OMA and the Ministry of Health and Long-Term Care Memorandum of Agreement for 2003-2004 resulted in a series of changes to the OHIP Schedule of Benefits in April 2003 and August 2003 and significant increases in psychiatry fees:

K197 & K198, out-patient psychotherapy and psychiatric care, increased from $54.15 [2002] to $58.40 [2003] per half hour, an almost 8% increase.

A197 & A198, consultative interview with parents & child, increased form $107.20 [2002] to $125.00 [2003], a 16.6% increase.

K199, in-patient psychiatric care, increased from $60.10 [2002] to $62.60 [2003], a 4.2% increase.

K191, K193, K195, & K196, family psychiatric care and psychotherapy codes, increased from $61.40 [2002] to $63.95 [2003], a 4.2% increase.

C895, hospital consultation, increased from $134.25 [2002] to $140 [2003], a 4.3% increase.

A195, outpatient consultation, increased from $122 [2002]] to $125 [2003], a 2.5% increase.

In addition, subsequent visit fees have increased from $18.25 to $23.00 for all specialists.

Two new codes - an Extrapyramidal System Assessment and a code for Team Psychiatric Management of Disturbed Behaviour - passed by CTC, have not yet been accepted by the Ministry of Health and Long-Term Care.

The Section was successful also, during the 2003 CTC Marathon sessions, in having the CTC recommend a further 10% increase to psychiatry consultation fees. It is hoped that these fees are implemented in 2004.

Upcoming Events for 2004

The Section on Psychiatry is presently preparing an initial list of requested changes for the 2004 CTC Marathon sessions. The Section will be pursuing the two new codes further so that they will eventually be adopted in the OHIP Schedule of Fees. Also, because negotiations for a new agreement between the OMA and Ministry will be commencing in 2004, we will need to work to ensure psychiatric tariff and practice issues are addressed during this set of negotiations.

I would like to acknowledge and thank the Coalition of Ontario Psychiatrists and the psychiatrists who support the Coalition for continuing to fund my work as Tariff Chair. In addition, I want to thank the over 450 psychiatrists who took the time to write to the OMA during the letter writing campaign. These efforts have strengthened the voice of Ontario psychiatrists and have led to the issues of disparities in relativity finally (starting!) to be addressed. Of course, full relativity still has not been achieved. Your continued support will ensure that we are able to continue to advocate effectively on behalf of all Ontario psychiatrists.

As always, we would be pleased to hear from psychiatrists directly regarding any suggestions for items for the Section to pursue or if you have any suggestions for the 2004 CTC Marathon session. Please contact Dr. K. S. Gaind, at (416) 769-9159, or e-mail at: psych@rogers.com

OPHHS Hospital Contract Consultation

On, Saturday, November 15th, the OMA Medical Assembly held a Negotiations Strategy meeting at the Hilton Toronto hotel. Input was received from all members regarding issues and concerns for the upcoming negotiations of the OMA/MoHLTC 2004 Master Agreement, scheduled to begin in early 2004. The OMA Section on Ontario Psychiatric Hospitals and Hospital Schools presented a number of issues. One area of concern is that of contracts presently being negotiated individually with the receiving hospitals by psychiatrists and physicians from the divested psychiatric hospitals. As a result of this meeting, Dr. Greg Flynn, OMA Board member has agreed to host a consultation session to address the physicians now working in non-governmental hospitals who are in the position of negotiating contracts with their new employers. This will be in concert with the OPA Annual Meeting to be held at the Toronto Marriott Eaton Centre Hotel. Therefore, you are invited to attend a Wine and Cheese Reception at 5:15 to be followed by the OPHHS Hospital Contract Consultation from 6:00 p.m. to 8:00 p.m. in York A, on Thursday, January 29, 2004. RSVP to Nancy Sarino ^ 1-800-268-7215 ext. 2941, 416-340-2941 or Nancy_Sarino@oma.org

Detecting Malingered Memory Impairment in Neuropsychiatry: Part 1

By: Drew J.A. Moulden M.D., Ph.D., OPA Council Member

Malingering is characterized by the voluntary production of false or grossly exaggerated physical or psychological symptoms. It is intentional deceptive behaviour, not a medical or psychiatric disorder. In the Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV)1 malingering receives a V code on Axis I as one of the other conditions that may be a focus of clinical attention. This diagnosis rests on the identification of conscious gain as the motivation of behaviour. This differs from factitious disorder, which refers to feigning symptoms for an unconscious purpose. Common motivating goals for malingerers include:

- To avoid difficult or dangerous situations, work, family responsibilities, or punishment (jail).
- To obtain money or something valuable from a government, insurance company, or lawsuit. Compensation neurosis malingerers are often preoccupied with recompense rather than cure.
- To obtain drugs/narcotics.
- To obtain shelter, food, or attention.

Some physicians believe that a thorough clinical interview – "bedside screening" - can detect malingering most of the time. This simply is not true. Informally testing malingering will not work. Most of the commonly held maxims about separating genuine from feigned patients do not hold up under scrutiny. Liars do not reliably purse their lips, touch their mouth, avoid eye contact, fidget, blink more, or use less detail in their explanations. When someone does exhibit these behaviors, there are many equally plausible explanations besides malingering.

Most people recognize that memory impairment is a common symptom of brain injury. Feigning a memory disorder is therefore more frequently encountered in neuropsychiatry than feigning the less familiar symptoms of apraxia, perseveration, agnosia, inattention, disinhibition, or impaired executive functions.

This article and the next one (which will be published in the March 2004 *Dialogue*) will outline ways in which malingered memory disorder can be assessed objectively.

Amnesia is usually viewed, by most people, as a unitary entity. Most malingerers do not appreciate that memory consists of verbal, spatial, declarative, procedural, incidental, encoding, retrieval, recognition, immediate, short and long-term domains. Poor cooperation, inconsistent performance, and "I don't know" responses may be evidence of attempts to circumvent this vague appreciation.

When to suspect Malingering?

Malingering should be suspected if there is a medico-legal context to the presentation, a marked discrepancy between the claimed disability and objective findings or mechanism of injury, a lack of cooperation during the diagnostic evaluation, non-compliance with the prescribed treatment regimen, or a co-morbid antisocial personality disorder. Secondary gains may be evident. Questions about improbable symptoms may yield positive responses. Refusal to accept a clean bill of health or an encouraging prognosis is common and the patient may refuse to return to work or school despite medical clearance.

Detecting Malingering Informally

Sometimes tests of malingering can be informally created to provide a rapid impression of truthfulness, though one must be cautious about overestimating the validity of the result. Familiarity with the standardized tools allows the clinician to creatively incorporate components of these tests into the standardized Mini Mental Status Exam. For example, I have used hospital ID badges, drivers licenses, photographs, office supplies, parking passes, colored crayons, syringes, and GO transit tickets in a bedside forced-choice assessment of memory, malingering, and extinction to double simultaneous stimulation.

Sometimes, an assessment tool must be created from scratch. One defendant, who had no history of severe mental illness and no current psychiatric symptoms, was accused of motor manslaughter. He was one of three intoxicated occupants in the front cab of his truck. The vehicle flipped over at high speed and one of the occupants was killed. The police alleged the defendant was driving the vehicle. The defendant stated that he struck his head in the accident and did not remember who was driving, or most of the evening in question. Defense counsel successfully argued that the Crown could not prove the defendant was indeed the driver.

Outside of court, the defendant was given a list of 22 details from the night of the accident. He was asked to search his memory as hard as he could to try to remember each item. A forced-choice technique was used. The defendant was told he must answer "present" or "absent" for every item even if he had only a very subtle impression rather than a clear memory. Details included things such as - Were you wearing shorts? Was the truck on its side? Was there a dog barking? Was the radio on? Was there a full moon? Did you try and help the deceased out of the truck? The patient was not told, but would have been able to discern if he remembered, that only half of the details on the list had actually been present, while the other half were fictitious. Had the defendant answered randomly, he would have been expected to answer about 11 of the 22 items correctly. If he had simply answered "present" to every item, the test would have been invalid. Had he remembered and answered honestly, he would have been expected to be correct for some number much greater than 11. Instead, he answered 20 of 22 items incorrectly. This strongly suggested that he remembered the accident and his actions (including who was driving) but was trying to deceive the evaluator and the judicial system. The Crown Attorney could not prove the case. The defendant was acquitted.

In the next issue of Dialogue: Detecting Malingered Memory Impairment in Neuropsychiatry: Part 2, I look at the formal tests that are available for detecting malingering.

Reference:
1. American Psychiatric Association. Diagnostic and Statistical manual of mental disorders, 4th edition. Washington, DC: American Psychiatric Association, 1994.
Disclaimer: This article contains general clinical and clinical-forensic opinions that should not be construed as applying to any specific case.

CHILDREN'S MENTAL HEALTH

One of the many ideas that came out of the Shared Mental Health Care Conference in June 2004 was to establish a working group / e-mail list for individuals interested in Shared Care for Children and Adolescents. Helen Spenser is co-coordinating this initiative and further details can be found on the website at:
www.shared-care.ca or by e-mailing Helen at spenser@exchange.cheo.on.ca

Source: Shared Mental Health Care in Canada, Newsletter: November 2003