Ontario Psychiatric Association
DIALOGUE
THE NEWSLETTER OF THE ONTARIO PSYCHIATRIC ASSOCIATION / UNE PUBLICATION DE L'ASSOCIATION DES PSYCHIATRES DE L'ONTARIO
DECEMBER
2005

MESSAGE FROM THE PRESIDENT

Fall is my favourite time of year, with its glorious colors, warm days and cool evenings, and promise of celebrations ahead such as Diwali, Hannukah, Eid, and Christmas. In fact, we have had a lot to celebrate here at the OPA too.

We had an absolutely successful Fall Conference. Dr. Cinda Dyer deserves our sincerest gratitude for organizing this great event, with Dr. Glen Gabbard providing a thoughtful and thought-provoking discussion. The feedback was excellent and we are all looking forward to another similar treat next October!

The Coalition of Ontario Psychiatrists held their fall retreat in Toronto in late October. The OPA is a key member of the Coalition, and we celebrated gains made this past year, including the fee negotiations and new fee schedule, new billing codes, and the Billing Guide written by Dr. Sonu Gaind. We were able to identify our new top priorities and set concrete goals for the coming two years. Dr. Doug Weir, our fearless leader of the Coalition for the past three years, is retiring from this position and moving on to other challenges on the Mental Health Funding Working Group. All of his hard work and achievements on behalf of Ontario Psychiatrists were celebrated.

The Advocacy Committee, headed by Dr. Dick O'Reilly, has partnered with the Schizophrenia Society of Ontario, to create a complete package to assist psychiatrists in lobbying MPP's to advocate for increases in ODSP rates.

The Annual Meeting - a key OPA celebration - is fast approaching. Mark the date, Bring A Buddy, and plan to attend. It will be held at the Toronto Eaton Centre Marriott Hotel on January 26-28, 2006. Dr. Prochaska will be holding a pre-conference workshop on January 25 on transtheoretical aspects of psychotherapy.

The theme speaker is Dr. Mike Myers, from Vancouver, on the theme of Physician Health. There will be so much to offer; it is difficult to highlight just a few presentations.
Dr. Jon Davine will lead a workshop on Making Presentations More Interactive; Dr. Derek Puddester will review Hot Topics and Papers in Child and Adolescent Psychiatry in 2005; Dr. Alan Kindler will address psychotherapy with narcissistic personalities. The Annual General Meeting will take place on Friday morning, and don't forget to attend the President's Dinner on Friday evening, a popular and lively evening. The T.A. Sweet Award will be presented to Senator Michael Kirby at the Dinner. Women psychiatrists will get the opportunity to meet at a special workshop on Saturday morning - a real experience not offered elsewhere. The exhibits will, once again, include art work by Sherry Tompalski. If you know of other artists that would like to exhibit, please contact the office for more details.

As my term draws to an end, I pause to reflect on how lucky I have been to be a part of all these activities. I am impressed by the dedication and hard work shown by Council members, and how much of themselves they give to the OPA. It has been a real privilege to work with them, and a huge source of inspiration to me. It is so easy to become cynical or settle for things in medicine, as we are busy and overwhelmed. Yet, I watch colleagues volunteer their time and energy, burn with passion and foresight and a vision of how practicing medicine in Ontario could and should be, and work to make this happen. We are in medicine because we love it, and find it rewarding and satisfying. It is worth it to work together to maintain this sense of fulfillment. Come join us!

Mamta Gautam, MD, FRCPC
2005 OPA President

Ontario Psychiatric Association Executive and Council

President
Dr. Mamta Gautam

President-Elect
Dr. Susan Abbey

Past President
Dr. Doug Wilkins

Secretary
Dr. Keith Anderson

Treasurer
Dr. Derek Puddester

Dr. Cinda Dyer

Dr. Deborah Elliot

Dr. Elizabeth Esmond

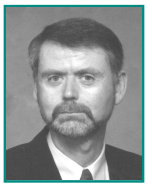
Dr. Rosemary Meier

Dr. Andrea Waddell

Dr. Chiachen Cheng

No Picture Available

Dr. Leo Murphy



Dr. Richard O'Reilly

Dr. Toba Oluboka

Dr. Oleg Savenkov

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 2005 includes a report on recent past activities such as the Fall Conference with Dr. Glen Gabbard on Borderline Personality Disorders which was a great success. However, the focus of this issue of Dialogue is really on the future as we move closer to 2006.

The Advocacy Committee has partnered with the Schizophrenia Society of Ontario to launch a new campaign ***Financial Dignity for Ontarians with Disabilities.*** With the next provincial budget expected in May 2006, we will be lobbying MPPs throughout Ontario to increase ODSP payments by 10%.

As part of the Coalition of Ontario Psychiatrists, Council members took part in a full day retreat to set the direction and priorities for the next two years.

The Annual Meeting in January will include topics that are important and integral to psychiatry and psychiatrists for the future.

As the Ontario government moves the transformation agenda forward, the planning and decision making for health in the province will shift to Local Health Integration Networks. All 14 LHINs now have a Chair and CEO. During September and October 59 meetings and satellite broadcasts were held in 46 cities and towns across Ontario. 950 people attended these sessions. Mental health has been prominent in the priorities set by communities for the LHINs, and it is important that we focus our thoughts on the future and position psychiatry as an essential stakeholder in designing the new health care system.

Although 2006 promises to be busy, we also want to take the time to thank members for their support over the last year and to wish you a happy holiday season.

As always, your comments, suggestions, ideas are welcome at any time.

June Hylands

Editor

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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.

January 30-31, 2006: **Delivering Private Healthcare In Canada - Understanding Current Private Healthcare Practices and Playing within the Rule Book**
The Four Seasons Hotel, Toronto, ON, Canada
For details go to: http://www.canadianinstitute.com/Health___Pharmaceutical/private.htm

Ontario Psychiatric Association - Council Meeting AGENDA

Date: Friday September 30th, 2005
Time: 11:00 - 3:00 P.M.

1.0 Remarks from the President and Approval of Agenda

2.0 Approval of Minutes of Council meeting June 3rd, 2005

3.0 Business Arising
- 3.1 President Theme Update
  - 3.1.1 Insurance
  - 3.1.2 Doctors facing mental illness
  - 3.1.3 Physician Appreciation Week

4.0 Treasurer's Report
- 4.1 Report on finances

5.0 Reports of Task Forces and Committees
- 5.1 Advocacy Committee
  - 5.1.1 Coroner's Reports re: Adolescent psychiatry
  - 5.1.2 ODSP MPP Campaign
- 5.2 Communications Committee
- 5.3 Continuing Education Committee
- 5.4 Finance/ Audit Committee
- 5.5 Member Services Committee
- 5.6 Task Force on Governance

6.0 Standing Reports
- 6.1 CPA Reports
  - 6.1.1 Directors
  - 6.1.2 Council of Provinces
  - 6.1.3 Standing Committees
    - 6.1.3.1 Education
    - 6.1.3.2 Professional Standards & Practice
    - 6.1.3.3 Scientific & Research
- 6.2 OMA Section on Psychiatry
- 6.3 Coalition
- 6.4 Section Reports
- 6.5 Executive Director Report
- 6.6 Section Reports

7.0 New Business

Why join the OPA?

Dedicated to excellence in psychiatric education, advocacy, representation and the advancement of public policy.

The Ontario Psychiatric Association was incorporated in 1956. Dr. Edward Ryan, Superintendent of Rockwood Hospital, established the Ontario Neuro-Psychiatric Association in 1920.

Objectives of the Ontario Psychiatric Association:

- **EXCHANGE** of scientific information
- **PROMOTE** an optimal level of professional development and practice
- **ADVOCATE** for persons with mental illness and their families
- **REPRESENT** the members in their relationships with governments at all levels, universities, other medical associations and other associations
- **PROMOTE** the prevention of mental disorders in Ontario

Member Benefits:

- Access to specialty Sections, workshops and courses
- Opportunities for networking
- Peer Mentorship Programme
- Registration discounts for the Annual Conference
- Complimentary membership for Residents and longstanding members
- Voting privileges at the Annual General Meeting and general meetings (Full Member, Life Member and Member in Training only)
- Opportunities for maintenance of competence and continuing education credits
- Effective representation to the Canadian Psychiatric Association, the Alliance of Mental Health Services
- Joint partnership, with the Ontario Medical Association Section on Psychiatry, by means of the Coalition of Ontario Psychiatrists
- *Dialogue* - the quarterly Association Newsletter provides up-to-date information on issues affecting psychiatry and psychiatric practice

Other Information:

- Standing Committees;
  Advocacy, Communications, Continuing Education, Finance/Audit, and Member Services
- Membership Categories:

Full Member - is a legally qualified practitioner who is licensed to practice medicine in Ontario and is:
(a) Registered as a specialist in psychiatry by the Royal College of Physicians and Surgeons of Canada, and is in active practice, or,
(b) Teaching psychiatry in a university or other senior psychiatric position.

Member-in-Training - is a person who is registered in an approved, psychiatric, post-graduate training programme, or, in an undergraduate medical programme, in Ontario.

Associate Member - is any person who is a legally qualified medical practitioner or who occupies a position in nursing, psychology, social work, occupational therapy, or any other profession or occupation, closely related to psychiatry.

Life Member - is any Member who has reached the age of 65 and whose years of age and years of Full Membership totals 80 in the Association.

For more information about the OPA please visit our website at www.eopa.ca.

The Coalition of Ontario Psychiatrists: History

By: Douglas C. Weir M.D. F.R.C.P.(C)

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 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 Services (AGHPS), the Association of Ontario Physicians and Dentists in Public Hospitals (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 bylaws 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.

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 General 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. The Section Executive in part consists of representatives from the various other organizations such as the OPDPS, the AGHPS, the OPA, Ontario psychoanalysts; and the Academy of Child Psychiatry. There are monthly teleconference calls with participation by the Directors of the Coalition, representatives from the OPDPS and the AGHPS and 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, in addition they represent other physicians and dentists in public service. 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 the 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. They represent approximately 50 hospitals. Their Board of Directors is comprised of 22 Chiefs of Psychiatry and Directors of Mental Health Programs throughout Ontario. Currently the President of AGHPS 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. Recently, a member of the Ontario Chapter of the APA has also been invited to share in the teleconference calls.

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 them address issues relating to how ACT psychiatrists are reimbursed and the Coalition has been working together with them 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.

Recent Changes

The Coalition activities have been coordinated by myself with the help of Ms. Lorraine Taylor in the past few years. Ms. Taylor this summer moved on to new opportunities and I want to thank her for her help over the last several years. In May of this year I was elected by the OMA Counsel to the OMA Board of Directors as the Medical Assembly Director and as of September 2005 will no longer act as the Chair of the Coalition. The Coalition is actively recruiting one of the Coalition Directors to take over the role of Chair. In the interim Dr. Mamta Gautam, President of the OPA and Dr. Michael O'Mahony will rotate the role of Chair of the Coalition. The Coalition has also engaged the services of J. Hylands & Associates Inc. to help manage the Coalition. June Hylands and her staff have solid experience managing professional associations, including the OPA and the AGHPS. June has a background in nursing, hospital administration, and an MBA. Her background and association with OPA and AGHPS gives her a working knowledge of many aspects of the Coalition's work to date and we are sure she will improve the running of the Coalition.

THE COALITION OF ONTARIO PSYCHIATRISTS HOLD SUCCESSFUL RETREAT

By: Douglas C. Weir M.D. F.R.C.P.(C)

On Saturday, October 22 the Section Executive of the OMA Section on Psychiatry and the OPA Council held a joint meeting to discuss the goals of the Coalition of Ontario Psychiatrists for the next two years.

Invited guests included Dr. Greg Flynn, President OMA and Dr. Jonathan Gus, Chief Executive Officer, OMA who spoke about the OMA Strategic Planning. They addressed the Ontario Government's Transformation agenda, LHINs, Information Technology, Primary Care Initiatives and Family Health Teams. They described the CPSO's proposal for Revalidation.

Mr. Peter Regenstrief and Mr. George Boddington who have worked with the Coalition to assist us in our lobbying efforts with the Ontario Government reviewed the current political landscape and discussed the next two years leading up to the next provincial election October 2007. They also addressed the Government's Transformational Agenda especially LHINs which is the initiative that will affect psychiatrists and the delivery of mental health in the province.

Mr. Bruce Light who has been working with the Coalition since 1997 gave his view of the need to keep involved and keep our priorities on the agenda of the OMA and the government and not to let the successes of the last few years lull us into complacency.

Mr. Steven Harrison from the OMA Policy Department described in more detail LHINs and other issues which psychiatry will be interested in over the next few years such as the regulation of psychotherapy done by non-regulated practitioners, CTOs, etc.

Dr. Douglas Weir, OMA Co-Chair of the Mental Health Funding Working Group reported on the new Mental Health Sessional Fee Supplements and Psychiatric Stipend both effective October 1, 2005.

Ms. June Hylands reported on the activities and plans of the AGHPS. Dr. Bill Komer reported on the activities of the Association Ontario Physicians and Dentists in Public Service (OPDPS) and that by the end of 2005 only one Provincial Psychiatric Hospital would remain as the other two would be divested by the end of this year. Dr. Sonu Gaind reported on his activities presenting on behalf of the OMA Section on Psychiatry to the OMA Central Tariff Committee, a survey of psychiatrists about issues pertaining to work satisfaction and remuneration, and his work on an updated Psychiatry Billing Guide to be available early in 2006.

The day ended with a discussion of the priorities for the Coalition for the next two years. Dr. Mamta Gautam facilitated the discussion. The following goals were arrived at:

1. Communicate more to membership recruit, input or feedback.
2. Funding for Psychiatry - continue efforts re: relativity, fee negotiations, human resources
3. Promote role of Psychiatry in Government and OMA's agendas, LHINs, wait times, adequate resources for programs.
4. Revalidation
5. Succession Planning - how to strategize with all of the groups to advocate for adequate resources for programs and to attract new leaders in psychiatry to participate in the OMA Section Executive and the OPA Council.

To attain these goals specific suggestions for action were developed:

1. Dr. Susan Abbey will develop Coalition Newsletter to all psychiatrists.
2. I agreed to write this column for the OPA Dialogue and others will report in the OPA Dialogue on Coalition Activities in the months ahead.
3. The Coalition will seek feedback from psychiatrists as to what they would like our priorities and goals to be.
4. Dr. Gaind will go ahead with the Psychiatry survey.
5. The Coalition will actively identify and recruit leaders.
6. Leaders of the OMA Section on Psychiatry and the OPA Council will continue to jointly meet with provincial government leaders and talk about strategies so that psychiatry is well represented in the new regional LHINs.

Dear OPA Members,

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 27th, 2006 at the Toronto Marriott Eaton Centre Hotel, 525 Bay Street, Toronto.
A buffet breakfast will be provided.
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 16th 2006. Proxy forms may also be given to your designate who will attend the AGM.
The financial statements for the fiscal year ending December 31st 2005 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 2006 issue of *Dialogue.*
I look forward to your attendance as well as your participation at the OPA 2006 Annual General Meeting.

Sincerely,
Mamta Gautam, MD, FRCPC
OPA 2005 President

Ontario Psychiatric Association
Annual General Meeting Agenda

Friday, January 27th, 2006 - 8:30a.m.
Toronto Marriott Eaton Centre Hotel, Salon C/D

1. Call to order - M. Gautam
2. Introduction of Guests - M. Gautam
3. Approval of Agenda
4. Approval of Minutes of the January 28th 2005 Annual General Meeting
5. OPA President's Report - M. Gautam
6. OPA Treasurer's Report - D. Puddester
7. Appointment of Auditor
8. OPA President's Address - M. Gautam
9. Presentation of 2006 Budget - D. Puddester
10. Election Results for 2006 Council - D. Wilkins
11. Other Business
12. Adjournment

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 27th, 2006 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 27th, 2006

PROXY

I,_____

(Please print your name)

Will be unable to attend the January 27, 2006 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 _____

The Ontario Psychiatric Association Annual Meeting
January 26th - 28th, 2006

The OPA Annual Meeting will be held at The Marriott Eaton Centre Toronto Hotel.

The Conference will bring together an audience of approximately 200 community and academic psychiatrists, as well as psychologists, residents, and other stakeholders with an interest in mental health.

The format of this three-day Conference will combine plenary sessions, thematic sessions and smaller group workshops, all designed to promote dialogue, debate and healthy controversy. These sessions will be interspersed with opportunities for social interaction and networking.

A Message from the Continuing Education Committee Chair

The OPA Continuing Education Committee is excited about the programme for this year's Annual Meeting. There is a wide range of topics covering clinical issues as well as sessions with information on important professional matters. In addition, the programme is intended to provide practical information for psychiatrists - "take away" messages that can be applied immediately in your practice and in other parts of your life. In keeping with the President's theme of **"Healthy Practices: Promoting Physician Health"** we have endeavoured to balance information to assist you in your treatment of patients, and information that will support you in a healthy lifestyle.

As always, the Annual Meeting is a time to network with colleagues from across Ontario, and discuss the latest biological treatments with representatives from pharmaceutical companies.

Also, the first Annual Dr. Ann Thomas Award for the Best Resident Presentation will be presented at this year's conference.

The Friday Night dinner dance will feature a buffet dinner and live band. We are delighted that the Honourable Michael Kirby will be in attendance to receive the TA Sweet Award. The Senate Social Affairs Committee is planning to release its final report on Mental Health, Mental Illness and Addiction in January 2006, and Senator Kirby has expressed an interest in hearing the reaction from our members. Clearly, you won't want to miss this outstanding event.

A pre conference workshop on January 25th will feature Dr. Prochaska on the topic of transtheoretical psychotherapy. (For more information on this please visit our web site at www.eopa.ca or call the OPA office at 905-827-4659)

Finally, please plan to attend the OPA Annual General Meeting on Friday morning.

This has been my first term as program chair of the conference. It has been a real pleasure to work with my colleagues in putting together the programme for 2006. Together we have designed a conference that reflects a variety of issues and topics that are relevant and interesting to all psychiatrists, regardless of where they practice, or where they are in their career path. We encourage you to attend and "bring a buddy". We look forward to seeing you in January 2006.

Roumen Milev, MD, PhD, MRCPsych (UK), FRCP(C)
Chair, Conference Organization Committee

Bring A Buddy!

We are excited to announce a new program aimed at increasing attendance at the Annual Conference and saving registrants some money! Any member that recruits a new registrant to the Annual Meeting will receive recognition through the “Bring a Buddy” campaign.

Here is how it works….

- ✓ The referring OPA member will receive a $50 discount on their registration fee for the Annual Conference.
- ✓ The new registrant will also receive a $50 discount on their registration fee for the Annual Conference.
- ✓ A “New registrant” is defined as a person who has not attended the Annual Conference for the last 3 years.
- ✓ The recruiter's registration form must indicate the name of the “Buddy” recruited.
- ✓ The new registrant registration form must indicate who referred them.

There will be a poster at the Annual Conference acknowledging those who have participated in “Bring a Buddy”, and an acknowledgement will also appear in the issue of *Dialogue* following the Conference.

The Association of General Hospital Psychiatric Services (AGHPS)

Provided the following update to the OPA on its past and future activities:

As indicated in our last report, we have resurveyed members on issues related to implementation of the ***Resident Assessment Instrument Mental Health (RAI-MH).*** We are in the process of collating the results and will post these to our web site (www.aghps.com).

As part of our 2-year project looking at issues relating to people at risk of suicide that present to general hospitals - A study of Coroners Reports is being undertaken. This will be a review of "past" incidences and evidence that will lead to the development of a summary of lessons learned, and give more clarity to precipitating factors. Dr. Brian Hoffman, president of the AGHPS, will be presenting the work to date at the OPA Annual Meeting in January 2006.

OPA Section on Psychotherapy

Fall Conference a Great Success!

On October 1st, 125 registrants gathered at the Toronto Faculty Club to hear Dr. Glen Gabbard speak on the topic of Borderline Personality Disorders. The morning focused on the mind-brain interface in borderline personality disorder, and the afternoon was dedicated to the topic of combining medication and psychotherapy in the treatment of borderline personality disorder.

Evaluations from participants were extremely positive and indicate that the information was both interesting and practical.

Some comments….

"I feel it will help me in a practical way to be a more effective therapist with borderlines"

"Will be looking more at neurobiological concepts in my treatment"

"Enhanced understanding of transference"

"Be more flexible in my approach with BPD patients"

"To use mentalization promoting techniques in therapy with BPD patients"

"Be more aware of the neuro anatomical inferences on the progress of therapeutic interventions"

We wish to thank Dr. Gabbard for his excellent presentation and Genpharm for providing us with an unrestricted educational grant.

Dr. Cinda Dyer

MEMBERS ON THE *MOVE*

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, 344 Lakeshore Road East, Suite B, Oakville, Ontario, L6J 1J6 or by email to: opa@bellnet.ca. Please ensure these are clearly marked "*Dialogue* Members on the Move".

The OPA Advocacy Committee Is Launching a New Campaign

Financial Dignity for Ontarians with Disabilities

1 in 10 working age people in Canada (15-64) have disabilities - almost 2 million people

The World Health Organization indicates that 5 of 10 leading causes of disability in the developed world are psychiatric disorders.

In Ontario over one-third (36%) of people in receipt of Ontario Disability Support Program (ODSP) live with a mental illness. Half of these, approximately 35,000 people, suffer from psychosis related illnesses such as schizophrenia.

Many members of the OPA thanked the Association for writing to Ms. Pupatello, the Ontario Minister of Community and Social Services this Spring to request both increased financial benefits and a fair and less bureaucratic process for obtaining Ontario Disability Support Programme (ODSP) benefits. The Advocacy Committee is committed to continuing our efforts by advocating that people with disabilities in receipt of ODSP receive an increase in their base ODSP benefits of 10% in 2006. We note that, even after this increase, the cumulative raise over the last 13 years will be a mere 1% per annum, well below increases in the cost of living.

The Ontario Psychiatric Association has formed a partnership with the Schizophrenia Society of Ontario (SSO) to lobby Members of Ontario's Provincial Parliament to increase ODSP payments by 10% in the 2006 budget. The OPA is asking for members to join this campaign. If you are willing to meet with your own MPP to request an increase in the ODSP base rate, please let Sheryl Keenan know by e-mailing her at skeenan@jhylands.com. She will put you in contact with a Schizophrenia Society member from your constituency who will accompany you to the meeting with the MPP.

The OPA and the SSO have prepared a package of materials that will assist you in the meeting with your MPP. This package includes an outline of the steps required to set up the meeting with your MPP. It also includes information about ODSP that can be left with the MPP.

The next provincial budget is expected to be tabled in May 2006. From now until May 2006 we are urging OPA and SSO members to schedule as many meetings with MPPs as possible. The OPA and SSO will work in an effort to ensure every MPP in Ontario is lobbied at least once. When families, people with schizophrenia, and psychiatrists come together we send a strong message to decision makers.

Are you moving?

Has your phone, fax or email information changed?
Help keep our database up to date, and please let us know!
Email any updates to the OPA office at opa@bellnet.ca.
Or fax them to 905-849-8606.

"Seroquel"

quetiapine fumarate tablets
25, 100 150 200 and 300 mg

THERAPEUTIC CLASSIFICATION Antipsychotic Agent

INDICATIONS AND CLINICAL USE **Schizophrenia** SEROQUEL (quetiapine) is indicated for the management of the manifestations of schizophrenia. The antipsychotic efficacy of SEROQUEL was established in short-term (6 week) controlled inpatient trials. The efficacy of SEROQUEL in long-term use, that is, for more than 6 weeks, has not been systematically evaluated in controlled trials of patients with manifestations of schizophrenia. **Bipolar Disorder - Mania** SEROQUEL is indicated as monotherapy for the acute management of manic episodes associated with bipolar disorder. The efficacy of SEROQUEL in bipolar disorder - mania was established in two 12-week clinical trials of bipolar patients. The safety and effectiveness of SEROQUEL for long-term use and for prophylactic use in bipolar disorder has not been evaluated.

CONTRAINDICATIONS SEROQUEL (quetiapine) is contraindicated in patients with a known hypersensitivity to this medication or any of its ingredients.

WARNINGS **Neuroleptic Malignant Syndrome (NMS)** Neuroleptic Malignant Syndrome is a potentially fatal symptom complex that has been reported in association with antipsychotic drugs, including SEROQUEL (quetiapine). The clinical manifestations of NMS are hyperthermia, muscle rigidity, altered mental status, and evidence of autonomic instability (irregular pulse or blood pressure, tachycardia, diaphoresis, and cardiac dysrhythmia). Additional signs may include elevated creatine phosphokinase, myoglobinuria (rhabdomyolysis), and acute renal failure. In arriving at a diagnosis, it is important to identify cases where the clinical presentation includes both serious medical illness (e.g., pneumonia, systemic infection, etc.) and untreated or inadequately treated extrapyramidal signs and symptoms. Other important considerations in the differential diagnosis include central anticholinergic toxicity, heat stroke, drug fever and primary central nervous system pathology. The management of NMS should include immediate discontinuation of antipsychotic drugs, including SEROQUEL, and other drugs not essential to concurrent therapy; intensive symptomatic treatment and medical monitoring; and treatment of any concomitant serious medical problems for which specific treatments are available. There is no general agreement about specific pharmacological treatment regimens for uncomplicated NMS. If a patient requires antipsychotic drug treatment after recovery from NMS, the potential reintroduction of drug therapy should be carefully considered. The patient should be carefully monitored since recurrences of NMS have been reported. **Tardive Dyskinesia (TD)** A syndrome of potentially irreversible, involuntary, dyskinetic movements may develop in patients treated with antipsychotic drugs. Although the prevalence of the syndrome appears to be highest among the elderly, especially elderly women, it is impossible to rely upon estimates to predict which patients are likely to develop the syndrome.

It has been hypothesized that agents with a lower EPS liability may also have a lower liability to produce TD. In controlled clinical trials with SEROQUEL, the incidence of EPS was not statistically significantly different than placebo across the recommended therapeutic dose range. This may predict that SEROQUEL has less potential than standard antipsychotic agents to induce TD. The risk of developing TD and the likelihood that it will become irreversible are believed to increase as the duration of treatment and the total cumulative dose of antipsychotic drugs administered to the patient increases. However, the syndrome can develop, although much less commonly, after relatively brief treatment periods at low doses. There is no known treatment for established cases of TD, although the syndrome may remit, partially or completely, if antipsychotic treatment is withdrawn. Antipsychotic treatment, itself however, may suppress (or partially suppress) the signs and symptoms of the syndrome and thereby may possibly mask the underlying process. The effect that symptomatic suppression has upon the long-term course of the syndrome is unknown. Given these considerations, SEROQUEL should be prescribed in a manner that is most likely to minimize the occurrence of TD. Chronic antipsychotic treatment should generally be reserved for patients who appear to suffer from a chronic illness that is known to respond to antipsychotic drugs and for whom alternative, equally effective, but potentially less harmful treatments are not available or appropriate. In patients who do require chronic treatment, the smallest dose and the shortest duration of treatment producing a satisfactory clinical response should be sought. The need for continued treatment should be reassessed periodically. If signs and symptoms of TD appear in a patient on SEROQUEL, drug discontinuation should be considered. However, some patients may require treatment with SEROQUEL despite the presence of the syndrome.

PRECAUTIONS **Hyperglycaemia** As with some other antipsychotics, exacerbation of pre-existing diabetes hyperglycaemia, diabetic ketoacidosis and diabetic coma including some fatal cases have been reported very rarely (<0.01%) during the use of SEROQUEL, sometimes in patients with no reported history of hyperglycaemia (see ADVERSE REACTIONS, Post-Marketing Experience). Appropriate clinical monitoring is advisable in diabetic patients and in patients with risk factors for the development of diabetes mellitus. **Hypotension and Syncope** As with other drugs that have high α1-adrenergic receptor blocking activity, SEROQUEL (quetiapine) may induce orthostatic hypotension, dizziness, and sometimes syncope, especially during the initial dose titration period. Syncope was reported in 1% (23/2371) of patients treated with SEROQUEL, compared with 0% (0/404) on placebo and 0.4% (2/527) on active control drugs. The risk of hypotension and syncope may be reduced by more gradual titration to the target dose (see DOSAGE AND ADMINISTRATION). SEROQUEL should be used with caution in patients with known cardiovascular disease (e.g., history of myocardial infarction or ischemic heart disease, heart failure or conduction abnormalities), cerebrovascular disease, or other conditions predisposing to hypotension (e.g., dehydration, hypovolemia and treatment with antihypertensive medications). **Cataracts The development of cataracts was observed in association with quetiapine treatment in chronic dog studies at 4 times the recommended human dose. Lens changes have also been observed in patients during long-term SEROQUEL treatment, but a causal relationship to SEROQUEL use has not been established. The possibility of lenticular changes during long-term use of SEROQUEL in man, thus can not be excluded at this time. Eye examinations (e.g., slit lamp exam) prior to or shortly after initiation of treatment with SEROQUEL and at 6 month intervals thereafter, are recommended. If clinically significant lens changes associated with SEROQUEL use are observed, discontinuation of SEROQUEL should be considered. Seizures** In controlled schizophrenia clinical trials, there was no difference in the incidence of seizures in patients treated with SEROQUEL or placebo (incidence of 0.4% or 2 events per 100 patient years in patients given SEROQUEL, compared with 0.5% or 6.9 events per 100 patient years for placebo). Nevertheless, as with other antipsychotics, caution is recommended when treating patients with a history of seizures or with conditions associated with a lowered seizure threshold. **Hypothyroidism** Clinical trials in schizophrenia demonstrated that SEROQUEL is associated with a dose-related decrease in total and free thyroxine (T_4). On average SEROQUEL was associated with about a 20% mean reduction in thyroxine levels (both total and free). Forty-two percent of SEROQUEL-treated patients showed at least a 30% reduction in total T_4 and 4% showed at least a 50% reduction. Maximum reduction of thyroxine levels generally occurred during the first two to four weeks of treatment with SEROQUEL. These reductions were maintained with out adaption or progression during longer term treatment. Decreases in T_4 were not associated with systematic changes in TSH or clinical signs or symptoms of hypothyroidism. Approximately 0.4% (12/2595) of patients treated with SEROQUEL (schizophrenia and bipolar studies combined) experienced persistent increases in TSH, and 0.25% of patients were treated with thyroid replacement. **Cholesterol and Triglyceride Elevations** In short-term placebo-controlled schizophrenia trials, SEROQUEL-treated patients showed mean increases from baseline in cholesterol and triglycerides of 11% and 14%, respectively, compared to mean decreases in the placebo treated patients. There was little relationship between these changes and weight changes observed during the trial. **Hepatic Impairment** Decreased clearance of SEROQUEL was observed in patients with mild hepatic impairment. Patients with mild hepatic impairment should be started on 25 mg/day. The dose should be increased daily in increments of 25 to 50 mg/day to an effective dose, depending on the clinical response and tolerability in the individual patient. No pharmacokinetic data are available for any dose of SEROQUEL in patients with moderate or severe hepatic impairment. However, should clinical judgement deem it necessary, the drug should be used with great caution in patients with moderate or severe hepatic impairment (see DOSAGE AND ADMINISTRATION). **Transaminase Elevations** During premarketing clinical trials, therapy with SEROQUEL was associated with elevation of hepatic transaminases, primarily ALT (SGPT). With a clinical trial database of 1892 SEROQUEL-treated schizophrenia patients, with baseline ALT (SGPT) values <60 IU/L, 3.9% (101/1892) had treatment-emergent ALT (SGPT) elevations to >120 IU/L, 1.3% (29/1892) had elevations to >200 IU/L, and 0.2% (2/1892) had elevations to >400 IU/L. No patients had values in excess of 500 IU/L. None of the SEROQUEL treated patients who had elevated transaminase values manifested clinical symptomatology associated with liver impairment. The majority of transaminase elevations were seen during the first two months of treatment. Most elevations were transient (80%) while patients continued on SEROQUEL therapy. Of the 121 SEROQUEL-treated patients whose enzyme levels increased to >120 IU/L, 40 discontinued treatment while their ALT (SGPT) values were still raised. In 114 SEROQUEL-treated patients whose baseline ALT (SGPT) was >60 IU/L, only 1 experienced an elevation to >400 IU/L. In the bipolar disorder - mania trials, the proportions of patients with transaminase elevations of > 3 times the upper limits of the normal reference range, was approximately 1% for both SEROQUEL-treated and placebo treated patients. Precautions should be exercised when using SEROQUEL in patients with pre-existing hepatic disorders, in patients who are being treated with potentially hepatotoxic drugs, or if treatment-emergent signs or symptoms of hepatic impairment appear. For patients who have known or suspected abnormal hepatic function prior to starting SEROQUEL, standard clinical assessment, including measurement of transaminase levels is recommended. Periodic clinical reassessment with transaminase levels is recommended for such patients, as well as for patients who develop any signs and symptoms suggestive of a new onset liver disorder during SEROQUEL therapy. **Hyperprolactinemia** Elevation of prolactin levels was not seen in clinical trials with SEROQUEL. Increased prolactin levels were observed in rat studies with this compound. As is common with compounds which stimulate prolactin release, the administration of SEROQUEL resulted in an increase in the incidence of mammary neoplasms in rats. The physiological differences between rats and humans with regard to prolactin make the clinical significance of these findings unclear. To date, neither clinical nor epidemiological studies have shown an association between chronic administration of drugs that stimulate prolactin release, and mammary tumorigenesis. Tissue culture experiments, however, indicate that approximately one third of human breast cancers are prolactin dependent, in vitro, a factor of potential importance if preexposure of these drugs is contemplated in a patient with previously detected breast cancer.

Possible manifestations associated with elevated prolactin levels are amenorrhea, galactorrhea, and menorrhagia, in the multiple fixed-dose schizophrenia clinical trials, there were no differences in prolactin levels at study completion for SEROQUEL across the recommended dose range, and placebo. **Weight Gain** In controlled schizophrenia clinical trials (up to 6 weeks), mean weight gain was approximately 2.3 kg compared to a mean weight gain of 0.1 kilograms in patients taking placebo (n=127). In open-label extension trials, after 9 to 13 weeks of quetiapine monotherapy the mean weight increase was 1.58 kg (n=173). After 58 to 78 weeks of treatment, the mean weight increase was 1.96 kg (n=137). These data are obtained from uncontrolled, open-label trials; the relevance of these findings to clinical practice is unknown. Weight change over time appeared to be independent of quetiapine dose (see ADVERSE REACTIONS). In the acute placebo-controlled bipolar mania clinical trials (up to 12 weeks), mean weight gain in patients taking SEROQUEL was 1.8 kg compared to a mean weight loss of 0.1 kg in patients taking placebo. In patients completing the entire 12 weeks of treatment, mean weight gain in patients taking SEROQUEL was 2.8 kg.

Potential Effect on Cognitive and Motor Performance Somnolence was a commonly reported adverse event in patients treated with SEROQUEL, especially during the initial dose titration period. Since SEROQUEL may cause sedation and impair motor skill, patients should be cautioned about performing activities requiring mental alertness, such as operating a motor vehicle or hazardous machinery, until they are reasonably certain that SEROQUEL therapy does not affect them adversely. **Antiemetic Effect** Consistent with its dopamine antagonist effects, SEROQUEL may have an antiemetic effect. Such an effect may mask signs of toxicity due to overdosage of other drugs, or may mask symptoms of disease such as brain tumor or intestinal obstruction. **Body Temperature Regulation** Although not reported with SEROQUEL, disruption of the body's ability to reduce core body temperature has been attributed to antipsychotic agents. Appropriate care is advised when prescribing SEROQUEL for patients who will be experiencing conditions which may contribute to an elevation of core temperature, e.g., exercising strenuously, exposure to extreme heat, receiving concomitant medication with anticholinergic activity or being subject to dehydration. **Suicide** The possibility of suicide or attempted suicide is inherent in bipolar disorder and schizophrenia, and thus close supervision of all appropriate clinical management of high-risk patients should accompany drug therapy. **Drug Interactions** Given the primary central nervous system effects of quetiapine, SEROQUEL should be used with caution in combination with other centrally acting drugs. **The Effect of SEROQUEL on Other Drugs** *Alcohol:* SEROQUEL potentiated the cognitive and motor effects of alcohol in a clinical trial in subjects with psychotic disorders. Alcoholic beverages should be avoided while taking SEROQUEL. *Antihypertensive Agents:* Because of its potential for inducing hypotension, SEROQUEL may enhance the effects of certain antihypertensive agents. *Levodopa and Dopamine Agonists:* As it antibits *in vitro* dopamine antagonism, SEROQUEL may antagonize the effects of levodopa and dopamine agonists. *Lithium:* The single dose pharmacokinetics of lithium were not altered when coadministered with SEROQUEL. *Antipyrine:* SEROQUEL did not affect the single dose pharmacokinetics of lorazepam. *Divalproex:* Co-administration of SEROQUEL (150 mg bid) and divalproex (500 mg bid) increased the mean oral clearance and the mean maximum plasma concentration of total valproic acid (administered as divalproex) by 11%. These changes were not clinically relevant. **The Effect of Other Drugs on SEROQUEL** *Hepatic Enzyme Inducers:* Concomitant use of SEROQUEL with hepatic enzyme inducers such as carbamazepine may substantially decrease systemic exposure to quetiapine. In a multiple dose trial in patients to assess the pharmacokinetics of quetiapine given before and during treatment with carbamazepine (a known hepatic enzyme inducer), co-administration of carbamazepine significantly increased the clearance of quetiapine. This increase in clearance reduced systemic quetiapine exposure (as measured by AUC) to an average of 13% of the exposure during administration of quetiapine alone; although a greater effect was seen in some patients. As a consequence of this interaction, lower plasma concentrations can occur, and hence, in each patient, consideration for a higher dose of SEROQUEL, depending on clinical response, should be considered. It should be noted that the recommended maximum daily dose of SEROQUEL is 800 mg/day and continued treatment at higher doses should only be considered as a result of careful consideration of the benefit-risk assessment for an individual patient. Co-administration of SEROQUEL and another microsomal enzyme inducer, phenytoin, caused five-fold increases in the clearance of quetiapine. Increased doses of SEROQUEL may be required to maintain control of psychotic symptoms in patients co-administered SEROQUEL and phenytoin and other hepatic enzyme inducers (e.g. barbiturates, rifampicin, etc.). The dose of SEROQUEL may need to be reduced if phenytoin or carbamazepine or other hepatic enzyme inducers are withdrawn and replaced with a non-inducer (e.g., sodium valproate). *CYP 3A4 Inhibitors:* CYP 3A4 is the primary enzyme responsible for cytochrome P450-mediated metabolism of quetiapine. Thus, co-administration of compounds (such as ketoconazole, erythromycin, diltiazem, fluvoxamine, norfluoxetine, nefazodone, etc.) which inhibit CYP 3A1, may increase the concentration of SEROQUEL. In a multiple-dose trial in healthy volunteers to assess the pharmacokinetics of quetiapine given before and during treatment with ketoconazole, co-administration of ketoconazole resulted in an increase in mean C_{max} and AUC of quetiapine of 235% and 522%, respectively, with a corresponding decrease in mean oral clearance of 84%. The mean half-life of quetiapine increased from 2.6 to 6.8 hours, but the mean t_{max} was unchanged. Due to the potential for an interaction of a similar magnitude in a clinical setting, the dosage of SEROQUEL should be reduced during concomitant use of quetiapine and potent CYP3A4 inhibitors (such as azole antifungals and macrolide antibiotics). Special consideration should be given to elderly and debilitated patients. The risk-benefit ratio needs to be considered on an individual basis in all patients. *Divalproex:* Co-administration of SEROQUEL (150 mg bid) and divalproex (500 mg bid) increased the mean maximum plasma concentration of quetiapine by 17% without changing the mean oral clearance. *Cimetidine:* In a clinical study examining the pharmacokinetics of SEROQUEL, following coadministration with cimetidine, a non-specific P450 enzyme inhibitor, no clinically significant interaction was observed. *Thioridazine:* Coadministration of thioridazine (200 mg b.i.d.) with SEROQUEL (300 mg b.i.d.) increased the clearance of SEROQUEL by 65%. *Risperidone, Imipramine, Haloperidol, and Risperidone:* Fluoxetine (60 mg daily), imipramine (75 mg b.i.d.), haloperidol (7.5 mg b.i.d.), and risperidone (3 mg b.i.d.)

did not significantly alter the steady-state pharmacokinetics of SEROQUEL. **Use in the Elderly** The number of patients 65 years of age or over, with schizophrenia or related disorders, exposed to SEROQUEL during clinical trials was limited (n=38). When compared to younger patients the mean plasma clearance of quetiapine was reduced by 30% to 50% in elderly subjects. In addition, as this population has a more frequent hepatic, renal, central nervous system, and cardiovascular dysfunctions, and more frequent use of concomitant medication caution should be exercised with the use of SEROQUEL in the elderly patient. (see DOSAGE AND ADMINISTRATION). **Use in Pregnancy** Patients should be advised to notify their physician if they become pregnant or intend to become pregnant during treatment with SEROQUEL. The safety and efficacy of SEROQUEL during human pregnancy have not been established. Therefore, SEROQUEL should only be used during pregnancy if the expected benefits justify the potential risks. **Use in Nursing Mothers** The degree to which quetiapine is excreted into human milk is unknown. Women who are breastfeeding should therefore be advised to avoid breast feeding while taking SEROQUEL.

ADVERSE REACTIONS The stated frequencies of adverse events represent the proportion of individuals who experienced, at least once, a treatment-emergent adverse event of the type listed. An event was considered treatment-emergent if it occurred for the first time or worsened while receiving therapy following baseline evaluation. The prescriber should be aware that the figures in the tables and tabulations cannot be used to predict the incidence of side effects in the course of usual medical practice where patient characteristics and other factors differ from those that prevailed in the clinical trials. Similarly the cited frequencies cannot be compared with figures obtained from other clinical investigations involving different treatments, uses, and investigators. The figures cited, however, do provide the prescribing physician with some basis for estimating the relative contribution of drug and non-drug factors to the side effect incidence in the populations studied. **Commonly Observed Adverse Events in Short-Term Placebo-Controlled Clinical Trials** *Schizophrenia:* The following treatment-emergent adverse events, derived from Table 1, commonly occurred during acute therapy with SEROQUEL (quetiapine) (incidence of at least 5%, and an incidence at least 5% higher than that observed with placebo): somnolence, dizziness, dry mouth, postural hypotension, and elevated ALT (SGPT) levels. *Bipolar Disorder - Mania:* In the bipolar mania studies, the following treatment-emergent adverse events, commonly occurred during acute therapy with SEROQUEL (incidence of at least 5%, and an incidence at least 5% higher than that observed with placebo): somnolence, dry mouth, and weight gain. **Adverse Events Associated with Discontinuation** Short-Term Placebo-Controlled Clinical Trials:

Schizophrenia: Overall, 9.9% of SEROQUEL treated patients (n=577) discontinued treatment due to adverse events compared with 7.9% of placebo treated patients (n=206). Somnolence, the single most common adverse event leading to withdrawal from quetiapine treatment, led to the withdrawal of four quetiapine-treated patients and no placebo-treated patients. Postural hypotension, hypotension and/or tachycardia led to withdrawal of 1.8% of quetiapine-treated subjects, compared to 0.5% of placebo-treated subjects. *Bipolar Disorder - Mania:* Discontinuations due to adverse events were similar for SEROQUEL (5.7%) and placebo (5.1%). Combined Short- and Long-term Controlled Trial Database in Schizophrenia: In a pre-marketing controlled clinical trial database of 1710 SEROQUEL-treated patients 5% discontinued due to an adverse event. Somnolence was the single most common adverse event leading to withdrawal of 24 patients from SEROQUEL, and was the only adverse event leading to withdrawal that occurred in more than 1% of patients. Cardiovascular adverse events (e.g. postural hypotension, hypotension, tachycardia, dizziness) accounted for 20% of all subjects withdrawals from quetiapine treatment. Seizure (0.9%) of quetiapine-treated subjects were withdrawn due to elevated liver enzymes. Four quetiapine-treated subjects were withdrawn because of leucopenia. Two of these subjects had at least one clinically significant, non-baseline low neutrophil count. Two quetiapine-treated subjects were withdrawn from the trial because of suspected neuroleptic malignant syndrome (NMS). **Incidence of Adverse Events in Placebo-Controlled Clinical Trials** Certain portions of the discussion below relating to objective or numeric safety parameters are derived from studies in patients with schizophrenia and have not been disclosed for bipolar mania trials. However, this information is also generally applicable to bipolar mania. Table 1 enumerates the incidence, rounded to the nearest percent, of treatment-emergent adverse events that occurred during acute therapy (up to 6 weeks) of schizophrenia in 1% or more of patients treated with SEROQUEL (doses of 150 mg/day or more) where the incidence in patients treated with SEROQUEL was greater than the incidence in placebo-treated patients.

Weight Gain: During acute therapy (up to 6 weeks) in placebo-controlled schizophrenia clinical trials, mean weight gain in patients taking SEROQUEL was 2.5 kilograms compared to a mean

Table 1 Adverse Events Reported For At Least 1% Of Quetiapine-Treated Subjects (Doses > 150 mg/day) And For A Higher Percentage Of Quetiapine-Treated Subjects Than Subjects Who Received Placebo In Short-Term, Placebo-Controlled Schizophrenia Phase II-III Trials

Body system and COSTART Term	Percentage of subjects with adverse events*	
	Quetiapine(n = 449)	**Placebo(n = 202)**
Whole body		
Headache	20	17
Abdominal pain	4	1
Back pain	2	1
Fever	2	1
Nervous system		
Somnolence	18	11
Dizziness	10	4
Digestive system		
Constipation	9	5
Dry mouth	7	2
Dyspepsia	6	2
Gamma glutamyl transpeptidase increased	2	1
Cardiovascular system		
Postural hypotension	8	2
Tachycardia	7	5
Palpitation	1	0
Metabolic and nutritional disorders		
SGPT increased	7	2
SGOT increased	4	1
Weight gain	2	0
Endocrine system		
Hypothyroidism	1	0
Skin and appendages		
Rash	4	3
Respiratory system		
Rhinitis	3	1
Hemic and lymphatic system		
Leucopenia	2	0
Special senses		
Ear pain	1	0

*Subjects may have had more than one adverse event.

weight gain of 0.1 kilograms in patients taking placebo. In open-label exploratory trials with quetiapine monotherapy, mean weight gain after 9 to 12 weeks was 1.58 kg, after 14 to 26 weeks, 0.26 kg, after 27 to 39 weeks, 1.86 kg, after 40 to 52 weeks -1.53 kg and after 53 to 78 weeks, 1.38 kg (see PRECAUTIONS). In the acute placebo-controlled bipolar mania clinical trials (up to 12 weeks), mean weight gain in patients taking SEROQUEL was 1.6 kg compared to a mean weight loss of 0.1 kg in patients taking placebo. In patients completing the entire 12 weeks of treatment, mean weight gain in patients taking SEROQUEL was 2.9 kg. **Seizures:** There have been occasional reports of seizures in patients administered SEROQUEL, although the frequency was no greater than that observed in patients administered placebo in controlled clinical trials (see PRECAUTIONS). **Priapism:** There have been very rare reports of priapism in patients administered SEROQUEL. **Somnolence:** Somnolence may occur, usually during the first two weeks of treatment, which generally resolves with the continued administration of SEROQUEL. **Neuroleptic Malignant Syndrome:** As with other antipsychotics, rare cases of neuroleptic malignant syndrome have been reported in patients treated with SEROQUEL (see WARNINGS). **Vital Signs:** As with other antipsychotics with adrenergic blocking activity, SEROQUEL may induce postural hypotension, associated with dizziness, tachycardia and, in some patients, syncope, especially during the initial dose titration period (see PRECAUTIONS). In placebo-controlled clinical trials in schizophrenia, postural hypotension was reported with an incidence of 8% in SEROQUEL-treated patients compared to 2% in placebo-treated patients. SEROQUEL was associated with a mean baseline to endpoint increase in heart rate of 3.9 beats per minute, compared to 1.6 beats per minute among placebo-treated patients. **Laboratory Changes:** As with other anti-psychotics, leucopenia and/or neutropenia have been observed in patients administered SEROQUEL. Occasionally, eosinophilia has been observed. There were no cases of persistent severe neutropenia or agranulocytosis reported in controlled clinical trials with SEROQUEL. Asymptomatic elevations in serum transaminases (SGOT (AST), SGPT (ALT)) or γ GT levels have been observed in some patients administered SEROQUEL. These elevations were usually reversible on continued SEROQUEL treatment (see PRECAUTIONS). Small elevations in non-fasting serum triglyceride levels and total cholesterol have been observed during treatment with SEROQUEL (see PRECAUTIONS). SEROQUEL treatment was associated with small dose related decreases in thyroid hormone levels, particularly total T_4 and free T_4. The reduction in total and free T_4 was maximal within the first 2 to 4 weeks of quetiapine treatment, with no further reduction during long-term treatment. There was no evidence of clinically significant changes in TSH concentration over time. In nearly all cases, cessation of quetiapine treatment was associated with a reversal of the effects on total and free T_4, irrespective of the duration of treatment (see PRECAUTIONS). Smaller decreases in total T_3 and reverse T_3 were seen only at higher doses. Levels of TBG were unchanged and in general reciprocal increases in S-4 were not observed, with no indication that SEROQUEL causes clinically relevant hypothyroidism. **Peripheral Oedema:** As with other antipsychotic agents, rare cases of peripheral oedema have been reported in patients treated with SEROQUEL. **Hypersensitivity:** Very rarely, hypersensitivity including angioedema has been reported. **ECG Changes:** Between group comparisons for pooled placebo-controlled trials reveal no statistically significant SEROQUEL/placebo differences in the proportions of patients experiencing potentially important changes in ECG parameters, including QT, QTc, and PR intervals. However, the proportions of patients meeting the criteria for tachycardia were compared in four 3- to 6-week placebo-controlled clinical trials for the treatment of schizophrenia revealing a 15% (47/299) incidence for SEROQUEL compared to 0.6% (1/166) incidence for placebo. SEROQUEL was associated with a mean increase in heart rate, assessed by ECG, of 7 beats per minute compared to a mean increase of 1 beat per minute among placebo patients. This slight tendency to tachycardia may be related to SEROQUEL's potential for inducing orthostatic changes (see PRECAUTIONS). In bipolar disorder - mania trials the proportion of patients meeting the criteria for tachycardia was 0.3% (1/392) for SEROQUEL compared to 0% (0/178) for placebo. **Extrapyramidal Symptoms (EPS):** Table 2 enumerates the percentage of patients with treatment-emergent extrapyramidal symptoms in a short-term acute phase clinical trial in patients with schizophrenia comparing five fixed doses of SEROQUEL with placebo (n = ~ 50 patients per group), as assessed by: 1) spontaneous complaints of parkinsonism (extrapyramidal symptoms: hypersonia, tremor, and cogwheel rigidity) or akathisia; 2) Simpson Angus scores (mean change from baseline); and 3) use of anticholinergic medication to treat emergent EPS

Table 2 Treatment-Emergent Extrapyramidal Symptoms, Assessed by Spontaneous Reports, Simpson Scale, and Incidence of Anticholinergic Use

	placebo	SEROQUEL				
		75mg	150 mg	300 mg	600 mg	750 mg
Spontaneous Reports of Parkinsonian Syndrome*	13%	6%	4%	4%	8%	4%
Spontaneous Reports of Akathisia	8%	2%	2%	0%	0%	2%
Simpson Scale	- 0.6	- 1.0	- 1.2	- 1.6	- 1.8	- 1.8
Incidence of Anticholinergic Use	14%	11%	10%	8%	12%	11%

*Patients may have had more than one parkinsonism adverse event

There were no differences between the SEROQUEL and placebo treatment groups in the incidence of EPS or concomitant use of anticholinergics and no evidence of dose-related increase in EPS or in the use of concomitant anticholinergics across the dose range of 75 – 750 mg/day. In 2 bipolar I, short - mania placebo-controlled clinical trials using variable doses of SEROQUEL, there were no differences between the SEROQUEL and placebo treatment groups in the incidence of EPS, as assessed by Simpson-Angus total scores and Barnes Akathisia rating scale, spontaneous complaints of EPS and the use of concomitant anticholinergic medications to treat EPS.

Post-Market Experience During post-marketing experience, leucopenia and/or neutropenia have been reported during SEROQUEL treatment. Resolution of leucopenia and/or neutropenia has followed cessation of therapy with SEROQUEL. Possible risk factors for leucopenia and/or neutropenia include pre-existing low white cell count and history of drug induced leucopenia and/or neutropenia. As with some other antipsychotics, exacerbation of pre-existing diabetes hyperglycaemia, diabetic ketoacidosis, and diabetic coma including some fatal cases have been reported very rarely (<0.01%) during the use of SEROQUEL sometimes in patients with no reported history of hyperglycaemia. A causal relationship to SEROQUEL has not been established.

SYMPTOMS AND TREATMENT OF OVERDOSAGE **Clinical Trials** In clinical trials experience with SEROQUEL (quetiapine) in overdosage is limited. Estimated doses of up to 20 g of SEROQUEL have been taken, no fatalities were reported and patients recovered without sequelae. **Postmarketing** In postmarketing experience, there have been cases of coma and death in patients taking a SEROQUEL overdose. The lowest reported dose associated with coma has been in a patient who took 5 g and had a full recovery within 3 days. The lowest reported dose associated with a death was in a patient who took 13.6 g. In general, reported signs and symptoms were those resulting from an exaggeration of the drug's known pharmacological effects (e.g. drowsiness and sedation, tachycardia and hypotension. **Treatment** There is no specific antidote to quetiapine. In cases of severe intoxication, the possibility of multiple drug involvement should be considered, and intensive care procedures are recommended including establishing and maintaining a patent airway, ensuring adequate oxygenation and ventilation, and monitoring and support of the cardiovascular system. Close medical supervision and monitoring should be continued until the patient recovers.

DOSAGE AND ADMINISTRATION **Schizophrenia** The usual starting dose of SEROQUEL (quetiapine) is 25 mg b.i.d., titrated with increments of 25-50 mg b.i.d. per day, as tolerated, to a target dose of 300 mg/day given b.i.d. within four to seven days. Further dosage adjustments may be indicated depending on the clinical response and tolerability in the individual patient. Dosage adjustments should generally occur at intervals of not less than 2 days, as steady state for SEROQUEL would not be achieved for approximately 1-2 days in the typical patient. When adjustments are necessary, dose increments/decrements of 25-50 mg b.i.d. are recommended. SEROQUEL can be administered with or without food. Clinical trials suggest that the usual effective treatment dose will be in the range of 300-600 mg/day. However, some patients may require as little as 150 mg/day. The safety of doses above 800 mg/day has not been evaluated. The need for continuing existing EPS medications should be re-evaluated periodically as SEROQUEL has not been associated with treatment-emergent EPS across the clinical dose range.

Bipolar Disorder - Mania Usual Dose: The titration rate, based on the clinical trials is shown in the table below

Day	1	2	3	4	5	6
BID	100 mg/day	200 mg/day	300 mg/day	400 mg/day	Up to 600 mg/day	Up to 800 mg/day

Dosage adjustments should be made depending on the clinical response and tolerability in the individual patient. Approximately 85% of patients responded between 400 and 800 mg/day, while over 50% of patients responded between 600 and 800 mg/day, the average median dose for responders during the last week of treatment was approximately 600 mg/day. The safety of doses above 800 mg/day has not been evaluated. **Elderly** In clinical trials, 38 patients with schizophrenia or related disorders, 65 years of age or over, were treated with SEROQUEL (see PRECAUTIONS). Given the limited experience with SEROQUEL in the elderly, and the higher incidence of concomitant illness and concomitant medication in this population SEROQUEL should be used with caution. The mean plasma clearance of SEROQUEL was reduced by 30% to 50% in elderly subjects when compared to younger patients. The rate of dose titration may thus need to be slower, and the daily therapeutic target dose lower, than that used in younger patients. **Hepatic Impairment** Quetiapine is extensively metabolized by the liver. Therefore, SEROQUEL should be used with caution in patients with mild hepatic impairment, especially during the initial dosing period. Patients with mild hepatic impairment should be started on 25 mg/day. The dose should be increased daily in increments of 25 to 50 mg/day to an effective dose depending on the clinical response and tolerability in the individual patient. No pharmacokinetic data are available for any dose of SEROQUEL in patients with moderate to severe hepatic impairment. However, should clinical judgement deem treatment with SEROQUEL necessary, the drug should be used with great caution in patients with moderate or severe hepatic impairment (see PRECAUTIONS). **Renal Impairment** As clinical experience is lacking, caution is advised (see PRECAUTIONS).

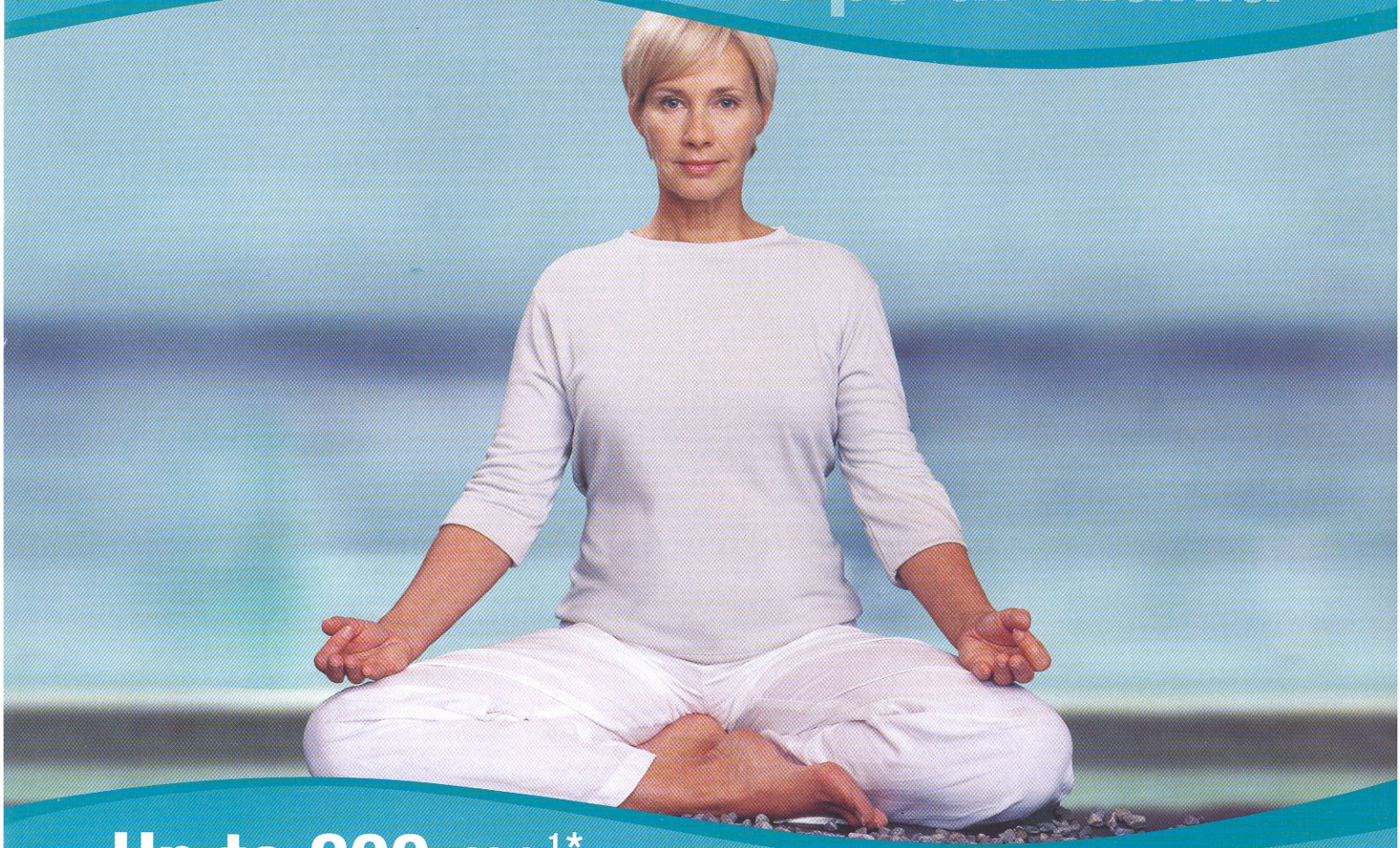
PHARMACEUTICAL INFORMATION **Composition** SEROQUEL is available in 5 strengths containing 25, 100, 150, 200 or 300 mg quetiapine (as fumarate). The core of the tablet contains the excipients povidone, calcium hydrogen phosphate, microcrystalline cellulose, sodium starch glycolate type A, acesulfame potassium and magnesium stearate. The coating of the tablet contains hydroxypropyl methylcellulose 2910, polyethylene glycol 400, titanium dioxide, yellow ferric oxide (25 mg, 100 mg and 150 mg tablets) and red ferric oxide (25 mg tablets).

AVAILABILITY OF DOSAGE FORMS SEROQUEL (quetiapine) is available as film-coated tablets containing quetiapine fumarate equivalent to 25 mg, 100 mg, 150 mg, 200 or 300 mg of quetiapine free base as follows: 25 mg quetiapine tablets are peach coloured, round, biconvex, imprinted with 'SEROQUEL' and '25' on one side and plain on the other, available in blister packages of 60 tablets and high-density polyethylene (HDPE) bottles of 100 tablets. 100 mg quetiapine tablets are yellow coloured, round, biconvex, imprinted with 'SEROQUEL' and '100' on one side and plain on the other, available in blister packages of 60 tablets and HDPE bottles of 100 tablets. 150 mg quetiapine tablets are pale yellow coloured, round, biconvex, imprinted with 'SEROQUEL' and '150' on one side and plain on the other, available in HDPE bottles of 100 tablets. 200 mg quetiapine tablets are white, round, biconvex, imprinted with 'SEROQUEL' and '200' on one side and plain on the other, available in blister packages of 60 tablets and HDPE bottles of 100 tablets. 300 mg quetiapine tablets are white, capsule-shaped, biconvex, imprinted with 'SEROQUEL' on one side and '300' on the other, available in HDPE bottles of 100 tablets.

Full Product Monograph available upon request.

REFERENCES: 1. Seroquel® Product Monograph. AstraZeneca Canada Inc., November 2002. **2.** Arvanitis LA, Miller BG. Seroquel Trial 13 Study Group. Multiple fixed doses of "Seroquel" (quetiapine) in patients with acute exacerbation of schizophrenia: a comparison with haloperidol and placebo. *Biol Psychiatry* 1997;42(4):233-46. **3.** Small JG, Hirsch SR, Arvanitis LA *et al.* Quetiapine in patients with schizophrenia. A high- and low-dose double-blind comparison with placebo. *Arch Gen Psychiatry* 1997;54:549-57. **4.** Velligan DI, Newcomer J, Pultz J *et al.* Does cognitive function improve with quetiapine in comparison to haloperidol? *Schizophrenia Research* 2002;53:239-48.

bipolar mania



Up to 800 mg[1*]

...and who knows how many peaceful moments?

Showed significant and sustained efficacy:

- Seroquel® demonstrated a significant change from baseline YMRS** total score at day 21 in a 12-week study[1†]
- Of patients with clinical response, 87% received doses between 400 and 800 mg per day (day 84 data)[1]
- In two individual studies, 52% and 81% of responders attained clinical response with 600-800 mg per day (day 84 data)[1‡]
- Dosage adjustments should be made depending on the clinical response and tolerability in the individual patient[1]

Trusted tolerability profile[1]:

Incidence of adverse events reported in schizophrenia is expected to be generally applicable to bipolar mania[1]:

- EPS profile was no different from placebo across the dose range[1]
- Elevation of prolactin levels was not seen in clinical trials[1]

Seroquel® is indicated as monotherapy for the acute management of manic episodes associated with bipolar disorder.

The efficacy of Seroquel® in bipolar disorder – mania was established in two 12-week clinical trials of bipolar patients. The safety and effectiveness of Seroquel® for long-term use, and for prophylactic use in bipolar disorder has not been evaluated.

Eye examinations are recommended prior to, or shortly after initiation of treatment, and at 6 month intervals thereafter. Caution should be used in the elderly and those with known hepatic or renal impairment. Common adverse events occurring during Seroquel® monotherapy in bipolar mania (incidence of at least 5%, and an incidence of at least 5% higher than that observed with placebo): somnolence, dry mouth, and weight gain.

*Seroquel® should be initiated in BID doses totaling 100 mg/day on day 1, increased to 400 mg/day on day 4, in increments of 100 mg/day in BID divided doses. Dosage adjustments up to 800 mg/day by day 6 should be in increments of no greater than 200 mg/day. Dosage adjustments should be made depending on the clinical response and tolerability in the individual patient. Clinical trials suggest that the usual effective treatment dose is 400 – 800 mg/day. Safety has not been evaluated beyond 800 mg/day.

**Young Mania Rating Scale

†Results of two 12-week, multi-centre, double-blind, placebo-controlled studies. LOCF data.

‡Responders (defined as a 50% decrease from baseline YMRS Total Score) in two, 12-week, multi-centre, double-blind, placebo-controlled studies.

1. Seroquel® Product Monograph. AstraZeneca Canada Inc. November 2004.

AstraZeneca

℞ Seroquel®
Quetiapine