DIALOGUE
ONTARIO PSYCHIATRIC ASSOCIATION

FEBRUARY 2009

President's Message

Dr. K. Sonu Gaind

This issue of *Dialogue* is the last one you will receive prior to the February 2009 OPA Annual General Meeting, and as such it marks my last time writing you as OPA President. It has been a very busy year, and I have been honoured to have had the chance to serve our Association with such a strong Council. I would like to thank all Council members for their ongoing dedication to the OPA, and especially to thank committee chairs Dr. Varinder Dua (Communications), Dr. Deborah Elliott (Advocacy, Finance), Dr. Anne Hennessey (Member Services), and Dr. Paul Mulzer (Continuing Education), and our section heads Dr. Doron Almagor (Psychotherapy), Dr. Patricia Cavanagh (ACT), Dr. Andrew Howlett (Resident), and Dr. Vinay Lodha (Geriatric).

Looking ahead to the coming year, the OPA is fortunate to be able to anticipate the steady leadership of Dr. Paul Mulzer, our incoming President. I am confident Paul and OPA Council will continue to build on the important work OPA is doing for psychiatrists and mental health issues across the province. At the same time, the coming year will mark the first year in many that Council will not have the benefit of Past President Dr. Richard O'Reilly's sage advice. Dick has been a reliable source of guidance for me, and I wish him well as he steps down from Council.

The coming year will also see another significant change at the OPA. The OPA is having a transition in association management firms, a change that has been in process over the past few months and will be completed by the time you receive this mailing. June Hylands, Sheryl Keenan and Zelda Musselman at J. Hylands and Associates have worked closely with OPA Council for several years, and we wish them well with all their future endeavours. OPA Council carefully worked through the process of evaluating several different management options, and I would like to thank Council and especially Dr. Doron Almagor in working with me to evaluate these options and facilitate a smooth transition process. We worked hard to ensure we remained within our usual budget in making this transition, and I am pleased there has been no increase in member dues for 2009.

It is an important time in our association's ongoing evolution. While any major transition can come with some 'growing pains', we were impressed by the professionalism and initiative demonstrated by our new management firm, BB&C Management Services, and I believe our association is well poised to continue to improve services to members and be an increasingly important voice for psychiatry in Ontario. I would like to formally welcome our new Association Manager, Halyna Troian, to the OPA, and hope you all get a chance to meet her at the upcoming Annual Conference.

As you likely know, OPA was busy on many fronts this year, and many of these initiatives continue. The Psychotherapy Section planned a successful Fall conference with speaker Dr. Bruce Fink, and the Education Committee is putting the 'finishing touches' on what promises to be an excellent Annual Conference in Toronto at the end of February. We undertook a collaborative project with the Canadian Medical Protective Association to jointly develop training sessions to assist physicians preparing for Review Boards. The OPA Advocacy Committee will continue to work on a position paper focusing on privacy issues and the unique sensitivity of patient psychiatric records, which we aim to have ready for members by the spring. On the political advocacy front, we unfortunately still have not seen a resolution to the disparities contained in the Family Health Team (FHT) model. However, the increased pressure over this issue, and psychiatry's unwillingness to allow such ongoing disparities to remain unchallenged, has already led to tangible benefits in negotiations, as evidenced by the precedent setting focus on relativity corrections in the latest OMA-MOHLTC Agreement.

A word on this year's presidential theme, *"Folie Adieux: Moving Beyond Stigmatization of Psychiatry"*. It was good to see the theme of institutionalized stigma gaining traction, not just across the province but across the country. There is increasing awareness that problems with stigma are not just about attitude, but lead to discriminatory policies that we must have a role in changing. I was pleased to hear that the Canadian Psychiatric Association (CPA) Board recently approved a Position Statement on Parity in Time-Based Models that had been drafted by the CPA Standing Committee on Economics. The CPA will communicate

continued on page 6

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Contents

From the Editor

WELCOME to our first 2009 issue of *Dialogue*!

On behalf of BB&C Management Services, I would like to take this opportunity to thank Dr. K. Sonu Gaind and OPA Council for the opportunity to work with the Association and its members. We are conscious of the important role that our staff have assumed in the management of OPA activities and look forward to working with all of you taking a team approach to moving the Association forward.

Appreciation is extended to Dr. K.S. Gaind, Dr. P. Mulzer, Dr. D. Almagor and other Executive and Council members, as well as to J. Hylands and her colleagues, for their support during the transition period. This was immensely helpful!

As we set priorities for the months to come, we realize that every downturn — being economic, political or personal — also presents us with new opportunities. During these challenging times we especially appreciate the opportunity to share mutual issues with our colleagues and peers, and benefit from their support and expert advice. That's why it is so important to remain active in your association. The OPA 89th Conference taking place on February 27 and 28, 2009, is an excellent opportunity to keep on top of recent developments in your field as it is a great source of professional information, networking possibilities and advice. I encourage you to review the Conference section of the newsletter for the most recent updates on the Conference Program. Please make a note of the OPA AGM on Friday, February 27, 2009, and if you are not able to attend do not forget to submit your proxy form.

In this issue you will find an Economic Update prepared by Dr. K. Sonu Gaind on recent developments related to the OMA-MOHLTC Agreement, and Family Health Teams. There are also updates on various OPA Committees and Sections activities, as well as a book review prepared by Dr. R. O'Reilly on the 2nd Edition of Canadian Mental Health Law and Policy.

We welcome your feedback regarding *Dialogue* and OPA activities in general. Please do not hesitate to contact me at the OPA office.

I look forward to meeting many of you at the OPA 89th Conference!

Halyna Troian, CAE
Editor

Economic Update

OMA-MOHLTC AGREEMENT

Since the publication of the last issue of the OPA *Dialogue* the OMA-MOHLTC Agreement has been ratified. Psychiatry voted strongly in favour of the Agreement, with 95% of psychiatrists who voted voting to accept the agreement (compared to 79% of overall voter support from OMA members). Psychiatry also had one of the highest overall response rates, with 54% of eligible psychiatrists voting compared to 34% of eligible physicians. The attention to addressing relativity disparities was no doubt a large factor in psychiatrist's positive response. Since ratification of the Agreement, the Medical Services Payment Committee has informed the OMA Section on Psychiatry that psychiatry's allocation increase for October 1, 2009, should be 9.5%, plus or minus 0.1%. The Section anticipates that the significant majority of this increase will be applied broadly to all psychiatric fees.

FAMILY HEALTH TEAMS

Family Health Teams (FHTs) were not addressed in the recently ratified OMA-MOHLTC Agreement, and the disparities between psychiatric/paediatric/geriatric and internal medicine sessional rates remain. As we have worked on this issue with the Coalition of Ontario Psychiatrists and the OMA Section on Psychiatry, we have found a range of problems in some FHTs aside from the fee disparities already noted. These include: (1) Q codes still not implemented; (2) psychiatrists being told by the Ministry that FHT time is not for direct patient care, but only for indirect services, which is counter to the entire intent of the comprehensive care model being sought; (3) FHT psychiatrists being asked to see patients not rostered in the FHT (reflecting 'cherry picking', where patients with difficult problems requiring more medical attention are kept on fee-for-service, but the FHT psychiatrist is expected to provide services during FHT sessional time); (4) psychiatrists not receiving the promised 10% shadow billing; (5) FHT patients being refused urgent/emergent care and follow-up, being directed back to the FHT psychiatrist for service instead; (6) psychiatrists not getting full funding for time spent, taking unwanted time off/vacation because of inadequate funding; and (7) lack of integration of psychiatric and medical care with the rest of the FHT team.

The Section has engaged the help of OMA legal services in trying to resolve these problems. If you are an FHT psychiatrist and are having these or other problems in your FHT, please contact me at *psych@rogers.com* to follow-up.

SETTING FEES

I was recently asked a question about setting rates when dealing with local agencies. A local agency was offering a psychiatrist $125 per hour for his services. How does this compare to "the going rates"?

There are several ways to calculate an hourly rate. If based on existing sessional rates, the recent agreement includes a sessional rate of $459 for 3 to 4 hours, effective April 1, 2009. The 3 to 4 hour range reflects the fact that sessional arrangements vary across the province. For 4 hours of service this comes out to $114.75 per hour, for 3 hours of service it works out to $153 per hour. Based on this, if you wish to base a rate on current sessional rates I would advise any psychiatrist negotiating a rate independently to seek a *bare minimum* of $153 per hour based on the fact that there are ministry funded sessionals paying $459 for 3 hours (and remember travel time is also remunerated at the sessional rate in the agreement).

There are other ways to calculate a rational and supported hourly rate. The current individual psychiatric care outpatient time-based K-code, K198, remunerates at $65.65 per unit, with each unit requiring a minimum of 20 minutes [group and family therapy rates are of course higher]. Based on three 20 minute units per hour, this comes out to $196.95 per hour (actually 3% higher with the current 'top-up') if you are basing your rate on current OHIP rates for insured services. If you are providing uninsured services, then you have a rationale to use the K198 fee in the OMA Schedule of Fees (SOF) rather than OHIP rates. In the OMA SOF K198 is listed as $133.36, and the same calculation of three 20 minute units yields $400.08 per hour.

In my experience, most psychiatrists significantly undercharge for their services. If you are basing your rate on current insured service rates, based on existing sessional and OHIP rates a rate of at least $150 to $200 per hour is easily supported. When providing uninsured services you have significant leeway in determining your rate, and even if you do not go as high as the $400 per hour calculation above you should know there is a readily defensible rational for charging such a rate (which may make it easier even if you are negotiating a rate lower than $400/hour).

If you have any questions on setting fees or any other billing matters, I would be happy to address them during the "Optimizing Billings for Psychiatrists" workshop on Saturday, February 28 during the upcoming OPA Annual Conference, or you can reach me at *psych@rogers.com*.

K. Sonu Gaind
Tariff Chair, OMA Section on Psychiatry

Resident Update

The OPA recognizes that Psychiatry Residents play a critical role in expanding and improving the OPA network. As your Resident Representatives, our input has been invited in many aspects of the OPA functioning. This speaks volumes to the importance that the OPA places on members-in-training.

All residents are invited to become members-in-training of the OPA throughout their residency with a no-charge registration fee. This offers immediate rewards including quarterly updates via *Dialogue*, online resources and services at *www.eopa.ca*, no-fee access to the annual conference in Toronto (held in February 2009) and the privilege to vote as an OPA member at the Annual General Meeting (February 2009). Last year's conference was a great success offering education on a broad range of topics from cutting edge research in psychotherapy to billing advice for residents. The conference serves as one of the only venues to meet other psychiatrists and psychiatry residents from across the province. As residents, this offers a fantastic opportunity for developing mentorship or educational opportunities. This year members-in-training will receive a complimentary ticket to the annual OPA Dinner, where the *TA Sweet Award* will be presented (this year's award winner is author Robert Munsch).

Perhaps one of the most exciting aspects of being involved in the OPA is the opportunity to be involved in the political arena as advocates for not only psychiatrists in the province but also for patients and organizations interested in mental health. We have both been involved in the OPA since February 2008. In our best attempt, we have provided a resident's perspective on relevant issues and engaged in liaising between residents and the OPA. We have also been actively involved in providing feedback to various committees responsible for organizing the conference and providing membership benefits. In this current time of transition, leaders in the OPA are ensuring that the organization provides a high standard of service to its members. We both hope to provide the OPA with feedback which reflects residents from all programs. We are eager to hear any of your ideas or concerns, so please do not hesitate to contact us at any time (*nadiaaleem@hotmail.com* and *alhowlett@gmail.com*).

It has been our experience that the OPA is actively interested in maintaining a network of psychiatrists that represents all stages of training and all types of practices. Getting involved early helps shape the future of psychiatry in Ontario in a way that offers the optimal practice environment for both ourselves and our patients. We look forward to serving as your Resident Representatives throughout 2009 and hope to see you at the conference on **February 27-28** at the King Edward Hotel in Toronto. Members-in-training application and conference registration forms can be found at *www.eopa.ca*.

Nadia Aleem, MD
PGY-4
Schulich School of Medicine
London, ON

Andrew Howlett, MD
PGY-2
Univeristy of Toronto
Toronto, ON

OPA Archival Project Update

A presentation at the Annual Meeting was an early summary of the Archives held at the OPA Offices and gave a better impression to the membership about the value of these old documents and artifacts. There is a lot of wonderful historic material there and so far we have only scratched the surface. We are still clearing a sizeable backlog and will soon be asking members and others who may have old OPA material stored away to donate it to the project. There will be some redundancy of course but that is better than losing valuable material.

We are asking OPA members who are interested in serving on an Archival Advisory Committee to contact us. This will help us to move ahead with this important project.

Appreciation is extended to those who have already offered their support. We invite others who may be interested in assisting in cataloguing and preserving the material to advise the OPA office.

John Deadman
Archivist

Communications Update

Dr. Varinder Dua is stepping down as Communications Committee chair, a role she has diligently served for several years. In the coming year, the Communications Committee plans on building on the work Dr. Dua and the Committee have done and updating the look and functionality of the OPA website. You will also see ongoing improvements in the OPA *Dialogue*. We would be happy to hear feedback from you regarding changes or suggested improvements as we proceed with these initiatives. Please e-mail *opa@bellnet.ca* to provide your comments.

K. Sonu Gaind
Interim Chair, OPA Communications Committee

Psychotherapy Section Update

I'm pleased to report that the Psychotherapy Section's Annual Fall Conference of last November 1st was once again a great success. The University of Toronto Faculty Club was sold out as Dr. Bruce Fink led the audience on a stimulating tour of Lacanian clinical theory. Dr. Fink has done much to popularize Lacanian theory in North America by showing how a complicated theory can be applied to real world practice and achieve good outcomes. Conference participants' feedback included comments like "Dr. Fink was clear and engaging" and "it was a very helpful presentation in how to use Lacan's ideas with my patients."

For 2009, the Section is delighted to announce that we will be hosting Dr. Nancy McWilliams on September 26, 2009. Dr. McWilliams' books are employed as standard curriculum in psychotherapy teaching programs and have been international bestsellers. She is a renowned speaker, known for her engaging and dynamic style. We expect a record turnout for this event. Look for details in upcoming issues of *Dialogue* on how to book early and reserve your spot at what's sure to be an exciting and educational day.

I would also like to take this opportunity to announce that I will be stepping down as Section Chair at our upcoming AGM in order to take on the broader interests of our profession as President-Elect of the OPA. It's been an honour representing the members of our Section. At this time I would like to welcome Dr. Tina Chadda, who has been elected to council and will become the new Section Chair. Dr. Chadda has been a very active member of our Section and I know she will do an excellent job on OPA Council and in organizing the future Fall Conferences!

Dr. Doron Almagor

Dr. Bruce Fink at the podium, University of Toronto Faculty Club.

Mark Your Calendars!

OPA Psychotherapy Section's
2009 Fall Conference
Saturday, September 26, 2009

Guest Speaker –
Dr. Nancy McWilliams, Ph.D.

Book Review

CANADIAN MENTAL HEALTH LAW AND POLICY, 2nd Edition, 2008
by John E. Gray, Margaret A. Shone and Peter F. Liddle
LexisNexis, Markham, ISBN 978-0-433-4447-3, 490 pages

In his foreword to the first edition of *Canadian Mental Health Law and Policy*, in 2000, Dr. Alan Eppel, then OPA President wrote: "This book marks a crucial point in the evolution of thinking in Canadian mental health law. If the voices of these authors are heeded, this will have been a striking blow for the life and liberty of those imprisoned by mental illness". The *2nd Edition* of this book, published in June, 2008, details the changes in legislation in Canada during the last 8 years, many of which are in accordance with the recommendations made in the first edition of the book. The book also addresses issues arising from recent court cases, changes in clinical practice and areas of heightened concern such as mental health courts, homelessness and early intervention.

The authors of *Canadian Mental Health Law and Policy, 2nd Edition* address the issues with a balance of experience and expertise. Dr. John Gray was a psychologist and mental health administrator, has developed mental health legislation for two provinces, was on the Board of Saskatchewan CMHA and is past president of the Schizophrenia Society of Canada. Ms. Margaret Shone is a lawyer who worked for the Alberta Law Reform Institute, and had a primary role in drafting a report on Alberta mental health legislation. Dr. Peter Liddle was the first Professor of Schizophrenia at the University of British Columbia. Now at Nottingham University, U.K. he is a world expert on brain functioning in psychosis and, as a clinician, runs a first episode psychosis service. This is a highly credible team for the task.

Canadian Mental Health Law and Policy, 2nd Edition explains the need for, and development of, mental health acts and other similar laws, how these differ between Canadian jurisdictions and makes recommendations on each major provision. These recommendations are based on "human needs principles" and experience in Canadian and foreign jurisdictions. The significant changes in mental health acts since 2000 in Nova Scotia, Newfoundland and Labrador and Alberta, are described and assessed. These changes include a broadening of the committal criteria to cover serious harms — not just physical danger — and the addition of a "likelihood of significant deterioration" committal criterion. Community treatment orders, rights advice for patients and their families, and mechanisms for dealing with treatment refusal by involuntary patients are additional new topics.

The *2nd Edition* addresses research studies and experience with these laws in the last 8 years including the community treatment orders that were part of Ontario's 2000 reforms. The international evidence on the effectiveness of community treatment disorders is examined. The authors also analyze Ontario's Starson case which was eventually adjudicated by the Supreme Court of Canada. The authors show that the Ontario, Mental Health Act and Health Care Consent Act were responsible for denying Mr. Starson his health and freedom for over 7 years.

The *2nd Edition* expands the chapter on Psychiatric Treatment and the Criminal Justice System to examine mental health courts.

I found *Canadian Mental Health Law and Policy, 2nd Edition* easy to read. It is free from jargon, uses "non-legal" language, makes effective use of fictional and real cases to illustrate points and is logically structured. The table of contents, index, and appendices greatly assist in finding topics.

At $150 the book is expensive but comparable to other books of similar quality. Given the potentially broad readership psychiatrists may want to approach their local hospital librarian and ask that the library acquire a copy. For more information or purchase, e-mail *jegray@shaw.ca* or *www.lexisnexis.ca/bookstore*.

Richard O'Reilly

President's Message

continued from page 1

more details about this directly, but the statement clearly links the issues of psychiatric fees, patient care and stigma, and reflects the sort of positions organized psychiatry must start to take to reverse embedded institutionalized stigma and discrimination against our patients.

Finally, I would like to thank all of you, our OPA members, for your continued support of your Association. This past year we once again saw a significant increase in membership, which both strengthens our Association and reflects recognition of the increasingly relevant role the OPA is playing in mental health issues in Ontario. Welcome to all new members, and a special welcome to our new resident members as you start a relationship with your Association that will last a professional lifetime.

Once again, thank you for the opportunity to have served as your president. I look forward to continuing to work with OPA Council over the next year as Past President, and hope to see you all at the OPA Conference and Gala in February in Toronto!

K. Sonu Gaind, MD, FRCP(C)
President, Ontario Psychiatric Association

OPA 89th Conference Update

I had a recent opportunity to stay at Le Méridien King Edward Hotel and the room, the great rate of $185/night, and a terrific menu delighted me. I visited the conference venues and I think you will be pleased by this wonderful setting for the OPA's 89th Conference. The open foyer and well-situated sitting areas should foster socializing, good fun and collegiality. I think if you miss the dinner and dance that would be a great shame. This glamorous ballroom has witnessed countless thousands of swirling partners and great music for more than a century. I have it on reliable authority that Dr. Dick O'Reilly will inspire us with his dancing skills. You may even end up in one of our candid photos.

Dr. Gaind's Presidential Theme on institutionalized stigma, *"Folie Adieux: Moving Beyond Stigmatization of Psychiatry"* is well-represented in our program. Our hope is the theme of destigmatization will encourage discussion on how we can individually and collectively overcome barriers to access and foster legitimacy for the suffering of our patients. For those who don't know my passion, let me assure you that I'm deeply committed to overcoming institutional barriers that marginalize the mentally ill. We have a very impressive list of speakers and a 'value added' CME. I look forward to your attendance and hope to have an opportunity to discuss your opinions on the future direction of our provincial organization. I think this is a very important time in the evolution of our Association and on behalf of our Council let me again express our commitment to continue to be a relevant and critical voice for enhanced mental health and improved quality of care for patients in Ontario.

Dr. Paul Mulzer
Continuing Education Committee Chair

Ontario Psychiatric Association would like to acknowledge and thank the following sponsors and exhibitors (status as of February 11, 2009) for their support of the OPA 89th Conference.

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ONTARIO PSYCHIATRIC ASSOCIATION

Included in your Member/Member Resident registration: Complimentary continental breakfast, luncheon symposium, morning and afternoon coffee breaks each day. One complimentary ticket to the OPA Dinner/Dance. Included in your Non-Member registration: Complimentary continental breakfast, luncheon symposium, morning and afternoon coffee breaks each day. Tickets to the OPA Dinner/Dance are available at an additional $95.00. (25% of content devoted to interactive discussion.)

Le MERIDIEN	Kensington	Knightsbridge
FRIDAY		
8:00 - 8:45	Registration & Continental Breakfast – *Vanity Fair Foyer*	
8:45 - 9:00		
9:00 -10:00		
10:00 - 11:30	***Practice Management: Effective OHIP Billing*** - Dr. Vinay Lodha	***When Stigma is Institutionalized*** - Dr. Sonu Gaind
11:30 - 12:00		**OHA Videotape – *Mental Health and Stigma***
12:00 - 1:30	**Lunch / OPA AGM** – *Vanity Fair Ballroom*	
1:30 - 2:30	***Strategies for an Effective CCB Presentation*** - Dr. G. Chaimowitz, Dr. D. Bell & Ms. L. Stewart	***Capacity and Care Issues Facing the Elderly in Nursing Homes*** - Dr. Anne Hennessy & Dr. Michelle Tremblay
2:30 - 3:00	Networking Break – *Vanity Fair Foyer* – Please Visit the Exhibitors!	
3:00 - 4:00	***Poster Presentations and Judging for the*** **Ann Thomas Award**	***The Disruptive Physician: Strategies to Manage Unacceptable Behaviour*** - Dr. Joy Albuquerque
4:00 - 5:00	**LHINS and MCSS *Networks and the Transformation Process*** - Dr. Deborah Elliott & Dr. Sarah Jarmain	***The Impaired Physician: Treating Physicians in Distress*** - Dr. Joy Alburquerque
6:00 - 6:30	Pre-dinner Cocktails – *Lobby Lounge*	
6:30	**OPA Annual Dinner Dance: *Investiture of 2009 President, Dr. Paul Mulzer / T. A. Sweet Award Presentation***	
SATURDAY		
8:00 - 8:45	Registration & Continental Breakfast – *Vanity Fair Foyer*	
8:45 - 10:00		
10:00 - 12:00	***Why is my patient refractory to treatment? Revisiting Mood Disorders and Addictions*** - Dr. Paul Mulzer	***Mind and Medication in Depression*** - Dr. Barry Gilbert
12:00 - 1:30	Lunch / Mr. Glenn Thompson – The Mental Health Commission – *Vanity Fair Ballroom*	
1:30 - 2:30	***Antidepressant Treatment During Pregnancy and Postpartum: Serious Concerns or Much Ado About Little*** - Dr. Meir Steiner	***Any Holes in Your Financial Safety Net?*** - John Vachon - Peter Papamichalopoulos
2:30 - 3:00	Networking Break – *Vanity Fair Foyer* – Please Visit the Exhibitors!	
3:00 - 4:00	***Mini-Retreat for Women Psychiatrists*** - Dr. Anne Hennessy & Dr. Susan Abbey	**Archival Project of the OPA: *A History of Psychiatric Care in Ontario*** - Dr. John Deadman
4:00 - 5:00		
6:00	**Conclusion of Conference**	

This event is an accredited group learning activity (section 1) as defined by the Maintenance of Certification Program of the Royal College of Physicia

89th Annual Conference

February 27 & 28, 2009

Vanity Fair Ballroom	Belgravia	Windsor A&B
		OMA Section on Psychiatry Meeting
Welcoming Remarks from OPA President and Conference Chair(s)		
Plenary: The Mental Health Challenges Associated with Military Operations - Brigadier General Hilary Jaeger		
Prevention of Suicide The AGHPS presents the results of a 2 year project: *Suicide Vignettes* - Dr. Brian Hoffman; *Police, the Emergency Department and the Suicidal Patient* - Dr. David Gotlib; *Moderator* - Dr. Gerry McNestry	***Collaborative Psychiatric Care: The Role of the Nurse Practitioner in Psychiatric Practice*** - Ms. Vivian Johnston ***Military Service and Incarceration*** - Dr. Isabelle Cote	***Obsessive Compulsive Disorder*** - Dr. Randi McCabe
Jane Chamberlin *Lecture and Award* ***Clinical Updates from the Literature*** - Dr. Paul Links	***The Neglected Addiction: Smoking Cessation*** - Dr. Paul Mulzer	***Psychodynamic Psychotherapy of Psychotic Disorders*** - Dr. Doron Almagor & Dr. Clive Thomson
Sharing Tebwewin: Advocating for Culturally Safe Mental Health Care for Aboriginal Peoples - Dr. Cornelia Wieman ***Mental Health and Racism*** - Dr. Kwane McKenzie	***Psychiatric Rehabilitation: An Introduction*** - Dr. Abraham Rudnick	***Cognitive Behavioural Therapy for GAD*** - Dr. Randi McCabe
to Mr. Robert Munsch – *Sovereign Ballroom*		
Plenary: Politics and Mental Health of Victims - Dr. Janice Stein		
Clinical Pearls In GP Psychotherapy and Psychiatry	***Psychoanalytic Couples Therapy: Theory and Technique*** - Dr. Sarah Usher	***Optimizing Billing for Psychiatrists: Best Practices and Common Pitfalls*** - Dr. Sonu Gaind
Clinical Pearls In GP Psychotherapy and Psychiatry *(Continued)*	***Borderline Personality Disorder: The Good News Story!*** - Dr. Steve Webb	***Fibromyalgia and Mood Disorder*** - Dr. Susan Abbey
UNDERSTAND THIS! Clinical Moments in Video: Teaching the Basics of Empathic Understanding - Dr. Alan Kindler	***E-doctoring: A Demonstration*** (The Computerized Office) - Dr. Darryl Vance	***Movement Disorders in Psychiatry*** - Dr. Mandar Jog

Notice of Bylaw Change

As you were informed in the previous issue of OPA *Dialogue*, OPA Council is proposing a bylaw change for the quorum requirements for Annual General and General Meetings of the Association. The bylaws currently set quorum at 10% of members, as follows: "Quorum shall be 10% of Members at the beginning of the meeting and the meeting may continue even though member leaving may reduce the number to less than quorum."

As the Association has continued to grow, this 10% quorum requirement has become increasingly onerous. You may recall that last year the February meeting failed to achieve quorum and we had to arrange a special meeting with voting done by mail ballots. The Council has reviewed this issue and proposes a bylaw change to decrease quorum to a fixed size rather than a percentage of Members. Specifically Council is proposing quorum be changed to 33 (thirty three), which is double the number of Council members plus one. This ensures that decisions made at future OPA Annual General and General Meetings require support from both Council and non-Council Members, since Council alone would not have a majority.

The following bylaw is proposed to replace the current one: **"Quorum shall be 33 (thirty-three) Members at the beginning of the meeting [based on two times the maximum number of Council positions plus one]. The meeting may continue even though members leaving may reduce the number to less than quorum."**

Please note that the current quorum requirement of 10% will still need to be met to open this year's Annual General Meeting (AGM), which will be held on Friday, **February 27**. If you are not planning on attending the AGM (and even if you are unable to attend the conference at all), please ensure you have forwarded a Proxy to the OPA offices to help us make quorum (use or photocopy the proxy form printed below).

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 27, 2009, 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

PROXY

I, _____
(Please print your name)
will be unable to attend the February 27, 2009, 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 _____

Please submit the completed proxy form to the OPA office by Wednesday, February 25, 2009, by mail (2233 Argentia Road, Suite 100, Mississauga, ON L5N 2X7), fax (905-826-4873) or e-mail *opa@bellnet.ca*.

The Annual General Meeting (AGM) of the Ontario Psychiatric Association will be held at 12:00 noon on Friday, February 27, 2009, at Le Méridien King Edward (Vanity Fair Ballroom), 37 King Street East, Toronto.

Member's Corner

PONY TAIL ENVY –
Psychiatrists Dr. Sean O'Riordan (Credit Valley), Dr. Varinder Dua (London) and Dr. Denis O'Flanagan (Strathroy) share a laugh and compare grooming tips.

MDAO Hope Award

Dr. Emmanuel Persad, Psychiatry Site Co-ordinator at Markham-Stouffville Hospital, is this year's recipient of the *Mood Disorders Association of Ontario (MDAO) Hope Award*. The MDAO Hope Award is awarded annually to a health care professional or scientist who uses their expertise to develop new solutions or treatment approaches that bring hope to those who suffer from mood disorders. Congratulations, Dr. Persad!

OMA Elections

Dr. K.S. Gaind, outgoing OPA president, is running for a position on the Ontario Medical Association (OMA) Board of Directors in the upcoming OMA District 11 [Toronto] elections. District 11 has five Board positions, one of these five positions is up for election this year. Specialist voting turnout is typically quite low, and all five District 11 Board positions have been held by family physicians for many years. District 11 members are encouraged to vote, the voting deadline is 2:00 pm **February 25**. To obtain a ballot please contact Nicole Scott at (416) 599-2580, ext. 3303, or by email at *nicole_scott@oma.org*.

Doing Anything Interesting…?

Do you have an item of interest you would like to share with your colleagues? Are you a shutterbug with photos of psychiatrists in dynamic (psychotherapeutically speaking, of course) situations? The OPA would like to give our members a glimpse of what other psychiatrists around the province are doing. If you have a photo, story, or other information that your colleagues might be interested in, please forward it to the OPA offices at *opa@bellnet.ca*.

Once Daily

Seroquel XR

quetiapine

Prescribing Summary

Patient Selection Criteria

SEROQUEL XR (quetiapine fumarate extended-release) is indicated for the management of the manifestations of schizophrenia, as monotherapy for the acute management of manic episodes associated with bipolar disorder and as monotherapy for the acute management of depressive episodes associated with bipolar I and bipolar II disorder. *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 fumarate extended-release) 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 breastfeeding should be advised to avoid breastfeeding 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=63). 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 ADMINISTRATION). Use in Geriatric Patients with Dementia: Overall Mortality: Elderly patients with dementia treated with atypical antipsychotic drugs showed increased mortality compared to placebo in a meta-analysis of 13 controlled trials of various atypical antipsychotic drugs. 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 (mostly duration of 10 weeks) in these patients showed a mean 1.6 fold increase in death rate in the drug-treated 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 (quetiapine fumarate extended-release) 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 (discontinuation) Symptoms:* Acute discontinuation symptoms such as, insomnia, nausea, headache, diarrhea, vomiting, dizziness and irritability, have been described after abrupt cessation of antipsychotic drugs including SEROQUEL XR. Gradual withdrawal over a period of at least one to two weeks is advisable. Symptoms usually resolved after 1 week post-discontinuation. *Cardiovascular: Hypotension and Syncope:* As with other drugs that have high α1-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 little difference in the adverse reaction reporting rate of syncope in patients treated with SEROQUEL XR (0.3%, 4/1239) compared to patients on placebo (0.3%, 2/619). Syncope was reported in 1% (35/4083) of patients treated with SEROQUEL (quetiapine, immediate release formulation), compared with 0.3% (3/1006) 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. In a 3-week bipolar mania clinical trial, SEROQUEL XR treated patients had increases from baseline in mean cholesterol and triglycerides of 2% and 20%, respectively, compared to decreases in mean cholesterol and triglycerides of 2% and 5% for placebo-treated patients. In a bipolar depression clinical trial, SEROQUEL XR treated patients had increases from baseline in mean cholesterol and increases from baseline in mean triglycerides of 2% and 11%, respectively compared to decreases in mean cholesterol and triglycerides of 3% and 2% for placebo-treated patients. Very common (≥10%) cases of elevations in serum triglyceride levels (>2.258 mmol/L on at least one occasion) and elevations in total cholesterol (predominantly LDL cholesterol) (≥6.2064 mmol/L on at least one occasion) have been observed during treatment with quetiapine in clinical trials (see ADVERSE REACTIONS). Lipid increases should be managed as clinically appropriate. Endocrine and *Metabolic: Hyperglycaemia:* As with some other antipsychotics, hyperglycaemia, 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 hyperglycaemia (see ADVERSE REACTIONS, Post-Market Adverse Drug Reactions). Increases in blood glucose and hyperglycaemia, and occasional reports of diabetes, have been observed in clinical trials with quetiapine (see ADVERSE REACTIONS, Abnormal Hematologic 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 hyperglycaemia-related adverse events is not completely understood. However, epidemiological studies suggest an increased risk of treatment-emergent hyperglycaemia-related adverse events in patients treated with the atypical antipsychotics. Precise risk estimates for hyperglycaemia-related adverse events in patients treated with atypical antipsychotics are not available. Any patient treated with atypical antipsychotics should be monitored for symptoms of hyperglycaemia including polydipsia, polyuria, polyphagia, and weakness. Patients who develop symptoms of hyperglycaemia during treatment with atypical antipsychotics should undergo fasting blood glucose testing. In some cases, hyperglycaemia 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. *Hyperprolactinaemia:* An elevation of prolactin levels was not demonstrated in schizophrenia clinical trials with SEROQUEL XR as compared with placebo. In bipolar disorder clinical trials with SEROQUEL XR, elevation in prolactin levels occurred in 2.4% (7/288) of patients treated with SEROQUEL XR compared to 0.7% (2/300) of patients treated 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 tumourigenesis. 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 schizophrenic 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% (4/805) 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 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 experienced persistent increases in TSH, and 0.25% of patients were treated with thyroid replacement. *Weight Gain:* In 6-week placebo-controlled schizophrenic 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). In a 3-week placebo-controlled bipolar mania clinical trial, for patients treated with SEROQUEL XR mean weight gain was 1.3 kg (n=151) compared to 0.1 kg (n=160) in patients treated with placebo. In an 8-week placebo-controlled bipolar depression clinical trial, for patients treated with SEROQUEL XR mean weight gain was 1.3 kg (n=137) compared to -0.2 kg (n=140) in patients treated with placebo. *Gastrointestinal: Anticholinergic Effect:* Consistent with its dopamine antagonist effects, SEROQUEL XR may have an anticholinergic effect. Such an effect may mask signs of toxicity due to overdosage of other drugs or may mask symptoms of disease such as brain tumour or intestinal obstruction. *Hematologic: Neutropenia:* Severe neutropenia (<0.5 x 10⁹/L) has been uncommonly reported in quetiapine clinical trials. There was no apparent dose relationship. Possible risk factors for leucopenia and/or neutropenia include pre-existing low white cell count (WBC) and history of drug induced leucopenia and/or neutropenia. SEROQUEL XR should be discontinued in patients with a neutrophil count <1.0 x 10⁹/L. These patients should be observed for signs and symptoms of infection and neutrophil counts followed (until they exceed 1.5 x 10⁹/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 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 placebo-controlled trials ranged between 1% and 2% for SEROQUEL XR compared to 2% for placebo.

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 schizophrenic 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 (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 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) and Extrapyramidal Symptoms (EPS):*** 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. In short-term placebo-controlled clinical trials in schizophrenia and bipolar mania, the aggregated incidence of EPS-related adverse events was similar to placebo (schizophrenia: 7.8% for quetiapine and 8.0% for placebo; bipolar mania: 11.2% for quetiapine and 11.4% for placebo). In short-term placebo-controlled clinical trials in bipolar depression, the aggregated incidence of EPS-related adverse events was 8.9% for quetiapine compared to 3.8% for placebo. The incidence of individual EPS-related adverse events (e.g., akathisia, extrapyramidal disorder, tremor, dyskinesia, dystonia, restlessness, muscle contractions involuntary, psychomotor hyperactivity and muscle rigidity), however was generally low and did not exceed 4% for any individual adverse event. In long-term studies of schizophrenia and bipolar disorder the aggregated exposure adjusted incidence of treatment-emergent EPS was similar between quetiapine and placebo. 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%, 1/1259) or placebo (0.5%, 3/619). Nonetheless, 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 very 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 dog studies at 4 times the recommended lowest 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 exams) 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 bipolar disorder, and thus close supervision and appropriate clinical management of high-risk patients should accompany drug therapy. In a bipolar mania clinical trial, the incidence of treatment emergent suicidal ideation or suicidal behavior, as measured by the Columbia Analysis of Suicidal Behaviour, was 1.3% for SEROQUEL XR treated patients and 3.8% for placebo-treated patients. In a bipolar depression clinical trial, the incidence of treatment emergent suicidal ideation or suicidal behaviour, as measured by the Columbia Analysis of Suicidal Behaviour, was 0.7% for SEROQUEL XR treated patients and 1.4% for placebo-treated patients. **Renal:** There is little experience with SEROQUEL XR in patients with renal impairment, except in a few (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 ADMINISTRATION).

ADVERSE REACTIONS

Commonly Observed Adverse Events in Short-Term Placebo-Controlled Clinical Trials: ***Schizophrenia:*** 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. ***Bipolar Disorder: Bipolar Mania:*** 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, constipation, dizziness, weight gain and dysarthria. ***Bipolar Depression:*** 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 dry mouth, somnolence, sedation, increased appetite, weight gain and dyspepsia. **Adverse Events Associated with Discontinuation in Short-Term Placebo-Controlled Clinical Trials:** ***Schizophrenia:*** In short-term, placebo-controlled schizophrenic trials, there was no difference in the incidence of adverse events associated with discontinuation of SEROQUEL XR or placebo. Overall, 6.4% of SEROQUEL XR-treated patients discontinued treatment due to adverse events compared to 7.5% of placebo-treated patients. ***Bipolar Disorder: Bipolar Mania:*** In a 3-week placebo-controlled bipolar mania trial, 4.6% of patients on SEROQUEL XR discontinued due to adverse events compared to 8.1% on placebo. ***Bipolar Depression:*** In an 8-week placebo-controlled bipolar depression trial, 13.1% of patients on SEROQUEL XR discontinued due to adverse events compared to 3.6% on placebo. Sedation (6.6%) and somnolence (3.6%) were the most common adverse events leading to discontinuation in the SEROQUEL XR treatment group (see SUPPLEMENTAL PRODUCT INFORMATION).

To report adverse events:
AstraZeneca Canada Inc.
Mississauga, Ontario L4Y 1M4
www.astrazeneca.ca T 1-800-433-0783 F 1-800-267-5743

DRUG INTERACTIONS

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

8 Administration

SEROQUEL XR (quetiapine fumarate extended-release) tablets should be swallowed whole and not split, chewed, or crushed. SEROQUEL XR can be administered with or without food. SEROQUEL XR should be administered once daily, generally in the evening. **Schizophrenia:** **Usual Dose:** The titration rate, based on the clinical trials, is shown in the table below.

	Day 1	Day 2	After Day 2
Once daily dosing	300 mg	600 mg	Up to 800 mg

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. In schizophrenia, 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 XR has not been associated with treatment-emergent EPS across the clinical dose range. **Bipolar Disorder: Bipolar Mania:** **Usual Dose:** The titration rate, based on the clinical trial is shown in the table below.

	Day 1	Day 2	After Day 2
Once daily dosing	300 mg	600 mg	Up to 800 mg

The dose should be adjusted within the effective dose range of 400 mg to 800 mg/day, depending on the clinical response and tolerability of the patient. In bipolar mania, the safety of doses of above 800 mg/day has not been evaluated. **Bipolar Disorder: Bipolar Depression:** **Usual Dose:** The titration rate, based on the clinical trial is shown in the table below.

	Day 1	Day 2	Day 3	Day 4 and thereafter
Once daily dosing	50 mg	100 mg	200 mg	300 mg

The usual target dose is 300 mg/day. The dose may be further increased depending on the response and tolerability of the patient. The maximum dose is 600 mg/day. In SEROQUEL clinical trials antidepressant efficacy was demonstrated with SEROQUEL at both 300 mg/day and 600 mg/day, however no additional benefit was seen in the 600 mg group during short-term treatment. In bipolar depression, the safety of doses of quetiapine above 600 mg/day has not been evaluated. **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. Dosing Considerations in Special Populations: *Elderly:* As with other antipsychotics, SEROQUEL XR should be used with caution in the elderly, especially during the initial dosing period. The rate of dose titration of SEROQUEL XR may need to be slower, and the daily therapeutic target dose lower, than that used in younger patients. Elderly patients should be started on the lowest available dose (i.e., 50 mg/day) of SEROQUEL XR. The dose can be increased in increments of 50 mg/day to an effective dose, depending on the clinical response and tolerance of the individual patient. *Hepatic Impairment:* Quetiapine is extensively metabolized by the liver. Therefore, SEROQUEL XR 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 the lowest available dose (i.e., 50 mg/day) of SEROQUEL XR. The dose should be increased daily in increments of 50 mg/day to an effective dose, depending on the clinical response and tolerance of the individual patient (see WARNINGS AND PRECAUTIONS, Hepatic). *Renal Impairment:* As clinical experience is lacking, caution is advised (see WARNINGS AND PRECAUTIONS, Renal). *Missed Dose:* SEROQUEL XR should be taken at the same time each day. If a previous days dose has been missed, administration should be resumed the next day at the normal administration time. Dosage Forms and Packaging: SEROQUEL XR (quetiapine fumarate extended-release) is available as film-coated tablets containing quetiapine fumarate equivalent to 50 mg, 200 mg, 300 mg or 400 mg of quetiapine free base as follows: 50 mg quetiapine tablets are peach coloured, capsule-shaped, biconvex, imprinted with "XR 50" on one side and plain on the other, available in high density polyethylene (HDPE) bottles of 60 tablets. 200 mg quetiapine tablets are yellow, capsule-shaped, biconvex, imprinted with "XR 200" on one side and plain on the other, available in HDPE bottles of 60 tablets. 300 mg quetiapine tablets are pale yellow, capsule-shaped, biconvex, imprinted with "XR 300" on one side and plain on the other, available in HDPE bottles of 60 tablets. 400 mg quetiapine tablets are white, capsule-shaped, biconvex, imprinted with "XR 400" on one side and plain on the other, available in HDPE bottles of 60 tablets.

SUPPLEMENTAL PRODUCT INFORMATION

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. *Clinical Trial Adverse Drug Reactions:* 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 stated 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 nondrug factors to the side effect incidences in the population studied. The information below is derived from a clinical trial database for SEROQUEL XR (quetiapine fumarate extended-release) consisting of 1329 patients exposed to SEROQUEL XR for the treatment of schizophrenia, bipolar mania and bipolar depression, in short-term placebo-controlled trials. The experience corresponds to approximately 82.9 patient-years.

Table 1 Adverse Events Reported for at Least 1% of SEROQUEL XR-Treated Subjects (Doses Ranging From 150G to 800G mg/day) and for a Higher Percentage of SEROQUEL XR-Treated Subjects than Subjects Who Received Placebo in Short-Term, Placebo-Controlled Schizophrenia Phase III Trials

Body system and MedDRA Term*	Percentage of subjects with adverse events*	
	SEROQUEL XR (n=457)	Placebo (n=319)
Whole body		
Fatigue	3	2
Anxiety	2	1
Irritability	1	0
Pyrexia	1	0
Nervous system		
Sedation	12	7
Somnolence	12	4
Dizziness	10	4
Tremor	2	1
Restlessness	2	1
Gastrointestinal system		
Dry mouth	12	1
Constipation	6	5
Dyspepsia	5	2
Cardiovascular system		
Orthostatic hypotension	7	5
Hypotension	3	1
Tachycardia	3	1
Heart rate increased	4	1
Metabolic and nutritional disorders		
Increased appetite	2	0
Special senses		
Vision blurred	2	1

* Events for which SEROQUEL XR incidence was equal to or less than placebo are not listed in the table, but included the following: headache, insomnia, and nausea.
† Patients with multiple events falling under the same preferred term are counted only once in that term.

Table 2 Adverse Events Reported for at Least 1% of SEROQUEL XR-Treated Subjects (Doses Ranging From 300G to 800G mg/day) and for a Higher Percentage of SEROQUEL XR-Treated Subjects than Subjects Who Received Placebo in a Short-Term (3-Week), Placebo-Controlled Bipolar Mania Phase III Trial

Body system and MedDRA Term*	Percentage of subjects with adverse events*	
	SEROQUEL XR (n=510)	Placebo (n=160)
General disorders and administration site conditions		
Fatigue	7	4
Contusion	1	0
Pain	1	0
Nervous system disorders		
Sedation	34	8
Somnolence	17	4
Dizziness	10	4
Dysarthria	5	0
Lethargy	2	1
Sluggishness	2	1
Dizziness postural	1	0
Gastrointestinal disorders		
Dry mouth	24	7
Constipation	10	3
Dyspepsia	7	4
Toothache	3	1
Cardiovascular disorders		
Heart rate increased	3	0
Orthostatic hypotension	3	0
Tachycardia	2	1
Metabolic and nutritional disorders		
Weight increased	7	1
Increased appetite	4	2
Musculoskeletal and connective tissue disorders		
Back pain	3	2
Arthralgia	1	0
Psychiatric disorders		
Abnormal dreams	3	0
Bipolar I disorder	1	0
Respiratory disorders		
Nasal congestion	5	1
Dry throat	1	0
Special senses		
Vision blurred	2	1

* Events for which SEROQUEL XR incidence was equal to or less than placebo are not listed in the table.
† Patients reports percentages rounded to the nearest integer.
‡ Patients with multiple events falling under the same preferred term are counted only once in that term.

Table 3 Adverse Events Reported for at Least 1% of SEROQUEL XR-Treated Subjects (Doses of 300G mg/Day) and for a Higher Percentage of SEROQUEL XR-Treated Subjects than Subjects Who Received Placebo in a Short-Term (3-Week), Placebo-Controlled Bipolar Depression Phase III Trial

Body system and MedDRA Term*	Percentage of subjects with adverse events*	
	SEROQUEL XR (n=157)	Placebo (n=140)
General disorders		
Fatigue	6	2
Irritability	4	3
Anxiety	2	1
Nervous system disorders		
Somnolence	29	6
Sedation	25	7
Dizziness	13	11
Paraesthesia	3	2
Dysarthria	2	0
Disturbance in attention	2	1
Hypersomnia	1	0
Akathisia	1	0
Akinesia	1	0
Gastrointestinal disorders		
Dry mouth	37	7
Constipation	8	4
Dyspepsia	7	1
Toothache	3	0
Cardiovascular disorders		
Heart rate increased	1	0
Infection and infestations		
Cystourethritis viral	4	1
Urinary tract infection	2	0
Metabolic and nutritional disorders		
Increased appetite	12	6
Weight increased	7	1
Decreased appetite	2	1
Musculoskeletal and connective tissue disorders		
Arthralgia	4	1
Back pain	3	1
Muscle spasms	3	1
Neck pain	1	0

Body system and MedDRA term[b]	Percentage of subjects with adverse events[a]	
	SEROQUEL XR (n=137)	Placebo (n=140)
Psychiatric disorders		
Abnormal dreams	3	0
Confusional state	1	0
Disorientation	1	0
Skin and subcutaneous tissue disorders		
Hyperhidrosis	2	1

[a] Events for which SEROQUEL XR incidence was equal to or less than placebo are not listed in the table. Table reports percentage rounded to the nearest integer.
[b] Patients with multiple events falling under the same preferred term are counted only once in that term.

Other Adverse Events: [illegible]

DRUG INTERACTIONS

[illegible]

OVERDOSAGE

[illegible]

Product Monograph is available upon request from AstraZeneca Canada Inc.

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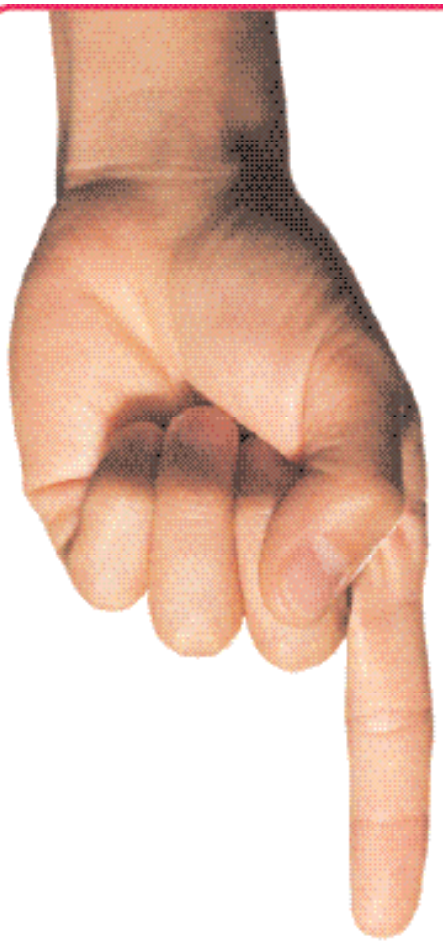

For The Ups

SEROQUEL XR®: The first treatment in Canada for both poles of bipolar disorder

For The Downs

Now you can treat bipolar mania and bipolar depression with SEROQUEL XR.* Once-a-day. And SEROQUEL XR was generally well-tolerated in clinical studies including outpatients.[1-4]

So, when it comes to treating your patients, whether they're up or down, there's SEROQUEL XR.

(Discontinuation rates due to adverse events for SEROQUEL XR vs. placebo: bipolar mania 4.6% vs. 8.1%; bipolar depression 13.1% vs. 3.6%)

SEROQUEL XR® is indicated for the management of the manifestations of schizophrenia, as monotherapy for the acute management of manic episodes associated with bipolar disorder, and as monotherapy for the acute management of depressive episodes associated with bipolar I and bipolar II disorder.[1]

The most common adverse events with incidences ≥5% and an incidence at least 5% higher than that observed with placebo: in schizophrenia – sedation (13%), somnolence (12%), dry mouth (12%), and dizziness (10%); in bipolar mania – sedation (34%), dry mouth (34%), somnolence (17%), constipation (10%), dizziness (10%), weight gain (7%), and dysarthria (5%); in bipolar depression – dry mouth (37%), somnolence (29%), sedation (23%), increased appetite (12%), dyspepsia (7%), and weight gain (7%). Please see Product Monograph before prescribing.[1]

Increases in blood glucose and hyperglycemia, and occasional reports of diabetes have been observed in clinical trials.[1]

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.[1]

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.[1]

* Comparative clinical significance is unknown.

– 3-week placebo-controlled trial in bipolar patients with manic or mixed episodes with or without psychotic features; n=309 (patients receiving at least 1 dose with at least 1 post-baseline YMRS assessment). SEROQUEL XR was given at a dose of 300 mg on Day 1 and at 600 mg on Day 2. From Day 3 to Day 21, SEROQUEL XR was given in flexible doses of 400 to 800 mg.

§ 8-week multicenter, randomized, double-blind, parallel group, placebo-controlled study; n=250 outpatients with bipolar I and II disorder, with or without a rapid cycling course; dosages of 300 mg or placebo were administered.

1. SEROQUEL XR® (quetiapine fumarate extended-release tablets) Product Monograph, AstraZeneca Canada Inc. August 18, 2008.

AstraZeneca

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Once Daily Seroquel XR® quetiapine

See prescribing summary on page