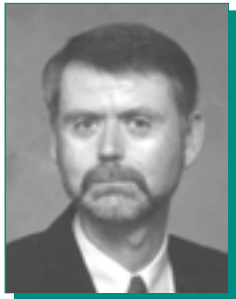




Ontario Psychiatric Association DIALOGUE

THE NEWSLETTER OF THE ONTARIO PSYCHIATRIC ASSOCIATION / UNE PUBLICATION DE L'ASSOCIATION DES PSYCHIATRES DE L'ONTARIO



TIME SENSITIVE INFORMATION

MESSAGE FROM THE PRESIDENT

Dear Colleague,

This year has rolled around oh so quickly and this is the last time I will write to you as President. It has been my honour to represent psychiatrists across Ontario and through you the patients whom we serve.

Probably the most controversial issue to arise during the year was the recommendation from the OMA and Ministry of Health and Long-term Care (MOHLTC) that psychiatrists should receive 34% less than an internal medicine specialist for providing the same service to the new family health teams (FHT). The OPA Council and our Coalition of Ontario Psychiatrists partner, the OMA Section of Psychiatry, could have let this issue pass or just raised a token objection. It is, after all, just one more example of a long-standing undervaluation of psychiatry as a medical specialty. Also, most psychiatrists will not work in a FHT so why get excited? The OPA and OMA Section took a different view - we were elected to provide leadership for our profession and if psychiatry were to acquiesce when the facts so clearly demonstrate unfairness we might as well all pack up and go home. On the other hand the FHT remuneration debacle provides us with an opportunity - if we achieve the higher rate for FHT sessions this will have a "knock on" effect on other sessional payments. As you will read in Dr. Gaind's article we have made steady progress toward this goal.

Most of you know that Dr. Sonu Gaind will succeed me as President in February 2008 and those of you who know Dr. Gaind no doubt share my belief that he will be a great leader for Ontario psychiatrists. But we cannot leave everything to Dr. Gaind - as noted in the key message in our recruitment campaign there is strength in numbers. This edition of *Dialogue* is being distributed to all 1800 psychiatrists in Ontario. If you are reading this and are not an OPA member join now. Even passive membership can have a real impact, allowing the OPA to speak more authoritatively to government and other groups. Of course, if you are interested and motivated we would welcome your more active involvement. You can complete the membership form inside *Dialogue* and fax it to our office or join directly through our web site www.eopa.ca I would also ask you to pay the \$275 Coalition fees by ticking the appropriate box when renewing your OMA membership. The Coalition fees will go directly to assisting us with the upcoming fee negotiations with the MOHLTC (see details under Coalition News inside).

Let me end by congratulating Dr. Paul Mulzer who has been nominated as President-Elect and will become President of the OPA in 2009. Dr. Mulzer has been much lauded recently for his production of the film "Seeking Bimaadiziwin" which describes the challenges posed by social and psychiatric problems in aboriginal communities. Dr. Mulzer has worked on Council for the last two years and will bring his considerable organizational skills and passion to lead the organization.

Richard O'Reilly
2007 OPA President



Ontario Psychiatric Association
Executive and Council



President
Dr. Richard O'Reilly



President-Elect
Dr. Sonu Gaind



Past President
Dr. Susan Abbey



Secretary
Dr. Varinder Dua



Treasurer
Dr. Deborah Elliott



Dr. Doron Almagor



Dr. Gary Chaimowitz



Dr. John Deadman



Dr. Alison Freeland



Dr. Sarah Jarman



Dr. Roumen Milev



Dr. Paul Mulzer



Dr. Anne Hennessy



Dr. Paul Sedge



Dr. Andrea Waddell

Dr. Leslie Buckley

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*The OPA reserves the right to refuse requests for advertising.
The views expressed in this newsletter do not necessarily
reflect the views of the OPA Council.*

FROM THE EDITOR

This issue of the *Dialogue* is being distributed to all psychiatrists in Ontario as a way of informing the profession about some of the important work being undertaken by the Ontario Psychiatric Association. Dr. Gaind provides an update on the status of parity for psychiatrists in Family Health Teams. Through the hard work of the OPA Council, and the Coalition of Ontario Psychiatrists, some real progress has occurred since our last newsletter.

The Fall conference held in October was a great success and we are grateful to the planning committee for their contribution to another successful event. We are looking forward to the OPA annual conference in Toronto February 8th and 9th. Dr. Roumen Milev, the chair of the continuing Education Committee will pass the torch to another Chair after this conference. It has been a real pleasure working with Dr. Milev and we wish him well in his new position as Head of Psychiatry, Queen's University.

On behalf of Council and the OPA staff, I would like to take this opportunity to thank Dr. Richard O'Reilly for his leadership and commitment as president over the last year. Dr. Abbey (president 2006) and Dr. O'Reilly (president 2007) collaborated on a two-year theme for the OPA. We have spent the last two years addressing *Relationships and Partnerships*. We have sought out new relationships and strengthened established ones. As we conclude this theme we are in a stronger position as a result of the insight and dedicating of these presidents - our thanks! We are looking forward to another busy and productive year as Dr. Sonu Gaind takes on the President role.

As we start into a new year, we encourage all Ontario psychiatrists to join the OPA so that we can speak with a clear and united voice.

This is our last issue of *Dialogue* of 2007 - we wish you a wonderful holiday season and health and happiness for 2008.

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

June Hylands
Editor

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Family Health Teams, and More: The Thin Edge of the Wedge (and Yes, You Can Make a Difference!)

Before reviewing significant recent developments on the Family Health Team (FHT) front, with OMA - MOHLTC negotiations just around the corner I think it timely to review why the FHT issue has such significance for all Ontario psychiatrists.

You will recall that under the current terms of the FHT funding model, psychiatrists, paediatricians, and geriatricians receive \$429 per 3 hour session plus 10% shadow billing, while internal medicine specialists receive \$575 per 3 hour session plus 10% shadow billing. The Council of the Ontario Psychiatric Association, the OMA Section on Psychiatry, and the Coalition of Ontario Psychiatrists have strongly opposed the disparities in this funding model.

Why have we put such effort into an issue, which on the surface, seems to affect only a relatively small number of psychiatrists? Also, aren't there issues aside from remuneration that might draw psychiatrists to practice in FHT's?

Naturally issues other than remuneration factor into individual decisions to provide sessional services in a collaborative care model. However, accepting a model based on explicit disparity has implications far beyond an individual's remuneration in that model. Aside from the fundamental and self-evident issues of fairness, it is important to remember that fees are not set in isolation. Changes in fees in one model eventually impact fees for similar services in other models. This applies to time-based sessional rates, alternate funding plan models, fee-for-service and any other model under which Ontario psychiatrists are remunerated. This may be particularly true of time-based FHT sessional rates and other psychiatric fees, as even OHIP fee-for-service psychiatric fees are predominantly time-based already.

Indeed, it has been made clear that the original FHT sessional rates were set lower than internal medicine sessional rates based on average OHIP billings calculations, highlighting that such comparisons are routine when setting rates. Success at achieving parity in the FHT sessional rates therefore has the potential to affect not only other sessional rates, but also other psychiatric fees in Ontario.

Failure to achieve parity carries even more consequences. The FHT model represents the first time other specialty services are being remunerated on a time-basis in direct comparison with psychiatric services, and I cannot imagine a more devastating blow to all future negotiations than allowing, or acquiescing to, the entrenchment of a time-based model based on explicit inter-specialty disparity.

Even so, some may argue that if psychiatrists continue to provide the excellent care they do despite such inequities, the existing funding models "must be OK", disparities and all (this is precisely what the government is arguing - see the letter from Mr. Hugh MacLeod in this edition of *Dialogue*). Even though some psychiatrists may wish to take the moral high ground and choose to believe that "money does not matter, unfortunately, the reality is that funding issues do affect practice patterns and recruitment over time. What message does the existing FHT model give to medical students who are considering a range of careers, if that model overtly values a psychiatrist's time 34% less than an internist's? What message do we as psychiatrists give to the same medical student, if we accept and collaborate in such a model? Moral high ground will not provide our patients' children the psychiatric services they might need when there aren't enough new psychiatrists who have entered the field. The apparently small and isolated issue of FHT funding really is the very thin edge of the wedge, and has significant implications for other psychiatric fees in Ontario and for our patients' access to care.

Family Health Teams, and More: The Thin Edge of the Wedge (and Yes, You Can Make a Difference!) Continued

Fortunately, through our efforts and the efforts of those of you who faxed in your letters opposing the existing FHT funding model, we have made some progress. At the recent OMA General Council meeting in November, the OMA Section on Psychiatry was successful at passing the following two motions regarding FHTs:

“That the OMA supports parity of remuneration for psychiatric, paediatric, geriatric and internal medicine consultant services in Family Health Team sessional payments.”

“That the OMA request a moratorium on new consultant recruitment to Family Health Teams until the consultant funding model is revised.”

You will recall that the original FHT funding model was approved by *both* the OMA and Ministry of Health and Long-Term Care (MOHLTC). The above motions represent a 180 degree change in position of the OMA, and as OMA Council is the policy setting body of the OMA these motions are now official OMA policy that the organization must act on. *These motions represent a significant landmark in Ontario as it is the first time the notion of parity of specialist services has been adopted as policy by the OMA.*

We have obviously made significant progress by succeeding at having the OMA adopt a policy of parity in this model when just a few months ago it was equal partner in implementing a model based on disparity. We have been successful in building “grassroots” support at the OMA on this issue over the past several months, first having the OMA Medical Assembly (the body that represents medical specialties, including internists paid at the higher FHT rate) unanimously adopt a position advocating parity, then at OMA Council having the Chair of the Section on Paediatrics second our first motion and the Chair of the Section on General and Family Practice second our second motion. Once the Section had an opportunity to present our arguments to OMA Council the motion on parity was passed unanimously by the entire Council, again speaking to the strength of our arguments. Even the MOHLTC has not presented a single cogent argument countering the Section’s concerns about disparity of patient services leading to access barriers.

However, the MOHLTC continues to roll out the existing flawed FHT model and seek specialist recruitment. Although the OMA now officially supports a policy of parity in FHTs, it is clear that the MOHLTC will continue to promote the existing model of disparity as long as it is able to recruit psychiatrists to work at the existing rates. This is made abundantly clear in recent correspondence from MOHLTC Assistant Deputy Minister Hugh MacLeod (copy published in this edition of *Dialogue*). Despite hearing our concerns regarding the inappropriateness of the current model and it’s negative impact on access to patient care over time, and despite the MOHLTC receiving nearly 450 signed faxes from Ontario psychiatrists opposing the current model, ADM MacLeod simply cites being “really pleased to see that FHTs have been very successful at recruiting and retaining psychiatrists” at the existing sessional rates.

While we are attempting to obtain more detailed information on the number of psychiatrists working with FHTs and which FHTs are receiving psychiatric sessional services, the latest information we have suggested that there are 25 or 26 psychiatrists across the province currently providing FHT sessions (almost all on a part-time basis). This is very close to the number we were told in May, 23 or 24 psychiatrists providing FHT sessions at that time, so I am uncertain how successful the Ministry has actually been in recruiting psychiatrists since we began raising awareness and opposing the existing funding model. Additionally, to date there still has not been a single non-psychiatrist specialist sign on to provide FHT sessional services.

Family Health Teams, and More: The Thin Edge of the Wedge (and Yes, You Can Make a Difference!) Continued

Since raising this issue, we have heard from several psychiatrists who agreed long ago to provide FHT services prior to being aware of the disparities in specialty funding in the current model. I was not surprised that many of these psychiatrists feel they would not have joined their FHT had they been aware of the overt funding disparities, but I was surprised to learn that many psychiatrists who have been providing FHT services for well over a year have not even been receiving the 10% 'shadow-billing' amount they are entitled to. I question whether such a situation would persist with our internal medicine colleagues for such a long time, or whether this again reflects a broader devaluation of psychiatric services. In any case, I think it completely unacceptable that this situation continue for so long, and it further illustrates that the flaws in the existing model will not be fixed unless Ontario psychiatrists take an active and concerted stand.

We have been advised that the MOHLTC will likely be attempting further FHT specialist recruitment by January 2008. From ADM MacLeod's response it seems clear that if the next round of psychiatrist recruitment is successful the Ministry will have little motivation to change the existing model. It seems equally clear that, if Ontario psychiatrists are able to take a firm stand and insist on a model based on parity by refusing to provide FHT services in the current disparity-based model, the chances of success are now much higher given the OMA's official position.

To be blunt, our greatest chance of failure now comes from our own members, if our own members fail to take a stand.

Once again, while the specific FHT issue may affect a relatively small number of psychiatrists, the principles involved will affect every Ontario psychiatrist, and every patient that requires psychiatric services in the future.

To ensure that psychiatric issues are regarded with the parity they deserve in present and future negotiations, and to avoid the inevitable access barriers that will arise if Ontario psychiatrists collaborate in a model based on disparity, the Coalition of Ontario Psychiatrists, OPA Council, and the OMA Section on Psychiatry Executive continue to advise all Ontario psychiatrists to refuse to sign on to provide sessional services to FHTs under the current model (this includes psychiatrists currently considering entering a new arrangement with an FHT, those being asked to increase their service to an FHT and psychiatrists considering renewing existing arrangements with an FHT). Collaborating in the existing disparity-based FHT model will simply ensure the current flawed model becomes entrenched, instead of a sustainable shared-care model based on parity.

Moving ahead, we are trying to track FHT recruitment and refusals to participate, and also want to ensure that psychiatrists already working in FHTs are receiving what they are entitled to under the terms of their agreement (e.g. the 10% shadow-billing issue raised above). If you are approached by an FHT for recruitment, please contact me via email at psych@rogers.com, or phone at **(416) 769-9159**. For any psychiatrist that had already agreed to provide FHT services before being aware of these issues, please contact me to discuss how you can contribute to ensuring a future model of parity while continuing to ensure patients receive necessary care.

Respectfully submitted,

K. Sonu Gaind
Email: psych@rogers.com

Coalition News

As this edition of *Dialogue* is being sent to all 1800 psychiatrists in the Province it is an opportunity to provide an overview of the Coalition of Ontario Psychiatrists. The Coalition is a partnership of the Ontario Psychiatric Association and the Ontario Medical Association's Section of Psychiatry. It was formed in the mid-1990s to ensure that psychiatrists in Ontario would speak with a strong and united voice on issues important to our specialty. Although the arrangement is sometimes a little cumbersome, overall we have found it advantageous to let one or other of the two Coalition partners take the lead on specific issues. For example, the OPA will generally take the lead in matters related to clinical services and standards of practice whereas the OMA Section takes the primary role in fee negotiations. The funds paid to the Coalition are used primarily to support our fee negotiations but also occasionally to help lobbying efforts on other issues.

This Fall has been a busy time for the Coalition. We had a retreat on September 8th in Toronto. Not surprisingly with the negotiations between the OMA and the MOHLTC commencing in the new year the focus of the retreat and subsequent work this Fall has been primarily getting ready for those negotiations. The survey of Ontario psychiatrists completed earlier this year emphasized the importance of increasing the fees under the K codes and this will be a priority for the Coalition in the upcoming negotiations.

Most psychiatrists would agree that the last contract with the MOHLTC provided a better deal for colleagues working in hospitals compared to those who work in office-based practices in the community. Increasing the K codes is a priority in ensuring that office-based psychiatrists are appropriately remunerated. The Ministry and other stakeholders are often ignorant of the work that office-based psychiatrists do and the complexity of the patient group seen by these psychiatrists. As part of a programme of education the Coalition has developed a position paper titled "Office-based practice in the community: a missing link." This paper will be made available on the OPA website www.eopa.ca. We acknowledge Dr. Desi Brownstone from London for taking the lead role in developing this paper.

The Coalition is aware that a number of psychiatrists who are primarily remunerated by salary receive little benefit from the OMA in negotiations. In an effort to determine how the OMA could more effectively represent these psychiatrists Dr. Doug Weir met by teleconference with the psychiatrists from the divested provincial psychiatric hospitals on November 15th and subsequently in-person with representatives from this group and with other salaried psychiatrists, including those working on assertive community treatment teams, on Wednesday 28th November 2007.

The Coalition remains committed to reversing the decision of the Primary and Community Care Committee (a joint OMA and MOHLTC committee) on the funding model for Family Health Teams. As you will see in the article by Dr. Sonu Gaiind we have made significant progress in reversing this decision on the OMA side. Again, please do not sign up or extend any commitment you have already given to these teams while negotiations are ongoing.

Finally, although we use your money frugally effective negotiating does cost. Colleagues who take time out of their practices to negotiate on your behalf must be compensated. We also require expert legal and occasional accounting advice during these negotiations. The Coalition dues will remain \$275 for the coming year. We ask everyone, but especially those of you who have not contributed in previous years, to commit this small, tax deductible, amount when you receive your OMA renewal form later in the year.

Rayudu Koka
Richard O'Reilly
Co-Chairs
Coalition of Ontario Psychiatrists



**Ministry of Health
and Long-Term Care**

Assistant Deputy Minister
Health System Accountability
and Performance Division

5th Floor, Hepburn Block
Queen's Park
Toronto ON M7A 1R3

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et des Soins de longue durée**

Sous-ministre adjoint
Division de la responsabilisation et de la
performance du système de santé

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Dr. Richard O'Reilly
Dr. Rayadu Koka
Dr. K. Sonu Gaind
Coalition of Ontario Psychiatrists
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Oakville ON L6J 1J6

Dear Dr. Richard O'Reilly and Colleagues,

Thank you for your correspondence regarding sessional stipends for psychiatrists in the Family Health Team (FHT) model to the Minister. I note your concerns about the parity of stipends for specialist services, and value your feedback.

As outlined in previous correspondence with the Ministry of Health and Long-Term Care, the sessional stipend for psychiatry services in FHTs is based on the latest billing data. We are really pleased to see that FHTs have been very successful at recruiting and retaining psychiatrists at this sessional rate.

Please be assured that your comments will be considered as we continue to monitor this issue. I appreciate the time you have taken to offer your thoughtful remarks.
Thank you again for writing.

Sincerely,

Hugh MacLeod
Assistant Deputy Minister
Health System Accountability and Performance Division

Official Notice of Annual General Meeting

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 am on Saturday, February 9th, 2008 in Salon CD at the Toronto Marriott Eaton Centre Hotel, 525 Bay St., 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 contracting 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 Friday, February 1, 2008. Proxy forms may also be given to your designate who will attend the AGM.

The financial statements for the fiscal year ending December 31, 2007 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 Spring 2008 issue of *Dialogue*.

I look forward to your attendance as well as your participation at the OPA 2008 Annual General Meeting.

Sincerely,

Susan Abbey, MD, FRCPC
OPA 2006 President

Ontario Psychiatric Association Annual General Meeting Agenda

Saturday, February 9th, 2008 - 8:15 - 9:00 am
Toronto Marriott Eaton Centre Hotel, Salon C/D

1. Call to order - R. O'Reilly
 2. Introduction of Guests - R. O'Reilly
 3. Approval of Agenda
 4. Approval of Minutes of the February 2007 Annual General Meeting
 5. OPA President's Report - R. O'Reilly
 6. OPA Treasurer's Report - D. Elliott
 7. Appointment of Auditor
 8. OPA President's Address - R. O'Reilly
 9. Presentation of 2008 Budget - D. Elliott
 10. Election Results for 2008 Council - S. Abbey
 11. Incoming President - Remarks and announcement of 2008 president's theme
 12. Other Business
 - 12.1 Consideration of bylaw change regarding quorum for AGM
 13. Adjournment
-
-

Ontario Psychiatric Association - Council Meeting AGENDA

Date: Friday November 23rd 2007

1.0 Remarks from the President and Approval of Agenda

2.0 Approval of Minutes of September 28th 2007

3.0 Business Arising

- 3.1 President Theme Update
- 3.2 AFP / FHT Funding
- 3.3 Sections Renewal
- 3.4 Incorporating for charitable status
- 3.5 Position on Torture

4.0 Reports of Task Forces and Committees

- 4.1 Executive Committee
- 4.2 Advocacy Committee
- 4.3 Communications Committee
- 4.4 Continuing Education Committee
- 4.5 Finance/Audit Committee
- 4.6 Member Services Committee

5.0 Treasurer's Report

6.0 Standing Reports

- 6.1 CPA Reports
- 6.2 OMA Section on Psychiatry
- 6.3 Coalition of Ontario Psychiatrists
- 6.4 Executive Director Report
- 6.5 Specialty Committee for Psych - Royal College

7.0 New Business

- 7.1 OPA nominee for T.A. Sweet Award
- 7.2 OPA nominations for Council
- 7.3 Conference registration rate for consumers
- 7.4 Conference sponsors



**Ontario Psychiatric Association
Annual General Meeting
Saturday February 9, 2008**

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
February 9th, 2008 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.**

PROXY

I, _____

(Please print your name)

Will be unable to attend the February 9, 2008

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 _____

Ontario Psychiatric Association's 88th Annual Conference "Relationships and Partnerships"

February 8th and 9th 2008
Marriott Downtown Eaton Centre Hotel
525 Bay Street Toronto

Be sure to take a look at the Preliminary Program of our 88th Annual Conference included with this issue of *Dialogue*.

The new look and feel for the meeting includes various tracks with something for everyone!

Psychotherapy
Clinical Challenges
Resident Programming
Professional Issues
And of course....the Annual Dinner & Dance!

Online registration now available at www.eopa.ca!

Congratulations to Dr. Paul Mulzer! Seeking Bimaadiziwin

As many of you know, OPA Council member Dr. Paul Mulzer led the production of the award winning film "Seeking Bimaadiziwin" or 'Seeking the Good Life'. This poignant film deals with tough issues such as, depression, suicide and racism. It is intended for therapeutic use with clients to encourage participation in group therapy and to spark discussion about these critical issues. It also serves to illustrate the diversity within modern Anishinawbe culture pointing out that different healing and spiritual approaches need to be used with different clients. This production is written by Michelle Derosier of Thunderstone Pictures.

Dr. Mulzer recently received the *Canadian Psychiatric Association Foundation Award* to promote this film in remote First Nation Communities.

Seeking Bimaadiziwin was conceived and coordinated by an advisory committee of First Nation's Individuals who formed the First Nation's Initiative Committee. From start to finish the production and its accompanying provider video were two years in the making. This was filmed entirely in Thunder Bay and highlights the talents of that cinematic community.

Seeking Bimaadiziwin has been internationally acclaimed and won awards including *The People's Choice Award* at the Bay Street Film Festival and the *Best Live Action Short Film* at the 32nd Annual American Indian Film Festival, San Francisco, CA. Seeking Bimaadiziwin was nominated as one of four films in the *Best Short Film* category in the Winnipeg Aboriginal Film Festival and is the Official Selection and the Heard Museum Film Festival in Phoenix Arizona. The film was also the Official Selection at the Native Revolution Film Festival in Fairbanks, Alaska and was recently selected by Kiev, Ukraine in their International Film festival Focused on Human Rights.

Noted psychiatrist and researcher appointed Head of Psychiatry at Queen's and Kingston's university hospitals

Kingston - Dr. Roumen Milev has been appointed as Head of Psychiatry at Queen's University, Hotel Dieu Hospital, Kingston General Hospital and Providence Care, effective October 1, 2007 through June 20, 2012.

As someone who is dedicated to life-long learning, Dr. Milev brings years of both clinical and teaching experience to the position. He is an accomplished psychiatrist and expert in the area of Mood Disorders, and continues to work directly with patients and clients of mental health services on a regular basis.

Dr. Milev is much sought after as a speaker at medical conferences because of his extensive knowledge in mental health, his innovative presentation skills and his international status. In addition, Dr. Milev is an established researcher, with a long list of publications and a teaching career at Queen's dating back to 2001.

Dr. Milev will continue his work as Clinical Director of the Mood Disorders Research and Treatment Service. His office as Head of the Queen's Department of Psychiatry is located at Providence Care, Mental Health Services.

Contact:
Jenn Goodwin
Communications Officer
Providence Care
613-548-5567 ext. 5668

Magic lasso in hand,
WONDER WOMAN
is a singular force to be reckoned with.

SHE'S ALSO FICTIONAL.

In the real world it takes more than one person to make big things happen. Sometimes it takes thousands. That's why it's so important that Ontario psychiatrists join the Ontario Psychiatric Association. The stronger our numbers, the better we can serve our community--and our profession--by representing our profession before government and other bodies, advocating for the mentally ill, and facilitating the exchange of scientific information. For more information on the OPA and to apply for membership, visit eopa.ca



905.827.4659

Did You Know That...

- Dr. Edward Ryan founded the OPA as the Ontario Neuro-Psychiatric Association in 1920?
- the OPA was the first psychiatric professional association in Canada?
- membership in the OPA is complimentary for Residents and longstanding members?
- you can serve on any of the five OPA committees and “make a real difference”?
- the OPA provides many avenues for collegiality?
- the most powerful resources we have are members and the strength of the “group lobby”?
- OPA members receive registration discounts and opportunities for maintenance of competence and continuing education credits at the Annual Conference and Fall Conference?
- the OPA effectively represents its members to the Canadian Psychiatric Association with seats on several Canadian Psychiatric Association Committees?
- the OPA provides joint partnership with the Ontario Medical Association Section on Psychiatry, by means of the Coalition of Ontario Psychiatrists?
- the OPA produces “*Dialogue*” a quarterly Association Newsletter that provides up-to-date information on issues affecting psychiatry and psychiatric practice?

The OPA is dedicated to excellence in psychiatric education, advocacy, representation and the advancement of public policy.

Prescribing Summary

Patient Selection Criteria

SEROQUEL XR (quetiapine) is indicated for the management of the manifestations of schizophrenia. **Geriatrics (> 65 years of age):** SEROQUEL XR is not indicated in elderly patients with dementia. **Pediatrics (< 18 years of age):** The safety and efficacy of SEROQUEL XR have not been established.

CONTRAINDICATIONS

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

Special Populations:

Pregnant Women: Patients should be advised to notify their physician if they become pregnant or intend to become pregnant during treatment with SEROQUEL XR. The safety and efficacy of SEROQUEL XR during human pregnancy have not been established. Therefore, SEROQUEL XR should only be used during pregnancy if the expected benefits justify the potential risks. **Nursing Women:** The degree to which quetiapine is excreted into human milk is unknown. Women who are breast-feeding should be advised to avoid breast-feeding while taking SEROQUEL XR. **Pediatrics (< 18 years of age):** The safety and efficacy of SEROQUEL XR have not been established. **Geriatrics (> 65 years of age):** The number of patients >65 years of age exposed to SEROQUEL XR during clinical trials was limited (n=68). Mean plasma clearance of quetiapine was reduced by 30% to 50% in elderly subjects vs. younger patients. In addition, as this population has 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 XR in the elderly patient (see DOSAGE AND ADMINISTRATION). **Use in Geriatric Patients with Dementia: Overall Mortality:** Elderly patients with dementia treated with various atypical antipsychotic drugs showed increased mortality compared to placebo. In two placebo-controlled trials with oral SEROQUEL in this population, the incidence of mortality was 5.5% for SEROQUEL-treated patients compared to 3.2% for placebo-treated patients. SEROQUEL XR is not indicated in elderly patients with dementia. **Dysphagia:** Esophageal dysmotility and aspiration have been associated with antipsychotic drug use. Aspiration pneumonia is a common cause of morbidity and mortality in elderly patients, in particular those with advanced Alzheimer's dementia. SEROQUEL XR and other antipsychotic drugs should be used cautiously in patients at risk for aspiration pneumonia.

Safety Information

WARNINGS AND PRECAUTIONS

Serious Warnings and Precautions: Increased Mortality in Elderly Patients with Dementia: Elderly patients with dementia treated with atypical antipsychotic drugs are at an increased risk of death compared to placebo. Analyses of thirteen placebo controlled trials with various atypical antipsychotics (modal duration of 10 weeks) in these patients showed a mean 1.6 fold increase in death rate in the drug-related patients. Although the causes of death were varied, most of the deaths appeared to be either cardiovascular (e.g., heart failure, sudden death) or infectious (e.g., pneumonia) in nature.

General: Body Temperature Regulation: Disruption of the body's ability to reduce core body temperature has been attributed to antipsychotic agents. Appropriate care is advised when prescribing SEROQUEL XR 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.

Acute Withdrawal Symptoms: Acute withdrawal symptoms, such as nausea, vomiting, and insomnia have very rarely been described after abrupt cessation of atypical antipsychotic drugs, including SEROQUEL XR. Gradual withdrawal is advisable. **Cardiovascular: Hypotension and Syncope:** As with other drugs that have high α_1 adrenergic receptor blocking activity, SEROQUEL XR may induce orthostatic hypotension, dizziness, and sometimes syncope, especially during the initial dose titration period. In placebo-controlled SEROQUEL XR trials, there was no difference in the adverse reaction reporting rate of syncope in patients treated with SEROQUEL XR (0.3%, 3/951) compared to patients on placebo (0.3%, 1/319). Syncope was reported in 1% (23/2371) of patients treated with SEROQUEL (quetiapine, immediate release formulation), compared with 0% (0/404) on placebo, and 0.4% (2/527) on active control drugs. SEROQUEL XR 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) (see OVERDOSAGE). **Cholesterol and Triglyceride Elevations:** In schizophrenia clinical trials, SEROQUEL XR treated patients had increases from baseline in mean cholesterol and triglycerides of 4% and 14%, respectively, compared to decreases from baseline in mean cholesterol and triglycerides of 2% and 6% for placebo treated patients. Uncommon cases of small elevations in non-fasting serum triglyceride levels and total cholesterol (predominantly LDL cholesterol) have been observed during treatment with quetiapine in several clinical trials (see ADVERSE REACTIONS). **Endocrine and Metabolism: Hyperglycemia:** As with some other antipsychotics, hyperglycemia, and diabetes mellitus (including exacerbation of pre-existing diabetes, diabetic ketoacidosis, and diabetic coma including some fatal cases) in the aggregate have been reported rarely ($>0.01\%$ - $<0.1\%$) during the use of SEROQUEL in post-marketing experience, sometimes in patients with no reported history of hyperglycemia (see ADVERSE REACTIONS, Post-Market Adverse Drug Reactions). Increases in blood glucose and hyperglycemia, and occasional reports of diabetes, have been observed in clinical trials with quetiapine (see ADVERSE REACTIONS, Abnormal Hematology and Clinical Chemistry Findings). Assessment of the relationship between atypical antipsychotic use and glucose abnormalities is complicated by the possibility of an increased background risk of diabetes mellitus in patients with schizophrenia and the increasing incidence of diabetes mellitus in the general population. Given these confounders, the relationship between atypical antipsychotic use and hyperglycemia-related adverse events is not completely understood. However, epidemiological studies suggest an increased risk of treatment-emergent hyperglycemia-related adverse events in patients treated with the atypical antipsychotics. Precise risk estimates for hyperglycemia-related adverse events in patients treated with atypical antipsychotics are not available. Any patient treated with atypical antipsychotics should be monitored for symptoms of hyperglycemia including polydipsia, polyuria, polyphagia, and weakness. Patients who develop symptoms of hyperglycemia during treatment with atypical antipsychotics should undergo fasting blood glucose testing. In some cases, hyperglycemia has resolved when the atypical antipsychotic was discontinued; however, some patients required continuation of anti-diabetic treatment despite discontinuation of the suspect drug. Patients with risk factors for diabetes mellitus (e.g., obesity, family history of diabetes) who are starting treatment with atypical antipsychotics should undergo fasting blood glucose testing at the beginning of treatment and periodically during treatment. Patients with an established diagnosis of diabetes mellitus who are started on atypical antipsychotics should be monitored regularly for worsening of glucose control. **Hyperprolactinemia:** An elevation of prolactin levels was not demonstrated in clinical trials with SEROQUEL XR as compared with placebo. Increased prolactin levels with quetiapine were observed in rat studies. As is common with compounds which stimulate prolactin release, the administration of quetiapine 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 prescription 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 trial there were no differences in prolactin levels at study completion for SEROQUEL, across the recommended dose range, and placebo. **Hypothyroidism:** In SEROQUEL XR clinical trials, 0.5% (4/806) of patients on SEROQUEL XR compared to 0% (0/262) on placebo experienced decreased free thyroxine and 2.7% (21/786) on SEROQUEL XR compared to 1.2% (3/256) on placebo experienced increased TSH; however, no patients experienced a combination of clinically significant decreased free thyroxine and increased TSH. No patients had events of hypothyroidism. In clinical trials, 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, and 7% 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 without adaptation or progression during longer term treatment. Decreases in T₄ 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 experienced persistent increases in TSH, and 0.25% of patients were treated with thyroid replacement. **Weight Gain:** In six-week placebo-controlled schizophrenia clinical trials, for patients treated with SEROQUEL XR mean weight gain was 1.77 kg (n=951) compared to 2.19 kg (n=414) in patients treated with SEROQUEL. For patients treated with placebo the mean weight gain was 0.26 kg (n=319). **Gastrointestinal: Antiemetic Effect:** Consistent with its dopamine antagonist effects, SEROQUEL XR may have an antiemetic effect. Such an effect may mask signs of toxicity due to overdose of other drugs, or may mask symptoms of disease such as brain tumor or intestinal obstruction. **Hematologic: Neutropenia:** Severe neutropenia ($<0.5 \times 10^9/L$) has been uncommonly reported in SEROQUEL clinical trials. There was no

apparent dose relationship. Possible risk factors for leukopenia and/or neutropenia include pre-existing low white cell count (WBC) and history of drug induced leukopenia and/or neutropenia. Quetiapine should be discontinued in patients with a neutrophil count $<1.0 \times 10^9/L$. These patients should be observed for signs and symptoms of infection and neutrophil counts followed (until they exceed $1.5 \times 10^9/L$). (See ADVERSE REACTIONS, Abnormal Hematologic and Clinical Chemistry Findings and Post-Market Adverse Drug Reactions).

Hepatic: Hepatic Impairment: Decreased clearance of SEROQUEL was observed in patients with mild hepatic impairment. No pharmacokinetic data are available for quetiapine in patients with moderate or severe hepatic impairment. However, should clinical judgement deem treatment with SEROQUEL XR necessary, the drug should be used with great caution in patients with moderate or severe hepatic impairment (see DOSAGE AND ADMINISTRATION).

Transaminase Elevations: Asymptomatic, transient and reversible elevations in serum transaminases (primarily ALT) associated with SEROQUEL XR have been reported. The proportions of patients with transaminase elevations of >3 times the upper limits of the normal reference range in a pool of 6-week placebo-controlled schizophrenia trials were approximately similar for both SEROQUEL XR and placebo (1%). During premarketing clinical trials, therapy with SEROQUEL was associated with elevation of hepatic transaminases, primarily ALT. Within a clinical trial database of 1892 SEROQUEL-treated schizophrenia patients, with baseline ALT levels <60 IU/L, 5.3% (101/1892) had treatment-emergent ALT elevations to >120 IU/L, 1.5% (29/1892) had elevations to >200 IU/L, and 0.2% (3/1892) had elevations to >400 IU/L. No patients had values in excess of 800 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 101 SEROQUEL-treated patients whose enzyme levels increased to >120 IU/L, 40 discontinued treatment while their ALT values were still raised. In 114 SEROQUEL-treated patients whose baseline ALT was >90 IU/L, only 1 experienced an elevation to >400 IU/L. Precautions should be exercised when using SEROQUEL XR 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 XR, 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 XR therapy.

Neurologic: Neuroleptic Malignant Syndrome (NMS): Neuroleptic Malignant Syndrome is a potentially fatal symptom complex that has been reported in association with antipsychotic drugs, including SEROQUEL XR. 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 (hemosymyolysis) 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 XR, 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): Tardive dyskinesia is a syndrome of potentially irreversible, involuntary, dyskinetic movements that 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. 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 increase. 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 XR 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 XR, drug discontinuation should be considered. However, some patients may require treatment with SEROQUEL XR despite the presence of the syndrome.

Seizures: In controlled clinical trials with SEROQUEL XR, there was no difference in the incidence of seizures in patients treated with SEROQUEL XR (0.1%, 1/951) or placebo (0.9%, 3/319). 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 (see ADVERSE REACTIONS).

Potential Effect on Cognitive and Motor Performance: Somnolence was a commonly reported adverse event in patients treated with SEROQUEL XR, especially during the initial dose titration period. Since SEROQUEL XR 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 therapy with SEROQUEL XR does not affect them adversely.

Ophthalmologic: Cataracts: The development of cataracts was observed in association with quetiapine treatment in chronic drug 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 XR 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 XR and at 6-month intervals thereafter, are recommended. If clinically significant lens changes associated with SEROQUEL XR use are observed, discontinuation of SEROQUEL XR should be considered.

Psychiatric: Suicide: The possibility of suicide or attempted suicide is inherent in schizophrenia, and thus close supervision and appropriate clinical management of high-risk patients should accompany drug therapy.

Renal: There is little experience with SEROQUEL XR in patients with renal impairment, except in a low (subclinical) single dose study with SEROQUEL. SEROQUEL XR should thus be used with caution in patients with known renal impairment, especially during the initial dosing period (see DOSAGE AND ADMINISTRATION).

ADVERSE REACTION SERIOUSNESS AND INCIDENCE

Commonly Observed Adverse Events in Short-Term Placebo-Controlled Clinical Trials: During acute therapy with SEROQUEL XR, the most commonly observed adverse events associated with the use of SEROQUEL XR (incidence of at least 5%, and an incidence at least 5% higher than that observed with placebo) were sedation, dry mouth, somnolence, and dizziness.

Adverse Events Associated with Discontinuation: In short-term, placebo-controlled trials, there was no difference in the incidence of adverse events associated with discontinuation of SEROQUEL XR (quetiapine) or placebo. Overall, 6.4% of SEROQUEL XR-treated patients discontinued treatment due to adverse events compared to 7.5% of placebo-treated patients (see SUPPLEMENTAL PRODUCT INFORMATION).

To report adverse events:
AstraZeneca Canada Inc.
Mississauga, Ontario L4Y 1N4
www.astrazeneca.ca T 1-800-433-0733 F 1-800-267-5743

DRUG INTERACTIONS

Drug-Drug Interactions: Given the primary central nervous system effects of quetiapine, SEROQUEL XR (quetiapine) should be used with caution in combination with other centrally acting drugs (see SUPPLEMENTAL PRODUCT INFORMATION).

Administration

Recommended Dose and Dosage Adjustment: SEROQUEL XR (quetiapine) should be administered once daily, generally in the evening. The daily dose of SEROQUEL XR at the start of therapy is 300 mg on Day 1, 600 mg on Day 2 and up to 800 mg after Day 2. The dose should be adjusted within the effective dose range of 400 mg to 800 mg per day, depending on the clinical response and tolerability of the patient. In a controlled clinical trial, the treatment effect size of 600 mg and 800 mg doses of SEROQUEL XR was greater than that of the 400 mg dose. The safety of doses above 800 mg/day has not been evaluated.

	Recommended Initial Dosing Schedule		
	Day 1	Day 2	After Day 2
Once daily dosing	300 mg	600 mg	Up to 800 mg

Switching patients from SEROQUEL tablets to SEROQUEL XR tablets: For more convenient dosing, patients who are currently being treated with divided doses of SEROQUEL (quetiapine, immediate release formulation) may be switched to SEROQUEL XR at the equivalent total daily dose taken once daily. Individual dosage adjustments may be necessary. The need for continuing existing EPS medications should be re-evaluated periodically as SEROQUEL XR has not been associated with treatment-emergent EPS across the clinical dose range.

Dosing Considerations



days

to a therapeutic dose

With new **SEROQUEL XR**, a therapeutic dose of **600 mg/day** can be reached by **day 2**¹ in schizophrenia. SEROQUEL XR was generally well-tolerated, with simple, once-a-day dosing for you and your patients.^{1,2}

New
 **Seroquel XR**[™]
quetiapine

SEROQUEL XR[®] is indicated for the management of the manifestations of schizophrenia.[†]

The most common adverse events in schizophrenia with incidences $\geq 5\%$ and an incidence of at least 5% higher than that observed with placebo: sedation (13%), somnolence (12%), dry mouth (12%), and dizziness (10%). Please see Product Monograph before prescribing.[†]

Increases in blood glucose and hyperglycemia, and occasional reports of diabetes have been observed in clinical trials.[†]

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.[†]

Serious Warnings and Precautions. Increased Mortality in Elderly Patients with Dementia: Elderly patients with dementia treated with atypical antipsychotic drugs are at an increased risk of death compared to placebo. Analyses of thirteen placebo-controlled trials with various atypical antipsychotics (modal duration of 10 weeks) in these patients showed a mean 1.6-fold increase in death rate in the drug-related patients. Although the causes of death were varied, most of the deaths appeared to be either cardiovascular (e.g., heart failure, sudden death) or infectious (e.g., pneumonia) in nature.[†]

[†] See Product Monograph for complete dosing recommendations.

1. Kahn RS et al. Efficacy and Tolerability of Once-Daily Extended Release Quetiapine Fumarate in Acute Schizophrenia: A Randomized, Double-Blind, Placebo-Controlled Study. *J Clin Psychiatry* 2007;68:6:832-42.
2. SEROQUEL XR[®] (quetiapine fumarate extended-release tablets) Product Monograph, AstraZeneca Canada Inc. October 22, 2007.

AstraZeneca 

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