

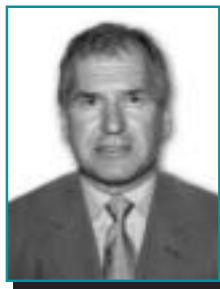


Ontario Psychiatric Association

DIALOGUE

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

JUNE
2003



MESSAGE FROM THE PRESIDENT

One of the objectives of the Ontario Psychiatric Association is "to represent the members in their relationships with governments at all levels, universities, other medical associations and other associations".

The OPA does this in many ways and through various means. Much of our advocacy work, particularly in the areas of government relations and economics, is done through the Coalition of Ontario Psychiatrists, which is a formal association of the OPA and the Section on Psychiatry of the Ontario Medical Association (OMA). The Coalition provides a stronger advocacy voice than either organization can present alone.

As the OPA representative to the OMA Section on Psychiatry, as well as a member of the Coalition, by virtue of my position as OPA President, along with the Past President and President Elect of the OPA (currently Dr. Margaret Steele and Dr. Doug Wilkins, respectively), I have had the opportunity to experience, first-hand, what the Coalition has been doing this past year. The Coalition has, in fact, been very successful in advocating for fair and reasonable remuneration of psychiatric services to the OMA and the Ministry of Health and Long-term Care. The Coalition has also been busy negotiating an increase in sessional fees, and, has been instrumental in getting the OMA to adopt the recommendations of its Central Tariff Committee, which included increases to some of the psychiatric codes.

The Coalition solicits a fee because it needs funds to finance the considerable work that is needed to properly represent psychiatry in the economic forum. For example, Dr Doug Weir and Dr. Sonu Gaind spent a great deal of time and energy arguing psychiatry's position before the RBRVS Committee. Coalition funding enabled them to prepare materials that were necessary to substantiate psychiatry's case that the OMA Section on Psychiatry would not have been able to do with the limited OMA funds that were available. I urge you to continue supporting the Coalition, in addition to your membership in the Ontario Psychiatric Association, because the Coalition funds necessary work and because the Coalition is successful at what it does. While the RBRVS process ultimately failed to correct the fee for service relativity problems, the Coalition continues to advocate for this issue to be addressed. I think that the RBRVS Commission lost credibility when it failed the common sense test. An example of that was its recommendation that GP psychotherapy should be remunerated more than psychotherapy delivered by a psychiatrist. This may have made sense according to their formula, but it made no sense to have the

specialist paid less than the generalist for the same service. Right now many hospital-based psychiatrists have to deal with SARS and the effect it has had on providing care and services to patients. Psychiatrists who have their offices in hospital are severely restricted in their ability to see patients. Although the Ministry approved some temporary codes for telephone services this was not done until mid May and most of the restricted access was in April. Thus, most psychiatrists are limited in being able to take advantage of these codes.

The OPA Council and the Executive of the OMA Section on Psychiatry have planned a retreat in June to map the strategic direction of the Coalition for the coming years. If you have suggestions please get in touch with me, or a Council member, so that your views can be heard.

Have an enjoyable summer.

Robert Buckingham, MD, FRCPC
2003 OPA President

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IN SEPTEMBER 2003
• In the September issue – Consent to Treatment, Mental Health and Aging, Dialogue Survey Results, Highlights from CIHI's First Annual Report on Hospital Mental Health Services



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Executive and Council**



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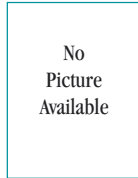
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Dialogue is published March, June, Sept. & December each year by the Ontario Psychiatric Association and is sent to all OPA members. Deadline for contributions is the 15th of the previous month.

Publisher: Adrian Hynes **Editor:** Elizabeth Leach
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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.*

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From THE EDITOR

Mental health is receiving more attention than in the past. I expect future issues will carry even more information about the changes in the mental health system in Ontario and the subsequent changes that will be made by various organizations. Future issues of *Dialogue* will focus on these changes and let you know about them.

This issue features a number of legal articles on a variety of topics that will be of interest to you – records management, assisting sexually abused patients to determine when they should consult with a lawyer, and recent decisions regarding regulatory process issues.

There are updates on some topics that have been covered in the past – tariff issues and recent fee increases, the disability tax credit, as well as information about the current and future activities of the CPA. A special article on the Kirby Commission from the CPA is also included.

The Guest Column in this issue describes the activities of a self-help organization that is branching out – the Mood Disorders Association – and where they are heading in the future. The Resident Column features an interview with an OPA member who participated with the Scientific Advisory Committee to the Global Business and Economic Roundtable on Addiction and Mental Health in preparing the recently published background paper entitled “Mental Health and Substance Use at Work: perspectives from research and implications for leaders”.

The review of “Beyond Crazy” is included so that you can decide whether or not you would like to read it for yourself.

The annual readership survey is included in this issue. Please take a few minutes to fill this out and return. The survey is also being sent by email to those members who have given us email addresses and we hope that this will continue to increase the number of responses. We will share the results of the survey with you in the September issue.

Dialogue depends on hearing from you as to what is happening throughout the province. Are there new programs or websites that you know of? Let us help you share your experiences with your colleagues.

Do you have other topics that you would like covered in *Dialogue*? Are there other resources or websites that you have heard about that you could share with colleagues? Are there legal issues that you think should be explored? What else do you want to know about?

Your comments, suggestions and contributions are always welcome.

Elizabeth Leach
Editor

CALENDAR OF EVENTS



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

Ontario Psychiatric Association 2003 Council Meetings

Toronto – Friday, June 20; Friday, September 5; Friday, November 14, 2003; Space is limited, please contact Lorraine Taylor, OPA Executive Assistant, for locations or further details; (905) 827-4659, email: opa@bellnet.ca

Harvard Medical School 14th Annual Summer Seminars

June 16 – 20, 2003

Sonesta Beach Resort, Bermuda

A) Treating Complex Forms of Posttraumatic Stress Disorder: An Overview and Update B) Update on Neuroscience: Clinical Relevance of Recent Finding: 2003 C) Psychopharmacology in the Trenches: Comprehensive Review of Pharmaceuticals and Natural Therapies.

Contact information: Jean-Marie Flynn, 617-629-9427

email: jean-marie_flynn@hms.harvard.edu

20th Annual Cape Cod Summer Symposia

June 16 – August 22, 2003

The 20th Annual Cape Cod Summer Symposia provides mental health professionals with an outstanding opportunity to combine a stimulating symposium with a relaxing summer vacation. Distinguished faculty, many of whom are leaders in their fields, will present 30 different week-long symposia during the ten weeks of summer from June 16 through August 22. Each symposium will convene at the Sheraton, Four Points Hotel, Eastham, 9:00 a.m. – 12:15 p.m., Monday through Friday.

Contact information: New England Educational Institute, 92 Elm Street, Pittsfield, MA, 01201, Phone: 413-499-1489, fax: 413-499-6584, website: www.neei.org, email: educate@neei.org

Centre for Addiction and Mental Health 5th Anniversary Celebration Events

June 19 - 5th Anniversary Annual General Meeting at the Queen Street site
June 25 - 5th Anniversary Workman Theatre Project Being Scene Art Show, Queen Street site

August 24 - 10th Annual Don River Run, a 5 or 10 km walk or run at the Brentcliffe Road (Donwood) site

September 21 - CAMHfest, a big 5th anniversary afternoon celebration at the Queen Street site

November 12 – 16 – Rendezvous with Madness Film Festival

Contact information: CAMH, Queen Street Site, 1001 Queen St. West, Toronto, Ontario

M6J 1H4, (416) 535-8501 ext. 6076 Website: www.camh.net

4th National Shared Care Conference

June 21 & 22, 2003 – Halifax, N.S.

This is the first time the National Shared Mental Health Care Conference will be held in Atlantic Canada. Invited speakers from Canada and overseas will examine relationships between primary care, specialist mental health services, community services, consumers and carers. Our focus this year will be on services for marginalised groups and the programme will include visits to local services. Contact information: Donna Fraser, #508, 5651 Ogilvie St., Halifax, NS, B3H 1B9, email: dfraser@sprint.ca, Fax: 902-425-5884, website: www.shared-care.ca

Brief Therapy 4 Day Summer Intensive Micro-Skill Development

June 23 – 27, 2003

Further develop your clinical skill, increase your theoretical knowledge, and have fun doing it in this interactive advanced training experience.

Contact information: The Hincks-Dellcrest Centre, 114 Maitland Street, Toronto,

Ontario, M4Y 1E1, tel: 416-972-1935 ex. 3341, Fax: 416-924-9808
email: enerlich@hincksdellcrest.org

Applied Suicide Intervention Skills Training Workshop (ASIST)

June 26-27, 2003

Woodstock, ON

Contact information: Canadian Mental Health Association, Oxford County Branch, phone: (519) 539-8055, fax: (519) 539-8317, email: branch@cmhaoxford.on.ca

Partnerships for Recovery: Confronting the Mental Health Crisis in our Communities

June 28 – July 1, 2003 – Minneapolis, MN

Organized by the National Alliance for the Mentally Ill (NAMI), This year's symposium will explore the importance of quality mental healthcare services for American Indians and other Native Americans, as well as provide opportunities for American Indian community members and NAMI members to join together to address the most pressing mental healthcare concerns of American Indian family members and consumers.

Contact information: National Alliance for the Mentally Ill, Colonial Place Three, 2107 Wilson Blvd., Suite 300, Arlington, VA 22201 Phone: 703-524-7600; NAMI HelpLine: 1-800-950-NAMI [6264]; TDD: 703-516-7227 or 888-344-6264
website: www.nami.org

Institute on Addiction Studies - Personal Focus for Professional Development

July 6 - 10, 2003

Alcohol and Drug Concerns Inc., Barrie, Ontario

This is a 5-day accredited conference and targets Addiction Workers, First Nations Support Workers, Employee Assistance Providers, Social Workers, Educators, Medical and Health Care Professionals, Clergy and Spiritual Counsellors, Problem Gambling Prevention Workers, Emergency Response Workers and Corrections Workers. In interactive workshops and seminars, delegates learn the most current information on alcohol and drug prevention, treatment and aftercare from North America's leading specialists. The Institute also provides self-care opportunities for delegates and speakers.

Contact Information: Kari Sutoski, Phone: 416-293-3400

email: k.sutoski@concerns.ca

Website: www.concerns.ca/ioas_2003.htm

Harvard Medical School 14th Annual Summer Seminars

July 7 – 11, 2003

Cape Cod Seminars, Ocean Edge Resort and Golf Club, Brewster, MA

A) Mind/Body Medicine, Spirituality: The Breakout Principle B) Enhancement of Peak Performance in Sports, the Performing Arts and the Worksite C) Treating Eating Disorders: An Integrative Approach

Contact information: Jean-Marie Flynn, 617-629-9427

email: jean-marie_flynn@hms.harvard.edu

Admission, Discharge and Assessment Tool (ADAT) Training

July 7 – September 14, 2003

Organized by the Centre for Addiction and Mental Health
This is an online course that will help you to learn to use Ontario's standardized package of assessment tools for clients with substance use problems and to link the assessment results to the Admission and Discharge Criteria.

Contact information: http://www.camh.net/ets/online_learning/index.html

Registration: <http://info.camh.net/register/courses/html>

7th Annual McMaster Muskoka Seminars

July 14 – August 15, 2003

The McMaster Muskoka Seminars are designed to provide clinicians (family doctors, psychiatrists, mental health professionals) with an outstanding opportunity to combine a stimulating symposium with a relaxing summer vacation. This series of seminars is hosted by the Faculty of Health Sciences, Department of Psychiatry, McMaster University, in conjunction with St. Joseph's Healthcare, Hamilton. We utilize two wonderful resorts in Ontario's vacationland, Blue Mountain Resort (Collingwood) and Muskoka Sands (Gravenhurst). The week-long seminars run Monday to Friday, 9:00 a.m. to 12:15 p.m. through July and August. Most seminars employ the Problem Based Learning/Small Group Model pioneered at McMaster and adopted by medical schools internationally. Group size will be limited to facilitate collegial interaction. Courses include: Updates in Psychotic Disorders; Mood Disorders through the Lifespan; Practical Geriatric Psychiatry; Neuropsychiatry; Psychopharmacology; CBT; IPT; Interviewing and Formulation; Consent & Capacity; Risk Assessment and two Psychiatric Updates for Family Physicians. Contact information: www.mcmastermuskokacme.com

Building Community Supports – Canadian Mental Health Association, National Conference

July 18 – 21, 2003 – Yellowknife, NWT

The Conference will run from July 18, 2003 to July 21, 2003 and will consist of 12 workshops over a two day period with a key note address on Friday morning by Stephen Lewis. The mental health of children has been identified by many of the NWT communities as a major concern, and to this end Mr. Lewis' address, and the theme of the workshops will be directed towards achieving an understanding that will begin a process that will hopefully lead to a proactive mental health policy for all our youngsters throughout the territories.

Contact information: CMHA Northwest Territories Division, PO Box 2580, Ste. 204 5102-50th Ave. (Courier only), Yellowknife, NT X1A 2P9, Tel: (867) 873-3190 Fax: (867) 873-4930, Manager: Mike Mann Email: cmha@yk.com

The Unconscious in Cognitive Neuroscience and Psychoanalysis

July 25 - 28, 2003 – Toronto

The program consists of an 'Optional Educational Day' providing introductory information; a 'Congress' where recent findings will be presented in a systemic, integrated programme of interdisciplinary papers by leading authorities in discussion with the audience; and an 'Optional Research Day'. Information about submissions for the Optional Research Day may be obtained from Dr. Oliver Turnbull, o.turnbull@bangor.ac.uk For Congress information: Paula.Barkay@neuro-psychoanalysis.org

Harvard Medical School 14th Annual Summer Seminars

July 28 – August 1, 2003

Cape Cod Seminars, Sea Crest Oceanfront Resort & Conference Centre, Old Silver Beach, North Falmouth, MA

A) The Practice of Grief Counseling: From Uncomplicated Grief to Complicated Grief to the Aftermath of Terror B) Diagnosis and Treatment of Difficult Couples: A Relational Approach C) Agents of Therapeutic Change: The Clinician's Guide to Psychotherapeutic Intervention

Contact information: Jean-Marie Flynn, 617-629-9427, email: jean-marie_flynn@hms.harvard.edu

International Psychoanalytic Association 43rd Congress – “Working at the Frontiers”

July 29 – August 2, 2003

The 5-day conference will be multi-disciplinary in approach and include contributions on topics such as psychoanalytic education, neuroscience, psychiatry, art, literature and philosophy as well as core psychoanalytic areas.

Opening address by Prof. Antonio Damasio “The Neurobiology of Feeling”

Contact information: Phone: +44 20 8446 8324. Fax: +44 20 8446 7527. E-mail: congress@ipa.org.uk

Harvard Medical School 14th Annual Summer Seminars

August 4 – 8, 2003

Cape Cod Seminars, Sea Crest Oceanfront Resort & Conference Centre, Old Silver Beach, North Falmouth, MA

A) Contemporary Psychodynamic Psychotherapy: From Theory to Clinical Practice B) The Treatment of Special Traumatized Populations C) Essential

Psychopharmacology, 2003: Practice and Update

Contact information: Jean-Marie Flynn, 617-629-9427, email: jean-marie_flynn@hms.harvard.edu

Harvard Medical School 14th Annual Summer Seminars

August 11 – 15, 2003

Cape Cod Seminars, Sea Crest Oceanfront Resort & Conference Centre, Old Silver Beach, North Falmouth, MA

A) The Body is Part of the Mind: Psychoanalytic Theory and Technique Meet Neurobiologic Reality or “Bodywork With Words” B) Cognitive-Behavioural Therapy and Dialectical Behaviour Therapy C) Psychotherapy for Difficult Patients: Applying Multiple Interacting Psychotherapies in Different Phases of Treatment

Contact information: Jean-Marie Flynn, 617-629-9427, email: jean-marie_flynn@hms.harvard.edu

International Psychogeriatric Association 11th Congress. Enhancing the Human Connection in the Age of New Technologies: Implications & Opportunities for the Aging

August 17 - 22, 2003 – Chicago.

Contact information: 1 847 784-1701; fax: 1 847 784-1705; e-mail, chicago2003@ipa-on-line.org; website, www.ipa-online.org

Harvard Medical School 14th Annual Summer Seminars

August 25 – 29, 2003

Martha's Vineyard, Harbor View Resort & Conference Center

A) Psychopharmacology Across the Life Cycle: From Paediatrics to Geriatrics B) The Psychology of Investing in 2003: A Survival guide C) Psychodynamic/Systemic Couple Therapy Contact information: Jean-Marie Flynn, 617-629-9427

email: jean-marie_flynn@hms.harvard.edu

New Two Year Training Program in Psychotherapy.

September 2003

The Institute for the Advancement of Self Psychology is offering a two year clinically oriented training program in psychoanalytic psychotherapy. The program will consist of weekly seminars and case supervision. Some experience of personal psychoanalytic psychotherapy is expected of candidates.

Contact information: Rosemary Adams 416 690-3722

email: rosemary.adams@sympatico.ca

Brief Therapy with Families, Couples and Individuals

September 2003 – June 2004

Brief and Narrative Therapy Extern Program

(Level 1) A Year-Long Intensive Training Program Advanced Brief & Narrative Therapy Extern Program (Level 2) An Advanced Level Year-Long Training and research Project These two intensive brief therapy extern programs offer a comprehensive training experience in the latest, up-to-date theory and practice of brief therapies in supportive and encouraging learning environments.

Contact information: The Hincks-Dellcrest Centre, 114 Maitland Street, Toronto, Ontario, M4Y 1E1, tel: 416-972-1935 ex. 3341, Fax: 416-924-9808

email: enerlich@hincksdellcrest.org

Royal College of Physicians and Surgeons Annual Conference on Achieving Quality Health Care through Education, Professional Development and Research

September 11-13, 2003

Halifax, Nova Scotia. Changes in Health Care: Charting a New Course.

The three-day conference comprises plenary sessions, interactive workshops, symposia, named lectures, research paper presentations, poster competitions, training sessions, business meetings, Convocation and Awards ceremony, and networking activities. The program is designed for health care professionals providing services, undertaking research and administering programs in residency education, faculty development and continuing professional development; mentoring young clinician investigators and students of history of medicine; and those who have an interest in promoting quality specialty health care and professionalism. Contact information: <http://rcpsc.medical.org/english/meetings/>

The Science and Business of Occupational Medicine: Practical Approaches to Fundamental Issues- 21st Annual Scientific Conference and General Meeting of The Occupational and Environmental Medical Association of Canada (OEMAC)

September 21 - 23, 2003 – Toronto Hilton Hotel

Hosted by The Section on Occupational and Environmental Medicine of the Ontario Medical Association.

Workplace Psychiatry is featured at the OEMAC 21st annual conference in Toronto. This is a unique opportunity to learn from leading psychiatrists about the practical assessment and accommodation of mental disability, mental health and productivity, and how to appropriately evaluate the risk of workplace violence.

Psychiatric presentations include: Mental Health and the Workplace - Productivity Drain or Productivity Weapon, Dr. Sam Ozerskey, Consulting Psychiatrist, UHN and Founder, Medra Health Care, Dr. Ronald J. Walsh, Occupational Medicine Consultant, Proctor and Gamble Inc.; Mental Illness, Psychiatric Disabilities and Workplace Accommodation, Dr. Brian Hoffman, Chief of Psychiatry, NYGH; Workplace Violence Risk Assessment: Organizational Variables and Individual Differences, Dr. Philip Klassen, Director, Workplace Violence Risk Assessment Clinic, CAMH, Dr. Roohi Qureshi, Chief Resident in Occupational Medicine, U of T. The Science and Business of Occupational Medicine: Practical Approaches to Fundamental Issues is the theme for main presentations focused on workplace accommodations in relation to pregnancy, cardiac events, diabetes, multiple sclerosis and epilepsy, and sessions on the disability paradigm in daily practice, fitness to drive, SARS and a variety of other topics and practical pre-conference workshops. Contact information: www.oemac.org

Making Gains: Research, Recovery and Renewal in Mental Health and Addictions
September 28 to October 1, 2003

Hilton Niagara Falls Hotel, Niagara Falls, Ontario
CMHA Ontario Division, CAMH, OFCMHAP, ADRAO
Four of the leading organizations in mental health, addictions and substance abuse in Ontario are hosting a major conference to talk about the newest developments in mental health and addictions.
Conference streams will focus on the following topics: Recovery, Dual Diagnosis, Organizational Strategies in Times of Change, Evidence Based Practices in Mental Health and Addictions, Concurrent Disorders and Addictions.
Contact Information: Rachel Gillooly, Phone: 7054548107, Fax: 7054549792
website: www.ontario.cmha.ca

Association for Academic Psychiatry 2003 Annual Meeting
Best Evidence Medical Education: How Well Does Psychiatry Measure Up?
October 1 – 4, 2003

Courtyard Marriott Hotel Philadelphia, PA
As evidence-based medicine is sweeping the country, educators have increasingly been asking themselves, "What evidence can I provide that the curriculum/assessment technique/teaching methodology that I use is successful?" We in psychiatric education are beginning to look into these issues as well. The conference promises to provide participants with lots of useful information, from designing and conducting effective research into psychiatric medical education, getting such medical education proposal funded and published, to some of the timely results on the forefront of psychiatric medical education done by our members. Obviously a can't miss meeting for all psychiatric educators.
Contact information: Debra Klamen, M.D. - Program Chair
dklamen@psych.uic.edu, 1601 W. Taylor, M/C 912, Room 508, Chicago, IL 60612, Phone: 312-996-6219, Fax: 312-996-7658

Mental Illness Awareness Week (MIAW)
October 5 – 11, 2003

The theme is Mental Illness and the Family. "Family" encompasses the nuclear and extended family, the family of health professionals, friends, schools, community, government and other support networks. Awareness activities can take any point of view ranging from the mental health consumer to that of the child, parent, sibling, relative, friend, health care professional and community that are impacted by the fear, denial and stigma that often accompanies mental illness.

MIAW, first launched by the Canadian Psychiatric Association (CPA) in 1992, aims to destigmatize mental illness by providing information on mental illnesses and their treatments as well as promoting public discussion and informed decision-making about mental illness issues. The CPA will provide support in the form of a guidebook for activity planning, generic newspaper articles and press releases, and posters. This year a bookmark has been developed as a leave behind item, and an e-postcard to federal and provincial members of parliament replaces the mail-in postcard. Print materials will be available in early June. For updates and campaign support materials call CPA at (613) 234-2815 or check out the CPA website at <http://www.cpa-apc.org/MIAW/MIAW.asp>

Together Against Stigma, Second International Congress

October 8 – 11, 2003 – Kingston, Ontario
The theme for the congress will be "Stigma Across the Life Span" in order to highlight special problems faced by children and youth, and the elderly. The congress will be hosted on behalf of the World Psychiatric Association's Open the Doors global program to fight stigma and discrimination because of schizophrenia. Contact information: Ms. Debbie Ball, Department of Psychiatry, Rm 546, Brock 5, Hotel Dieu Hospital, 166 Brock Street, Kingston, Ontario, K7L 5G2, tel: (613) 544-3400 ext. 2519, fax: (613) 547-1501, email: balld@hdh.kari.net website: <http://meds.queensu.ca/medicine/psychiatry/locate.htm>

World Mental Health Day

October 10, 2003
World Mental Health Day is an initiative of the World Federation for Mental Health (WFMH) and is co-sponsored by the World Health Organization. WMHD takes place on 10 October each year, and within Australia WMHD coincides with National Mental Health Week. The World Mental Health Day theme set by the WFMH for 2002 and 2003 is The Effects of Trauma and Violence on Children. Promotional material for WMHD, including posters, postcards, bookmarks, stickers and fact-sheets are available from the Mental Health Council of Australia. Contact information: Neil Wildman (02) 6285 3100 or email: wmhd@mhca.com.au.

Canadian Psychiatric Association 53rd Annual Meeting

October 30 – November 2, 2003
Halifax, Nova Scotia
Contact information: www.cpa-apc.org

"Today's Choices... Tomorrow's Care" - Ontario Hospital Association Annual Convention & Exhibition

November 3, 4 & 5, 2003
The 2003 OHA Convention & Exhibition will take place on November 3, 4 & 5 at the Metro Toronto Convention Centre. A mainstay of Ontario's health care industry, the Convention offers health care leaders a comprehensive mix of topical educational sessions, high-profile speakers, numerous networking opportunities and an unparalleled exhibition.
Contact information: Ontario Hospital Association, 200 Front Street West, Suite 2800 Toronto, Ontario M5V 3L1, Canada ph: 416- 205-1300 fax: 416-205-1301 website: <http://www.oha.com/convention>

Ontario Psychiatric Association 84th Annual Meeting - Destigmatizing Mental Illness

January 29, 30 and 31, 2004
Pre-conference, one-day Cognitive Therapy Workshop – Wednesday, January 28, 2004.
Toronto Marriott Eaton Centre Hotel, Toronto
Call for Papers Deadline: August 8, 2003
Contact information: phone: 905-827-4659, email: opa@bellnet.ca

Classified ads can be placed by contacting the OPA Office at (905)827-4659

Have you found any interesting/informative websites that you would like to share with others? Please forward the information to the Editor by email: opa@bellnet.ca or by fax: (905)469-8697.

CPA Presidential Address:



The following speech is based on a presentation given by CPA President, D. Blake Woodside MD FRCPC, during the OPA Annual General Meeting in 2003:

It's a pleasure for me to have an opportunity to address you as CPA President. As a past President of the OPA this is certainly 'home' for me and I am very happy to have had the opportunity the last few days to meet with many of you.

The relationship between the CPA and OPA remains critical to the health of the CPA. With nearly half the psychiatrists in the country, Ontario is the engine of Canadian psychiatry. Fully one-half of the members of CPA are from Ontario, and nearly 2/3 of Ontario psychiatrists are members of CPA. You can be assured that your association is committed to ensuring that Ontario's voice continues to be heard as a key player in the Canadian Psychiatric Association.

I'd like to take a few minutes to highlight some of our recent activities.

1. CAMIMH and Summit

The CPA co hosted, with the CMA and the Canadian Psychological Association, a Summit on Mental Illness and Mental Health, just prior to Mental Illness Awareness Week. About 20 national mental health groups participated in the development of a draft consensus statement they are now taking to their boards for approval. The CPA intent for the meeting was to nudge along the long-term goal of facilitating a broad national coalition focused on securing a national mental health action plan, since CAMIMH members were uncertain about the commitment of other national groups to such an agenda. The meeting's discussion was organized around the framework provided in CAMIMH's Action Plan document.

Simultaneously, CAMIMH received funding from Health Canada to support a strategic planning and consultation process on governance and membership composition. This plan was discussed in depth just after the CPA annual meeting. Prodded by the positive support demonstrated by the participants at the Summit, a membership framework that will, at long last, allow for an expansion of CAMIMH (beyond CPA, CMHA, Mood Disorders, SSC and the National Network) is being proposed. A consultation meeting between the founding CAMIMH members and the groups that signed up to be members of the Steering Committee, as a follow up to the Summit, was held on January 31 in Toronto to discuss CAMIMH's proposals.

2. Other recent CPA Advocacy activities

We have been active in maintaining the momentum that has been generated to keep mental health high on the agenda of the federal government. We have recently been one of a number of signatories of a letter to the Prime Minister urging him to make Mental Illness and Mental Health a priority for the last year of his mandate. We were pleased to see that the Romanow report did identify mental health as an under-resourced area but disappointed that the report was silent on issues relevant to specialists. We have been quietly providing information behind the scenes to the staff of the Kirby commission, and hope to be actively involved in these hearings. As part of our larger initiative around insurance issues, we have been actively involved in making submissions to the Department of Finance about the Disability Tax Credit issue. We also convened a meeting with the major Canadian commercial disability carriers to discuss our concerns about the way in which mental health disability claims are being handled. In both of these activities, one of our key messages has been that the playing field needs to be leveled for mental health vis-à-vis physical disability, and that as a profession, we can help establish appropriate standards and tools for assessing psychiatric disability. Human resource issues are as important to Ontario as they are to other provinces across the country. We have recently released our own manpower report, documenting the enormous difficulties faced by most jurisdictions in recruiting adequate numbers of psychiatrists. We are continuing to work with the CMA Task Force II on medical manpower issues, and hope to continue to work with other stakeholders to place this issue front and centre, federally and provincially. This effort will require a long-term commitment to aggressive advocacy and likely will require us to perform some additional modeling about our situation.

3. Issues more specific to Ontario

We continue our joint dues collection initiative with the OPA, an arrangement that has been beneficial to both parties. Tariff negotiators and tariff chairs are brought together for the weekend at our Annual Negotiations Workshop, to discuss strategy and share ideas about improving the financial position of Canadian psychiatrists. We are actively expanding our program of high-quality CPD events. (A second event, the first Ski-CPD, took place in Mt. Tremblant in February 2003).

CPA continues to be active on your behalf- and we know that you want more than for us to simply express the views of psychiatrists- you want us to make sure that those views are heard and that decisions that are made reflect your views. As CPA President, I remain committed to achieving these goals.

THE ONTARIO PSYCHIATRIC ASSOCIATION IS PLEASED TO WELCOME the following new members up to April 4, 2003

Fahad Aldosary
Simuran Brar
Amy Cheung
Michael Colleton

Simon Davidson
George Glumac
David Gotlib
Jodi Grenier

Alexandra Heber
Nick Kates
Elsbeth MacEwan
Kim McNichol

Gregory Motayne
Manbir Singh
Victoria Winterton
Anna Wisniewska

Congratulations to the following Members-in-Training who have completed their residencies, and have become OPA Full Members

Nadine Cossette
Michael Cheng

Alicja Fishell
Janice Van Kampen

CANADIAN PSYCHIATRIC ASSOCIATION

presentation to the House of Commons Sub-Committee on the Status of Persons with Disabilities, March 18, 2003. (Speaking Notes)

By Dr. Blake Woodside, MD, FRCPC

President, Canadian Psychiatric Association

Madame Chair and respected members of the Committee:

My name is Blake Woodside. I am the President of the Canadian Psychiatric Association. In my day-to-day work I head an inpatient program in Toronto that treats eating disorders.

Thank you for the opportunity to share our perspective about certain issues surrounding the social policy and administration of the program specifically as it affects persons living with a mental illness.

May I firstly commend this committee for work you have done to date to seek the views of Canadians about this program, namely the pre-study roundtable and the web-based consultations. If your report arising out of the disability tax credit consultations is any indication, I have confidence that the views of Canadians presented to you will be well presented in your report and recommendations.

1. Introduction

CMA has addressed issues that are generic for all physicians, largely around the administration of the program. I will focus my comments on the program as it relates to psychiatric disabilities and the role that psychiatrists play in supporting this program.

Mental illnesses represent the second largest class of beneficiaries for CPP. Mental health cases have risen three-fold in the last ten years and are likely to continue to increase over the next two decades according to evidence available on the burden of disability due to disease globally.

I will be speaking to two general issues:

- Social policy of income support for persons with psychiatric disorders
- Current assessment tools to measure impairment and disability due to mental illness.

2. Where does CPP fit in income support for individuals disabled on account of mental illness?

The CPP program is one of a collection of federal initiatives providing support for those individuals who are disabled because of mental illness. We do not have definitive data about the extent to which the combination of current income support programs is providing income support for such individuals. The multitude of programs providing this type of support makes it difficult to assess who is receiving what from what program.

While about 63,000 individuals with mental illness are supported annually by CPP (based on 2000 data), the best estimate of the prevalence of disabled mentally ill individuals is approximately 2% of the population, or at least 600,000 people. Clearly, while CPP is an important element in the support of these disabled individuals, it is only one of a variety of means of support.

Disabled Canadians generally have three classes of income protection. The more fortunate individuals are those whose coverage falls under a provincial workman's compensation program or private long-term disability insurance, or self-employed individuals who take out private insurance. These people are the most likely to have income above the poverty line. For those without private insurance or workman's compensation coverage, CPP may provide coverage if that person had enough earning years to qualify for a partial or maximum payment. The EI sickness program bridges both for the first 17 weeks of disability. The default option for those not fortunate enough to have private insurance is the various

provincial Social Assistance programs, which are not designed to be long-term income support programs. These programs do not coordinate well among themselves or with the health care system.

It should also be recognized that mental illnesses often have their onset early in life, before the person has been able to work sufficient years to fully qualify for a full CPP benefit. This relative disadvantage for mental illnesses should be addressed.

Clearly access to income replacement or security is not the same for everyone, with many disabled individuals with mental illness living below the poverty line and no clear national strategy to address this problem. The current patchwork arrangement of support is confusing for those who are disabled and for psychiatrists who are attempting to assist patients in accessing support to which they are entitled.

3. How equitably are claims handled?

Compared to other disability classes, mental health claims appear to be approved at similar rates. In a broad general way we are convinced that the program is treating those with mental illness equitably. However, we are aware that the assessment of mental health claims is made more complex by a lack of agreed-upon standards for the assessment of psychiatric disability and functional impairment. At present, the department has not issued a set of comprehensive guidelines that psychiatrists can use to organize their reports to provide the information that is required to assess a claim appropriately. The typical narrative report provided by psychiatrists is designed for a different purpose- diagnosis and treatment planning. The generation of an assessment instrument objectively assessing levels of impairment and level of functioning to measure disability would assist psychiatrists in providing the department with better information. The usual narrative report would then supplement the more focused information provided on such an instrument.

This is not to suggest that psychiatrists do not have access to information that is relevant to the department, but rather that psychiatrists need some assistance in teasing out from the great mass of information they have available that which is important to the department. The Association would be happy to consult with the department to help develop an impairment evaluation instrument for mental illness, one that included clear and reliable standards for disability and functional impairment specific to mental illness.

Recommendations.

1. The current patchwork system of income replacement and support for those disabled as a consequence of mental illness should be transformed into a cohesive system of income replacement and support. The goals of such a program would be to enhance the quality of life for those disabled from mental illness, provide opportunities for rehabilitation where this is possible, and be clear and transparent to disabled individuals and providers alike. Such a program could be part of a National Strategy on Mental Health and Mental Illness. This should include addressing issues specific to the early onset of mental illness and the effects this has on individuals to work full time at any point in their life.

2. Clear and transparent standards for disability and functional impairment related to mental illness should be developed. This should include the development of an impairment evaluation form specific to mental illness. ■

COMPLETING THE DISABILITY TAX CREDIT (DTC) CERTIFICATE T2201 FORM FOR INDIVIDUALS WITH SERIOUS MENTAL ILLNESSES

By: Lembi Buchanan

The question regarding mental functions, "Can your patient perceive, think and remember?" is problematic because psychiatric illnesses (such as mood disorders and schizophrenia) are not covered by the intent of this test. The federal government has acknowledged concerns about the T2201 form and recently appointed a Technical Advisory Committee on Tax Measures for Persons with Disabilities to examine the eligibility criteria, particularly for persons who suffer from episodic and mental conditions, as well as other issues identified by the disability community. In the meantime, the tax credit should not be denied to individuals with serious mental illnesses because the form is inadequate.

Once a doctor checks the "yes" box, in the eyes of CCRA, the patient does not meet the test even though the *Income Tax Act* specifies that individuals who have a "severe and prolonged" mental or physical impairment may qualify for the tax credit. Furthermore, case law has provided numerous examples indicating that the question can essentially be read as follows: Can your patient perceive, think or remember in a manner that conforms reasonably to common human experience?

Tips for Physicians

The legal tests to qualify for the tax credit are the following:

1. The impairment must be "severe and prolonged," expected to last 12 months or more. The severity of the impairment is the determining factor.
2. The impairment must "markedly restrict" one of the "basic activities of daily living," for example, the ability to "perceive, think and remember." Other activities of daily living, such as feeding or dressing oneself or personal care are not necessarily relevant tests for an individual with a mental illness. The example provided on the T2201 form is only a guideline and it is not intended to exclude individuals who are able to manage their personal care without supervision.
3. The impairment must result in the individual's inability to perceive, think and remember; "all or substantially all of the time." Unfortunately, this test does not address the complex issues characterizing psychiatric disability. Nevertheless, many persons with severe and prolonged mental illnesses have ongoing difficulty functioning in a reasonable and competent manner because their judgment may be dysfunctional or impaired, or their concentration and memory are very poor.

In May 2002, the Federal Court of Appeal (*Attorney General v. Buchanan*) set the legal standard for all individuals with mental impairments concluding that Mr. Buchanan qualified for the DTC because his "inability to perceive, think and remember was of such severity that the respondent was unable to perform the necessary mental tasks required to live and function independently and competently in every day life."

The court record indicates that Mr. Buchanan (diagnosed with bipolar disorder), is highly functional intellectually, drives a car and is a member of mental health committees. In *Buchanan v. The Queen*, Judge Diane Campbell stated, "... he can present himself as quite an intelligent, lucid individual while otherwise being in the midst of irrational and unpredictable behaviour." She said that this "is an obvious case" because Mr. Buchanan's judgment is severely impaired in a number of areas and he relies on his wife for "constant supervision, care and support."

In addition to the diagnosis, it is important to provide details about the disabling symptoms and impacts of the impairment to clarify the severity of the illness. When listing medications, please note when the medications have not fully stabilized the illness.

Supporting documents providing objective proof of the severity of a patient's illness may include: psychiatric discharge reports and/or psychological consult reports for the applicable tax year; treatment compliance issues; documentation of delusions, illogical thinking and impaired judgment, severe depression and suicidal ideation.

Privacy issues of medical documents and other reports need to be carefully considered before releasing them to CCRA.

Many doctors are sent a supplementary questionnaire requesting additional information for medical clarification. Unfortunately, some of the questions are not necessarily conclusive tests to determine the severity of the disability for someone with bipolar disorder though the questions may be very appropriate for an individual with dementia, such as:

"Can your patient make a simple purchase?"

"Does your patient understand the concept of danger?"

"Could your patient go out into the community alone?"

"Did your patient's condition restrict the ability to operate a motor vehicle?"

If a question is not relevant to the severity of your patient's impairment, please indicate the objection on the questionnaire.

Tips for Claimants

The patient and the person completing the T2201 form should both meet with the doctor to discuss in detail the disabling impacts of the illness.

A letter from the person completing the form can also be very helpful. Provide concrete examples to describe incapacity and the impact of the mental illness on a day-to-day basis, for example: illogical or dysfunctional thinking should be documented to show how it has affected the individual and those around them; examples and frequency of impaired judgment; impulsive decisions; inability to manage finances; problems with concentration and memory; hallucinations and delusions; inappropriate emotional outbursts; emotional withdrawal and/or isolation; irrational and paranoid behaviour. Also, outline the degree of supervision and/or assistance the individual requires especially if he or she lives alone. Reports from home care agencies and other community support services provide evidence that the individual is not able to function independently.

Photocopy all documents and letters that you send to CCRA.

Lembi Buchanan is a public relations consultant, the Chair of the Coalition for Disability Tax Credit Reform and a member of the Federal government's Technical Advisory Committee on Tax Measure for Persons with Disabilities. Ms. Buchanan has written on, and advocated extensively for, tax fairness for Canadians with disabilities and is a past contributor to the OPA Dialogue.

PROGRAM FOR YOUTH

ssoAWARE.com is a program that includes a public service awareness announcement and website aimed at young people between the ages of 15 - 24. This is the age when the symptoms of schizophrenia generally begin to appear. The goals of ssoAWARE.com are to raise awareness, promote early identification, link with intervention and treatment programs and eliminate misunderstanding and stigma.

National Mental Health Public Awareness Campaign

The Canadian Mental Health Association (CMHA) launched a national public awareness initiative during Mental Health Week (May 5 – May 11, 2003) to boost understanding of the prevalence of mental illness, and to combat the shame associated with it. The campaign was designed to force Canadians to question their attitudes about who gets a mental illness, to help people understand that anyone can develop a mental illness and to let them know help is available. The campaign consists of television, radio and print public service announcements. The radio PSA features Canadian double-platinum artist Chantal Kreviazuk. Currently performing throughout North America, Ms. Kreviazuk delivers the message that there is nothing shameful about mental illness and the first step towards de-stigmatizing it is to begin talking about it. Two 30-second television PSAs, developed by Naked Creative Consultancy Inc., take a unique, offbeat approach to the issue with the introduction of a character called Mr. Depression. An ordinary-looking, pleasant individual, he surprises people in everyday settings like an office mailroom and a men's washroom. In both spots, Mr. Depression appears where the other characters least expect him - behind the photocopier in the mailroom and in the men's room - and asks a series of questions related to their mental health. His probing ultimately

conveys the message that while many people do not think they could ever have a mental illness, sometimes everyday life events, such as the loss of a job or a spouse, can trigger depression.

A national survey conducted in December 2002 and January 2003 found that two-thirds (67 per cent) of Canadians have had experience with depression and/or anxiety, with more than one-third (36 per cent) saying they had personally experienced one or both. However, only about half of these people (52 per cent) saw a doctor about it. The stigma related to mental illness may be responsible for this reluctance to visit the doctor, as approximately one-third (34 per cent) of Canadians believe others would think less of them if it were known they suffered from depression or anxiety. People in Western Canada are the most likely to have experienced depression or anxiety themselves (British Columbia 46 per cent, Alberta 46 per cent); Quebec is the least depressed or anxious province, with only 24 per cent saying they have experienced depression or anxiety themselves; and Ontario and the Atlantic provinces fall in the middle, with 38 and 31 per cent saying they have experienced depression or anxiety.

MENTAL HEALTH WORKS

Mental Health Works, an initiative of the Canadian Mental Health Association (CMHA), Ontario, launched its new web site (mentalhealthworks.ca) on Tuesday, May 6, 2003 to provide employers and employees with new tools and resources to help them deal with mental illness in the workplace. Mental Health Works also provides resource kits and training materials.

Mental health is a critical issue for Canadian business. The World Health Organization is predicting that by 2020 depression will be the second leading

cause of disability in the workplace. In Canada, it is estimated that mental illness costs business more than \$30 billion a year in lost productivity.

For further information about Mental Health Works: Miriam Ticoll, Director, Mental Health Works, CMHA, Ontario Division, (416) 977-5580 ext. 4120; email: mticoll@ontario.cmha.ca

Report of the Continuing Education Committee

By: Ann Thomas, MD, FRCPC, Chair, Continuing Education Committee



Plans are well underway for the 2004 Annual Meeting. The theme for the meeting, as chosen by our President, Dr. Robert Buckingham, will be "Destigmatizing Mental Illness". We have also chosen a logo for the Annual Meeting:



Once again, the meeting will be held at the Toronto Marriott Eaton Centre Hotel, January 29, 30 and 31, 2004. Our Friday night President's dinner/dance will

once again feature a buffet dinner and live band.

As always, we have endeavoured to incorporate your suggestions provided to us through the "Personal Continuing Education Needs" responses as part of our "Call for Papers". Based on responses to our survey, we will be trying to have some talks that one usually does not find at a conference to attract those avid meeting goers who are well versed in meeting presentations.

Confirmed speakers are; Dr. Donald L. Nathanson of the Silvan S. Tomkins Institute and Clinical Professor of Psychiatry at Jefferson Medical College in Pennsylvania, speaking on shame; Dr. Charles Schulz of the University of Minnesota, addressing

the use of atypical antipsychotic agents in disease states other than schizophrenia; Dr. Michael Robinson of Queen's University will discuss delirium; and Dr. Susan Abbey of Toronto General Hospital will share her expertise on chronic fatigue syndrome.

New this year! We will be offering a pre-conference one-day Cognitive Therapy Workshop on Wednesday, January 28, 2004. We are pleased that Dr. Christine Padesky, Distinguished Founding Fellow of the Academy of Cognitive Therapy and a Co-Founder of the Center for Cognitive Therapy in California has agreed to present this workshop. This workshop is being offered in conjunction with the Canadian College of Family Practice.

We are working on confirming speakers on topics such as chronic pain, resistant bipolar disorder and dual diagnoses.

OPA Section luncheons, with speakers, are being planned for Saturday, January 31st.

Many thanks to the Continuing Education Committee Members, Krishna Balachandra, Bob Buckingham, Jane Howard, Elizabeth Leach, Rosemary Meier, Roumen Milev, Leo Murphy and Michael Paré.

So mark your calendar now - January 28, 29, 30 and 31, 2004 - Plan to attend, see your colleagues, and have a great time!

MNet and CPS team up to develop Media Pulse

In April, Health Canada announced a contribution of \$200,000 to Media Pulse, a project designed to raise awareness among health professionals about how media can influence the health and well-being of children and adolescents. The Media Awareness Network (MNet), a non-profit organization and Canada's leading media education source, has teamed up with the Canadian Paediatric Society (CPS) to develop Media Pulse, with funding from Health Canada's Population Health Fund. Media Pulse will encourage health professionals to incorporate awareness of media influences into their practices. Materials designed specifically for the health sector will include a media awareness guide and assessment tool for health practitioners to assess the impact of media on the lives of their young patients, as well as practical tips that physicians can offer parents.

Media Pulse will be launched at the Canadian Paediatric Society's 2003 Annual General Meeting to be held in Calgary, June 18-22, 2003. MNet has established a

Steering Committee comprised of child psychiatrists, a paediatrician and a family physician who, along with the CPS Psychosocial Paediatrics Committee, is advising on the development of Media Pulse.

Health Canada has adopted a population health approach to further its mandate to maintain and improve the health of Canadians. This approach recognizes that factors, in addition to the health care system, have a strong influence on health. The approach promotes prevention, and encourages positive action on determinants that affect the health of the population as a whole, or that of specific population groups. The goal of the Population Health Fund, which has an annual budget of \$14 million, is to increase community capacity for action on the determinants of health.

GUEST COLUMN

MORE THAN SELF HELP

By: Karen Liberman, Executive Director, The Mood Disorders Association of Ontario

It's probably not such a good thing that, as Executive Director of The Mood Disorders Association of Ontario (MDAO), I struggle with our mission statement that describes us, at least in part, as a "self help" organization. Frankly, I worry a little about the term "self help" and its implications for the people we serve.

People who struggle with mood disorders and their families know all too well the overwhelming feelings of hopelessness, helplessness and often powerlessness in the face of a vicious enemy. I worry that the term "self help" somehow implies that if we "just try harder", "just do more", "just pull up our socks", "count our blessings" just, just, just . . . that then we could help ourselves to get well. While there is much we can do help in our own recovery, there is much that, in reality, is in the hands and wisdom of others.

So then, if the MDAO is more than a "self help" organization, how is it that we can support people with mood disorders, their families and friends? First and foremost, we provide living breathing proof of our most fundamental belief statement; "You are not alone". Every person who attends one of our over 45 peer support groups throughout Ontario will be immediately welcomed by a community of fellow travelers . . . other people who have struggled and recovered from a mood disorder and others who are still on the journey.

Some of our peer support groups are illness specific (e.g. bipolar, concurrent disorder etc.) or specific to circumstance (e.g. women's only, family members etc.). Others are more general . . . if support groups, MDAO offers telephone information, referral and peer support. We also have an extensive lending library of informative books, pamphlets and videotapes as well as many items for sale or free for the asking. All of our services are provided by trained volunteers and offered free of charge.

MDAO has a strong role to play in helping the public to better understand and respond to the issues of mood disorders. We provide numerous public education forums, distinguished speakers, workshops, and conferences - all in an attempt to increase the community's understanding and acceptance of mood disorders, to encourage people to seek help, to reduce stigma and, above all, to eliminate discrimination.

One of the newest and most exciting programs of MDAO is Our Sisters Place. Our Sisters' Place is a community-based support network for women, with a focus on

mood disorders associated with hormonal changes throughout the lifespan. It is the only program of its kind in North America and will be launched on June 4th. Last fall, the MDAO undertook two needs assessments to determine the best way for MDAO to serve 1) communities where we do not currently have a presence through one of our support groups and 2) the needs of Toronto's multi-ethnic, multi-racial communities.

The assessment results indicated that we will need to provide support to MDAO groups throughout the province, outreach to communities where no MDAO groups exist, and, to work harder to reach out to the ethno-cultural communities in the Greater Toronto area. Specifically, we will need to provide MDAO groups with more up to date resources; literature, videos, a list of pamphlets on symptoms and signs and how to deal/cope and live with the illness. We will need to start new groups in communities where no groups currently exist. In order to reach out to the ethnic communities, we will be producing materials in many languages and working to meet people, hold groups and make presentations in different cultural settings/locations, for example, community centres, churches, mosques, etc.

Another important area of work for us is to further develop our Youth Outreach Strategy throughout Ontario. We would like to implement support groups for youth/young adults, publish a revised and updated "Youth Information Kit", develop and implement workshops for professionals working with young adults, and develop and implement a multi-media anti-stigma information resource for youth/young adults

These initiatives, as well as our on-going activities, create an environment that in some ways belies our own name. If anything, we are a study in enthusiasm, hope, and optimism. In my opinion, that's a whole lot more than "self help".

For more information please contact:

*Mood Disorders Association of Ontario, 40 Orchard View Blvd., Ste. 222, Toronto, ON M4R 1B9, Tel: (416) 486-8046, Toll Free 1-888-486-8236, fax (416) 486-8127
email info@mooddisorders.on.ca, website www.mooddisorders.on.ca*

Our Sister's Place: 40 Orchard View Blvd. #215, Toronto, Ont., M4R 1B9, Tel: (416) 486-7432, Toll Free 1-866-363-MOOD, www.oursistersplace.ca (launched June 4th 2003) ■

When Should the Survivor of a Sexual Assault Seek the Advice of a Civil Lawyer?

By: *Loretta P. Merritt, MA, Partner and Head of Civil Litigation Department, Torkin Manes Coben Arbus LLP*

Sexual assault is a traumatic event; one that can strip away one's trust in the legal system. If the system was not there to protect the survivor from the assault in the first place, how can it be there for them now? In some cases it may be appropriate to seek legal advice. Understandably, many survivors will be reluctant to seek legal advice, for this requires further disclosure. A certain amount of self-doubt or anxiety is to be expected in such cases. If the survivor has just recently revealed the abuse, it may be too soon to consult a lawyer. However, the law sets limitation periods, which are time limits within which individuals must commence legal proceedings or risk losing their rights to sue altogether. Some awareness of the legal issues involved in civil sexual assault cases is helpful.

After How Many Years Does The Survivor Lose The Right to Sue?

In most sexual assault cases, a survivor must commence legal proceedings within four years from the date when the "cause of action arose". The "cause of action" arises when the survivor has a substantial awareness of the harm suffered and its cause. This means that the "clock begins to tick" when the survivor realizes that the assault has caused them to suffer damages and understands the causal link between the harm and the abuse. The Supreme Court of Canada has suggested that in a recovered memory case the law presumes that the survivor only has this required level of awareness when he or she starts therapy, unless there is evidence to show otherwise. In Feb 2002 the Supreme Court of Canada said that in some cases a limitation period may be extended when the person suing can prove that he or she was mentally incapable of coming forward any earlier. If the sexual assault involves a breach of fiduciary duty (for example parent/child), there may be no limit on the time within which legal proceedings can be commenced. In these cases, the court will only dismiss the claim if there has been unreasonable delay. However in other cases there are very short limitation periods. For example, for Public Authorities - 6 months (eg., the government, the C.A.S.) or suing a deceased person - 2 years from the date of death.

Will We Win In Court?

In some cases, sexual assault is difficult to prove. The alleged offender may deny that the abuse occurred at all. There are usually no witnesses. These factors often compound the anxiety of going to court and telling the world what happened. A lawyer will first decide whether she has a realistic chance of winning the case before having a survivor of sexual assault go through this process. The lawyer will have to determine whether she can prove on a balance of probability (i.e., more likely yes than no) that the assault occurred and that damage was suffered. Although there may be no eyewitness proof of a sexual assault, there can be other corroborating evidence. Evidence is an important part of winning a case. Perhaps the survivor told a friend, family member or health care professional of the assaults as they occurred or shortly after. In some instances there may be evidence in the form of letters or diaries that the survivor kept during the abuse. The alleged offender's background may provide evidence of a history of abuse or relevant medical or psychological history or a tendency to be violent. If the offender has been criminally convicted, although it is not absolutely necessary, it is very helpful to the survivor's case. The alleged offender may tend to blame the survivor and rationalize, justify or excuse his or her own conduct. The offender may claim that the survivor actually consented to the sexual assault. It is important to remember that a consent is not a true and valid consent if it is obtained by threats, intimidation, or through breach of fiduciary duties.

Do The Benefits Outweigh The Costs Of Going To Court?

This decision can only be made by the survivor of sexual assault. There are no guarantees that a civil action will be won. With the advice of a lawyer, the survivor must weigh the likelihood of a successful outcome against the difficulties of going through the court process. Some of the following facts may be helpful in making this decision.

The current trend seems to be a rise in the number of large damages awards especially in cases of incest occurring over a period of years. The factors that the courts take into consideration in assessing general damages for pain and suffering are: the nature of the acts, the duration of the assaults, the resulting harm, the age

of the survivor, and the impact on the survivor's life including his or her education and career. General damages can range from a few thousand dollars for a single offence by a stranger to \$250,000.00 or more for the most serious incest cases. In addition, survivors can be awarded damages to cover the cost of past and future therapy as well as damages for past and future income losses. Awards of aggravated and punitive damages can also be quite substantial. These are awards based on punishing the offender for his or her conduct. However, sometimes aggravated and punitive damages are not awarded where there is criminal conviction and punishment.

Aside from the survivor, there may be other individuals with claims flowing from an assault. For example, the survivor's own parents, children or family members may have claims for loss of care, companionship and guidance under the Family Law Act. Family members may be awarded some damages because of the extra support they need to give to the survivor as a result of the effects of sexual abuse.

Vicarious Liability of Institutions For Intentional Torts

There are instances where a survivor of sexual assault may have recourse against defendants other than the perpetrator. These instances usually occur in employment relationships. An employer may be found to be liable for the acts of its employees. This liability can arise in one of two ways. First, the employer may be directly negligent for example, for failing to properly check the perpetrator's references or for failing to properly respond to and investigate earlier complaints. Even where there is no blameworthy conduct on the part of the employer, the employer may have automatic liability imposed by law i.e., vicarious liability. In two recent decisions, the Supreme Court of Canada developed guidelines on how to determine if an employer will be vicariously liable for the wrongful acts of its employees. The court considers the strength of the causal link between the opportunity created by the employment and the wrongful act.

The Supreme Court of Canada specifically addressed the power-dependency relationship between an employee whose mandate is to care for children and the survivors. The court made no distinction between for-profit and non-profit organizations when determining vicarious liability. It has been determined that the vulnerability of children alone is not a sufficient justification to impose vicarious liability on employers who work with children. There needs to be a "strong link" between the employment and the sexual assault. The greater the time spent with children and the greater the intimacy, the greater the opportunity for abuse. The court stated that the more the employer encourages the employee to foster the relationship with the child, and to gain their trust and respect, the more the risk may be enhanced, making the employer more susceptible to vicarious liability.

How to Select a Lawyer

In choosing a lawyer, a survivor may be referred to potential lawyers through friends, family members, health care professionals, therapists or through lawyer referral services such as the one sponsored by the Law Society of Upper Canada. In selecting a lawyer, the survivor should ensure that the lawyer is experienced generally in litigation and specifically in sexual assault cases. It is perfectly appropriate to ask the lawyer how many sexual assault cases he or she has handled in the past and to ask the lawyer for references from former clients. Of course, the lawyer will have to get permission before giving out any names of former clients. It is also advisable to discuss fees and make sure you understand the financial arrangements from the outset. As well, the survivor should ask the lawyer to provide an overview of the process involved in bringing a civil lawsuit, a description of the main steps in the case and rough estimates of the time frames involved. Finally, because the relationship between lawyer and client may be a long one and a sexual abuse lawsuit necessarily involves discussing personal and painful issues, it is extremely important that the client be comfortable with the lawyer he or she chooses.

How To Prepare For The First Meeting With The Lawyer

Before the first meeting with a lawyer, it may be helpful for the survivor to take the time to prepare for some of the questions that will need to be answered. The client can assist the lawyer in assessing the case by documenting a chronological history outlining personal background, education and work experience, a history

of the abuse, a list of treating physicians, a list of potential witnesses, and providing copies of any relevant documents. Preparing in this way can make this first step much more comfortable for the client.

Privacy Concerns

Often, survivors are concerned about the extent to which their privacy can be protected when they get involved in a civil lawsuit. As a general rule, civil trials are open to the public however, in reality they are rarely attended by persons other than the direct parties and witnesses to the case. In a civil lawsuit, there are many documents that are filed with the Court which identify the parties by name. These documents are also a matter of public record. However, in sexual assault cases, the Courts will allow the survivor to identify himself or herself by initials only and therefore have his or her identity in the documents protected.

In a civil case the survivor is coming to the Court and asking the Court to award compensation for the damages suffered as a result of the abuse. Therefore, a full inquiry into the effects of the abuse is justified. As a general rule, survivors who sue civilly will be required to produce medical and other records that are relevant to the case. Before deciding to start a civil case it is a good idea for survivors to discuss these disclosure requirements with their lawyer so that there are no surprises.

In cases where liability is strong (i.e., prior criminal conviction), damages are significant and there is a potential defendant who has financial means to satisfy a judgment, the survivor is well advised to seek legal opinion. A lawyer can advise

the client of his or her legal rights and remedies. The lawyer can explain the procedural and practical aspects of both criminal and civil proceedings. The lawyer can represent the client in litigation, arbitration or mediation or conduct settlement negotiations on behalf of the client. The lawyer can advise the client of the likelihood of success and the range of any potential recovery.

A civil lawsuit may well form a part of a constructive healing process for a survivor of sexual assault. It can be a means by which the survivor obtains the funds needed for therapy. It can also be a means for many survivors to take control over how the abuse affects their future. For many, it is a form of empowerment and is therefore one part of the healing process. Unlike criminal proceedings where a survivor is merely a witness for the crown and has no control over the process, in a civil case the survivor/plaintiff assumes a great deal of control over the manner in which the case is conducted.

For more information please contact Loretta Merritt, Torkin Manes Coben Arbus LLP, Barristers and Solicitors, 1500 - 151 Yonge Street, TORONTO Ontario M5C 2W7, email: lmerritt@torkinmanes.com, direct dial tel: 416-777-5404.

The issues raised in this release by Torkin Manes Coben & Arbus are for information purposes only. The comments contained in this document should not be relied upon to replace specific legal advice. Readers should contact professional advisors prior to acting on the basis of material contained herein. ■

Regulator's Authority Confirmed in a Recent High Court Decision

By: Bernard C. LeBlanc, Steinecke Maciura LeBlanc

The complaints and discipline processes and procedures used by regulators are always under close scrutiny. For example, must regulators advise their members to retain counsel during an investigation. Are investigators biased if they believe the allegations during the course of the investigation? To what extent can senior officers within a regulator participate in an investigation? What is the appropriate committee to conduct the investigation? Many of these issues were considered by the Divisional Court of Ontario in *College Veterinarians of Ontario v. Butterworth*.

In this case, a veterinarian faced a long list of allegations that amounted to animal abuse. The allegations were first made anonymously to the College, but the identity of the source of information was established before the allegations were considered by the Executive Committee. The Executive Committee appointed an investigator who interviewed the veterinarian without providing any notice of his visit to the clinic.

After the initial investigation, the Executive Committee referred the matter for possible incapacity proceedings. However, after a thorough review of the matter, a board of inquiry did not find mental illness and so the Executive Committee decided to refer the allegations to the discipline committee for a full hearing.

The veterinarian raised a number of concerns about the process. First, he argued that the Complaints Committee should have investigated the matter rather than the Executive Committee appointing an investigator. This would have permitted the veterinarian to obtain a copy of the allegations, afforded time to consider them and draft an appropriate response with the assistance of counsel. He also claimed that he should have been advised of his right to consult with counsel. Further, he alleged that the investigator was biased because he believed that the allegations might be true, and he criticized the registrar for attending a meeting of the board of inquiry and for his involvement in the misconduct investigation.

The Divisional Court found no merit in the veterinarian's complaints. As is the case with most regulators, the Divisional Court found that complaints can generally be dealt with either by the Executive Committee or the Complaints Committee, and the registrar therefore has some discretion as to how complaints ought to be

processed. This is an important determination, as the two processes are different and one process may not necessarily be appropriate in all circumstances, particularly where there are multiple complaints, the complaints are made not by the person receiving the services but by someone else with knowledge of them, evidence may be destroyed or there are issues of personal safety. The Court was anxious to maintain this flexibility for regulators.

The Divisional Court was also not concerned about the fact that the investigator did not give notice of his visit to the practitioner, nor recommend that he retain legal counsel. The Divisional Court also found that it is not inappropriate for an investigator to believe the allegations if he does not otherwise have a "closed mind". Finally, the Court was not concerned about the role played by the registrar, particularly in light of the evidence that in light of the size of the College, the regulator's role was supportive and administrative as opposed to decisive.

This case reaffirms the right of regulators to investigate their members with considerable discretion.

Update: The veterinarian brought a motion seeking leave to appeal this decision. This past fall, the Court of Appeal for Ontario declined to hear the case, which means that the Divisional Court's decision remains the law in Ontario. The Courts have therefore maintained a fairly wide degree of flexibility in terms of how investigations can and should be conducted.

This article was originally published in the March 2002 and the update was published in December 2002 issue of Professional Practice and Liability on the Net Professional Practice and Liability on the Net is a monthly Internet newsletter addressing issues of interest to a wide range of professionals. Please consult with a lawyer for specific legal advice.

For more information please contact the author at Steinecke Maciura LeBlanc, 393 University Avenue, Suite 2000, Toronto M5G 1E6. Or, call 599-2200, ext. 232, or email bleblanc@sml-law.com. ■

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Surveys can be returned by fax to the OPA Office at (905) 469-8697
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SEPARATING LEGAL FACT FROM LEGAL FOLLY: ACCESS TO RECORDS

By Michael Bay, *Juris Doctor*

It has often been said that Ontario has two Mental Health Acts. The first is the official Mental Health Act passed by the legislature. The second has no legal authority. In fact, it is not even written down anywhere. It is what I call the Mythological Mental Health Act. Unfortunately, the mythological Act is often the one that is followed. Nowhere is this problem more pervasive than in the case of access to records.

MYTH #1: Records cannot be exchanged between hospitals or other health facilities without the patient's consent.

THE TRUTH: Patient consent is usually not required. The hospital holding the records may legally provide copies to a health facility currently involved in the direct care of the patient. All that is required is a written letter of request from the CEO of the requesting facility.

MYTH #2: Lawyers who have been hired to represent patients before the Consent and Capacity Board need written authorization from the patient in order to access the file.

THE TRUTH: A lawyer hired to represent a patient with regards to a case pending before the Board has an automatic right of access to the patient's records unless the Consent and Capacity Board has made an order denying access. Consent is not required.

MYTH #3: Even if families and friends of the hospitalized patient want to volunteer information, this is impossible without the patient's consent.

THE TRUTH: The Mental Health Act places severe restrictions on the ability of physicians and hospital staff to share information. It does nothing, however, to prevent the receiving of information. Care should be taken not to inadvertently disclose privileged information during this process.

MYTH #4: If the patient signs the correct authorization form, the hospital must release the records to third parties.

THE TRUTH: As with consent to treatment, a signature on a form is not valid if the patient is not capable of making decisions regarding access to records. It is up to the attending physician to determine capacity for this purpose. Even if the patient gives valid, capable consent, the hospital still has some discretion to deny the records so long as this is done in good faith and for a valid reason.

MYTH #5: The hospital can deny a patient access to his or her own records if the attending physician considers this advisable.

THE TRUTH: Patients have an absolute right to access their own records unless the Consent and Capacity Board authorizes the withholding of the records. The application to the Board must be made within seven days of the patient's written request to access the record.

MYTH #6: Community mental health clinics, psychiatrists office's and similar settings require a signed Form 14 in order to grant access to a patient's chart.

THE TRUTH: The Form 14 is part of the Mental Health Act scheme for records. This scheme only applies to psychiatric facilities. It does not apply outside of hospitals that are recognized as psychiatric facilities under the law. It does, however, apply to facilities and programmes that are affiliated with psychiatric facilities. Nothing prevents others from using the form if they wish but it is not required.

MYTH #7: The parents of "minor children" are automatically entitled to receive information about their treatment and to access their clinical record.

THE TRUTH: Confidentiality has no age restrictions, everybody is entitled to their privacy. Parents can only access the clinical information in two situations. The first is if the patient has been found incapable of making treatment decisions, the parent is the lawful substitute, and the parent requires that information in order to an informed treatment decision. The second is if the patient has been found incapable for the purpose of access to records and the parent is his or her substitute with regards to the records.

MYTH #8: Any member of the hospital staff may access the patient's chart.

THE TRUTH: Access is only permitted by those staff members who are directly involved in the assessment or treatment of the patient and by those who are assisting them.

Michael Bay, former Chair of the Consent and Capacity Board, practices law in the areas of mental health and administrative law. Michael is available to provide education, dispute resolution, consultation and legal services in the areas of mental health, consent and substitute decision-making law and can be reached at 416-398-5368 or at baylaw@sympatico.ca.

Taxation Law: Dr. Incorporated

by Lewis Retik, *Gowling Lafleur Henderson, LLP*

The face of incorporated businesses in Ontario is constantly evolving. Most Canadians traditionally perceive corporations as businesses outside the realm of professional services. Such businesses include retailers, manufacturers and distributors. However, today's corporations are different.

Ontario has embraced a wave of changes that allow for certain professions to form and operate as corporations. Amongst the professions with this new ability are doctors. This means that doctors can now form a corporation under which they can provide medical services to their patients. Incorporating a medical practice essentially means that a doctor creates a separate legal entity from themselves. The corporation and the individual doctor that provides the service are two different legal persons. In operating the medical practice, the doctor would be an employee of the corporation. However, doctors that incorporate their medical practices are not governed exactly the same way as traditional corporations. Doctors are subject

to various differences in areas such as professional liability and the name under which a corporation can be formed.

There are two main benefits for a doctor to incorporate their practice. First, a doctor that does not need the entire income from the practice can defer paying taxes. Second, a doctor can use all or part of their \$500,000.00 capital gains exemption on the sale of their shares of the corporation, which will affect the tax payable on the sale of their practice. These benefits can translate into long term savings for the incorporated doctor that would otherwise be unavailable to them.

A doctor will not benefit from the ability to defer taxes using an incorporated medical practice if they intend to spend the entire income their medical practice earns. Under an incorporated medical practice, the earnings are attributed to the corporation. If the doctor requires these earnings, then he or she can collect the

funds through corporate dividends or salary. The amount of funds that remains with the corporation does not get taxed at the same rate as if the doctor received the funds directly. Such amounts get taxed at lower rates and therefore the additional payment of tax that would be applicable if the doctor received this income directly is deferred. For example, the first \$200,000.00 of corporate earnings in 2003 will be taxed at 18.62%. This compares favourably to the highest marginal tax rate in Ontario of over 46%.

The second main benefit, the tax exemption, arises out of the fact that every Canadian is entitled to a \$500,000.00 capital gains exemption on the sale of shares of a small business corporation. When a doctor incorporates their medical practice they own the practice as a shareholder in that they own the shares of the corporation. A doctor that sells their incorporated medical practice would actually be selling the shares of that practice. When an individual sells shares at a profit, that profit is taxed as a capital gain. Like all Canadians, doctors are entitled to a \$500,000.00 capital gains exemption as indicated above. This means that when a doctor wants to sell their incorporated medical practice, they may be able to receive all or part of the proceeds of the sale on a tax-free basis. Alternatively, when a doctor sells a medical practice that is not incorporated, the income from the sale would be taxed to some extent at the normal income tax rate. This means that the sale of the shares of an incorporated medical practice can translate into the selling doctor keeping substantially more of the proceeds from the sale.

As opposed to the above benefits, there are various reasons why a doctor may not benefit from incorporating their medical practice. For example, unincorporated doctors are able to claim many car expenses as tax deductions, which may not be available for them as employees of medical corporations.

Many of the benefits normally associated with a corporation often do not apply to the incorporation of a medical practice.

Limited liability is usually one of the main reasons a corporate structure is created. It helps insulate shareholders, officers and directors from personal liability. The fact that a corporation exists as a separate legal person allows the corporation to bear such liabilities. An incorporated medical practice does not benefit from the same insulation from liability, as doctors remain professionally liable for their actions. Although shareholders normally remain insulated from liability to creditors, shareholders of a medical corporation remain jointly and severally liable with the corporation for all professional liability claims against the corporation.

Normally, a corporation can be a vehicle for income splitting through its various shareholders. For example, income splitting can occur by using a corporation to distribute dividends to low income family members who own shares of the corporation. However, a professional corporation requires that all shareholders are members of that profession. This means that an incorporated medical practice requires that all shareholders of such a corporation are medical doctors. This limits the possibility of including family members as shareholders. Therefore, a doctor that incorporates their practice is in no better situation for income splitting than operating an unincorporated medical practice.

Another benefit a doctor may associate with incorporating their medical practice is the ability to use a business name other than their own. Corporations can use

almost any name that is not already used by an existing corporation or they can create a numbered corporation. When doctors incorporate their practice, they are subject to stringent restrictions regarding the name of their corporation. Doctors cannot use creative names such as Gastro Inc. or Dr. Bones Ltd. In fact, a medical corporation must include the surname of one or more shareholder of the corporation, the words "Professional Corporation" and the word "Medicine" to outline the actual profession that is incorporated. For example, if a doctor named John Smith would like to incorporate his practice, a basic corporate name that meets the legal requirements is "John Smith Medicine Professional Corporation". The name requirements for such a corporation also means that the corporation cannot be a numbered company. The purpose of this limitation is so that there is clarity regarding the function and type of corporation that is operating the medical practice.

Incorporated doctors should also remember that they cannot practice beyond their medical field under their corporate name. The creation of such a corporation is purely for the practice of medicine. This limitation does not apply as stringently to the investment of the corporation's surplus funds. Ontario's Business Corporations Act does allow for the temporary investment of surplus funds carried by the corporation. One should note that the Ontario Government is in the process of passing Bill 198. If passed, Bill 198 will amend Ontario's Business Corporations Act to remove the word "temporary", so that incorporated professionals can freely invest surplus funds earned by the corporation. This amendment would provide more investment freedom to a doctor that incorporates their medical practice.

It should be noted that The College of Physicians and Surgeons of Ontario plays an operative roll in the incorporation of medical practices. Once a doctor incorporates their practice, they are required to obtain a certificate of authorization from the College. There is an added cost of \$750.00 to apply for such a certificate. The College will ensure that the corporation meets the requirements of Ontario's Business Corporation Act, such as having a proper corporate name. The College will also make the name and address of the corporation, the names of all the shareholders, and any revocations of the corporation's certificate of authorization available to the public.

In conclusion, incorporating a medical practice can be beneficial to doctors who want to defer the payment of taxes or could benefit from the \$500,000.00 capital gains exemption. However, doctors that see the incorporation of their medical practice as an attractive option should remember that there can be increased paper work and administrative costs, there is no limitation of professional liability, and it does not create a better structure for income splitting purposes.

The comments contained in the Bulletin provide a brief overview only and should not be regarded or relied upon as legal advice or opinions. Gowlings Lafleur Henderson LLP would be pleased to provide more information or specific advice on matters of interest to our readers.

For additional information please contact Mark Siegel: mark.siegel@gowlings.com or (613) 786-0136 in Ottawa, or, Tim Wach: timothy.wach@gowlings.com or (416) 369-4645 in Toronto. ■

MEMBERS ON THE *MOVE MOVE*

To get your new appointment in "Members on the Move", send us the following information – your name, position, date of appointment, the organization you were with and the new organization (if applicable), your email, phone number and address. We will run these announcements as we receive them, and as space in

the *Dialogue* allows. Please forward your items in writing to the OPA Office, 1141 South Service Rd. W., Oakville, ON, L6L 6K4, by email to: opa@bellnet.ca or by fax to: (905) 469-8697.

THE KIRBY ROUNDTABLES:

In-depth study of mental health sheds different lights on issues*

After releasing its final report on the health care system last fall, the Standing Senate Committee on Social Affairs, Science and Technology met to decide which health care issues needed more in-depth study. According to Committee Chair Senator Michael Kirby, it didn't take long for the Committee to unanimously agree that the issue of mental health and mental illness in Canada requires greater study. "One of the things that struck us during our first set of hearings was that, to the extent that mental health issues arose it clearly was almost an orphan child of the health care system. It was always a peripheral issue; there was not any great degree of focus on it," said Senator Kirby.

The Committee is conducting a national study on mental health, following through on the recommendation in its final report, *The Health of Canadians - The Federal Role* (the Kirby Report). Phase One of the study involves a series of 14 roundtables, which were launched on Feb. 26, and consists mainly of gathering information, data and facts on mental health and mental illness, public hearings and site visits in Toronto and Montreal, as well as fact-finding trips in both Eastern and Western Canada. The result of these initial roundtable hearings, each involving a panel of expert witnesses, will be the tabling of a fact-finding report, which will highlight the main issues surrounding mental illness and mental health. The phase one report is to be tabled with the Senate this summer.

The first roundtable session (Mental Health Problems and Illnesses - Learning from Personal Experiences) started the study off by putting a human face to the issue, as three family members affected by mental illness and one consumer spoke candidly about their experiences. With first-hand experience of mental health issues, the four witnesses came from across the country to recount their personal stories to the committee. Together, the witnesses painted a picture for the committee of the stigma, frustration, fear and anger, of the impacts on the family, on siblings, on the social lives, on the workplaces and incomes of families living with mental illness. By telling their stories, which the Committee members agreed were moving, touching and very useful to the study, the witnesses helped shed light on issues such as access to treatment, communication or collaboration between care providers, social reintegration, access to resources, and patient rights and privacy issues.

In mid-March, Roundtables Two (Refresher on Mental Health and Mental Illness) and Three (Prevalence and Costs) added much more information to the study as witnesses from psychiatry, epidemiology, academia, Health Canada, Statistics Canada and CIHI made their expert presentations to the Committee. In Roundtable Two the Committee heard the difficulty of even defining key concepts such as mental health. "The terms 'mental health,' 'mental illness,' 'mental disorder,' and 'mental health problem' are often used interchangeably or inconsistently. In order to have a productive study of mental health and mental illness, it is helpful to review what the terms include and how they are interrelated. There are varying opinions about what each of these terms includes and excludes," explained Tom Lips, Health Canada, Senior Advisor, Mental Health.

With Tom Lips, witnesses Dr. Paul Links, Arthur Sommer Rothenberg Chair in Suicide Studies from St. Michael's Hospital, and Dr. Alain Lesage, Past President of the Canadian Academy of Psychiatric Epidemiology, gave the Committee necessary

background information on mental health problems and illnesses, discussed the federal and provincial-territorial roles and responsibilities where mental health and mental illness are concerned, they talked about the causes (etiology), consequences, co-morbidity, correlation and interactions between various determinants influencing mental health and mental illness, and the interdependent relationships between physical and mental health.

Dr. Lesage explained for Committee members that the stigma of seeking help for a mental illness still exists. "When people are asked in surveys why they do not seek treatment, the answer is always the same. People say that the problem will resolve itself, or that they can get through it on their own."

The third session, on prevalence and costs, drew out a great deal of data about mental illness, including the incidence of mental health problems and illnesses by age, sex, region, the economic burden of mental health problems and illnesses and the impact on quality of life. The witnesses also painted a picture of the state and availability of national health information for mental health and addiction services in Canada, with the witnesses indicating that the information Canada collects and currently has is limited.

"We need better information on outcomes of services. Are the services effective in achieving the desired short-term and long-term results? We need to know more about continuity of services. We need to know more about housing, jobs, training, education. We need to know more about the use of services — how, when and where services are used. What are the best practices of service delivery? What is working and what would be beneficial to adopt more broadly? We need to know more about the characteristics of clients who are using the services, who needs services and whose needs are not being met. We need national benchmarks that will speak to best practices, goals and targets for service delivery across the country," explained Carolyn Pullen, Consultant, Canadian Institute for Health Information.

Roundtables Four (Childhood Disorders) and Five (Adolescent Disorders) were held in late April. Phase Two of the Committee's mental health study is set to get underway in fall 2003, with the Committee addressing issues raised during Phase One, reviewing public policy with respect to mental health and mental illness in selected countries and holding hearings designed to consider potential options for Canada, including the creation of a national action plan on mental health. Phase Two would lead to a report detailing the Committee's recommendations, with the tabling of a final report set for December 2003.

The CPA established a working group, chaired by Dr. Elliot Goldner, to prepare a brief for the fact-finding phase of the Kirby Commission study. To follow the Senate Committee proceedings, or get more information on the Kirby hearings, visit www.cpa-apc.org and link to our Kirby Special Feature.

**This article was written by Canadian Psychiatric Association staff, specifically for Dialogue. ■*

Information on Community Programs will be in future issues of *Dialogue*.

If you have some information to share, please forward it to the Editor.

Please forward any submissions/articles for future issues of *Dialogue* to the Editor by email:

opa@bellnet.ca or by fax: (905)469-8697

The AGHPS Board submitted the following letter in response to the Mental Health Implementation Task Force Recommendations.

Honorable Tony Clement
Minister of Health & Long Term Care
80 Grosvenor St, 10th floor
Toronto, Ontario
M7A 2C4

March 7th 2003

Dear Minister:

RE: Mental Health Implementation Task Force Recommendations

The Board of the Association of General Hospital Psychiatric Services (AGHPS) takes this opportunity to outline our perspective on recommendations recently submitted to you by the province's Mental Health Implementation Task Forces.

The (AGHPS) is a professional association representing General Hospital, Schedule 1 psychiatric facilities throughout the province. This includes 48 different facilities, situated in all regions of Ontario.

- ✓ General hospital psychiatric 1 services collaborate with other hospital based specialty programs, public health departments, district health councils and a wide variety of community based health services.
- ✓ General hospital psychiatric services liaise closely with local family physicians, tertiary care hospitals and a plethora of community, social and mental health agencies providing support for severely mentally ill individuals and their families.
- ✓ Additionally, as the regional hub for emergency psychiatric care, we provide support for police, ambulance services, and mobile crisis teams.

Clearly, general hospitals are in the unique position of collaborating with all caregivers along the mental health continuum. Our perspective, therefore, is important, comprehensive and focused.

We congratulate the Task Forces and their chairs for completing their reports through extensive research and broad stakeholder input, including consumers, family members, physicians and community-based agencies.

We endorse almost all of the Task Forces' recommendations.

- ❖ We support the attempt to roll out policies described in the Ministry's "Putting People First" document.
- ❖ We agree with the elaboration of a mental health system, which is comprehensive, accessible, integrated and accountable.
- ❖ Additionally, we are pleased to see a system design based on a seamless flow of services and supports provided to mentally ill individuals as they proceed along the path of recovery. We are certain that patients and their families will benefit greatly from a much less fragmented and more accessible spectrum of care. With new and enhanced information and referral programs, service agreements among care providing agencies and expansion of shared care networks involving collaboration between psychiatrists and family physicians, gaps in care should close.

The AGHPS believes that a mental health system needs to be held accountable to those in need. Accountability mechanisms should involve measures of clinical effectiveness, sensitivity to the consumer and fiscal responsibility. In an attempt to address this issue, **eight out of nine task forces have proposed regional mental health authorities. Not wanting to undermine the Task Forces, we do however, challenge this recommendation**, based on our research and experience. Below we articulate our concerns regarding regional mental health authorities, if the authorities would control the funding and resources of general hospital psychiatric services.

1. Splitting off mental health system governance would alienate psychiatry from primary health care and other specialties. To do this would distinguish Ontario as the only province which places Hospital based psychiatry under separate accountability from the largest medical specialties. Such a schism would reverse a highly positive trend in General Hospital and community psychiatry. The close association between general medicine and psychiatry has stimulated psychiatry to embrace modern scientific methods, and base treatments on evidence, not theory. In turn, psychiatry has encouraged greater awareness of the psychological needs of medical and surgical patients.

Increasingly, there is acknowledgment that the backbone of the mental health system is primary care.¹ The great majority of Ontario citizens have primary care physicians and most have seen one over the past year.² As neurosciences generate increasingly safe and effective biological treatment and evidence based psychotherapies, primary care physicians have become the main access point for people with mental illness. For most people, family physicians provide their most accessible health care service, and through them, they can receive care which integrates all body systems. Thus, with care for both body and mind combined, a person with mental illness has the potential to feel integrated and whole. This is a cornerstone of mental health promotion, treatment and rehabilitation. Over the past 20 years, Schedule 1 Hospital psychiatry programs have established close relationships with community physicians, supporting them and their patients with specialized expertise. Family physicians inform us that without the provision of emergency psychiatric services, inpatient care and specialty outpatient programs, they would have great difficulty managing mentally ill patients.³ Additionally, over the past 20 years, synchronous with mental health reform, Schedule 1 facilities have developed extensive networks based on collaboration and partnerships with community agencies. To an increasing extent, these are often based on formal contracts, a practice which should proliferate with encouragement from the Task Forces.

2. The examples of successful regional authorities are not applicable to Ontario. We are not impressed by cited case examples of regional authorities. While there are positive examples of health authorities in two North American jurisdictions, Philadelphia and New Brunswick, their circumstances are very different from ours. In these jurisdictions, community psychiatric programs received a significant infusion of new money as state/provincial psychiatric facilities were downsized and closed. This does not appear to reflect the current situation in Ontario. Without a major financial stimulus, we fear that the cost of establishing mental health authorities could deplete funds vitally needed for the provision of care. Additionally, new service alignments would require funding re-allocations from program to program. Dramatic changes in service alignment may be slow and disrupt service provision. We are opposed to directing current or additional funding to support infrastructure changes at a time when

funding is urgently required for provision of care.

3. The costs are likely to be high. While we do not currently have accurate information about costing, regional authorities could significantly increase administrative costs in the mental health system. Currently, the expense associated with mental health administration is low. According to recent Ministry data, with \$8.1 million, the MOHLTC manages community-based mental health services with administrative costs at \$592.8 million and hospital based services at \$683.8 million. With administrative costs of less than 1%, these figures are impressive when taken against administrative costs for managed systems in general, whether in the mental health sector or in general health care. Furthermore, we anticipate administrative costs in hospitals to increase when we are required to report to both a regional authority, and a hospital board. In Toronto and Peel, hospital administration and staff would also need to liaise with a 3rd entity – the local care delivery network.⁴

4. In order to incorporate mental health budgets into a regional envelope, there would be a need to identify the actual cost of operating mental health programs within a hospital. This would pose a challenge, since the true costs are significantly greater than those customarily identified within Schedule 1 budgets. Hospitals provide various types of overhead services, such as human resources, occupational health, security, health records, infrastructural support, including information technology systems and back-up from other specialty services. Hospitals also provide rent-free space and additional financial benefits including extra funds from their global budgets to provide for union agreements, cost of living increases, and staff recruitment. Clearly, reported costs under-represent the true expense. These are not currently calculated nor is there an existing formula to capture these costs. To the extent that such funds are not identified and incorporated into regional envelopes, how could we protect funds needed for the ongoing operation of hospital based mental health services? How could we be secure that regional health authorities would support these costs? Without doing so, they would severely undermine the ability of hospital psychiatric services to deliver quality service and attract well-trained and committed professionals.

5. Additionally, through fundraising, hospitals purchase new equipment, renovations and new buildings. **There is evidence from regional health authorities throughout Canada that hospital fundraising deteriorates when local hospital governance is taken over by regional authorities.**⁵

6. Throughout Canada, there has been considerable experience with regionalization. Research findings point to the inability of regional health authorities to provide cost containment, adequate planning or service integration. Furthermore, **the extent to which regional health authorities provide greater democratization and broader citizen involvement has been challenged.** Recently, in Saskatchewan, only ten percent of the electorate turned out. We understand that Saskatchewan is now moving towards appointed, not elected, boards. As for democratization, we believe that there is no system superior to the accountability of government to an elected legislature.⁶ Research on the composition of regional elected boards challenges the assumption that they make decisions more effectively than a government which canvasses stakeholder input and closely monitors services, through improved data collection.⁷

7. Looking at Canadian experiences, most regional health authorities, except Alberta, New Brunswick and Manitoba have integrated mental health under the umbrella of regional health authorities. In at least two of those provinces, Alberta and New Brunswick, separate mental health authorities are being disbanded. The reasons for this warrants further investigation. In Ontario, we have considerable experience with positive examples of mental health service integration, not requiring regional authorities. In southwestern Ontario, where a regional board was not recommended, we have integrated partnerships in Grey Bruce, Essex County and London. These are models which can be replicated elsewhere.

In summary, the Association of General Hospital Psychiatric Services respectfully challenges Task Force recommendations for the development of separate mental health authorities especially if the authorities controlled the resources and funding of General Hospital Psychiatric Services.

We recommend as a governance model enhanced accountability to the Ministry of Health and Long Term Care.

- It is our observation that with regionalization, the MOHLTC is becoming increasingly effective as manager of the mental health system.
- We recommend further enhancement, to include improved data collection of service characteristics such as volumes, outcomes and consumers satisfaction measurements. Currently the field is increasingly moving in this direction as we develop validated measurements to gauge the effectiveness of mental health services.
- Consistent with this, we welcome the inclusion of mental health services in the hospital report card process. Through service agreements with individual hospitals, the Schedule 1 hospitals and the MOHLTC can work together to develop suitable performance expectations and monitoring, consistent with modern management systems.
- Overarching this, the mental health system would continue to be accountable to Ontario's political process involving an elected cabinet and its accountability to the legislature and the media. These are buttressed by parliamentary tradition and safeguards over the accountability of bureaucracy.

We are united in believing that the public interest would best be served through such an enhanced method of accountability to the Government, in addition to the oversight of hospital boards, regulated health professions, and ultimately of our patients and their families.

We respectfully submit these perspectives and would be pleased to meet with the Minister at any time to discuss them further.

Sincerely,
June Hylands
Executive Director
On behalf of Board of Directors

References:

¹ Lin E. Goering P. Offard D. Campbell D. Boyle MH The Use of Mental Health Services in Ontario: epidemiologic findings. Canadian Journal of Psychiatry 1996; 4-1 : 572 - 577

¹(Anonymous) Decision Research Report to the College of Family Physicians of Canada. Toronto: Science Research:1

³ Kates N. Craven M et al. Shared Mental Health Care in Canada. Position Paper approved by the Canadian Psychiatric Association and the College of Family Physicians of Canada, Canadian Journal of Psychiatrists vol. 42 #8, Canadian Family Physicians vol. 43 October 1997.

⁴ Toronto – Peel Mental Health Implementation Task Force. Chair, Honorable Michael Wilson.

⁵ Regional Health Authorities in Canada Sessions for Ontario. A discussion paper. Ontario Hospital Association Research Services. January 2002.

⁶ Abelson J. Lomas J et al. Does the Community Want Devolved Authority? Results of Deliberative Polling in Ontario. Canadian Medical Association Journal. August 15, 1995 153(4).

⁷ Lomas J. et al. Devolving Health Care in Canada: Provinces. Canadian Medical Association Journal. Series of 4 articles. February 1, February 15, March 1.

HIGHLIGHTS OF THE ONTARIO 2003 BUDGET:

- guaranteed stable base funding increases for the hospital sector over the next three years, a minimum of 11.2 per cent increase in base funding over the next three years;
- increases in hospital funding for 2003/04 by 5.1 per cent to \$10.3 billion from \$9.8 billion in 2002/03;
- more than \$400 million in funding for capital infrastructure and \$130 million for the acquisition of new medical and diagnostic equipment for hospitals;
- \$250 million over five years for mental health reform, including:
 - a provincial public education campaign to build awareness and understanding of mental health issues and to combat stigma and discrimination against those living with serious mental illness;

- a new Center of Excellence in Children's Mental Health at the Children's Hospital of Eastern Ontario;
- complete divestment of the provincial psychiatric hospitals in Whitby and North Bay;
- creation of A Premier's Council on Mental Health to raise the profile of mental health and mental illness, address key Provincial initiatives, and promote collaboration and monitor progress on mental health reform;
- expansion of early intervention and prevention service capacity across the province; and,
- support for consumer-led activities, such as self-help support services, consumer-run businesses and leadership skills training

April 24, 2003

Honourable Tony Clement, Minister
Ministry of Health and Long-Term Care
Hepburn Block, 80 Grosvenor St., 10th Floor
Toronto, Ontario M7A 2C4

Dear Minister:

As providers involved in the delivery of mental health services in Ontario, we would like to thank you, Minister Ecker and Premier Eves in addressing the challenges of mental illness in the 2003 Ontario Budget.

We are pleased with the announcement of a Premier's Council for Mental Health, as it clearly demonstrates the Government's commitment to addressing the needs of people with mental illness. We welcome the Government's commitment to allocate \$250 million over the next five years to move forward with mental health care reform and applaud the investment in early intervention and consumer-led initiatives.

While this new funding will begin the difficult process of building community based services for mental health, we are concerned that the funding is one-time and insufficient to meet community needs. Without significant increases in funding for mental health, critical reforms will be difficult to implement, such as addressing long waiting lists for mental health services and divesting the remaining provincial psychiatric hospitals.

In addition, the Provincial Themes report and recommendations from the nine regional Mental Health Implementation Task Forces went considerably further than the Ontario Budget in recommending significant investments in mental health. We can only hope that the Premier's Council on Mental Health will be able to address the significant funding needs required to provide the necessary support systems for some of our most needy and vulnerable citizens in the province.

Therefore, we would recommend that the 2003 Speech from the Throne build on the Ontario Budget commitment to mental health by announcing clear targets for addressing mental health reform in the province. This would reaffirm the Government's commitment to mental health and offer hope to patients and their families throughout the province.

We will be contacting your office, in the next week, to schedule a meeting.

Yours truly,

June Rickard, President, Canadian Mental Health Association, Ontario; Doug Weir, Chair, Section of Psychiatry, Ontario Medical Association; Hilary Short, President & CEO, Ontario Hospital Association; David Kelly, Executive Director, Ontario Federation of Community Mental Health and Addiction Programs; Robert Buckingham, MD, FRCP, President, Ontario Psychiatric Association; June Hylands, Executive Director, Association of General Hospital Psychiatric Services; Karen Liberman, Executive Director, Mood Disorders Association of Ontario; Dr. Ester Cole, President, Ontario Psychological Association

Department of Psychiatry and Behavioural Neurosciences **MC MASTER WEBSITE**

PsychDirect (<http://www.psychdirect.com>) is the public education website for the Department of Psychiatry & Behavioural Neurosciences at McMaster. The emphasis is on evidence-based mental health information and education. The content has been developed for both the professional mental health and general lay-public audiences. At the moment, both the professional and the public information can be accessed by any visitor – the function of the website is to educate the public so that they can play a more active and informed role in their own care.

The site content is expanding all the time. Currently on-line:

- Depression & Mood Disorders
- Anxiety Disorders
- First Episode Psychosis
- Women's Mental Health
- Forensic Psychiatry (including criminal criminology and psychiatry & the law).

OMA Section on Psychiatry – UPDATE

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

PSYCHIATRISTS CAN EXPECT INCOMES TO INCREASE IN 2003-2004. AS A RESULT OF THE NEW OMA/MOHLTC AGREEMENT, FEES FOR SPECIFIC PSYCHIATRIC SERVICES WILL INCREASE.

The Executive of the OMA Section on Psychiatry supports the OMA members of the PSC on the Memorandum of Agreement for 2003-2004 announced in April. The new arrangement stems from the provision contained in our current Master Agreement, which allows for both parties to revisit the allocated two per cent fee increase to be applied in the final year of the Agreement. The OMA Board of Directors and the Government of Ontario have approved a complex, multi-faceted physician compensation package for fiscal 2003-2004 - \$180 million of which will flow as new fee revisions and targeted enhancements to be phased in during 2003-2004, along with expanded access to the \$100 million in primary care renewal funding that exists in our current Master Agreement.

The Section Executive have advocated, for a number of years, that the OMA Central Tariff Committee adjustments be implemented and that new money not be allocated to across-the-board fee increases to the Schedule of Benefits, since this would perpetuate existing fee inequities. The new agreement achieved both of these objectives. The agreement obtained more than the two per cent increase – the agreement will implement the vast majority of outstanding Central Tariff Committee adjustments, including the recommendations regarding psychiatric services; and, does not give across-the-board fee increases to the Schedule of Benefits. Instead, it allocates them in a more equitable fashion, making changes to the Schedule of Benefits, which will initiate rebalancing of Sectional disparities.

Ontario physicians were entitled to \$90 million (annualized) if we had only received a 2% fee increase. All together the OMA achieved \$327 million (annualized). Total Professional fees in 2002-2003 were \$4.1 billion. The total change as a result of implementing CTC recommendations and rebalancing is \$180 million (annualized) or an increase of over 4% to professional fees.

Psychiatrists, as a result of implementing the CTC recommendations, which are effective April 1, 2003, gained an additional \$9.6 million and as a result of rebalancing, an additional \$7 million (annualized), a total increase of \$16.6 million (annualized), or, an overall increase of 6.64%. Because the rebalancing fee increases are not effective until August 1, 2003, the real increase for 2003-2004 is somewhat less; however, this means that beginning April 1, 2004, we are starting with a bigger base. The average psychiatrist, who in 2002-2003 billed OHIP \$143,000, in 2003-2004, will receive over \$8,000 in additional money from OHIP. This is the actual dollar increase; if you use the annualized figure, it is about \$9,500, but since OHIP will not be paying the rebalance money until August, the \$8,000 figure is what psychiatrists can actually expect for this year. Table 1 shows the effect the CTC Recommendations and Rebalancing has on other Sections, on an annualized basis.

The economic adjustments, which will be phased in between April 1 and October 1, 2003, are a positive stride forward as we look ahead to the next round of negotiations for a comprehensive Agreement, scheduled to begin in January 2004. The Section Executive will continue close communications and consultation with all appropriate committees, to advocate for the 2004 negotiations, to continue rebalancing Sectional disparities and ensure that, like this agreement, the 2004 agreements not give across-the-board fee increases.

I once more want to thank the over 450 Ontario Psychiatrists who wrote Dr. Halparin, then OMA President, who was open and receptive to our concerns. OMA Council at its November meeting reconfirmed its recommendation to implement the CTC recommendations, which set the priorities for the reopener negotiations to

implement CTC and not give across-the-board fee increases.

The accompanying table (Table 2) outlines the new fees for psychiatric services and when they take effect. In addition to the codes below, K032 Specific Neurocognitive Assessment – Diagnosis of Dementia, a new code comes into effect July 1, 2003 and the fee will be \$50.45. The table also shows that, starting April 1, 2003, the Psychiatric K and other specific fee codes increases are in accordance with the CTC recommendations. Further you will see that as of August 1, 2003, specific psychiatric fee codes increase, as a result of the additional funding to initiate the process of rebalancing Sectional disparities on a going-forward basis.

The complete OMA/MoHLTC document is posted in its entirety on the OMA Members' Home Page (www.oma.org) and was also published in the April issue of the Ontario Medical Review.

SESSIONAL FEES

Sessional funding is a mechanism to pay for a variety of 'indirect' psychiatric services provided by psychiatrists in the general hospital system and through community mental health programs. In most cases, a multidisciplinary team including a psychiatrist delivers psychiatric services in these settings. Sessional funding compensates these physicians (on an hourly rate basis) for participating in indirect case management and for consulting with other professionals to plan, monitor and evaluate care. The sessional rate has remained unchanged for over 10 years at \$311 per three-hour block or \$103.67 per hour. Psychiatrists in 2002-2003 were paid \$108.30 per hour when they saw an outpatient for direct psychiatric service and billed either individual psychotherapy or individual psychiatric care.

In 1993 the NDP government unilaterally cut sessional funds by 25%, further worsening the general hospitals' ability to attract psychiatrists. In 2000 the current government restored the sessional funds back to their 1993 level. However, the rate did not change. Sessional Fees for 2001/02 for Community Mental Health Agencies, Children Mental Health Institutional Programs and General Hospital Psychiatric Programs totaled \$20 million. Psychiatrists working in Provincial Psychiatric Hospitals recently completed negotiations and obtained a 15% increase to their sessional rate from \$311 (\$103.67 per hour) to \$358 (\$119.33 per hour).

Representatives of the Ontario Psychiatric Association, the OMA Section on Psychiatry and the Association of General Hospital Psychiatric Services have been talking to the MoHLTC to increase the sessional rate paid to psychiatrists working in Community Mental Health Agencies, Children Mental Health Institutional Programs and General Hospital Psychiatric Programs. We have had positive discussions and they agreed with the need for consistency in the Sessional Rate in PPHs and other settings. We hope that by the time you read this issue of the OPA Dialogue the Minister of Health will have made an announcement regarding this issue.

MOVING FORWARD

The OMA and the MoHLTC will start negotiations early in 2004 for a new memorandum of agreement to replace the present agreement that ends March 31, 2004. The Coalition will continue to fund the activities of Dr. Gaid, the OMA Section on Psychiatry Tariff Chair and myself to ensure that we can advocate for the interests of Ontario Psychiatrists as we prepare for those negotiations. The Coalition of Ontario Psychiatrists will be having an all day retreat June 21, 2003 to identify priorities for the next year and to discuss how to achieve them. Members of the OPA Council and the Executive of the OMA Section on Psychiatry will all be there. Please let us know your concerns and what you would like to see as a priority in the next year.

TABLE 1

CTC/REBALANCING CHANGES: EFFECT BY SPECIALTY			
SPECIALTY	TOTAL CHANGE (%)	SPECIALTY	TOTAL CHANGE (%)
Geriatrics	13.11%	Haematology	3.50%
Neurosurgery	11.13%	Respiratory Diseases	2.80%
Neurology	8.33%	Otolaryngology	2.53%
Anaesthesia	8.31%	Gastroenterology	2.15%
Obstetrics & Gynaecology	7.77%	Orthopaedic Surgery	1.53%
Clinical Immunology	7.66%	Thoracic & Cardiovascular Surgery	1.28%
General Surgery	6.77%	Cardiology	1.17%
Psychiatry	6.64%	Urology	0.98%
Paediatrics	6.19%	Plastic Surgery	0.65%
Rheumatology	5.88%	Dermatology	0.60%
Nuclear Medicine	5.84%	Lab Medicine	0.55%
Internal Medicine	4.85%	Diagnostic Radiology	0.31%
General Practice	4.70%	Clinical Biochemistry	0.22%
General Thoracic Surgery	4.55%	Ophthalmology	0.11%
Physical Medicine & Rehab	4.50%	Therapeutic Radiology	0.10%
Emergency Medicine	4.39%		

The above estimates are provided by the Department of Economics, Ontario Medical Association

TABLE 2 - PSYCHIATRIC FEES 2003/2004

CODE	SCHEDULE OF BENEFITS CODE LABEL	2002 OHIP FEE effective April 1	2003 OHIP FEE	2003 OHIP FEE effective August 1	TOTAL FEE Increase \$	TOTAL FEE Increase %
A195	Consultation	\$122.00		\$125.00	\$3.00	2.5%
A197	Consultation on behalf of disturbed child – consultative interview with parents	\$107.20	\$122.00	\$125.00	\$17.80	16.5%
A198	Consultation on behalf of disturbed child – consultative interview with child	\$107.20	\$122.00	\$125.00	\$17.80	16.5%
C192 C197 C198 C199 W192 W193	Subsequent visits - Inpatient Services Chronic Care Nursing Homes	\$18.25	\$23.00		\$4.75	26.0%
C895	Hospital In-Patient Services - Consultation	\$134.25		\$140.00	\$5.75	4.3%
K190	Individual in-patient psychotherapy	\$54.15	\$56.40		\$2.25	4.2%
K191	Family psychiatric care, in-patient	\$61.40	\$63.95		\$2.55	4.2%
K193	Family psychotherapy - in-patients	\$61.40	\$63.95		\$2.55	4.2%
K195	Family psychotherapy - out-patients	\$61.40	\$63.95		\$2.55	4.2%
K196	Family psychiatric care, out-patient	\$61.40	\$63.95		\$2.55	4.2%
K197	Individual out-patient psychotherapy	\$54.15	\$56.40	\$58.40	\$4.25	7.8%
K198	Psychiatric care, out-patient	\$54.15	\$56.40	\$58.40	\$4.25	7.8%
K199	Psychiatric care, in-patient	\$60.10	\$62.60		\$2.30	3.8%
K200	Group psychotherapy, in-patients – 4 people	\$13.45	\$13.95		\$0.50	3.8%
K201	Group psychotherapy, in-patients – 5 people	\$11.10	\$11.60		\$0.50	4.5%
K202	Group psychotherapy, in-patients – 6-12 people	\$9.55	\$9.85		\$0.30	3.1%
K203	Group psychotherapy, out-patients - 4 people	\$13.45	\$13.95		\$0.50	3.8%
K204	Group psychotherapy, out-patients - 5 people	\$11.10	\$11.60		\$0.50	4.5%
K205	Group psychotherapy, out-patients - 6-12 people	\$9.55	\$9.85		\$0.30	3.1%
K206	Psychotherapy, Family Psychotherapy, Hypnotherapy and Psychiatric Care - Group psychotherapy, out-patients – per member, per 1/2 hour - (seventh hour onward, to a maximum of 3 hours)	\$8.70	\$9.15		\$0.45	5.0%
K207	Psychotherapy, Family Psychotherapy, Hypnotherapy and Psychiatric Care - Group psychotherapy, in-patients – per member, per 1/2 hour - (seventh hour onward, to a maximum of 3 hours)	\$8.70	\$9.15		\$0.45	5.0%
	Other psychiatric fees unchanged					

Health Canada Approves Zyprexa (Olanzapine), Treatment For Bipolar Disorder

Zyprexa® (olanzapine) has been approved in Canada for the treatment of manic and mixed episodes associated with bipolar disorder. Zyprexa provides rapid symptom control of a broad range of symptoms associated with mania and helps prevent relapse back into mania. Zyprexa is also indicated in Canada for the acute and maintenance treatment of schizophrenia and related psychotic disorders. Since introduced in 1996, Zyprexa has been prescribed to nearly 11 million people worldwide.

Bipolar disorder affects approximately one to two per cent of the adult population.¹ Bipolar disorder is a lifelong illness characterized by disruptive swings in mood--from euphoria and irritability (manic episodes), to periods of depression. A patient may experience either "pure" episodes (manic or depressive symptoms) or "mixed" episodes (a mixture of manic and depressive symptoms at the same time). In addition to the profound impact that the illness has on patients, there can be an equally severe impact on the patient's family and caregivers. Twenty-five to 50 per cent of people with bipolar disorder will attempt suicide at least once.²

Clinical Trial Results:

In ongoing clinical trials with bipolar patients, Zyprexa has been shown to provide rapid symptom control, help patients remain in remission longer and help prevent relapse into mania:

- Rapid symptom control in bipolar mania: studies show that Zyprexa demonstrated greater efficacy than placebo in the treatment of bipolar mania,^{3,4} including a higher rate of response (65 per cent vs. 43 per cent respectively).³ Zyprexa has been shown to produce a significantly greater improvement in symptoms of mania vs. divalproex³
- Effective in depression symptoms: Zyprexa has been shown to manage depressive symptoms in patients with manic and mixed episodes. These symptoms are particularly resistant to standard anti-manic treatment. Nearly a seven-fold improvement in depressive symptoms was seen when Zyprexa was added to another mood stabilizer⁶

- More effective than the current gold standard - lithium: a year-long study showed that in the maintenance treatment of bipolar disorder, patients taking Zyprexa relapsed into mania only half as often as patients taking lithium⁶

Zyprexa is generally well tolerated. Adverse events reported in clinical trials included somnolence, dizziness and dry mouth, but rarely led to discontinuation of trial. As with other mood stabilizers, Zyprexa can also be associated with increased appetite leading to weight gain.

The recommended beginning dose of Zyprexa to treat acute manic episodes is 10 milligrams in combination therapy or 15 milligrams by itself, taken once a day without regard to meals.

References

1. Mood Disorders Society of Canada website, <http://www.mooddisorderscanada.ca>
2. Jamison KR. Suicide and bipolar disorder. *J Clin Psychiatry* 2000; 61 (Suppl 9):47-51
3. Toben, M et al., Efficacy of olanzapine in acute bipolar mania. *Arch Gen Psychiatry* 2000;57:841-849
4. Toben M et al., Olanzapine vs. placebo in the treatment of acute mania. *Am J Psychiatry* 1999; 156:702-709
5. Toben M et al., Olanzapine versus divalproex in the treatment of acute mania *Am J Psychiatry* 2002; 159:1011-1017.
6. Toben M et al., Olanzapine versus lithium in relapse prevention in bipolar disorder: a randomized double-blinded controlled 12-month clinical trial. Presented at the Third European Stanley Foundation Conference on Bipolar Disorder in Freiburg, Germany.

SOURCE: Eli Lilly Canada Inc

Retrieved April 3, 2003 from: Doctor's Guide DGNews,

<http://www.docguide.com/news/content.nsf/EAC/8525697700573E1885256CED00562AE9?Op=en&type=DGNews>

First Annual Report on Hospital Mental Health Services

In the fall of 2003, the Canadian Institute for Health Information (CIHI) will release the first Annual Report on Hospital Mental Health Services. This report will contain highlights of national, provincial and regional-level data analysis using inpatient hospital data from the national Hospital Mental Health Database. The

focus of the report will be on hospital services utilization indicators calculated using the only national, standardized mental health data available.

The September issue of Dialogue will provide a summary of the highlights.

AGENDA OPA Council

April 4, 2003

MT. SINAI HOSPITAL

600 University Ave., Conference Room 336, Main Floor

1.0 Remarks from the President

Approval of Agenda

2.0 Approval of Minutes of January 29, 2003, and February 1, 2003 OPA Council and January 31, 2003 OPA AGM

3.0 Business Arising

3.1 Mental Health Implementation Task Forces/Authorities

3.2 Review of OPA Liaison

3.3 Child Psychiatry Task Force

4.0 Treasurer's Report

5.0 Reports of Task Forces and Committee

5.1 Advocacy Committee

5.2 Communications Committee

5.3 Continuing Education Committee

5.4 Finance/Audit Committee

5.5 Member Services Committee

6.0 Standing Reports

6.1 OMA Tariff/RBRVS

6.2 CPA Report

6.3 Working Group on Mental Health Services

6.4 Coalition

6.5 Council of Provinces

6.6 Alliance for Mental Health Services

6.7 CPA Standing Committee on Education

6.8 Section Reports

7.0 New Business

7.1 Guest – R. John Harper Chair & CEO of Consent & Capacity Board

7.2 Dinner with Lt. Gen. (Ret.) Roméo Dallaire

BOOK REVIEW:

Beyond Crazy: Journeys Through Mental Illness By Julia Nunes and Scott Simmie

Review by John Deadman, M.D. Associate Clinical Professor, Department of Psychiatry and Behavioural Neuroscience, McMaster University.

Scott Simmie collaborated with Julia Nunes on this book, which is a follow-up to their previous book "The Last Taboo". The two books have the same theme - mental illness from the perspective of the person suffering from it - but the format of their new book is different. It uses biographical accounts from many well-known people who have experienced mental illness personally or in a spouse, child or parent.

This book is written for a broad lay audience but clinicians should find it interesting as well. The authors wrote short introductions to each chapter but otherwise act as editors of other people's biographical accounts. Because direct quotes from people who suffer from mental illness were used extensively, there is little technical language and little attempt to strike a 'balance' or to explain complex concepts in layman's language. And because of the use of direct source material from a wide range of human experience, and relatively little editorial intrusion by the authors, the book seemed to me to be less judgmental, better balanced and more compelling for the reader than their previous book "The Last Taboo." The conclusions are more complex and tempered and hence more accurately reflect the complex world of mental health care and of human experience.

The book is divided into five chapters, an Introduction by the authors and an Afterward in two parts. Chapter One, entitled "Who's Affected" gives biographical accounts of six people whose names would be recognized by most Canadians. Elizabeth Manley describes her struggle with depression and a number of other symptoms that finally ended her skating career. David Reville lost his legal career due to mental illness, but went on to be a successful politician and advocate for the mentally ill. Patricia van Tighem, a writer, describes her struggle with post-traumatic stress disorder. Michael Wilson, a former Minister of Finance, describes how he coped with his son's schizophrenia and subsequent suicide. Katherine Best describes her battle with her inner demons that eventually forced her to leave an established administrative career. The book also includes the well-known story of system failure - Edmond Yu, the medical student who slipped into paranoia and psychosis and was shot by police when he became aggressive on a city bus. In Chapter Two, "What it Feels Like" Andrea Woodside, Kim Honey, Lynda Wong, Diane F. Jane Lowrey, Karen Bond and Sue Goodwin give telling accounts of what it feels like to experience the symptoms of mental illness.

In Chapter Three, "Where the Heart is" stories by Scott Thompson, Eufemia E., Heather Riley, Tom Morris, Ronnie and Wanda Hawkins, and Tara and Terry-Lee Martinen describe the impact of receiving the diagnosis and prognosis of mental illness on the patient, family and friends.

In Chapter Four, "Why it Happens" several well-known people from a variety of backgrounds tell their stories and explain what they (and the authors) think may have caused their illnesses.

Chapter Five, "When (And How) People Move on" describe how people struggle to get appropriate treatment. Several treatment approaches, such as psychotherapy, drugs, psychosocial rehabilitation and alternative medicines are discussed. It becomes clear to the reader that the most important activity for those who suffer from mental illness is simply coming to terms with themselves and their illness and then getting on with their lives. This chapter helps us to understand the personal experience of different people with different psychiatric conditions in a very graphic way.

The Afterward is entitled "A Call to Arms" and is in two parts, one by Don Tapscott and one by the authors. The message is clear - mental illness is a very important and huge problem for the health care system and because of stigma, neglect, avoidance, denial, and who knows what else, it does not receive the attention it deserves or anything like the attention that other areas of health care receive. This book tells us that stigma damages the self-esteem of the mentally ill and their ability to deal effectively with their problems, and prevents other people from becoming involved. This book deals with the difficulty that most people have as they try to find the kind of help they need. But it also praises the advances in psychiatric treatment and the good treatment programs that exist in many parts of Ontario.

As a practicing psychiatrist, I winced at some people's descriptions of their encounters with the system, but I also recognized that these things happen more often than we would like to think. I was also struck by the similarity of the symptoms experienced by people with schizophrenia, anxiety disorders, depression, eating disorders, post-traumatic stress disorder and other conditions. It made me wonder about the seeming triviality of the differences in patients' experience, which our diagnostic manuals claim are critically important distinctions.

I liked "Beyond Crazy" better than "The Last Taboo". The many first-hand accounts gave the book a gripping reality which held this reader's interest throughout.

For more information, visit the Authors' website at www.goodmentaltbealth.info

Do you know of a book that should be reviewed for Dialogue? Would you like to be a book reviewer? If so, please contact the Editor by email at: opa@bellnet.ca or by phone at (905) 827-4659.

Are you moving? Has your phone, fax or email changed recently? Please let us know.

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RESIDENT'S REVIEW



As we all know, mental illness can have a devastating impact on social, occupational, and other areas of functioning. This is reflected in the current nosology of many mental disorders in the DSM-IV. Although residency programs excel at training future psychiatrists to empathically interview patients, provide comprehensive assessments and treatment plans, there is a lack of focus on rehabilitation and improving function beyond symptom reduction. Residents are not taught about re-integration of individuals back to society. In addition, there may not be equal emphasis on all of the CanMEDS roles (for more information see the May 2003 issue of the Canadian Psychiatric Association Journal.)

The WHO study on burden of illness suggests that major depression will be the second leading cause of disability by the year 2020. Residents are in a unique position to be exposed to areas of psychiatry in addition to the core curriculum. Often, residents pursue an area of interest for further study.

The following interview highlights one resident's experience and future plans in the field of organizational and occupational psychiatry. Dr. Maurice Siu is a 5th year resident at the University of Toronto who is interested in this area. He was recently part of the Scientific Advisory Committee to the Global Business and Economic Roundtable on Addiction and Mental Health which published a background paper entitled "Mental Health and Substance Use at Work: perspectives from research and implications for leaders". Dr. Siu has demonstrated a proactive approach in his residency in terms of pursuing special areas of interest. During our interview, he also highlighted the importance of mentoring (for more information please contact me about the OPA Peer Mentoring Program):

Dr. Balachandra: How did you first learn about the field of organizational and occupational psychiatry?

Dr. Siu: During my general psychiatry experience I was struck by the impact of mental illness on the various aspects of a person's life. One area was the impact on a person's occupational functioning. Even something as simple as taking time off work due to illness was a major issue if the cause was mental illness. In addition to suffering, a person had to endure stigmatization. I found there were limited resources available to assist individuals suffering from mental illness during the course of taking leave from work and transitioning back to work. Supports, which provide strategies and practical information regarding how to return back to work after a prolonged period of absenteeism, are limited. The determination of when an individual is 'ready' to return to work is often subjective in nature. Supports, which can provide an objective measure of an individual's ability to return to work, are needed.

Dr. Balachandra: Where did this interest lead you?

Dr. Siu: I also have an interest in forensic psychiatry. During my training in law and mental health I had the opportunity to perform various assessments. Some involved assessments for a large company regarding workplace violence and workplace mental health. I met psychiatrists who are actively practicing in this area. Next, I joined the Academy of Organizational and Occupational Psychiatry. A recent meeting in San Diego focused on the impact of stigma.

Dr. Balachandra: Tell me more about the project that you participated in with the Global Business and Economic Roundtable on Addiction and Mental Health.

Dr. Siu: The problem of depression, anxiety, and substance abuse on Canadian workplace productivity has been estimated around \$11 billion per year and is likely an underestimate. I had the opportunity to be part of the Scientific Advisory Committee (SAC) to the Global Business and Economic Roundtable on Addiction and Mental Health. This committee was chaired by Dr. M. Shain who is a Senior Scientist at the Centre for Addiction and Mental Health. The role of the SAC was to provide a report based on the analysis of over 3000 studies centering on mental health and substance use at work. This paper can be accessed at <http://www.mentalhealthroundtable.ca> for those who are interested. This paper aims to provide a summary of the research findings and direction for future research in the workplace setting.

Dr. Balachandra: What is the role of a psychiatrist in this field?

Dr. Siu: The majority of patients with mental illness first seek help through their family physician. However, psychiatrists who specialize in this field may offer specific insights. For example, if you look at depression, experiencing an episode of major depression increases the risk of future episodes. Major depressive episodes, which are inadequately detected or detected late, are often more severe in nature and require longer treatment, thus impacting more severely on socio-occupational-educational functioning. In providing specific treatment advice in a consultative or shared care capacity, the psychiatrist could collaborate in reducing stigma while simultaneously increasing mental health resources. The net effect would be returning a person to their previous level of functioning as soon as possible.

Dr. Balachandra: How can residents get involved in this area?

Dr. Siu: Unfortunately, there are currently no fellowship opportunities in organizational and occupational psychiatry in Canada or the United States. As such, residents are left to develop their own educational objectives during their residency. Residents who are interested in developing a skill set and knowledge base in this field should attempt to find supervisors/mentors who are working directly with companies as psychiatric consultants. They should familiarize themselves with the research literature in occupational psychiatry and psychology. An organization called the Academy of Organizational and Occupational Psychiatry (AOOP) is worth checking out for those of you interested in developing a full time career in organizational and occupational psychiatry. This can be accessed at <http://www.aoop.org> for those of who are interested.

Dr. Balachandra: What does the future hold for you?

Dr. Siu: I'm certainly interested in pursuing further opportunities in workplace mental health. I like to have variety in my practice. I'd like to have a mix of forensic psychiatry and be involved in workplace mental health. In fact, I'll be playing a role in the development of a return to work program at the Scarborough Hospital.

Please forward your comments and ideas for Resident's Review to Dr. Krishna Balachandra at kbalacha@uwo.ca