Ontario Psychiatric Association
DIALOGUE

JUNE 2004

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

MESSAGE FROM THE PRESIDENT

Those of us who work in general hospitals are well aware of the increasing demands on our time and the restricted resources we must work with. The shortage of hospital psychiatrists has been well known for many years and there is no clear solution.

Residency training positions in psychiatry have been decreased to the point that in ten to fifteen years we will have 30% fewer psychiatrists practicing in Canada than we do currently. The hospital that I work in, like many in the province, is currently undergoing an expansion that includes a doubling of the size of the emergency room which will likely cause our workload to increase. Our medical/surgical beds are being increased by almost 50%. In contrast, psychiatry beds are expanding from 22 to 25 - twenty years ago we had 26 psychiatry beds. Many general practitioners complain that they have difficulty accessing psychiatric services for their patients. This problem is only going to get worse and the complaints are only going to get louder.

I have no doubt that the stresses that we experience in the hospital psychiatric system will spread to all other practices of psychiatry including community psychiatry.

The current "psychiatrist" system is not sustainable!

I can assure you that the Ministry of Health and the Minister of Health are well aware of the problems with psychiatric care in this province. The OPA, as part of the Coalition of Ontario Psychiatrists, has had several meetings with senior officials in the last few months so we know that the Ministry of Health is aware but uncertain as to how to address the problems. We know too that the Minister of Health has a greater interest in mental health than his predecessors. The OPA is working with the OMA Section on Psychiatry and the Association of General Hospital Psychiatric Services so that we have a strong, unified voice for psychiatry.

The OPA is well positioned to take the lead in representing Ontario psychiatrists by providing input as to the solutions we want in place to solve the problems we face.

Up until now I suspect that many psychiatrists felt somewhat protected from the increasing stresses affecting the mental health system. Those days are coming to an end.

My presidential theme of "The Times: Are They Changing?" could easily have been "The Times Are Changing, and What Are We Going to do About it?". We need to be innovative and proactive in our interactions with government. They don't just want complaints. They want solutions. If we do not speak up, they will listen to others. I want to assure you that the Ontario Psychiatric Association is committed to representing psychiatrists. It can't be said enough - we need your input and feedback in order to do so.

Doug Wilkins, MD, FRCPC
2004 OPA President

PSYCHIATRIC MEDICATION AND WEIGHT GAIN

This issue of *Dialogue* includes a brochure entitled "Psychiatric Medication and Weight Gain" developed by the Women's Program at the Centre for Addiction and Mental Health and the Canadian Mental Health Association – Ontario.

Weight gain is an issue of importance for both men and women although women, especially, have problems with weight gain because even a small amount of extra weight is associated with an increased risk of other physical ailments. In addition, women are socialized to equate feelings of self-worth with their weight levels.

This brochure addresses weight gain as a serious side effect. Weight gain can cause women to stop taking their medication leading to exacerbation or relapse of illness. The health risks associated with various medication classes are described. The brochure also provides practical management strategies including activity, nutritional and adjustment of medications.

The brochure was funded through the Canadian Institutes of Health Research and was developed with the clinical advice and approval of Dr. Diane Whitney, Vice President of Medical Services and Clinical Director of the Women's Program at the Centre for Addiction and Mental Health. Additional brochures on violence, depression, work life balance and parenting are planned for the future. Psychiatric Medication and Weight Gain is available at the CAMH website: www.ontario.cmha.ca/women

For additional copies of this free brochure, please contact: Christine Bilusak, Web Developer, Canadian Mental Health Association, Ontario, 180 Dundas St. West, Suite 2301, Toronto, ON M5G 1Z8

Phone: 416-977-5580 ext.4123 Fax: 416-977-2813
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and more....

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From THE EDITOR

You may be aware of recent changes with respect to the Consent and Capacity Board. This issue of *Dialogue* provides you with information on these changes as well as the views of the OPA – in the form of a recent letter to the Minister of Health – and an interesting Q & A on legal/psychiatric issues first published many years ago in another publication.

Continuing with the theme of mental health and the workplace, this issue includes information from the WSIB on their policy related to traumatic mental stress as well as a lawyer's view of what should be done about mental stress in the workplace.

A special feature, a brochure on psychiatric medication and weight gain, is included for your information. In addition, several community services are highlighted to bring you information about different sorts of programs that may be of interest to you and your patients. This issue includes Youth Net programming – run by youth for youth, mental health services provided by COTA, a variety of programs and services for Ontario seniors as well as an article from the Ontario Hospital Association on Partial Hospitalization Programs for Mental Health Patients.

OPA Council's liaison with the sections, Dr. Elizabeth Esmond, brings you up to date with issues that are being discussed by the OPA sections. For more information, contact the Section Chairs. And, Dr. Ann Thomas provides us with a glimpse of what OPA's Annual Meeting is shaping up to look like for next January.

This issue also features something new - Interesting Websites for You to Explore. If you have found some interesting websites of your own, please let me know so they can be shared with other OPA members. Perhaps some of the sites will be favorite ones or maybe they are newly discovered gems but they should provide useful and interesting information. The plan is to share half a dozen websites in each issue of *Dialogue* for as long as possible.

I am writing this the day after the May 18, 2004 Ontario Budget announcements. There is to be an expansion of community mental health services, serving an additional 78,600 patients annually by 2007-08, including increased access to case management, crisis response and early intervention services and providing $463 million in 2004-05, growing to $583 million in 2007-08. The Ontario government indicated that it will work with the federal government and municipalities to increase the number of affordable housing units in Ontario, with a particular focus on appropriate housing for persons suffering from mental illness, victims of domestic violence and the working poor. And, it was announced that an additional $25 million for children's mental health would be made available for programs for 2004-05, growing to $38 million in 2005-06, in order to help an additional 7,000 children each year.

We'll keep you advised as to how this is implemented in the future.

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

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 EVENTS

Ontario Psychiatric Association 2004 Council Meetings
MEMBERS WELCOME !
Toronto – Friday, June 11; Friday, October 1. Space is limited, please contact the OPA office for locations or further details; (905) 827-4659, email: opa@bellnet.ca

Ontario Psychiatric Association Psychotherapy Section Fall Meeting
Free Association…a day with Christopher Bollas
Saturday, October 2, 2004
Mount Sinai Hospital Auditorium, 600 University Ave., Toronto
Christopher Bollas will discuss what he terms 'The Freudian Pair'— that partnership composed of the freely associating analysand and the evenly suspended attentive psychoanalyst. He will examine this object relation in a wide context that begins by regarding it as a seminal moment in the history of western culture. This 'Freudian Pair' is arguably the most sophisticated form of unconscious thinking we possess and, as Christopher Bollas argues, has far more wide-ranging implications than we ever imagined. He will also discuss the technical implications for working with free association— especially what Freud called 'the logic of sequence'— and he will provide clinical vignettes to illustrate his argument.
Contact information: Ontario Psychiatric Association, 1141 South Service Rd. W., Oakville, ON, L6L 6K4, Phone: 905-827-4659, fax: 905-469-8697, email: opa@bellnet.ca or Dr. Cinda Dyer at 416-922-6699/Dr. Doron Almagor at 416-482-8900

Ontario Psychiatric Association Annual Meeting
The Times: Are They Changing?
January 27 – 29, 2005
OPA Annual General (Business) Breakfast Meeting Friday, January 28, 2005 (time to be confirmed), Toronto Marriott Eaton Centre Hotel, 525 Bay St., Toronto
Call for Papers Deadline for Submissions: August 6, 2004
Contact information: OPA Office, phone: (905) 827-4659, fax: (905) 469-8697, email: opa@bellnet.ca

Treatment of Depression: A Life-Span Perspective
June 17, 2004
Ottawa
Presented by Leading Edge Seminars Inc. in association with Family Services.
Led by Donald Meichenbaum
The major focus of this practical workshop will be on how to employ specific cognitive-behavioural and related interventions with children, adolescents and their family members, and with adults. Issues in working with the depressed elderly will also be addressed. For more information about Family Services please visit www.familyservicesottawa.org
Contact information: Leading Edge Seminars Inc., 88 Major Street, Toronto, ON, M5S 2L1 toll-free at 1-888-291-1133 (in Toronto 416-964-1133), http://www.leadingedgeseminars.org/register.html

15th Annual Trauma & Dissociation Conference: The Many Faces of Trauma
June 17 & 18, 2004
Ottawa
Sponsored By: The Ottawa Anxiety & Trauma Clinic, with Dr. Anna Salter, Dr. Sue Johnson and Dr. Diane McIntosh
For our 15th Annual two-day conference we are pleased to have an internationally renowned American psychologist and author Anna Salter, Ph.D., as our featured speaker. She is one of the world's foremost experts on sexual abuse and sex offenders and has conducted seminars in 45 states and 8 countries. As well, we are pleased to have two Canadians who also are internationally respected speakers in the field of trauma: Sue Johnson, Ph.D., CPsych, speaking on the topic of trauma and relationships, and Diane McIntosh, M.D.,FRCPC., specializing in psychopharmacology for trauma-related and comorbid disorders.
Contact information: Ottawa Anxiety & Trauma Clinic, Billings Bridge Plaza, Suite 202 - 2277 Riverside Drive, Ottawa, Ontario, K1H 7X6, CANADA, Tel: (613) 737-1194 Fax: (613) 737-5884, e-mail: ottanx@igs.net, www.anxietyandtraumaclinic.com

Angry and Aggressive Behaviour: A Life-Span Treatment Approach
June 18, 2004
Ottawa
Presented by Leading Edge Seminars Inc. in association with Family Services.,
Led by Donald Meichenbaum
This workshop will examine the nature and development of aggressive behaviour from a life-span perspective. Such questions as how aggressive behaviour develops and what parents, schools, therapists and communities can do to alter this developmental trajectory will be considered. For more information about Family Services, Ottawa please visit www.familyservicesottawa.org
Contact information: Leading Edge Seminars Inc., 88 Major Street, Toronto, ON, M5S 2L1 toll-free at 1-888-291-1133 (in Toronto 416-964-1133), Website: http://www.leadingedgeseminars.org/register.html

Cape Cod Summer Symposia
June 21 – August 27, 2004
Four Points by Sheraton, Eastham, MA
The 21st 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. Each symposium will convene at 9:00 am until 12:15 pm, Monday through Friday.
Contact information: New England Educational Institute 92 Elm Street, Pittsfield, MA 01201, phone: 413-499-1489, fax: 413-499-6584, www.neei.org, educate@neei.org

Brain Injuries Conference
June 22, 2004
Intercontinental Toronto Centre, 225 Front St. West
Presented by: Ontario Hospital Association
Join us for the first ever Conference on Brain Injuries. Conference objectives include providing the delegates with the following: An awareness of the continuum of care required for people living with acquired brain injury; Exploration of challenges and solutions for each component along the continuum of care; Understanding the current policy framework and economic impact of ABI; Greater understanding and appreciation of the consumer's experience; Appreciation of the importance of prevention of ABI and its complications.
Contact information: Educational Services, Ontario Hospital Association, 200 Front St. W., Suite 2800, Toronto, M5V 3L1, phone 416-205-1362, fax: 416-205-1340, email: gfernandes@oha.com; website: www.oha.com/education

Training Institutes -- Developing Local Systems of Care for Children and Adolescents with Emotional Disturbances and their Families: Early Intervention

June 23 – 27, 2004
Hilton San Francisco, San Francisco, California
Organized by: National Technical Assistance Center for Children's Mental Health, Georgetown University Center for Child and Human Development
The Institutes will focus on developing local systems of care for children and adolescents with or at risk for emotional disturbances and their families. Such systems of care emphasize community-based care, comprehensive and individualized services and supports, services provided within the least restrictive environment, full participation of families, coordination among child-serving agencies and programs, and cultural competence. In-depth, practical information will be provided on how to develop, organize, operate, finance, and sustain systems of care and how to provide high quality, effective, evidence-based clinical interventions within them. The 2004 Institutes will include a special emphasis on early intervention, with a dual focus on providing mental health services to young children and their families and on identifying mental health problems at an earlier stage and providing appropriate interventions to maximize the likelihood of positive outcomes. Select four separate half-day Institutes on a wide range of topics critical for developing, operating, and sustaining systems of care and for providing services. Institutes will address both public policy and clinical practice, reflecting the importance and interdependence of both. Many Institutes will address recommendations from the President's New Freedom Commission on Mental Health.
Contact information: National Technical Assistance Center for Children's Mental Health, Georgetown University Center for Child and Human Development, 3307 M Street, NW, Suite 401, Washington, DC, 20007, Phone: 202-687-5000, Fax: 202-687-1954,Email: institutes2004@mindspring.com

Psychiatry in 2004

June 24 – 26, 2004
Marriott Hotel Cambridge, Kendall Square, Two Cambridge Ctr., Cambridge, MA
Offered by: McLean Hospital, Department of Psychiatry
Participants will explore recent advances in diagnosis; learn about the latest developments in psychopharmacology; understand advances in psychosocial treatments of various psychiatric disorders and how to incorporate these into a comprehensive treatment plan; learn about medical and neurological issues to consider in psychiatric patients; be given the opportunity to review and discuss cases with expert faculty through question and answer sessions and panel discussions.
Contact information: Harvard MED-CME, P.O. Box 825, Boston, MA 02117-0825.call: (617) 384-8600, 10:00am-4:00pm Eastern Time, Monday-Friday, fax: (617) 384-8686 email: hms-cme@hms.harvard.edu

Cognitive Therapy Summer Training Institute 2004

June 24, 25, 26, 2004
Centre for Addiction and Mental Health, Addiction Research Foundation Site, Meeting Centre, 2nd Flr, 33 Russell Street, Toronto
Presented by: CAMH and the University of Toronto, Department of Psychiatry
Participants will; learn the basic principles in conducting short-term cognitive therapy for Depression and Panic Disorder; learn how to assess if a patient is suitable for this approach; how to formulate a case from a cognitive perspective; how to identify and implement specific cognitive interventions for Depression; how to identify and implement specific cognitive interventions for panic Disorder.
Contact information: Continuing Medical Education Program, CAMH, 33 Russell St., Room #2017, Toronto, Phone: 416-535-8501, X 6017, Fax: 416-595-6644

Being Scene – A CAMH Art Exhibit

June 30, 2004 – June 30, 2005
Toronto, Ontario
Organized by the Centre for Addiction and Mental Health
The Workman Theatre Project presents its third annual art show Being Scene at the Centre for Addiction and Mental Health.
The Centre for Addiction and Mental health believes that the creative process can have a healing effect, leading people to recover strengths and a sense of well being.
This year's show contains approximately 78 pieces by more than 70 artists. The artists, some of them established in the field, are unified in that they have all been, or are currently, clients of the Centre. While many of these pieces explore mental health issues, there are plenty that are scenes of peacefulness. Most of the pieces are available for sale ranging from $40.00 - $8,000.00.
Contact information: CAMH, 33 Russell St., Toronto, phone 416-535-8501, website: www.camh.net

15th Annual Summer Seminars

July 5 - 9, 2004
Brewster, Massachusetts Cape Cod
The Summer Seminars are a series of courses of current interest to the health professional. Taught by a distinguished faculty, the courses allow participants an opportunity to combine learning and relaxation. Seminars include: Mind/Body Medicine, Spirituality: The Breakout Principle.(Herbert Benson, MD and Ann Webster, PhD); The Psychiatrist as Expert Witness: Beginning and Developing Your Forensic Practice,(Thomas G. Gutheil, MD and James T. Hilliard, JD); The Curative Factors in the Psychotherapeutic Process (Anna Ornstein, MD and Paul H. Ornstein, MD)
Contact information: call: (617) 384-8600, fax: (617) 384-8686, email: hms-cme@hms.harvard.edu, website: www.cme.hms.harvard.edu

The 11th Ottawa International Conference on Medical Education, "Preparing health professionals for the future".

July 6 - 8, 2004 - Barcelona, Spain.
Contact information: www.ottawa@bcmedic.com

Canadian Mental Health Association Annual Conference Honoring our Past, Charting our Future

July 7 - 11, 2004
Saint John, New Brunswick
This 2004 National Annual Conference entitled "Honouring our Past, Charting our Future" will be jointly hosted by New Brunswick Division of CMHA (CMHA-NB) and the Schizophrenia Society of New Brunswick (SSNB), in Saint John, New Brunswick, from July 7th-11th. On this special occasion, our two provincial organizations will join forces to create one dynamic, exciting event in a picture perfect setting. The conference this year will be centred around four main themes; Wellness, Suicide, Primary Health Care and Justice. Consumers, families, professionals, front line workers, experts in the field of mental health and the public at large will find the event educational and informative with ample opportunities for networking.
Contact information: Joy Haines-Bacon, Conference Coordinator E-mail: conference2004@nb.aibn.com Phone: (506) 455-5231, website: www.cmhanb.ca/files/program.pdf

Stuck in the Vortex of Despair: Responding Effectively to Clients Who Experience Chronic Frustration and Hopelessness

July 8 – 9, 2004
With the use of popular film and documentary videos participants will examine how early attachment patterns and early childhood trauma can predispose some individuals to develop debilitating adult coping mechanisms. A conceptual framework for understanding and guiding your work with complex individuals will be outlined.
Contact information: The Hincks-Dellcrest Centre - Gail Appel Institute, 114 Maitland Street, Toronto, Ontario, Canada M4Y 1E1, Telephone: (416) 972-1935, Fax: (416) 924-8208, e-mail: institute@hincksdellcrest.org, website: http://www.hincksdellcrest.org/institute/calendar.php?month=Jul&year=2004&dep

Anger Management Certification Training

July 8 - 9, 2004
8:30am - 5:30pm, Anderson & Anderson, 12301 Wilshire Blvd, Suite 418, Los Angeles, California
Organized by the American Association of Anger Management Providers
Anger management is a lucrative niche market for Educators, H.R.Consultants and Counselors. When there are aggressors in the workforce, no one wants to be there. This causes tardiness, absenteeism, and finally, turnover. The cost to productivity is profound. Diminished aggression in the workplace yields greater productivity.

The Anderson & Anderson Anger Management Curricula is the only anger management training approved by the states of Texas and California for the training of Probation, Parole and Correctional Officers. Our certification training and approved provider list is the industry standard nationwide. The Employee Development Center of the U.S. Postal Services, an Anderson & Anderson Affiliate is training trainers throughout the federal government in this model. This curriculum is used in Canada, Philippines, Guam, U.S., Bermuda and Italy. H.R. Departments routinely use our provider list worldwide to make referrals. The Anderson & Anderson model was demonstrated on an episode of Titan Televisions, "Together" in March, 2004.(Sweden). Both days of training will include training in the use of the Conover Anger Management Assessment Component. The Conover software will be available for purchase at the training while the Anderson & Anderson client workbooks will be complimentary to each participant for each day of training. In addition, participants will receive: The Anderson & Anderson Anger Management Facilitators' Guide and Tips for Managing Anger.
Contact information: Anderson & Anderson, Phone: 310-207-3591, Fax: 310-207-6234, Email: georgeanderson@aol.com , www.andersonservices.com

Women Across the Lifespan: A National Conference on Women, Addiction and Recovery

July 12-13, 2004
Baltimore Marriott Inner Harbour
The Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT) is pleased to host "Women Across the Life Span: A National Conference on Women, Addiction and Recovery." This 2-day conference will feature over 50 invited speakers to discuss current issues and practices in providing gender-specific treatment to women throughout their lives. Speakers include nationally recognized experts on women's substance abuse treatment, as well as practitioners testing innovative and promising practices to address a range of problems experienced by women with substance use disorders, and their families. You will learn, through interactive sessions with experts in the field, about best practices and proven strategies for helping the women and families that you serve. Topic areas for the plenary sessions and workshops, as they pertain to women, include: Co-occurring Mental Health Disorders; Treatment Capacity; Prevention and Early Intervention; Addressing Needs of Children and Families; Homelessness; Infectious Diseases; Criminal Justice; Trauma and Violence.
Contact information: Ayanna Dixon at (301) 495 - 3787, ext. 3130 or e-mail at ADixon@jbs1.com , website:
http://conferences.jbs.biz/women_and_childwelfare/lifespan

15th Annual Summer Seminars

The Summer Seminars are a series of courses of current interest to the health professional. Taught by a distinguished faculty, the courses allow participants an opportunity to combine learning and relaxation.

July 12 - 16, 2004
Bermuda
Psychopharmacology Across the Life Cycle: From Pediatrics to Geriatrics, (Barbara J. Coffey, MD, MS and Russell G. Vasile, MD);, The Diagnosis, Treatment, and Prevention of Alcohol and Other Substance-Related Disorders, (Bert Pepper, MD). A Clinician's Approach to Neuroscience: What We Should Do and Why We Should Be Doing It, (John J. Ratey, MD)
July 26 - 30, 2004
North Falmouth, Massachusetts Cape Cod
Enhancement of Peak Performance: State of the Therapist - A Way of Being with Patients, (Daniel Brown, PhD, ABPH and Andrea T. Lindsay, LICSW); Trauma, Consciousness and the Body (Janina Fisher, PhD); Contemporary Psychodynamic Psychotherapy: How the Processes of Attachment, Affect Regulation, and Mental Representation Influence Change, (George G. Fishman, MD)
August 2 - 6, 2004
North Falmouth, Massachusetts Cape Cod
Essential Psychopharmacology, 2004: Practice and Update,(Alan I. Green, MD, Barbara J. Coffey, MD, MS, Carl Salzman, MD and Andrew L. Stoll, MD); The Psychology of Investing: A Survival Guide for 2004 (John Schott, MD); Agents of Therapeutic Change: Knowledge, Experience and Relationship, (Martha Stark, MD)
August 23 - 27, 2004
Martha's Vineyard, Massachusetts
Complex Forms of Psychological Trauma: A Treatment Overview and Update, (Christine A. Courtois, PhD); Psychotherapy of Patients with Personality Disorders, (Dan H. Buie, MD)
Psychopharmacology in the Trenches: Comprehensive Review of Pharmaceuticals and Natural Therapies, (Andrew L. Stoll, MD); Harvard Medical School Continuing Education Department
Contact information: call: (617) 384-8600, fax: (617) 384-8686, email: hms-cme@hms.harvard.edu, website: www.cme.hms.harvard.edu

8th Annual McMaster Muskoka Seminars

July 12 –August 20, 2004
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 Deerhurst Resort (Gravenhurst).
The week-long seminars begin on Monday and are designed to present current and topical information. 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. Class time will be from 9:00 a.m. to 12:15 p.m. to give participants the opportunity to combine continuing medical education, relaxation and activity. Topics being covered include; Consent, Capacity, and Substitute Decision-Making; Clinical Neuropsychiatry; Clinical Psychopharmacology; Cognitive Behavioural Treatment for Mood and Anxiety Disorders: An Advanced Workshop and more.
Contact information: Dr. Gary Chaimowitz, 100 West 5th Street, P.O. Box 585, Hamilton, Ontario L8N 3K7, tel: (905) 522-1155 ext. 2949, fax: (905) 381-5606,email: info@mcmastermuskokacme.com, website: www.mcmastermuskokacme.com

Putting the Pieces Together: 1st National Conference on Substance Abuse, Child Welfare and the Dependency Court

July 14-15, 2004
Baltimore Marriott Inner Harbour
The Substance Abuse and Mental Health Services Administration (SAMHSA) and the Administration for Children and Families (ACF), agencies within the U.S. Department of Health and Human Services (DHHS), are pleased to host "Putting the Pieces Together: The 1st National Conference on Substance Abuse, Child Welfare and the Dependency Court." The conference is organized to provide attendees with multiple opportunities to learn about relevant research and innovative program models. A wide range of workshop topics and nationally-recognized experts were selected through a peer review process from over 100 proposals that were submitted from across the nation.
This 2-day conference is designed to benefit front-line practitioners and administrators of child welfare and substance abuse services and the dependency court, as well as policymakers and researchers. The theme of the conference, "Putting the Pieces Together," will be addressed in both the plenary and workshop sessions. Sessions are organized around four focus areas related to improving outcomes for children and families in the child welfare system who are affected by substance use disorders. These focus areas are based on the National Center on Substance Abuse and Child Welfare's (NCSACW) technical assistance needs assessment. The topic areas for workshops are:
Serving children of substance abusers in the child welfare system; Practice and clinical issues; Increasing collaboration, funding, and systems issues; Workforce and staff development.
Contact information: Ayanna Dixon at (301) 495 - 3787, ext. 3130 or e-mail at ADixon@jbs1.com, website:
http://conferences.jbs.biz/women_and_childwelfare/together/

Two Days of Anger Management Certification Training

July 15 - 16, 2004
8:30am - 5:30pm, Anderson & Anderson, 1323 W. Covina Pkwy., Suite D, West Covina, California
Organized by the American Association of Anger Management Providers

The Anderson & Anderson Anger Management Curricula is the one and only anger management training approved by the state for the training of Probation, Parole and Correctional Officers in California. This model is also used in Canada, England, United States, Bermuda and Italy. Our certification training and approved provider list is the industry standard and dominates the internet. This training is also available on interactive CD's. Please visit www.AndersonServices.com for more information.
The July 15th training will focus on Adolescent Anger Management and will use the Anderson workbook "Controlling Ourselves" as the text. Videos and exercises will be used. This one-day training is designed for Nurses, School Counselors/Psychologists, Substance Abuse Counselors, Clinicians, Probation Officers, as well as staff from group homes, and agencies serving families and youth. This curriculum is currently being used in school districts in Los Angeles, Oakland, Sacramento, Concord and San Diego, as well as school districts in Texas and Louisiana. In addition, probation departments in Arizona, Kansas, California and Texas are using this model. On July 16th , Adult Anger Management will be examined. "Gaining Control of Ourselves," in conjunction with experiential exercises and videos, will be used to introduce the participants to this intervention. Many major corporations have accepted this model for use by H.R. and EAP Managers. Executive Coaching in relation to anger management will also be explored.
Contact information: Anderson & Anderson, Phone: 310-207-3591, Fax: 310-207-6234, Email: georgeanderson@aol.com, website: www.andersonservices.com

Summer Emotions Institute, Level One with Les Greenberg, Ph.D.
August 9 - 12, 2004
9:00am - 4:30pm, York University, Toronto, Ontario
Organized by: Emotion Focused Therapy
The program provides participants with a solid grounding in the skills required to work more directly with emotion in psychotherapy. Participants receive in-depth skills training through a combination of brief lectures, video demonstrations, live modeling, case discussions, and extensive supervised role-playing practice.
Contact information: www.emotionfocusedtherapy.org or phone Sara at 416-410-6699

Interpersonal Psychotherapy Training Institute – Summer 2004
August 12 –14, 2004
Meeting Centre, Centre for Addiction and Mental Health, 33 Russell Street
Sponsored by: the Mood & Anxiety Disorders Program, CAMH; Psychotherapy Program, CAMH and Mount Sinai Hospital and the University of Toronto, Department of Psychiatry.
The participant will; gain a theoretical framework in the basic principles of IPT; learn which patients are most likely to benefit from IPT and which patients will require combined IPT and pharmacotherapy; lean to formulate an appropriate focus for the therapeutic work; and, lean about the strategies and techniques of Major Depression.
Contact information: Continuing Medical Education Program, CAMH, 33 Russell St, Rm 2017, Toronto, phone: 416-535-8501 ext. 6017, fax: 416-595-6644

137th Annual Meeting of the Canadian Medical Association
August 15 –18, 2004
Toronto,
The CMA Annual Meeting will take place at the Sheraton Centre Toronto, a beautiful, modern, facility with guestrooms and meeting space. General Council will meet on Monday, Tuesday and Wednesday (other sessions may be scheduled closer to the date of the meeting). All registered members and observers are invited to attend. Information booths will be open from Sunday morning to Wednesday noon. Some of the CMA's affiliates and associated societies take advantage of the national forum to hold their own meetings. The Canadian Medical Protective Association will hold its annual meeting on Wednesday, 18 August 2004.
Contact information: CMA head office: 1867 Alta Vista Drive, Ottawa, Ontario, K1G 3Y6 Tel: Toll free 1 800-457-4205, Fax: (613) 236-8864, website: http://www.cma.ca/multimedia/staticContent/HTML/N0/l2/who_we_are/annual_meeting/137/AGM2004.pdf

Summer Emotions Institute, Level Two with Les Greenberg, Ph.D.
August 16 - 19, 2004
9:00am - 4:30pm, York University, Toronto, Ontario
Organized by: Emotion Focused Therapy
The program provides participants advanced training in the skills required to work more directly with emotion in psychotherapy. Participants receive in-depth skills training through a combination of brief lectures, video demonstrations, live modeling, case discussions, and extensive supervised role-playing practice.
Pre-requisite: Summer Institute Level One (or equivalent).
Contact information: www.emotionfocusedtherapy.org or phone Sara at 416-410-6699

7th World Congress in Psycho-Oncology
August 25 - 28, 2004
Copenhagen
Please visit our website for further information about the Congress, including the newly established, unique Psychosocial Academy designed for providing training and education within clinical practice and research methodology. Please also note that applications for Grants for Participants from Developing Countries can no longer be submitted. Looking forward to seeing you in Copenhagen
Contact information: www.capo.ca

Cognitive Therapy Tools
September 10, 2004
9:00am - 4:30pm, Harbourfront, Toronto, Ontario
Organized by: International Academy of Cognitive Therapy
This practical one-day intensive gives professionals a rare opportunity to gain confidence from practicing CBT tools while under expert supervision.
Dr. Greg Dubord explains the key features of each tool and clearly demonstrates step-by-step how each is best implemented. Participants then receive coaching while practicing the tools in dyads. Over twenty tools are taught, including counter-attitudinal advocacy, Chicken Little logging, distortion identification, exposure & response prevention (E/RP), multiplied ratios, reductio ad absurdum, Socratic questioning and systematic desensitization. Applications reviewed include panic disorder, recurrent depression, hypochondriasis, alcoholism, borderline PD and chronic worry. We'll discuss how to integrate CBT tools within natural practice styles and with real-life cases. Experience the benefits of small-group learning!
Contact Information: Visit the website at:www.cbt.ca or phone Sara at 416-410-6699

The 3rd World Conference - The Promotion of Mental Health and Prevention of Mental and Behavioural Disorders - From Research to Effective Practice
September 15 - 17, 2004
Auckland, New Zealand
Organized by: The World Federation for Mental Health, The Clifford Beers Foundation and the Mental Health Foundation of New Zealand In collaboration with The Carter Center, co-sponsored by the World Health Organization.
This plans to be a stimulating, challenging and enjoyable conference which will celebrate mental health promotion activity from across the world.
Contact information: for more details please visit the website: http://www.charity.demon.co.uk/conference.htm

Day in Psychiatry XII: A Weekend of Theatre at Stratford Festival
September 24, 2004
Contact information: Dr. Heather Sylvester, Stratford General Hospital, Huron Perth Healthcare Alliance, University of Western Ontario, Department of Psychiatry
90 John Street South, Stratford, ON N5A 2Y8, Telephone : 519-272-8246, Fax : 519-272-8226

Anger Management: Behavioral, Cognitive, and Affective Intervention
September 27 – 28, 2004
Contact information: Edythe J. Nerlich, Hinks-Dellcrest Centre, Gail Appel Institute
114 Maitland Street, Toronto, ON M4Y 1E1, Telephone : 416-972-1935 , Fax : 416-924-9808

Narrative Therapy: When All the Time you Have is Now
September 27 – 28, 2004
Participants will learn; therapist posture – ways of being with people in time sensitive
Conversations; useful pre-session questions; setting the agenda – ways to determine focus that differs from goal setting; a Narrative therapy "map" that guides time limited therapy; engaging people in deeply meaningful therapeutic conversation; getting to know the person away from the problem; developing thick, rich stories of what is "other than" the problem; finding and making use of outsider witnesses within and outside of the session; in-session note taking and creation of therapeutic documents.
Contact information: BTTC-I, The Hincks-Dellcrest Centre - Gail Appel Institute Telephone: (416) 972-1935 ext. 3345, Fax: (416) 924-9808, email: enerlich@hincksdellcrest.org

The 4th International Conference on Early Psychosis
September 28 – October 1, 2004
Vancouver Convention and Exhibition Center, 999 Canada Place, Vancouver, British Columbia
Organized by: International Early Psychosis Association (IEPA)
The Conference will highlight rapid progress across the full spectrum of biological, epidemiological, psychological and sociological research into early psychosis. This broad perspective will aid the translation of new evidence into clinical advances that will enhance early detection, expert clinical care and sustained recovery.
Contact Information: Venue West Conference Services, Phone 604-681-5226, Fax: 604-681-2503
Email: congress@venuewest.com website: www.venuewest.com/2004/iepa

Stuck in the Vortex of Despair: Responding Effectively to Clients Who Experience Chronic Frustration and Hopelessness
September 30 & October 1, 2004
With the use of popular film and documentary videos participants will examine how early attachment patterns and early childhood trauma can predispose some individuals to develop debilitating adult coping mechanisms. A conceptual framework for understanding and guiding your work with complex individuals will be outlined.
Contact information: The Hincks-Dellcrest Centre - Gail Appel Institute, 114 Maitland Street, Toronto, Ontario, Canada M4Y 1E1, Telephone: (416) 972-1935, Fax: (416) 924-8208, e-mail: institute@hincksdellcrest.org, website: http://www.hincksdellcrest.org/institute/calendar.php?month=Jul&year=2004&p

Royal College of Physicians and Surgeons of Canada Annual Conference
Informed by our past, focused on our future
September 30 – October 2, 2004
Ottawa
The goal of the conference is to be a forum for activities that reflect the mission and core functions of the College, and assist Fellows with their professional development by promoting quality health care through education, research, sound health and public policy, ethics, and other generic topics related to specialty medicine.
Contact information: Meetings and events, RCPSC, phone 613-730-6231 or 1-800-668-3740 ext. 231 Fax: 613-730-8252, email: meetings@rcpsc.edu, web: www.rcpsc.medical.org/meetings/

Making Gains in Mental Health and Addictions: Knowledge, Integration, Action
Second Annual Making Gains Conference
October 3–6, 2004
Toronto, Ontario
Presented by: Canadian Mental Health Association, Centre for Addiction and Mental Health, Ontario Federation of Community Mental Health and Addiction Programs and the Alcohol and Drug Recovery Association of Ontario.
This year's conference, Making Gains in Mental Health and Addictions: Knowledge, Integration, Action, incorporates two key themes: how to communicate and use new knowledge whether in the delivery of services or building a better organization. Drawing on Toronto's diversity, the conference also focuses on the challenge of meeting the complex and diverse needs of all members of the community through creative and innovative strategies. This year the conference will incorporate seven different streams over two-and-one-half days. The streams include: knowledge transfer and exchange; building better organizations; community, culture and health; building solutions for affordable housing; influencing decision makers; health promotion and prevention; and, integrating addiction and mental health services.
Contact information: Rachel Gillooly, Conference Planner, Tel: 705-454-8107 or Toll-free: 877-372-2435, Fax: 705-454-9792, E-mail: rachel@haliburtonhighlands.com

Ontario Psychiatric Association Psychotherapy Section Fall Meeting
Free Association…a day with Christopher Bollas
Saturday, October 2, 2004
Mouunt Sinai Hospital Auditorium, 600 University Ave., Toronto
Christopher Bollas will discuss what he terms 'The Freudian Pair'— that partnership composed of the freely associating analysand and the evenly suspended attentive psychoanalyst. He will examine this object relation in a wide context that begins by regarding it as a seminal moment in the history of western culture. This 'Freudian Pair' is arguably the most sophisticated form of unconscious thinking we possess and, as Christopher Bollas argues, has far more wide-ranging implications than we ever imagined. He will also discuss the technical implications for working with free association— especially what Freud called 'the logic of sequence'— and he will provide clinical vignettes to illustrate his argument.
Contact information: Ontario Psychiatric Association, 1141 South Service Rd. W., Oakville, ON, L6L 6K4, Phone: 905-827-4659, fax: 905-469-8697, email: opa@bellnet.ca or Dr. Cinda Dyer at 416-922-6699/Dr. Doron Almagor at 416-482-8900

Association for Academic Psychiatry Annual Meeting - Leadership in Academic Psychiatry: Preparing, Becoming, and Being Leaders for our Profession"
October 6 - 9, 2004
Albuquerque, New Mexico
Contact information: Carole Berney, AAP Executive Office, Suite 4200,725 Concord Avenue, Cambridge, MA 02138, Phone: 617-661-3544, Fax: 617-661-4800 http://www.hsc.wvu.edu/aap/home.htm

The World Mental Health Day Project: The Relationship between Physical and Mental Health: Co-occurring mental and physical disorders
A Global Mental Health Education Campaign of the World Federation for Mental Health
October 10, 2004
Seventeenth-century philosopher Rene Descartes conceptualized the distinction between the mind and the body. He viewed the "mind" as completely separable from the "body". And for almost two centuries, mental health advocates have been trying to put them back together. This separation between so-called "mental" and "physical" health has no real relevance to the scientific understanding of health in the 21st century; yet the myths and misinformation persist. Mental health advocates all over the world have, in almost apologetic posturing, said that this false premise should no longer exist and yet these voices continue to go unheard. The time has come to reinforce what we stand for--mind and body are inseparable: health is a complete state of well-being -- and there is no health without mental health.
Contact information : World Federation for Mental Health, P.O. Box 16810, Alexandria, Virginia 22302-0810 U.S.A. ,Fax: +1.703.519.7648, Email: info@wfmh.com, http://www.wfmh.org/wmhday/index.html

Canadian Psychiatric Association 54th Annual Meeting
Culture and Mental Health: Not a Minor Matter
October 14 – 17, 2004
Montreal, Quebec
The cultural mosaic of Canada presents a multi-faceted dimension for psychiatry that is often underappreciated. Canadians are immigrants. They are the children of immigrants. They are native born of culturally diverse families. They are also native born of relatively homogenous parents. Each of us may be born into a cultural context but as we grow and develop we are altered by the surrounding culture—we become a sum of the parts. These are complex interactions. Also, the influence brought to bear by our culture and our patients' culture cannot be underestimated. It affects how they see us, how we see them and how they

perceive their problems.
Contact information: The Canadian Psychiatric Association, 260-441 MacLaren Street, Ottawa, Ontario, K2P 2H3, Telephone: 613-234-2815, Fax: 613-234-9857 email: agm@cpa-apc.org, website: www.cpa-apc.org

12th Annual Santa Fe Symposia
October 15-17, 22-24, 29-31, 2004
The 12th Annual Santa Fe Symposia will provide mental health professionals with an outstanding opportunity to combine a stimulating symposium with an enjoyable vacation in the beautiful Southwest. Distinguished faculty, leaders in their fields, will present nine different weekend symposia over three weekends in the fall.
Each symposium will convene at the Radisson Santa Fe from 8:00 a.m. until 1:30 p.m. on Friday, Saturday, and Sunday. The Radisson Santa Fe is just minutes away from the world famous art, adobe-lined streets, colorful courtyards, and quaint shops that are uniquely and unmistakably "Santa Fe."
Contact information: New England Educational Institute 92 Elm Street, Pittsfield, MA 01201, phone: 413-499-1489, fax: 413-499-6584, www.neei.org, educate@neei.org

Challenges for Inpatient Mental Health Units:
Striving for Best Practices in the 21st Century
Friday, October 29, 2004
Sponsored By: St. Michael's Hospital Mental Health Service Association of General Hospital Psychiatric Services
This conference is intended for all who are involved and interact with Inpatient programs. Program & Registration form will be circulated by September 2004.
Contact information: Jeff Loudermilk, Mental Health Service Tel:(416) 864-6060 ext 6481 Fax:(416) 864-5480 e-mail: loudermilkj@smh.toronto.on.ca

Report on OPA Sections

By: Elizabeth Esmond, MB, BS, FRCP(c)

Elizabeth Esmond, MB, BS, FRCP(c) is the Sections Liaison on OPA Council. Dr. Esmond, a Council Member, also serves on the Finance/Audit and Member Services Committees. In this report she brings OPA members up to date on current activities of some of the six OPA sections:

Child and Adolescent Section of the OPA – Chair, Dr. Margaret Steele
Community Section of the OPA - Chair, Dr. Karen Hand
Consultation-Liaison Section of the OPA – Chair, Dr. Susan Abbey
Geriatric Section of the OPA – Chair, Dr. Rosemary Meier
Psychotherapy Section of the OPA – Chair, Dr. Cinda Dyer
Resident Section of the OPA – Chair, Dr. Andrew Moulden

So far this year, the OPA Council has been diligently pursuing the issues that relate to our Sections. Some of the goals of the Sections are more long term in nature and so it will be some time before there are major results arising from these efforts.

The Child and Adolescent Section is discussing issues that are already of great concern to those in the sub-specialty the decrease in trainees coming into our programs and the drift of trained Child & Adolescent Psychiatrists into adult work. Shortages of trained specialists in this field are world-wide and it is clear that there are multiple factors that have led to the decrease in available resources. Extensive debates about the required length of training continue on many different levels. Committees from various concerned organizations are examining the issues of the retention of trained specialists. While it is not this Section's mandate to duplicate this work, it is helpful, I believe, for our membership to have the appropriate data so that we can advocate if/when we are needed do so, in an informed and directed manner. To this end, I will be getting information from various resources, over the coming months, and hope to have a report ready for the Section Meeting at the OPA Annual General Meeting in January 2005.

Dr Cinda Dyer has been increasing our awareness of all the work being done by the Psychotherapy Section. Their annual fall conference will be held on October 2, 2004, at the Mount Sinai Hospital Auditorium in Toronto. The guest speaker will be Dr. Chris Bollas and the theme for the day will be "Free Association". Plans are in place for the 2005 conference to be held on October 15, also at Mount Sinai. In 2005 we will welcome Dr. Glen Gabbard. Both speakers are known for their excellent presentations and participants will undoubtedly have a stimulating learning experience. Dr. Dyer is looking at ways to involve other high caliber speakers on psychotherapy topics in other OPA events in the future.

Dr. Rosemary Meier, Chair of the Geriatric Section of the OPA, will be attending a meeting of the Public Guardian and Trustee Advisory Committee next month and will report back to us about what she has learned.

Dr. Andrew Moulden, Chair of the Resident Section reports that the CPA Economics subcommittee has identified remuneration packages for graduating physicians as a concern. It is felt that residents may not have enough information on the relative merits of salaried positions, AFPs and fee-for-service arrangements to make an informed decision. The subcommittee is thinking about gathering some data for residents on this topic and perhaps clarifying certain aspects of return-for-service agreements, fee schedules, contractual commitments for duration of service, and incentives available for practice in certain hospitals/regions. Dr. Moulden would like to hear from the membership as to what their views are and if they are interested in having this information.

HAMILTON HOSPITAL RECEIVES FUNDING TO REDEVELOP, EXPAND MENTAL HEALTH SERVICES

An announcement was made by the provincial government in May to provide $16 million to St. Joseph's Healthcare Centre in Hamilton to improve access to mental health services. The funds will be used to redevelop the regional centre for Mountain Health Services so that a range of mental health services will be together under one roof, and expands services available to treat people with mental illnesses close to home.

2005 ANNUAL MEETING INFORMATION

By: Ann Thomas, Chair, Continuing Education Committee

The Continuing Education Committee has begun planning for the 2005 Annual Meeting to be held on January 27, 28 & 29, 2005. We anticipate Dr. Wlkins' Presidential theme - "The Times: Are They Changing?" - will allow for a broad scope of thought provoking topics.

The meeting will be held, once again, at the Toronto Marriott Eaton Centre Hotel, 525 Bay St., Toronto. This venue was a top choice, as determined by the attendees at the 2004 meeting who completed their programme evaluations.

We have Jeanne Safer, author of the book "The Normal One" confirmed for our programme and we look forward to her presentation on the Psychodynamics of growing up with a damaged and disabled sibling. Dr. Dick O'Reilly and a yet to be confirmed opponent will debate the functioning of the Consent and Capacity Board. We will be confirming speakers in the months to come on topics such as attention deficit disorder, traumatic brain injury, anxiety disorders, severe & persistent mental illness, hormonal treatment for sex offenders, mood disorders, psychopharmacology, and addiction issues.

We will also be offering a one-day pre-conference Workshop, co-sponsored with the OMA Section on G.P. Psychotherapy, on Interpersonal Psychotherapy Training to be held on Wednesday, January 26, 2005. Look for more details in future issues of *Dialogue.*

You should have received your "Call for Papers" in the mail by now. The deadline for submissions is August 6, 2004. We look forward to your contributions.

Many thanks to the C.E. Committee Members; Cinda Dyer, Mamta Gautam, Elizabeth Leach, Rosemary Meier, Roumen Milev, Drew Moulden, Michael Paré, Derek Puddester, Oleg Savenkov and Doug Wilkins.

If you have any comments and/ or suggestions you would like to share with our Committee, please contact me at my email address athomas2@uwo.ca.

MEET A COUNCIL MEMBER

Cinda Dyer, M.D., CCFP(EM), F.R.C.P.(C), is currently in private practice in downtown Toronto. She is an active member of the Toronto Psychoanalytic Institute and practices mainly psychoanalytic psychotherapy and psychoanalysis. Dr. Dyer participates in an ongoing study group and writing group whose members consist mainly of training psychoanalysts from the Toronto Institute of Psychoanalysis. She is currently in the process of completing a paper entitled "Inexplicable Sadness, the psychoanalytic understanding of a case of Seasonal Affective Disorder".

OPA: What is your current position on the OPA Council and on what committee do you serve?
Cinda: I am a Council member, the Chair of the Psychotherapy Section and a member of the Continuing Education Committee.

OPA: Tell us a bit about your background.
Cinda: I was born in Toronto. I graduated from University of Toronto medical school in 1984. I then completed the family practice residency in 1986. I later attained the emergency medicine certificate in family medicine, CCFP(EM). Following graduation, I moved to Washington D.C. and practiced emergency medicine full time at three teaching hospitals affiliated with Georgetown University. I returned to Toronto in 1990 and was appointed staff emergency doctor at The Toronto Hospital, where I practiced for three years. The Toronto Hospital is a teaching hospital affiliated with University of Toronto.
Although I enjoyed the challenge, excitement and camaraderie of emergency medicine, I felt disconnected from the patients. The routine concretized management plans became less then stimulating. I decided that I wanted a change and had always been very interested in psychiatry during my medical training. I then completed a psychiatry residency at University of Toronto, with a special interest in psychotherapy. Following graduation, I started a private practice and entered the advanced training program in psychotherapy that was a two-year program offered by the Toronto Psychoanalytic Institute. I then went on to complete the four year training program to become a psychoanalyst.

OPA: When did you join the OPA and why?
Cinda: I joined the OPA 1995 when I graduated. I was impressed with the OPA's involvement at that time, when the Ministry of Health was considering delisting psychotherapy. The OPA organized an emergency meeting of psychiatrists in Ontario that I felt was very effective.

OPA: In what ways have you seen the OPA change over the last 10 years?
Cinda: I have been concerned over the last ten years regarding the amount of attention given to the field of psychotherapy and psychoanalysis within the OPA. It seems that there has been much more of an emphasis placed on the biological therapies. I feel that a division has resulted between those members of the OPA who are more comfortable prescribing drugs and those who practice psychotherapy and psychoanalysis.

OPA: If you weren't a psychiatrist, what other professional endeavor would you be pursuing?
Cinda: I'd entertain the idea of again practicing emergency medicine or family practice in a small town in Northern Ontario. I have also always been interested in participating in Doctors without Borders.

OPA: If you had 3 wishes, what would they be?
Cinda: Aside from wishes for good health and best wishes for my family, I hope to finish the play I have been thinking about for ten years and have just started to write over the last year, thanks to the coaching from a dramateur of a theatre company. I also hope to make a significant contribution to the field of psychiatry and psychoanalysis. And lastly, I'd like to travel the world.

OPA: If you had 3 wishes for the profession of psychiatry, what would they be?
Cinda: I would like to see an increased interest in psychotherapy and psychoanalysis amongst psychiatry graduates as well as medical students. In a perfect world, there would be funding for psychotherapy, and psychoanalysis world-wide. A bridge would be built across the gap that exists between the biological psychiatrists and those trained in psychotherapy and psychoanalysis. Government agencies would focus their attention on prevention in psychiatry. There would be funding of research regarding attachment theory and its implications for the identification and early intervention of high risk, insecure attachment cases. This, I hypothesize, could have a profound effect with respect to mental health statistics, as well as the incidence of crime. My hypothesis stems from the fact that a large proportion of infants who exhibit a disorganized attachment have a much higher risk of suffering from borderline personality disorder and antisocial personality disorder. Early intervention has been shown to have a dramatic effect on mother infant interaction.

AGENDA OPA Council

FRIDAY, APRIL 2, 2004 Toronto Marriott Eaton Centre Hotel

1.0 Remarks from the President
i) Approval of Agenda
2.0 Approval of Council Minutes of January 28, 2004 and January 31, 2004
Approval of Annual General Meeting Minutes of January 30, 2004
3.0 Business Arising
3.1 Mental Health Implementation Task Forces/Authorities
3.2 Strategic Planning and Governance
3.2.1 Review of Role Descriptions
3.2.2 Nominations and Election Procedures
3.3 Implementation of the Personal Information Protection and Electronic Documents Act (PIPEDA)
3.4 Travel problems
4.0 Treasurer's Report
5.0 Reports of Task Forces and Committees
5.1 Advocacy Committee
5.2 Communications Committee
5.3 Continuing Education Committee
5.4 Finance/Audit Committee
5.5 Member Services Committee
6.0 Standing Reports
6.1 CPA Reports
6.1.1 Directors – B. Buckingham/A. Moulden
6.1.2 Council of Provinces – K. Anderson
- discussion re: length of training time
6.1.3 Standing Committees
6.1.3.1 Education – D. Puddester
6.1.3.2 Professional Standards & Practice – R. Milev
6.1.3.3 Scientific & Research – B. Swenson
6.2 OMA Tariff/RBRVS
6.2 Working Group on Mental Health Services
6.3 Coalition
6.5 Alliance for Mental Health Services
6.6 Section Reports
7.0 New Business
7.1 CPA Standing Committee Vacancies
7.2 Older Person's Mental Health and Addictions Network of Ontario (OPMHAN)
7.3 Shared Care Fee Code
7.4 Region 3 Representative on the Specialty Committee in Psychiatry

Consent and Capacity Board - Update

In April 2004, Mr. Theodore Nemetz was named Chair and Chief Executive Officer of the Consent and Capacity Board. Mr. Nemetz has come to this position with the goal of restoring and improving the image of the Board.

Theodore Nemetz is a lawyer who was initially called to the Bar in British Columbia in 1973 and then in Ontario in 1981. His primary practice was in the area of family law. He was first appointed to the Consent and Capacity Board as a lawyer member in 1996 and in 1999 was designated as a senior lawyer, which allowed him to conduct hearings as a single panel member.

Mr. Nemetz believes that to perform its statutory mandate, the Board must be a highly skilled body. He states – "All Board Members must keep abreast of the ever-growing body of jurisprudence in this area. The Board has been publishing its significant decisions on the internet so that everyone can review the decisions as a means of continuing education. The Board also publishes a monthly newsletter informing the members of the significant decisions and providing analysis. The Board is also undertaking an outreach program whereby we become involved in the education and training of those who are consumers of our services. The Board will provide speakers to any hospital or any other group who wishes education and training in conducting a hearing before the Board or in learning about the Board and the work that we perform. All that needs to be done is contact the Board to arrange a training program."

On April 1, 2004 the Board brought into force new Rules of Practice. These Rules were the product of a lengthy consultation process and are designed to ensure a fair hearing for all parties and to ensure a uniform process throughout the province. The Rules codify many of the practices previously employed by the Board and are to be used when appearing before the Board.

For more information please contact: Consent and Capacity Board, 151 Bloor St. West, 10th Flr., Toronto ON M5S 2T5, phone: (416) 327-4142, Facsimile: (416) 327-4207, website: www.ccboard.on.ca

Editor's Note: CCB cases are posted on the Canadian Legal Information Institute Website at: www.canlii.org/on/cas/onccb/
You can search cases by year and name/initials. You can access this legal website through the www.ccboard.on.ca website as well. Reading the cases provides information on the necessity for documenting the evidence and can help to understand the challenges posed by legal counsel, the patient or board members.
The new Rules of Practice, mentioned above, are available from the Consent and Capacity Board website as well, or you can contact the OPA office for an electronic version.

Canadian Psychiatric Association Position Paper – Emerging Trends and Training Issues in the Psychiatric Emergency Room

This CPA Position Paper by Dr. Ian Dawe was developed in collaboration with the CPA Standing Committee on Education and was approved on April 14, 2003. To obtain a copy of this paper, please contact the CPA, 260-441 MacLaren Street, Ottawa, ON K2P 2H3; Tel: 613-234-2815; e-mail: cpa@cpa-apc.org. Reference 2004-44.

Mental Health Legislation Video for the Deaf and Hard of Hearing

Reach Canada in Ottawa has produced a video that provides an overview of Mental Health Legislation in Canada and uses American Sign Language and captioning for deaf and hard of hearing individuals. This overview is based on The Ontario Mental Health Act. An accompanying guide explains the Act in more detail and includes variations in all provinces and territories. For an order form see, http://www.reach.ca/images/Video%20order%20form.jpg

LAW OR PSYCHIATRY:
WHICH SERVES CONSUMERS BETTER ?

Few people are more sensitive to the clash of values between law and medicine in dealing with the mentally ill than Ron Sklar. Mr. Sklar joined the staff of McGill University in 1973 to teach criminal law and psychiatry. Here Sklar clarifies the legal-medical issues and explains why there are, at present, few real solutions to this thorniest of ethical conflicts.

Q: Can you explain the differences in the approach to consumers taken by psychiatrists and lawyers?

Sklar: It's the law rather that the lawyers that's in question here. There are two big controversies between psychiatry and the law. One is the grounds for forcing a person into a hospital. The other is whether a person can be compelled to undergo treatment. The law says you can't confine someone in a psychiatric hospital unless he is a danger to himself or others. Neither can someone be confined simply because he needs treatment. Take the situation where a woman is quite depressed. It's clear that treatment would help and her family thinks she'd be better off in a hospital. But she doesn't want help; she just wants to be left alone. A lawyer will fight to keep her out of the hospital, because under the legal standard she's not a danger to herself or others. The fact that she could benefit from treatment, that it's in her best interest to receive treatment, is not a basis for confinement. Now this is frustrating to the medical profession. So when you say the lawyer and the psychiatrist are at odds, it's really because of the legal definitions. The law guarantees the rights of the patient. Of course, if someone is muddled and not thinking correctly, the lawyer may certainly suggest seeking some kind of psychiatric help.

Q: And if someone is dangerous?

Sklar: If a person is suicidal, say, and the family wants to get him into a hospital, they must seek an order before the court. The patient has a right to legal help, but the lawyer will not make false representations to the court. He will admit there's a threat of suicide and the patient will be confined.

Q: And legally no one can be forced to undergo treatment?

Sklar: That's right. The law says that we all have rights over our bodies, including the right not to be treated. You sometimes hear of a Jehovah's Witness refusing to undergo a life-saving blood transfusion on the grounds of religious belief. Many of us would feel that the person's best interests are being sacrificed, but here the law and ethics both say we can't do that person's thinking for him. But the law remains that as long as a person has sufficient understanding and is not totally delusional, he or she has a right to self-determination and freedom.

Q: Have you ever found yourself in the middle of a conflict over rights?

Sklar: A lawyer once consulted with me concerning a person suffering from manic depression who was in hospital and wanted to get out. The hospital hadn't filed the correct forms for his confinement and we got him released. It was obvious to me that the man was quite manic. It was also obvious that he was being detained illegally. The lawyer got him released, but in truth, he probably would have been better off in hospital.

Q: So who benefited?

Sklar: It probably wasn't good for the patient, but a lawyer must represent a client's interests within the law. Concerning this case, it wasn't the lawyer's job to make a diagnosis and say, "Look, you should be under supervision and take medicine." Doctors do that, not lawyers. If the laws were different, if the basis for confinement were a person's need for treatment, then that patient would have stayed in the hospital.

Q: In your opinion, is the law successful the way it stands now?

Sklar: Personally, I think it would be better off if we had a standard for commitment for a person whose health is seriously deteriorated and who needs psychiatric treatment. The dangerousness criterion can prevent people from getting needed treatment. Having to mark time until a crisis occurs is not in the best interest of the patient or the patient's family. However, just because a person's behaving in a bizarre fashion, or difficult to live with, or because she walks in the street talking to herself, that shouldn't be a basis for locking her up. That's what we used to do. I wouldn't want to see the law revert to that.

Q: Given the substance of the law is there anything consumers can do to help themselves?

Sklar: There is a useful system called Advance Directives in Ontario. During a period of wellness, a person can sign a document stating that "Should I become mentally ill and unable to make decisions for myself, I hereby give consent to be treated and brought to a psychiatric hospital." That directive is binding. It will be honoured by a hospital and the court (a Substitute Decision-maker may be set up through a lawyer when you are well).

Editor's Note: This article was published in Share & Care, the newsletter of Ami-Quebec, Spring 1998, in The Link, the newsletter of The Mood Disorders Association of Ontario, Summer 1998, and in The Krasman Centre's newsletter in January 2004. Many thanks to the Krasman Centre for providing this article to Dialogue.

RVIC: Son of RBRVS By: Dr. Philip Barron*

Well, not really. It won't cost $4 million for a start – the reputed cost of the much maligned RBRVS process. But what is RVIC anyway?

OMA observers will remember that when the OMA Council voted to reject the RBRVS report in November 2002, it was determined that since fee inequities were still a continuing disgrace, a new approach should be undertaken by the OMA. A Committee, the Relative Value Implementation Committee (RVIC), reporting to the OMA Board was established to be chaired by John Rapin, President elect of the OMA, with a mandate to look at ways in which these inequities might be addressed.

It consists of representatives from Family Practice, Psychiatry, General Surgery, the Ministry, and a representative from the Central Tariff Committee. It met regularly through 2003 and into 2004 and presented an Interim Report to the OMA Council in November 2003. Is it important? Probably, since it is proposed that a portion of the monies available as a result of the upcoming contract negotiations (if there is any money) be made available to address fee inequities.

The committee discussed a number of options and sought input from the sections. Interestingly once more, the Section on Radiology distinguished itself by rejecting out of hand any initiatives. Whilst undoubtedly many radiologists are fine fellows, the Ontario Association of Radiologists seem to believe in the methodology of Ghengis Khan in their approach to fee discussions. The committee finally adopted an unfortunate badly named proposal called "Fee for Income", which formed the basis of its report.

Briefly, OHIP data was used to determine professional billings above $60,000 for each specialty. Canada Revenue Agency data (Rev Canada) was used to calculate overhead expenses. Hours of work were obtained from the Ontario Human Resources Committee survey, which stratifies by specialty hours of work and stand-by hours. To take into account unsocial hours of work, after hour premiums as a proportion of OHIP billings per specialty was used to inflate hours of work for each specialty.

Based on these figures, the average net income of a specialist in 2002-2003 was $186,011 and this was used as the benchmark for further calculations. For each specialty the deviation from this figure is used to calculate an adjustment.

In the case of General Surgeons, the average net income in this period was $157, 656. An adjustment was then made upwards to 50% of the deviation and expressed as a percentage to arrive at a 4.2% relativity adjustment to General Surgery fees. This of course would be in addition to any across the board increases and any other adjustments to on call stipends or after hours premiums. How the 4.2% is to be allocated within the specialty would be decided by the specialty subject to oversight by the Central Tariff Committee.

For GPs, the deviation is calculated from 80% of the net average specialist income. The average net income of Cardiac Surgeons is $251,221 – well above the net average specialist income and in consequence the relativity adjustment for them would be 0%. It goes without saying that Opthalmology falls into this category. It may be asked why not make the adjustment to 100% of the net specialist income? The numbers do change each year and the relativity adjustments are planned to be an annual event. It also avoids large annual changes.

There has been some criticism of the figures, but these are the best available and have been reproducible year on year. It is also not necessary to have the calculations exact to the last decimal point as it is the trend, which is more important. The committee also recognizes that it is not perfect and is working to refine it, but it is a start to an iniquitous problem.

*Dr. Philip Barron, Section Chair and O.A.G.S. past president, is on staff at the Ottawa Hospital.

Editor's Note: This article was first published in The Cutting Edge, Spring 2004 and is reprinted with permission of the author. Thanks to Dr. Doug Weir for suggesting this article for Dialogue.

Community-Based Mental Health Case Management at COTA

COTA provides client-centred care to individuals with mental illness using a shared care mental health approach. Some of these clients are homeless and chronically ill. Their Granby Case Management Program serves individuals living in downtown Toronto, most of whom have no other way to access health care services. This prevention-oriented program offers mental health treatment and supports to clients with serious mental illness who are at risk of losing their housing or are living in a supportive housing environment. The program is staffed by five mental health case managers, a full-time psychiatric nurse and a psychiatrist, Dr. Bruce Menchions, who works one day a week. The psychiatric nurse conducts a comprehensive intake and assessment for each referral. Case managers provide ongoing case management and support services, crisis response, and home visits. Dr. Menchions provides weekly consultations, monitors medications, renews prescriptions, conducts one-on-one assessments with clients and/or family members, and provides phone consultation with family physicians and other psychiatrists.

The average length of service can range anywhere from one to three years. Upon discharge, approximately 75% of clients are referred to day programs, 10% are transitioned to more specialized mental health teams, in order to focus on a specific issue or concern, while the remaining clients are referred to hospitals, nursing homes and/or independent living arrangements.

COTA recently expanded their rehabilitation, but not their mental health, services through the local Community Care Access Centres in the London and Ottawa areas. COTA's intent is to work with mental health clients in these local communities in the future.

To make a referral or to receive more information about the Granby Case Management Program, please call 416.785.9230 or 1.888.785.2779 and speak with one of COTA's Information and Referral Coordinators, 700 Lawrence Avenue West, Suite 362, Toronto, Ontario M6A 3B4 E-mail: info@cotarehab.ca Web: www.cotarehab.ca

Health Canada Advisory: Stronger Warnings for SSRIs and Other Newer Anti-depressants

Health Canada advises that all newer anti-depressant prescription drugs - Selective Serotonin Re-uptake Inhibitors (SSRIs) or Serotonin Noradrenalin Re-uptake Inhibitors (SNRIs) - are to carry stronger warnings in the information packages received by patients and in the prescribing information available to health professionals.

The stronger warning to patients, of all ages, states that they may experience behavioural and/or emotional changes that may put them at risk of self-harm or harm to others should they take the following drugs:
Bupropion (Wellbutrin(R) and Zyban(R) - Note that both of these drugs share the same active ingredient. Zyban, a smoking cessation drug, now carries an appropriately modified version of the above warning; Citalopram (Celexa(R));
Fluoxetine (Prozac(R)); Fluvoxamine (Luvox(R)); Mirtazapine (Remeron(R))
Paroxetine (Paxil(R)); Sertraline (Zoloft(R)); Venlaflaxine (Effexor(R))

Health Canada has not authorized these drugs for use in patients under 18 years of age. The prescribing of drugs is considered to be the physician's responsibility and the prescribing of these drugs to children are at the
physician's discretion. Health Canada acknowledges that the off-label use of these drugs in children is an important tool for doctors and advise careful monitoring of patients of all ages for emotional or behavioural changes that may indicate potential for harm, including suicidal thoughts and the onset or worsening of agitation-type adverse events.

Health Canada advises that patients, their families and caregivers should note that a small number of patients taking drugs of this type may feel worse instead of better, particularly within the first few weeks of treatment or when doses are adjusted, and, should they experience unusual feelings of agitation, hostility or anxiety, or have impulsive or disturbing thoughts that could involve self-harm or harm to others, they should consult their doctor immediately, but should not discontinue taking their medication on their own, without first consulting with their doctor, due to the labelled risk of discontinuation symptoms with all of these drugs, except bupropion. Treatment with these types of medications is safest and most effective when the patient communicates well with the treating physician about how he or she is feeling.

This advisory stems from advice given by an independent expert panel and is the result of Health Canada's extensive review of the latest worldwide safety data available for these drugs. Health Canada conducted an analysis of all adverse reactions experienced by patients taking SSRIs. Although Health Canada did not find a direct link between taking SSRIs and incidents of death, the Department felt it important to let health professionals and consumers know of the possible risks associated with the drugs.

Youth Net: For Youth and By Youth

By: Alicia Savage*

Youth Net/Réseau Ado (YN/RA) is a bilingual, local mental health organization for youth, run by youth with clinical and professional backup on call if necessary. YN/RA Ottawa (see: www.youthnet.on.ca) reaches across Eastern Ontario and Western Quebec and there are 12 other active sites across Canada and in the UK. Its purpose is to help youth develop and maintain good mental health. This goal is attainable through education, early intervention and destigmatization. Educating teens, the community, and the government on mental health issues is vital in increasing awareness. Early identification of youth that may be in crisis allows for an intervention to happen early and the youth can be connected to resources in the community for ongoing help. In our society, mental health and mental illness is perceived as something we don't talk about. YN/RA works to increase awareness about mental health and mental illness and to break down the barriers and dispel the myths that surround these subjects.

How did it all start? In 1993, the Canadian Psychiatric Association conducted a survey called the Canadian Youth Mental Health and Illness Survey. Results from the survey showed youth were at an increased level of risk for mental health problems and that youth were disappointed with the existing mental health services. Statistics showed that youth didn't feel comfortable turning to these services for support. It was also shown that youth experiencing mental health problems were more likely to turn to other youth, before talking to a parent or professional. The following year, statistics showed that suicide was the second leading cause of death among Canadian youth. As a result, Dr. Ian G. Manion, Director of Mental Health Research at the Children's Hospital of Eastern Ontario, and Dr. Simon Davidson, then Chief of Staff at CHEO came up with a concept that later became Youth Net/Réseau Ado. Today, YN/RA has conducted focus groups with over 11,000 youth in Ottawa and the surrounding area to discuss mental health.

YN/RA has evolved over the past ten years to not only meet youth's needs for a link to mental health services, but is now providing services of its own for youth. These initiatives are designed to help youth learn positive coping strategies and allow youth with varying degrees of mental health to interact within a supportive and safe environment. Clinical backup is always on call for any YN/RA activity, to support the youth and the facilitators.
Support groups are conducted in the community, at schools and community centres, and also at YN/RA. They consist of 8-12 youth with 2 youth facilitators. The usual duration of a support group is 12 weeks (2 hours per week). The VENT support group is offered to 17-20 year olds who have had trouble finding services that meet the needs of their specific age group. Support group facilitators are provided with clinical supervision on a weekly basis for additional support.

YN/RA also offers three seasonal recreational activities known as Youth Initiatives. These initiatives were all started by youth that have been involved with YN/RA. Pens and Paints is a program offered in the fall and the winter. It focuses on visual arts and creative writing. It consists of 10-15 youth with 2 facilitators and it lasts 8 weeks, running 3-hour sessions each week. Freeride, a snowboarding program supported by Camp Fortune, is offered in the winter months and focuses on physical activity and building healthy self-esteem. It lasts for 6 weeks and can include up to 30 youth. Take a Hike is a hiking initiative and is offered in the spring/summer. It also focuses on physical activity and enjoying nature. It consists of 10-15 youth with 2 facilitators and it lasts for 6 weeks.

In addition, newsletters known as Youth Faxes are written and edited by youth for youth on different mental health issues and are available for free upon request. YN/RA also offers Applied Suicide Intervention Skills Training (ASIST), a two-day training program in suicide first aid. There are 6 workshops a year offered to YN/RA staff, co-op students, volunteers and community members.

For further information on the Youth Net/Réseau Ado program, please contact Erin Elsmore at 613-737-7600 x3239 or via email at eelsmore@exchange.cheo.on.ca.

continued on next page

Other YN/RA sites in Ontario:

- Youth Net Halton, 1151 Bronte Rd Oakville ON L6M 3L1, Ph. 905-825-6060 x7606, Fax 905-825-8588
- Youth Net Peel, C/O CMHA 3-3181 Wolfedale Rd Mississauga ON L5C 1V8, Ph. 905-804-0123 x 137, Fax 905-804-0120
- Youth Net Hamilton, 1 Hughson St N 5th flr Hamilton ON L8R 3L5, Ph. 905-596-4119, Fax 905-546-4668
- Youth Net Grey Bruce, C/O CMHA 1024 2nd Ave E Owen Sound ON N4K 2H7, Ph. 519-371-3642 x30, Fax 519-371-6485

*Alicia Savage was a co-op student in the fall of 2003 at Youth Net/Réseau Ado from Hillcrest HS. She is an avid writer and also participates on her school's improv team. Alicia also participated in Youth Net's Pens and Paints program during her co-op placement.

Youth Mental Health in Ontario:
Survey Finds One-in-Ten Students Report Multiple Mental Health Issues

The Centre for Addiction and Mental Health (CAMH) released a report entitled, "The Mental Health and Well-Being of Ontario Students Report, in May 2004. This reports presents data from 2003, as well as trends from the past decade. One in ten students reported experiencing multiple (three or more) mental health issues including symptoms of depression and anxiety, problem drinking, other drug use and anti-social behaviour such as theft, vandalism or violence.

Highlights of the study include:

- Just under one-third of students reported experiencing elevated psychological distress, with females more likely to report this than males (39% vs 22%).
- About 11% of students visited a mental health professional at least once during the past year.
- 33%, or approximately one-third of students have been bullied at school. Just under one-third of students reported taking part in bullying other students.
- One-in-ten students report having low self esteem with females more likely to do so than males (11% vs 7%).
- About 4% of students report signs of pathological gambling, with males more likely to do so than females (6% vs 1%). Internet gambling was reported by about 2% of students.
- Over one-in-eight students had serious thoughts about suicide in the past year, with significantly more females than males reporting this (17% vs 8%).

The study also revealed that parent-child relationships, parental monitoring and school marks are the most common risk factors related to youth experiencing mental health issues such as depression, thoughts of suicide, pathological gambling and illicit drug use.

CAMH provides treatment services and has implemented a number of clinical, educational, research and program development initiatives for adolescents with addiction and/or mental health issues. A list of these initiatives and the executive summary of the mental health report is available at www.camh.net.

The mental health and well-being survey results were collected as part of CAMH's ongoing Ontario Student Drug Use Survey (OSDUS) and will continue to be reported every two years. OSDUS spans over two decades, based on 14 surveys conducted every two years since 1977. In the spring of 2003, 6,616 students (grades 7 to 12) from 37 school boards, 126 schools and 383 classes participated in the survey administered by the Institute for Social Research, York University. The executive summary of the 2003 OSDUS Mental Health and Well-Being Report is available at http://www.camh.net/pdf/ENExecSum_MH_OSDUS2003.pdf

OLDER PERSONS' MENTAL HEATH AND ADDICTIONS SERVICES RESOURCE GUIDE FOR FAMILY PHYSICIANS

The Older Persons' Mental Health and Addictions Network (OPMHAN) was initiated in 2002 under the sponsorship of the Ontario Gerontology Association. The Network actively seeks out and invites the participation of service providers, consumers and consumer groups, family caregivers, ethno-cultural groups, educational facilities, research organizations, governments, and associations with an interest or a stake in the mental health / addiction needs of seniors. To date the Network includes representation from 50+ regional and provincial organizations, consumers and family advocacy groups.

The Mood Disorders Association of Ontario and OPMHAN have formed a partnership with the Ontario College of Family Physicians' Collaborative Mental Health Care Network to develop an Older Persons' Mental Heath and Addictions Services Resource Guide for Family Physicians which will be distributed to all family physicians in Ontario. Current listings include:

- Addiction Services of Haldimand-Norfolk Health Unit
- Brentwood Community Program, Windsor
- Community Outreach Programs in Addictions (COPA), Toronto
- Community Psychiatric Services for the Elderly, Toronto
- Huron Addiction Services (HAS)
- Integrated System for Older Adults Addiction Services, Thunder Bay
- Lifestyle Enrichment for Senior Adults (LESA), Ottawa
- LOFT Community Services, Toronto
- OLDER WISER LIFESTYLES ™ , Hamilton
- Opus 55 (Older Persons Unique Solutions), CAMH, Toronto
- Peel Addiction Assessment and Referral Centre, Mississauga and Brampton.
- Prescott and Russell Psychogeriatric Service
- Sister Margaret Smith Center, Thunder Bay
- Sudbury Regional Hospital Psychogeriatric Outreach Program
- YWCA Choices for Living Program, North York

This is an opportunity to raise awareness and bring visibility to the services for older adults related to mental health and / or addictions. If you are interested in having certain programs and services listed in the Resource Guide, please provide information (a brief description/summary of the service, admittance criteria, if any, and the location and contract information for all locations across the province, or a central contact) to:
Randi Fine, Coordinator, Older Persons' Mental Health and Addictions Network of Ontario, Tel- 416-782-1601e:mail rfine@sympatico.ca

CTC Report

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

Each year, OMA Sections have an opportunity to submit proposals for revisions and new fee codes to the OMA Central Tariff Committee (CTC) during the CTC Marathon sessions. The OMA CTC is the committee responsible for suggesting adjustments to the OMA Schedule of Fees; it has no authority to set the OHIP Schedule of Benefits. While there is no legally binding obligation on the Ministry of Health and Long-Term Care to synchronize changes made to the OMA Schedule of Fees with the OHIP Schedule of Benefits, parallel changes to OHIP are usually made, with some exceptions, when OMA has made a request to do so. Typically, the rates in the OHIP Schedule of Benefits are approximately 60% of the rates in the OMA Schedule of Fees.

As you may recall, OMA General Council voted for several years to implement across-the-board increases rather than CTC recommendations; thus, none of the CTC recommendations from 1998, 1999, 2000, or 2001 were implemented by OHIP prior to 2002. These CTC recommendations included what would have been significant increases to psychiatric time-based fees. In November 2001, the Section on Psychiatry was successful in having the OMA change its policy of across-the-board increases and the backlog of CTC recommendations began to be implemented in the OHIP Schedule of Benefits in 2002.

Changes for 2003

Through a series of changes to the OHIP Schedule of Benefits in April 2003 and again in August 2003, the following changes occurred in 2003:

K197 & K198, out-patient psychotherapy and psychiatric care, increased from $54.15 [2002] to $58.40 [2003] per half hour, an almost 8% increase.
A197 & A198, consultative interview with parents & child, increased form $107.20 [2002] to $125.00 [2003], a 16.6% increase.
K199, in-patient psychiatric care, increased from $60.10 [2002] to $62.60 [2003], a 4.2% increase.
K191, K193, K195, & K196, family psychiatric care and psychotherapy codes, increased from $61.40 [2002] to $63.95 [2003], a 4.2% increase.
C895, hospital consultation, increased from $134.25 [2002] to $140 [2003], a 4.3% increase.
A195, outpatient consultation, increased from $122 [2002]] to $125 [2003], a 2.5% increase.

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

While the above changes represent significant gains for Ontario psychiatrists, two new codes, successfully passed by the CTC, have not yet been accepted by the Ministry of Health and Long-Term Care. These are codes for an Extrapyramidal System Assessment, and a code for Team Psychiatric Management of Disturbed Behaviour. The Section is planning on pursuing these codes further with the Ministry.

In addition, the Section was successful during the 2003 CTC Marathon sessions at having the CTC recommend a further 10% increase to psychiatry consultation fees. Hopefully this increase will be implemented in 2004, although the negotiations process is now underway and may defer the time of implementation of various CTC recommendations.

CTC Submission for 2004

For this year, the Section is pursuing the following items through the CTC:
1. Shared Care Consultation Fee ^ fee to remunerate psychiatrist and GP for telephone time discussing patient management
2. Increase to ECT fees
3. Transcranial Magnetic Stimulation (TMS) Fee
4. Review Board Preparation Fee ^ to remunerate for time spent in preparation of review board hearings

Psychiatry Billing and Practice Guide

This past year the Ontario Coalition of Psychiatrists began developing a Psychiatry Billing and Practice Guide for Ontario psychiatrists. This Guide will be a practical resource for psychiatrists and will include various aspects of practice and billing policies, both for OHIP services and non-insured services. It will cover such issues as the proper use of the most commonly billed OHIP codes, examining codes which may be "underutilized" by psychiatrists, billing for missed appointments, and implementing "block billing" in a practice. It is our intent to have the Guide distributed to Ontario psychiatrists this fall.

In conclusion, I would like to once again thank the Coalition of Ontario Psychiatrists and the Ontario Psychiatric Association for their ongoing support of tariff issues. While we have made gains for Ontario psychiatrists in recent years, lack of fee relativity and barriers to proper provision of psychiatric care in many domains continue to plague the profession. The continued support of the Coalition and the OPA will ensure that psychiatry has a strong voice in addressing these issues in the future.

MEMBERS ON THE *MOVE*

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

Ontario
Psychiatric Association

Association des
Psychiatres de l'Ontario

April 26, 2004

The Honourable George Smitherman
Minister of Health and Long-Term Care
10th Floor, Hepburn Block, 80 Grosvenor Street, Queen's Park
Toronto, Ontario M7A 2C4

Dear Minister:

I am writing on behalf of the Ontario Psychiatric Association whose members have expressed concern regarding Consent and Capacity Board hearings.

Our members indicate that hearings have become increasingly prolonged, complex, legalistic and adversarial in nature. There is a tendency for hearings to concentrate more on administrative and legal matters than patient issues. This results in the disruption of care and treatment of the patient as well as hardship for the patients' families who are concerned about their loved ones.

Psychiatrists expect to prepare for and present clinical findings at Board hearings. Increasingly however, psychiatrists are required to deal with complicated legal matters. The Consent and Capacity Board expects psychiatrists to call and cross-examine witnesses, file preliminary motions and file documents as exhibits, according to statutory requirements. Some psychiatrists believe that they will need additional legal training as well as access to legal advice and support so that they can function effectively before and during hearings. In fact, psychiatrists will require legal assistance in order to launch an appeal if one is necessary to provide appropriate treatment to patients. Currently, few appeals from psychiatrists occur, not because they are not necessary, but because psychiatrists do not have the capacity to commence an appeal.

Preparation time for psychiatrists is non-compensable and legal advice and assistance are not available to most psychiatrists. Psychiatrists may be at a considerable disadvantage when required to attend a meeting, mediation, hearing or appeal without legal representation. The Ontario Psychiatric Association wants to ensure that psychiatrists will be adequately trained and given the appropriate resources and compensation necessary to adequately prepare for their duties as required by the Consent and Capacity Board.

We are hopeful that the recently appointed Chair, Consent and Capacity Board will work to institute changes that will better meet the needs of all concerned. The OPA would be happy to meet with you and your staff at any time to find workable solutions to address the concerns of our membership.

Sincerely,

Doug Wilkins, MD, FRCPC
OPA 2004 President

cc: Dr. Doug Weir, Chair, Ontario Medical Association Section on Psychiatry
Dr. Brian Hoffman, President, Association of General Hospital Psychiatric Services

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

PARTIAL HOSPITALIZATION PROGRAMS FOR MENTAL HEALTH PATIENTS

Submitted by: The Ontario Hospital Association Mental Health Working Group and the Northeast Region's Acute Mental Health Working Group.

In September 2002, the Northeast Region's Acute Adult Mental Health Working Group presented a report to the Ontario Hospital Association Mental Health Working Group (MHWG) on partial hospitalization programs for mental health patients. (For the entire document please visit www.oha.com, click "clinical and professional issues" and then "mental health".)

Research has indicated that people who have used these programs report feeling less stigmatized than when they were admitted to hospital because their treatment takes place in a normalizing environment. With the support of professional staff, clients are expected to continue to deal with their usual social responsibilities. An important advantage of partial hospitalization programs is their lower cost due to staffing flexibility and the use of multidisciplinary teams. In addition, partial hospitalization programs provide a solution to the ongoing problem of hospital bed availability; scarce hospital beds can be reserved for other very severely disturbed patients who require intensive care (Warner 1995).

The MHWG found that partial hospitalization programs are an economical and clinically effective alternative for many acutely mentally ill patients and can lead to a more efficient use of inpatient resources. The flexibility of partial hospitalization programs allows the staff to respond to the human needs of their clients. Patients, who would otherwise be in an institutional setting, can retain autonomy and maintain links to the community.

The MHWG wanted a better understanding of the scope and roles of these programs and for that reason, in January 2003, a survey was sent to member

hospitals requesting information on partial hospitalization programs in Ontario. In total, 65 hospitals responded to the survey.

Mental Health Working Group Survey – Issues
The results of the survey indicated that there are provincial inconsistencies in the design and delivery of partial hospitalization programs across Ontario. (For results of the survey please visit www.oha.com under clinical and professional issues, mental health.) Hospitals with partial hospitalization programs have taken the initiative to develop and design them to meet their local needs, in the absence of having any clear definition or criteria. This has resulted in a variety of partial hospitalization programs across the province. Although there is a need for flexibility and latitude within hospitals, it is important to ensue there are some guiding principles in the development of these programs.

Furthermore, in reviewing the analyses, it came to the attention of the MHWG that hospitals have reported discrepancies in how the Ministry of Health and Long Term Care's Regional Offices are interpreting the role of the partial hospitalization programs. This has been most apparent in the feedback received from the Regional Offices to hospitals in the review of current and future programs as described in their functional program plans.

While Making it Happen (Government of Ontario, 1999) indicates that partial hospitalization programs are core components in the provision of mental health services within Schedule 1 facilities, it is silent on their role within specialty mental health hospitals. Some Regional Offices have interpreted this silence as an indication that partial hospitalization programs are in fact not a key component of the tertiary mental health service continuum.

MHWG Recommendations
In order to address the above noted concerns, the MHWG has recommended to the Ministry of Health and Long-Term Care (MOHLTC) that the Ministry clarify its position - that partial hospitalization programs are considered a core component for all hospitals - to their Regional Offices, and, that the Ministry develop a common framework and set of guiding principles for partial hospitalization programs.

BACKGROUND
HISTORICAL DEVELOPMENT OF PARTIAL HOSPITALIZATION PROGRAMS
"The concept of partial hospitalization for psychiatric disorders has evolved for more than 50 years. Its underlying premise is that most patients with serious mental disorders can be successfully treated in a less restrictive and less costly environment than an inpatient setting. At the same time, partial hospitalization should provide care that is more coordinated, intensive, comprehensive, and multidisciplinary than the outpatient treatment that is generally available" (Parker & Knoll, 1990).

In the late 1970's the American Association for Partial Hospitalization was formally established. This is a multidisciplinary organization that sponsors chapters throughout the United States, publishes the International Journal of Partial Hospitalization and holds annual meetings. Under its aegis, the group has developed standards and guidelines for partial hospitalization programs (Block and Lefkovitz, 1995).

REVIEWS AND OVERVIEWS
Three different types of evidence have been identified – "research, clinical experience and patient preference. While evidence from research, clinical experience, and the users of health care are recognized as important sources, it is argued that, whatever sources of knowledge are drawn upon, it needs to have been subjected to scrutiny and found to be credible. This acknowledges the importance of conducting critical appraisal before considering implementation." (Rycroft-Malone et.al., 2002). The literature on partial hospitalization contains elements of each of these types of evidence though all are limited.

A comprehensive review of the literature on partial hospitalization offered the following insights. Horvitz-Lennon et.al. (2001) found that partial hospitalization was not an option for all patients requiring intensive services and that outcomes for partial hospitalization patients were no different from those of inpatients. The significant finding was that patients and their families reported being more satisfied with partial hospitalization programs.

The results of a study by Jensen (2001) indicated that patients showed improvement in their symptoms/functioning from admission to discharge. Patient satisfaction questionnaires also reported a very high level of overall satisfaction within the group.

Rosie (1987) was of the opinion that "partial hospitalization programs are an economical, effective treatment alternative for a substantial number of acutely ill patients is firmly established by well-designed, large-scale, controlled and replicated studies." Olfson and Goldman (1996) cite evidence that non-dangerous patients, females and those suffering with acute rather than chronic conditions can be effectively served by day hospitals. They agree that partial hospitalization programs can be effective and provide a low-cost alternative in the range of services.

Wasylenki (1997) maintains that partial hospitalization programs are more economical and more in keeping with consumer and family preference. "Overall, community-based care resulted in comparable clinical and functional outcomes, was preferred by families and patients, resulted in improvements in quality of life, and seemed to be more economical."

A research study completed by Russell et. al. (1996) describes the establishment of an acute day hospital at the Ottawa General Hospital. The process involved the closure of six beds and used the staff and space resources to set up the program for the treatment of eight acutely ill psychiatric patients. The researchers concluded that a time limited day hospital program is clinically effective for acutely ill psychiatric patients and leads to more efficient use of inpatient resources.

INTERNATIONAL CONTEXT
There is a growing recognition (globally/internationally) that mental health policy documents must speak to the importance of reforming the existing systems. Mental health problems such as anxiety and depression are very common in the general public. Existing mental health policy has primarily focused on the 1% of the population that suffers from severe mental illness. Less attention has been spent on the greater percentage of the population (15%) diagnosed with a mental disorder. The burden of mental illness on health and productivity throughout the world has been profoundly underestimated. Data developed by the massive Global Burden of Disease Study conducted by the World Health Organization, the World Bank, and Harvard University reveal that mental illness, including suicide, ranks second in burden of disease in established market economies, such as Canada and the US. This data underscores the importance and the urgency of treating and preventing mental disorders and of promoting mental health in our society, not

continued on next page

just among those with the most severe mental illness, but also on the larger group with less severe disorders (Office of the Surgeon General, 1999).

CONCLUSIONS

Hospitalization for psychiatric illness has undergone revolutionary changes in the last three decades. Today people with mental illness have many treatment options depending upon medical need. The goal is to restore maximum independent living as rapidly as possible, using appropriate levels of care. In the United States, partial hospitalization has been a growing treatment modality for individuals with mental disorders. Partial hospitalization is a specialized and intensive form of treatment that is less restrictive than inpatient care but is more intensive than the usual types of outpatient care. An advantage of this treatment setting is that it can help patients maintain their abilities to function at home, at work and in their social circles. The treatment setting incorporates their support network of friends and family who can help monitor their condition when they are not in hospital and they can return home at night and on weekends.

In the future, the projected reduction in mental health beds provincially may create enormous pressures on the hospital systems. This is particularly true in areas where occupancy rates have remained high and where there has been an insufficient investment in the Community Mental Health system.

There is considerable evidence that improvements in community programming can markedly reduce the rate of readmissions among discharged patients. Partial hospitalization programs, that provide intensive care designed to be an alternative to hospital care and assist in minimizing the disruptive effects of inpatient care, should not be confused with rehabilitative programs. These programs are designed to provide an alternative to outpatient care for patients who have severe impairments in vocational or social performance by providing strong support and structure. (Rosie et. al. 1995)

Partial hospitalization programs may offer a financial solution that could help to address the economic realities of our health care system. From a cost perspective, partial hospitalization treatment today is considered less expensive than inpatient treatment (Creed, Mbaya, Lancashire, Tomenson, Williams, and Holme, 1997), and partial/day hospital treatment is appropriate for 60% - 80% of patients who would otherwise be served on the costlier inpatient unit (Knight, 1995). The research has indicated that patients and families report a high degree of satisfaction with partial hospitalization programs as well as indicating a preference for this option versus hospitalization if offered a choice.

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Traumatic Mental Stress Policy at the Workplace Safety and Insurance Board

Under the Workplace Safety and Insurance Act, 1997, legislation was amended to include entitlement to compensation benefits for the diagnosis of traumatic mental stress that is an acute reaction to a sudden and unexpected event arising out of and in the course of employment. Some stakeholders have questioned this definition of traumatic mental stress and have proposed that traumatic mental stress could also affect workers who, due to the nature of their occupation, may be exposed to multiple, sudden and unexpected events. In this article, the WSIB discusses the consultation process that took place in 2001 and how traumatic mental stress claims are defined and adjudicated under the Workplace Safety and Insurance Act.

THE CONSULTATION PROCESS

In June 2001, as part of the consultation process, the Workplace Safety and Insurance Board (WSIB) distributed copies of its proposed revised traumatic mental stress policy proposal to stakeholder groups in the employer and worker communities. The proposed changes to the policy included recognizing the cumulative effect traumatic stress can have on a worker, while also acknowledging that ongoing or continuing harassment in the workplace can be traumatic. To ensure a wide range of stakeholders had access to the traumatic mental stress policy proposal so they could comment, it was also placed on the WSIB website.

When the consultation period ended on October 5, 2001, submissions were received from the worker and employer communities as well as the Ontario Psychological Association, the Ontario Medical Association, the Industrial Accident Prevention Association and the Ontario Hospital Association.

Employer submissions

The vast majority of employer responses suggested that the traumatic mental stress policy proposal, with respect to the cumulative effect, would be in direct conflict with the wording and intent of the current Workplace Safety and Insurance Act. They believed that the legislators clearly intended to limit mental stress entitlement, and that this was disregarded through the development of the recent policy proposal. Further, the employers felt that

harassment should not fall within the purview of workplace safety and insurance, as it was the sole responsibility of the Ontario Human Rights Commission, and also addressed by the Canada Labour Code. Employers were concerned that the WSIB would become involved in an area in which it had no experience and that there would be broad labour relations implications for employers.

Worker submissions

Worker submissions were more supportive of the traumatic mental stress policy proposal. The general feeling was that the proposed change was a move in the right direction, and a step towards becoming more consistent with the Canadian Charter of Rights and Freedoms. Many expressed the view, however, that the policy proposal was still too narrow in focus, fell short of comprehensively tackling these issues, and should be expanded to cover all disablement-type work injuries. A number of submissions revisited the need to have a chronic stress policy.

Other submissions

A number of health professional associations submitted their views. These submissions pointed out that "trauma" could only be described in highly specific terms with respect to the criteria contained in American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) or the International Classification of Diseases (ICD). The person's exposure must involve "intense fear, helplessness or horror" in order to relate it to a professional diagnosis in accordance with DSM-IV. These particular submissions pointed out that lessor stressors are included in the diagnosis of adjustment disorders of various kinds.

Submissions also noted that many health care providers, who are not physicians, have no specific training related to diagnosing these types of cases. Even general practitioners, who do have some training, may accept their patient's complaints in an uncritical way. Mental health specialists may do likewise so that, at times, no objective assessment occurs. The loss of diagnostic specificity with regard to accepted claims must be addressed or the WSIB may allow cases that are not really linked to traumatic workplace events. It was suggested that, without changes to the guidelines, a very significant increase in claims would occur as psychiatric illness in the workplace increases.

The policy

The WSIB approved a revised policy on traumatic mental stress in May 2002. The revised policy takes into account any cases where cumulative traumatic events have triggered a psychiatric/psychological response. As was the case with the previous policy, a worker will not be entitled to benefits for traumatic mental stress because of an employer's employment decision or actions (for example, a layoff due to a plant closure).

Previously, entitlement was accepted if a worker witnessed a single sudden and unexpected traumatic event of a horrific nature, or was actually harmed or threatened with violence in the workplace. Entitlement has now been expanded to also include being the object of harassment that involves physical violence or the threat of physical violence, or being placed in a life-threatening or potentially life-threatening situation. The event must arise out of and in the course employment, and be:

- Clearly and precisely identifiable
- Objectively traumatic;
- And unexpected in the normal course of work.

Some examples might include:

- Witnessing a fatality or a horrific accident
- Being the object of an armed robbery
- Being the object of a hostage-taking; or
- A worker's family, friends or co-workers being the object of a death threat.

The worker must have suffered or witnessed, or heard the traumatic event first hand (for example, speaking with the victim on the radio or telephone as the event is taking place).

Sometimes the nature of an occupation will expose a worker to multiple, sudden and unexpected events. In these cases, a decision-maker must establish from clinical and other information that these events led to the worker's psychological state, even if the worker was able to tolerate them in the past. A final reaction to a series of sudden and traumatic events is considered to be the cumulative effect. The last traumatic event that triggers the cumulative effect may not be the most traumatic in a series of events.

In some cases, traumatic mental stress may trigger an acute reaction. The WSIB defines an acute reaction as a significant and severe reaction by the worker to a one-time or a series of work-related traumatic events that have a psychiatric/psychological response. The policy says an acute reaction is "immediate" if it takes place within four weeks of the event or "delayed" if it occurs after four weeks. In the case of delayed onset, the evidence must be clear and convincing that the psychiatric/psychological response is due to the sudden and unexpected traumatic event that arose out of and in the course of employment.

To consider a claim, decision-makers at the WSIB require an Axis I diagnosis in accordance with the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). Diagnosis may include:

- acute stress disorder
- post traumatic stress disorder ; or
- an anxiety or depressive disorder

For immediate acute reactions, a claim will be accepted if an appropriate, regulated health professional confirms the worker has a DSM-IV Axis I diagnosis. Where the acute reaction is delayed or the onset is due to cumulative effect or harassment, a claim will be adjudicated once there is a diagnosis provided by a psychiatrist or a psychologist.

The traumatic mental stress policy applies to any single traumatic event or, in the case of the cumulative effect, the most recent traumatic event taking place on or after January 1, 1989 (the date the WSIB formally began reviewing the issue of stress).

The Traumatic Mental Stress Team

The WSIB has a team of claims management professionals dedicated to handling traumatic mental stress claims for all of Ontario. Part of this team's goal is to help employers and workers determine ways to prevent or minimize the effects of traumatic mental stress, including early identification of risks and appropriate intervention methods.

The team is comprised of five adjudicators and five nurse case managers who deal with specific industry sectors (e.g. Services, Construction, Transportation).

The claims handled by this team include:

- all claims registered after July 2, 2002 for traumatic mental stress
- Adjudication decisions reconsidered under the revised policy

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The industry sector team, not the traumatic mental stress team, handles claims involving a significant physical injury in addition to the diagnosis of traumatic mental stress.

Review of Claims

The Traumatic Mental Stress Team has found that early intervention, identification and treatment leads to a better recovery prognosis and early and safe return to work. Duration of benefits for traumatic mental stress diagnoses in 2001 were an average of 68 days. When the specialized team started handling these claims, the average time off work was reduced to 42 days for the period July 2002 to June 2003. Early and safe return to work with the accident employer is in everyone's best interest. It restores the worker's quality of life and maximum income, and the employer regains a valuable member of their workforce.

More information on the traumatic mental stress policy and billing processes for health care professionals is available at www.wsib.on.ca. For more information about the traumatic mental stress team or a specific claim, you can contact Anne-Marie Hampton, Manager, Traumatic Mental Stress Team at (416) 344-2748 or by email at: anne-marie_hampton@wsib.on.ca.

IN MY VIEW:

How a Supreme Court Ruling on Workers' Compensation for Chronic Pain Disability Affects Ontario's Discriminatory Worker's Compensation Law for Mental Stress

By: Jo-Ann Seamon*

A recent Supreme Court ruling found that the Nova Scotia Workers' Compensation Board's restriction on chronic pain disability violated the Charter. This ruling has implications for Ontario and is important to psychiatrists because the Court considered the legality of a compensation system discriminating among workers, based on the nature of their disability.

In this particular case, the disability – chronic pain syndrome - is one that has a substantial non-organic component. "Chronic pain disability" or "chronic pain syndrome" refers to a medical condition that is not supported by "objective findings"; it is a pain disorder which can arise after a physical injury with pain that persists beyond the normal healing time for the underlying injury or that is disproportionate to the physical injury, and which is frequently accompanied by psychological symptoms such as depression.

Donald Martin and Ruth Laseur, two injured workers, brought a Charter challenge to the Nova Scotia Workers' Compensation Act, s. 10B, which limits benefits to a four week "functional restoration" program for workers who are diagnosed with chronic pain disability. These workers receive only this limited benefit, and are denied access to the general workers' compensation system.

The Court released its unanimous decision, written by Justice Gonthier, and allowed Mr. Martin and Ms. Laseur's appeals. There were two main issues in this appeal: (1) whether the Nova Scotia Workers' Compensation Appeals Tribunal (WCAT) has the authority to interpret and apply the Charter; and (2) whether Nova Scotia's chronic pain restriction violates the equality provisions (s.15) of the Charter.

On the first issue, the Supreme Court found that the Nova Scotia WCAT has the jurisdiction to interpret and apply the Charter. Justice Gonthier articulates several reasons for the Court's conclusions on this issue, including the need to provide Canadians with the most accessible avenues for asserting their rights, and a recognition that administrative tribunals such as the WCAT, which rule on the subject matters under appeal, are best placed to make factual findings and provide expert views when Charter issues arise.

On the second issue of equality rights, the Supreme Court found that Nova Scotia's limitation on benefits for injured workers with chronic pain violated s. 15 (1) of the Charter, and there was no legal justification for the government's legislation on chronic pain. The decision points out that although "Courts are not the appropriate forum for an evaluation of the medical evidence concerning chronic pain for general scientific purposes. Nevertheless … the question is whether the way in which a government handles chronic pain in providing services amounts to discrimination is a proper subject of judicial review."

There are several important aspects to the Martin decision. First, the Court recognizes that chronic pain disability is a real medical condition, despite the lack of a medical explanation for it and despite the lack of "objective" findings to verify its existence. Justice Gonthier notes that these very factors have resulted in "persistent suspicions of malingering on the part of employers, compensation officials and even physicians".

Second, the Court makes it clear that, in deciding whether there is an historical or pre-existing disadvantage faced by the group asserting its equality rights, it is not "a race to the bottom". That is, injured workers with chronic pain do not have to prove that they face greater discrimination than injured workers who do not have chronic pain.

Third, the Court expresses its view that the needs of disabled persons should be assessed on an individualized basis as much as possible. In rejecting the Nova Scotia WCB's argument that it is too difficult to assess chronic pain disability in injured workers, the Supreme Court relies on the policies and practices of other provinces, including Ontario, where individualized assessments for chronic pain are routinely done.

Fourth, the exclusion of workers with chronic pain disability from the general workers' compensation scheme is viewed by the Court as sending "a clear message that chronic pain sufferers are not equally valued and deserving of respect as members of Canadian society". The Court did not mince words when assessing the Nova Scotia government's legal defense that terminating benefits after a four week program is rehabilitative: "… far from dispelling the negative assumption about chronic pain sufferers, the scheme actually reinforces them by sending the message that this condition is not 'real', in the sense that it does not warrant individual assessment or adequate compensation".

What implications does the Martin decision have for Ontario's workers' compensation system?

In our legislation scheme, there is an equally discriminatory provision for stress-related psychological disabilities in subsections 13 (4) and (5) of the Workplace Safety and Insurance Act, which read:
(4) Except as provided in subsection (5), a worker is not entitled to benefits under the insurance plan for mental stress.

(5) A worker is entitled to benefits for mental stress that is an acute reaction to a sudden and unexpected traumatic event arising out of and in the course of his or her employment. However, the worker is not entitled to benefits for mental stress caused by his or her employer's decision or actions relating to the worker's employment, including a decision to change the work to be performed or the working conditions, to discipline the worker or to terminate the employment.

The Ontario Workplace Safety and Insurance Board (WSIB) has been applying this exclusion using a similarly discriminatory policy. In essence, only those workers who experience a form of stress which is viewed by the WSIB as "life-threatening" and "objectively traumatic" are entitled to benefits for their psychological conditions. For those workers whose psychological disability develops over time, as a result of workplace events or working conditions which do not meet the "sudden and unexpected traumatic event" criteria, there is disentitlement from any workers' compensation benefits or services.

There are two ways in which the Ontario mental stress limitation is discriminatory. First, it discriminates on the basis of mental disability, by denying workers with psychological disabilities the same benefits, which are provided to workers who have comparable physical disabilities. As with stress-related disabilities, physical disabilities can arise from acute "events" (a worker falls from a scaffold) or they can arise from working conditions which have an impact over a gradual period of time (a cashier who develops carpal tunnel syndrome over several years of work). Yet no distinction in entitlement to compensation is made between acute and gradual onset physical disabilities.

The second way in which the mental stress limitation discriminates is on the basis of sex, race, disability and sexual orientation because it disentitles many workers who are psychologically injured by workplace harassment. It is well established that workplace harassment is often subtle: therefore, in many cases there will be no "sudden and unexpected traumatic event", thus disentitling workers who are particularly vulnerable to discriminatory treatment at work.

The stigma of mental illness is still with us, and Ontario's treatment of workers who develop stress-related psychological disabilities from work perpetuates this stigma. It sounds something like this: "Anyone would react to watching their co-worker killed on the job. But a worker who becomes depressed from the racist behaviour of co-workers, or who develops panic attacks after being given the duties of her recently laid off co-worker's on top of her own, well she is just "too sensitive" and "not tough enough". Sound familiar? These are the stereotypes that underlie the workers' compensation restriction, and which are perpetuated by the restriction. The Supreme Court's decision in Martin is the wake-up call to our legislators and policy-makers that these types of laws are unacceptable.

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RESIDENT's REVIEW

Transcranial Magnetic Stimulation in Neuropsychiatry Part 1: " Fields" of the Future

By: Andrew J.A. Moulden M.A., M.D., Ph.D. OPA Council member, CPA director-in-training

Not since the charlatan days of Anton Mesmer (1734-1815) has the field of electromagnetism sparked such enthusiasm in psychiatry. Transcranial Magnetic Stimulation (TMS) is a rejuvenated tool that holds new promise for treating neuropsychiatric disorders. Recent technological advancements, which allow the stimulating capacitors to be portable, provide the capacity to non-invasively excite or inhibit focal neuron depolarization in an outpatient setting. As a resident in psychiatry, I find this field both exciting and promising. One device, NeoPulse (Neuronetic, Atlanta, GA) has recently received approval in Canada and Israel as a therapy for depression. A TMS code was recently put forward to the OMA Central Tariff Committee (CTC) for possible funding consideration (see Dr. Sonu Gaind's CTC report elsewhere in this issue for more information).

The TMS technique involves running electrical current through a figure-8 coil, which creates a magnetic field perpendicular to the current flow (for review see Wasserman & Lisanby, 2001). If a conducting medium, such as the brain, is located adjacent to the magnetic field, current is induced in the medium, bypassing the high resistance of intervening bone and fascia that electrode based ECT must overcome. The TMS pulse is brief (milliseconds) powerful (about 40,000 times the Earth's magnetic field), and induces electrical current in excitable neuronal tissue. The magnetic field penetrates cortical tissue to a depth of approximately 2 cm. There is considerable variability from patient to patient on how strong this magnetic field should be to achieve depolarization.

Unlike electrical stimulation from ECT, where the skull acts as a massive resistor, magnetic fields are not deflected or attenuated by intervening tissue. This means that TMS can be focally applied with therapeutic efficacy without seizure induction. A single TMS pulse over primary motor cortex causes involuntary movement of the contralateral musculature. The motor threshold is the smallest intensity of TMS required to induce contraction (i.e. thumb twitch) of a muscle contralateral to the stimulated cortex. Most of the research on TMS has used magnetic field intensities near the subject's motor threshold. It is assumed that approximating this threshold is required to effect depolarization.

Repetitive stimulation at a site is designated rTMS. When the repetitive stimulus is applied at 1 Hz or slower, the term slow frequency (SF-rTMS) may be used. When the stimulus is applied at greater than 1 Hz, the term fast frequency (FF-rTMS) is used (Menkes, Bodnar, Ballesteros, & Swenson, 1999). A time varying magnetic field is generated lasting up to 200 msec. The strength of the magnetic field is roughly 2 Tesla (similar to field strengths in MRI). The proximity of the brain to the time varying magnetic field results in current flow in neural tissue sufficient to produce neuronal depolarization.

In the Next Issue of Dialogue -
Transcranial Magnetic Stimulation in Neuropsychiatry
Part 2: The Efficacy of TMS in Treating Neuropsychiatric Disorders

References:

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quetiapine fumarate tablets
25, 100, 150, 200 mg and 300 mg

THERAPEUTIC CLASSIFICATION Antipsychotic Agent

INDICATIONS AND CLINICAL USE SEROQUEL® (quetiapine) is indicated for the management of the manifestations of schizophrenia. The antipsychotic efficacy of SEROQUEL was established in short-term (6 weeks) controlled inpatient trials. The efficacy of SEROQUEL in long term use, that is, for more than 6 weeks, has not been systematically evaluated in controlled trials.

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

WARNINGS Neuroleptic Malignant Syndrome (NMS) Neuroleptic Malignant Syndrome is a potentially fatal symptom complex that has been reported in association with antipsychotic drugs, including SEROQUEL (quetiapine). The clinical manifestations of NMS are hyperthermia, muscle rigidity, altered mental status, and evidence of autonomic instability (irregular pulse or blood pressure, tachycardia, diaphoresis, and cardiac dysrhythmia). Additional signs may include elevated creatine phosphokinase, myoglobinuria (rhabdomyolysis) and acute renal failure. In arriving at a diagnosis, it is important to identify cases where the clinical presentation includes both serious medical illness (e.g., pneumonia, systemic infection, etc.) and untreated or inadequately treated extrapyramidal signs and symptoms. Other important considerations in the differential diagnosis include central anticholinergic toxicity, heat stroke, drug fever and primary central nervous system pathology. The management of NMS should include immediate discontinuation of antipsychotic drugs, including SEROQUEL, and other drugs not essential to concurrent therapy; intensive symptomatic treatment and medical monitoring; and treatment of any concomitant serious medical problems for which specific treatments are available. There is no general agreement about specific pharmacological treatment regimens for uncomplicated NMS. If a patient requires antipsychotic drug treatment after recovery from NMS, the potential reintroduction of drug therapy should be carefully considered. The patient should be carefully monitored since recurrences of NMS have been reported. **Tardive Dyskinesia (TD)** A syndrome of potentially irreversible, involuntary, dyskinetic movements, may develop in patients treated with antipsychotic drugs. Although the prevalence of the syndrome appears to be highest among the elderly, especially elderly women, it is impossible to rely upon estimates to predict which patients are likely to develop the syndrome. It has been hypothesized that agents with a lower EPS liability may also have a lower liability to produce TD. In controlled clinical trials with SEROQUEL, the incidence of EPS was not statistically significantly different than placebo across the recommended therapeutic dose range. This may predict that SEROQUEL has less potential than standard antipsychotic agents to induce TD. The risk of developing TD and the likelihood that it will become irreversible are believed to increase as the duration of treatment and the total cumulative dose of antipsychotic drugs administered to the patient increase. However, the syndrome can develop, although much less commonly, after relatively brief treatment periods at low doses. There is no known treatment for established cases of TD, although the syndrome may remit, partially or completely, if antipsychotic treatment is withdrawn. Antipsychotic treatment, itself, however, may suppress (or partially suppress) the signs and symptoms of the syndrome and thereby may possibly mask the underlying process. The effect that symptomatic suppression has upon the long-term course of the syndrome is unknown. Given these considerations, SEROQUEL should be prescribed in a manner that is most likely to minimize the occurrence of TD. Chronic antipsychotic treatment should generally be reserved for patients who appear to suffer from a chronic illness that is known to respond to antipsychotic drugs, and for whom alternative, equally effective, but potentially less harmful treatments are not available or appropriate. In patients who do require chronic treatment, the smallest dose and the shortest duration of treatment producing a satisfactory clinical response should be sought. The need for continued treatment should be reassessed periodically. If signs and symptoms of TD appear in a patient on SEROQUEL, drug discontinuation should be considered. However, some patients may require treatment with SEROQUEL despite the presence of the syndrome. **INTERACTIONS** Concomitant use of SEROQUEL with hepatic enzyme inducers (such as carbamazepine) may substantially decrease systemic exposure to quetiapine. Depending on clinical response, higher doses of SEROQUEL may need to be considered. If SEROQUEL is used concomitantly with a hepatic enzyme inducer. During concomitant administration of drugs which are potent CYP3A4 inhibitors (such as azole antifungals and macrolide antibiotics), plasma concentrations of quetiapine can be significantly higher than observed in patients in clinical trials. As a consequence of this, lower doses of SEROQUEL should be used. Special consideration should be given in elderly and debilitated patients. The risk-benefit ratio needs to be considered on an individual basis in all patients. **PRECAUTIONS Hyperglycaemia** As with some other antipsychotics, exacerbation of pre-existing diabetes, hyperglycaemia, diabetic ketoacidosis, and diabetic coma including some fatal cases have been reported very rarely (<0.01%) during the use of SEROQUEL, sometimes in patients with no reported history of hyperglycaemia. (see ADVERSE REACTIONS, Post-Marketing Experience). Appropriate clinical monitoring is advisable in diabetic patients and in patients with risk factors for the development of diabetes mellitus. **Hypotension and Syncope:** As with other drugs that have high alpha-1 adrenergic receptor blocking activity, SEROQUEL (quetiapine) may induce orthostatic hypotension, dizziness, and sometimes syncope, especially during the initial dose titration period. Syncope was reported in 1% (20/1162) of patients treated with SEROQUEL, compared with 0% (0/306) on placebo and 0.5% (2/478) on active control drugs. The risk of hypotension and syncope may be reduced by more gradual titration to the target dose (see DOSAGE and ADMINISTRATION). SEROQUEL should be used with caution in patients with known cardiovascular disease (e.g., history of myocardial infarction or ischemic heart disease, heart failure or conduction abnormalities), cerebrovascular disease, or other conditions predisposing to hypotension (e.g., dehydration, hypovolemia and treatment with antihypertensive medications). **Cataracts: The development of cataracts was observed in association with quetiapine treatment in chronic dog studies at 4 times the recommended human dose. Lens changes have also been observed in patients during long-term SEROQUEL treatment, but a causal relationship to SEROQUEL use has not been established. The possibility of lenticular changes during long-term use of SEROQUEL in man, thus can not be excluded at this time. Eye examinations (e.g., slit lamp exam) prior to or shortly after initiation of treatment with SEROQUEL and at 6 month intervals thereafter, are recommended. If clinically significant lens changes associated with SEROQUEL use are observed, discontinuation of SEROQUEL should be considered. Seizure:** In controlled clinical trials, there was no difference in the incidence of seizures in patients treated with SEROQUEL or placebo (incidence of 0.4 % or 3 events per 100 patient-years in patients given SEROQUEL, compared with 0.3% or 0.9 events per 100 patient years for placebo). Nevertheless, as with other antipsychotics, caution is recommended when treating patients with a history of seizures or with conditions associated with a lowered seizure threshold. **Hypothyroidism:** Clinical trials demonstrated that SEROQUEL is associated with a dose-related decrease in total and free thyroxine (T_4). On average SEROQUEL was associated with about a 20% mean reduction in thyroxine levels (both total and free). Forty-two percent of SEROQUEL-treated patients showed at least a 30% reduction in total T_4 and 7% showed at least a 50% reduction. Maximum reduction of thyroxine levels generally occurred during the first two to four weeks of treatment with SEROQUEL. These reductions were maintained without adaptation or progression during longer-term treatment. Decreases in T4 were not associated with systematic changes in TSH or clinical signs or symptoms of hypothyroidism. About 0.4% (4/1096) of patients treated with SEROQUEL experienced persistent increases in TSH, and 0.25% of patients were treated with thyroid replacement. **Cholesterol and Triglyceride Elevations:** In short-term placebo-controlled trials, SEROQUEL-treated patients showed mean increases from baseline in cholesterol and triglycerides of 11% and 17%, respectively, compared to mean decreases in the placebo-treated patients. There was little relation between these changes and weight changes observed during the trial. **Hepatic Impairment:** Decreased clearance of SEROQUEL was observed in patients with mild hepatic impairment. Patients with mild hepatic impairment should be started at 25 mg/day. The dose should be increased daily in increments of 25 to 50 mg/day to an effective dose, depending on the clinical response and tolerability in the individual patient. No pharmacokinetic data are available for any dose of SEROQUEL in patients with moderate or severe hepatic impairment. However, should clinical judgment deem treatment with SEROQUEL necessary, the drug should be used with great caution in patients with moderate or severe hepatic impairment (see DOSAGE AND ADMINISTRATION). **Transaminase Elevations:** During premarketing clinical trials, therapy with SEROQUEL was associated with elevations of hepatic transaminases, principally ALT (SGPT). Within a clinical trial database of 1892 SEROQUEL-treated patients, with baseline ALT (SGPT) levels: <50 IU/L, 5.3% (101/1892) had treatment-emergent ALT (SGPT) elevations to >120 IU/L, 1.5% (29/1892) had elevations to >200 IU/L, and 0.2% (3/1892) had elevations to >400 IU/L. No patients had values in excess of 1000 IU/L. Many of the SEROQUEL-treated patients who had elevated transaminase values manifested clinical symptomatology associated with liver impairment. The majority of transaminase elevations were seen during the first two months of treatment. Most elevations were transient (80%) while patients continued on SEROQUEL therapy. Of the 101 SEROQUEL-treated patients whose enzyme levels increased to >120 IU/L, 48 discontinued treatment while their ALT (SGPT) values were still raised. In 114 SEROQUEL-treated patients whose baseline ALT (SGPT) was >80 IU/L, only 1 experienced an elevation to >400 IU/L. Precautions should be exercised when using SEROQUEL in patients with pre-existing hepatic disorders, in patients who are being treated with potentially hepatotoxic drugs, or if treatment-emergent signs or symptoms of hepatic impairment appear. For patients who have known or suspected abnormal hepatic function, prior to starting SEROQUEL, standard clinical assessment, including measurement of transaminase levels is recommended. Periodic clinical reassessment with transaminase levels is recommended for such patients, as well as for patients who develop any signs and symptoms suggestive of a new onset liver disorder during SEROQUEL therapy. **Hyperprolactinemia:** Elevation of prolactin levels was not seen in clinical trials with SEROQUEL. Increased prolactin levels were observed in rat studies with this compound. As is common with compounds which stimulate prolactin release, the administration of SEROQUEL resulted in an increase in the incidence of mammary neoplasms in rats. The physiological differences between rats and humans with regard to prolactin make the clinical significance of these findings unclear. To date, neither clinical nor epidemiological studies have shown an association between chronic administration of drugs that stimulate prolactin release, and mammary tumorigenesis. Tissue culture experiments, however, indicate that approximately one third of human breast cancers are prolactin dependent in vitro, a factor of potential importance if prescription of these drugs is contemplated in a patient with previously detected breast cancer. Possible manifestations associated with elevated prolactin levels are amenorrhea, galactorrhea, and hirsutism. **Weight Gain:** In controlled clinical trials (up to 6 weeks), mean weight gain was approximately 2.3 kg compared to a mean weight gain of 0.1 kilograms in patients taking placebo (n=427). In open-label extension trials, after 9 to 13 weeks of quetiapine monotherapy, the mean weight increase was 1.58 kg (n=1113). After 53 to 78 weeks of treatment, the mean weight increase was 1.98 kg (n=137). These data are obtained from uncontrolled, open-label trials; the relevance of these findings to clinical practice is unknown. *Weight change* over time appeared to be independent of quetiapine dose (see ADVERSE REACTIONS). **Potential Effect on Cognitive and Motor Performance:** Somnolence was a commonly reported adverse event in patients treated with SEROQUEL, especially during the initial dose titration period. Since SEROQUEL may cause sedation and impair motor skills, patients should be cautioned about performing activities requiring mental alertness, such as operating a motor vehicle or hazardous machinery, until they are reasonably certain that SEROQUEL therapy does not affect them adversely. **Antiemetic Effect:** Consistent with its dopamine antagonist effects, SEROQUEL may have an antiemetic effect. Such an effect may mask signs of toxicity due to overdosage of other drugs, or may mask symptoms of disease such as brain tumor or intestinal obstruction. **Body Temperature Regulation:** Although not reported with SEROQUEL, disruption of the body's ability to reduce core body temperature has been attributed to antipsychotic agents. Appropriate care is advised when prescribing SEROQUEL for patients who will be experiencing conditions which may contribute to an elevation of core temperature, e.g., exercising strenuously, exposure to extreme heat, receiving concomitant medication with anticholinergic activity, or being subject to dehydration. **Suicide:** The possibility of suicide or attempted suicide is inherent in psychosis, and thus close supervision and appropriate clinical management of high-risk patients should accompany drug therapy. **Drug Interactions:** Given the primary central nervous system effects of quetiapine, SEROQUEL should be used with caution in combination with other centrally acting drugs. SEROQUEL potentiated the cognitive and motor effects of alcohol in a clinical trial in subjects with psychotic disorders. Alcoholic beverages should be avoided while taking SEROQUEL. Because of its potential for inducing hypotension, SEROQUEL may enhance the effects of certain antihypertensive agents. As it exhibits in vitro dopamine antagonism, SEROQUEL may antagonize the effects of levodopa and dopamine agonists. CYP3A4 is the primary enzyme responsible for cytochrome P450-mediated metabolism of quetiapine. Thus, coadministration of compounds (such as ketoconazole, erythromycin, clarithromycin, diltiazem, verapamil, or nefazodone) which inhibit CYP3A4, may increase the concentration of SEROQUEL. In a clinical study examining the pharmacokinetics of quetiapine following coadministration with cimetidine, (a non-specific P-450 enzyme inhibitor), no clinically significant interaction was observed. Clinical study data on SEROQUEL co-administration with specific CYP3A4 inhibitors, however is not available. In a multiple-dose trial in healthy volunteers to assess the pharmacokinetics of quetiapine given before and during treatment with ketoconazole, co-administration of ketoconazole resulted in an increase in mean Cmax and AUC of quetiapine of 235% and 522%, respectively, with a corresponding decrease in mean oral clearance of 84%. The mean half-life of quetiapine increased from 2.6 to 6.8 hours, but the mean Tmax was unchanged. Due to the potential for an interaction of a similar magnitude in a clinical setting, the dosage of SEROQUEL should be reduced during concomitant use of quetiapine and potent CYP3A4 inhibitors (such as azole antifungals and macrolide antibiotics). The pharmacokinetics of quetiapine were not significantly altered following co-administration with the antidepressants imipramine (a known CYP2D6 inhibitor) or fluoxetine (a known CYP3A4 and CYP2D6 inhibitor). Coadministration of SEROQUEL and phenytoin (microsomal enzyme inducer) caused five-fold increases in clearance of quetiapine. Increased doses of SEROQUEL may be required to maintain control of psychotic symptoms in patients coadministered SEROQUEL and phenytoin, or other hepatic enzyme inducers (e.g., carbamazepine, barbiturates, rifampicin). The dose of SEROQUEL may need to be reduced if phenytoin is withdrawn and replaced with a non-inducer (e.g., sodium valproate). Coadministration of thioridazine (200 mg bid) with SEROQUEL (200 mg bid), increased the clearance of SEROQUEL by 65%. However, fluoxetine (60 mg daily), imipramine (75 mg bid), haloperidol (7.5 mg bid), and risperidone (3 mg bid) did not significantly alter the steady state pharmacokinetics of SEROQUEL. The pharmacokinetics of lithium were not altered when coadministered with SEROQUEL. However, in a multiple dose trial in patients to assess the pharmacokinetics of quetiapine given before and during treatment with carbamazepine (a known hepatic enzyme inducer), co-administration of carbamazepine significantly increased the clearance of quetiapine. This increase in clearance reduced systemic quetiapine exposure as measured by AUC to an average of 13% of the exposure during administration of quetiapine alone; although a greater effect was seen in some patients. As a consequence of this interaction, lower plasma concentrations can occur, and hence, in each patient, consideration for a higher dose of SEROQUEL, depending on clinical response, should be considered. It should be noted that the recommended maximum daily dose of SEROQUEL is 750 mg/day and continued treatment at higher doses should only be considered as a result of careful consideration of the benefit risk assessment for an individual patient. Co-administration of SEROQUEL and with another microsomal enzyme inducer, phenytoin, also caused increases in the clearance of quetiapine. Increased doses of SEROQUEL may be required to maintain control of psychotic symptoms in patients co-administered SEROQUEL and phenytoin and other hepatic enzyme inducers (e.g., barbiturates, rifampicin etc.). The dose of SEROQUEL may need to be reduced if phenytoin or carbamazepine or other hepatic enzyme inducers are withdrawn and replaced with a non-inducer (e.g., sodium valproate). Divalproex did not induce the hepatic enzyme systems involved in the metabolism of quetiapine. **Use in the Elderly:** The number of patients 65 years of age or over, with schizophrenia or related disorders, exposed to SEROQUEL during clinical trials was limited (n=38). When compared to younger patients the mean plasma clearance of quetiapine was reduced by 30% to 50% in elderly subjects. In addition, as this population has more frequent hepatic, renal, cerebral nervous system, and cardiovascular dysfunctions, and more frequent use of concomitant medication, caution should be exercised with the use of SEROQUEL in the elderly patient, (see DOSAGE AND ADMINISTRATION). **Use in Children and Adolescents:** The safety and efficacy of SEROQUEL in children under the age of 18 years have not been established. **Use in Patients with Renal Impairment:** There is little experience with SEROQUEL in patients with renal impairment, except in a few pharmacological single dose trials. SEROQUEL should thus be used with caution in patients with known renal impairment, especially during the initial dosing period (see DOSAGE AND ADMINISTRATION). **Use in Pregnancy:** Patients should be advised to notify their physician if they become pregnant or intend to become pregnant during treatment with SEROQUEL. The safety and efficacy of SEROQUEL during human pregnancy have not been established. Therefore, SEROQUEL should only be used during pregnancy if the expected benefits justify the potential risks. **Use in Nursing Mothers:** The degree to which quetiapine is excreted into human milk is unknown. Women who are breast feeding should therefore be advised to avoid breast feeding while taking SEROQUEL.

ADVERSE REACTIONS Commonly Observed Adverse Events in Short-Term Placebo-Controlled Clinical Trials The following treatment-emergent adverse events, derived from Table 1, commonly occurred during acute therapy with SEROQUEL (quetiapine) (incidence of at least 5%, and an incidence at least 5% higher than that observed with placebo): somnolence, dizziness, dry mouth, postural hypotension, and elevated ALT (SGPT) levels. **Adverse Events Associated with Discontinuation** Short-Term Placebo-Controlled Clinical Trials: Overall, 3.9% of SEROQUEL-treated patients (n=1116) discontinued treatment due to adverse events compared with 2.9% of placebo-treated patients (n=306). Somnolence, the single most common adverse event leading to withdrawal from quetiapine treatment, led to the withdrawal of four quetiapine-treated patients and no placebo-treated patients. Postural hypotension, hypotension, and/or tachycardia led to withdrawal of 1.3% of quetiapine-treated subjects, compared to 0.3% of placebo-treated subjects. Combined Short- and Long-term Controlled Trial Database: In a premarketing controlled clinical trial database of 1710 SEROQUEL-treated patients, 5% discontinued due to an adverse event. Somnolence was the single most common adverse event leading to withdrawal of 24 patients from SEROQUEL, and was the only adverse event leading to withdrawal that occurred in more than 1% of patients. Cardiovascular adverse events (e.g., postural hypotension, hypotension, tachycardia, dizziness) accounted for 39% of all subject withdrawals from quetiapine treatment. Sixteen (0.9%) quetiapine-treated subjects were withdrawn due to elevated liver enzymes. Four quetiapine-treated subjects were withdrawn because of neutropenia. Two of these subjects had at least one clinically significant, non-baseline low neutrophil count. Two quetiapine-treated subjects were withdrawn from the trial because of suspected neuroleptic malignant syndrome (NMS).

Incidence of Adverse Events in Placebo-Controlled Clinical Trials Table 1 enumerates the incidence, rounded to the nearest percent, of treatment-emergent adverse events that occurred during acute therapy (up to 6 weeks) of schizophrenia in 1% or more of patients treated with SEROQUEL (doses of 150 mg/day or more) where the incidence in patients treated with SEROQUEL was greater than the incidence in placebo-treated patients.

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

Body system and COSTART Term	Percentage of subjects with adverse event*	
	Quetiapine(n = 440)	Placebo(n = 202)
Whole body		
Headache	20	17
Abdominal pain	4	1
Back pain	2	1
Fever	2	1
Nervous system		
Somnolence	18	11
Dizziness	10	4
Digestive system		
Constipation	9	5
Dry mouth	7	2
Dyspepsia	6	3
Gamma glutamyl transpeptidase increased	2	1
Cardiovascular system		
Postural hypotension	8	2
Tachycardia	7	5
Palpitation	1	0
Metabolic and nutritional disorders		
SGPT increased	7	2
SGOT increased	4	1
Weight gain	2	0
Endocrine system		
Hypothyroidism	1	0
Skin and appendages		
Rash	4	3
Respiratory system		
Rhinitis	3	1
Hemic and lymphatic system		
Leucopenia	2	0
Special senses		
Eye pain	1	0

*Subjects may have had more than one adverse event.

Weight Gain: During acute therapy (up to 6 weeks) in placebo-controlled clinical trials, mean weight gain in patients taking SEROQUEL was 2.3 kilograms compared to a mean weight gain of 0.1 kilograms in patients taking placebo. In open-label extension trials with quetiapine monotherapy, mean weight gain after 9 to 13 weeks was 1.58 kg, after 14 to 26 weeks, 0.26 kg, after 27 to 39 weeks, 1.56 kg, after 40 to 52 weeks, -1.53 kg, and after 53 to 78 weeks, 1.98 kg (see PRECAUTIONS). **Seizures:** There have been occasional reports of seizures in patients administered SEROQUEL, although the frequency was no greater than that observed in patients administered placebo in controlled clinical trials (see PRECAUTIONS). **Priapism:** There have been very rare reports of priapism in patients administered SEROQUEL. **Somnolence:** Somnolence may occur, usually during the first few weeks of treatment, which generally resolves with the continued administration of SEROQUEL. **Neuroleptic Malignant Syndrome:** As with other antipsychotics, rare cases of neuroleptic malignant syndrome have been reported in patients treated with SEROQUEL (see WARNINGS). **Vital Signs:** As with other antipsychotics with α1 adrenergic blocking activity, SEROQUEL may induce postural hypotension, associated with dizziness, tachycardia and, in some patients, syncope, especially during the initial dose titration period (see PRECAUTIONS). In placebo-controlled clinical trials, postural hypotension was reported with an incidence of 8% in SEROQUEL-treated patients compared to 2% in placebo-treated patients. SEROQUEL was associated with a mean baseline-to-emergent increase in heart rate of 5.6 beats per minute, compared to 1.6 beats per minute among placebo-treated patients. **Laboratory Changes:** See Precautions. **Peripheral Oedema:** As with other antipsychotic agents, rare cases of peripheral oedema have been reported in patients treated with SEROQUEL. **Hypersensitivity:** Very rarely, hypersensitivity including angioedema has been reported. **ECG Changes:** Between group comparisons for pooled placebo-controlled trials revealed no statistically significant SEROQUEL/placebo differences in the proportions of patients experiencing potentially important changes in ECG parameters, including QT, QTc, and PR intervals. However, the proportions of patients meeting the criteria for tachycardia were compared in four 5- 6 week placebo-controlled clinical trials revealing a 1% (4/309) incidence for SEROQUEL compared to 0.8% (1/130) incidence for placebo. SEROQUEL use was associated with a mean increase in heart rate, assessed by ECG, of 7 beats per minute compared to a mean increase of 1 beat per minute among placebo patients. This slight tendency to tachycardia may be related to SEROQUEL's potential for inducing orthostatic changes (see PRECAUTIONS). **Extrapyramidal Symptoms (EPS):** Table 2 enumerates the percentage of patients with treatment-emergent extrapyramidal symptoms in a short term acute phase clinical trial comparing five fixed doses of SEROQUEL with placebo (n = ~ 50 patients per group), as assessed by: 1) spontaneous complaints of parkinsonism, dyskinesia/oral syndrome, hyperkinesia, tremor, and bradykinesia/ rigidity, or akathisia; 2) Simpson-Angus scores (mean change from baseline); and 3) use of anticholinergic medication to treat emergent EPS.

SIX INTERESTING WEBSITES FOR YOU TO EXPLORE

1. www.ontario.cmha.ca/family.

This website is an online resource centre for family members, friends, and caregivers of people with mental illness. The site includes frequently asked questions and answers, an annotated list of self-help and support groups including person-to-person support, educational support, and online discussion groups, online and print publications, and an annotated reading list of books and articles from professional journals on a range of topics, including family psychoeducation and family members' roles, stigma by association, and research on the experience of caregivers, siblings, children, teens, adult children, parents and partners as well as annotated links to other online resources.

2. www.ontario.cmha.ca/cmhei

The Community Mental Health Evaluation Initiative (CMHEI) is a provincial evaluation project conceived by the Ontario Mental Health Foundation, the Centre for Addiction and Mental Health, and the Canadian Mental Health Association, Ontario Division. The goal of the initiative is to research and advocate solutions for major issues and problems in the mental health arena. This website provides information and updates on a variety of research studies, for example, evaluating services currently being provided for the homeless mentally ill ("Evaluation of Intensive Case Management for Persons with Severe Mental Illness Who Are Homeless") and "The Longitudinal Evaluation of Family Initiatives" study and its sub-studies, a five-year study that examines the impact of self-help/mutual aid organizations on families of people with mental illness and on the mental health system.

3.www.ppao.gov.on.ca

The Psychiatric Patient Advocate Office (PPAO) was established in 1983 as an arms-length program of the Ministry of Health and Long-Term Care to protect the legal rights and entitlements of inpatients in the provincial psychiatric hospitals. The site contains a listing of Rights Guides (for example, "Incapacity: Making Treatment Decisions", "Rights Under Mental Health Law", "Making an Informed Treatment Decision" and "Complaining Against Health Professionals") and a variety of InfoGuides (all are in pdf format which you can download). The following are some of the InfoGuides available on this website: Community Treatment Orders; Accessing Clinical Records; Amicus Curiae for ORB Appeals; Appeal: Consent and Capacity ; Appeal: Ontario Review Board; Form 1: Assessment; Form 14: Disclosing Your Record; Involuntary Patients; Mental Health Act Violations – Section 80; Treatment Incapable In the Community; Informal Patients.
PPAO staff are available for speaking engagements for audiences of all sizes. In the past, staff have presented at a number of provincial and international conferences, workshops, grand rounds in general hospitals, community events, to consumer-survivor organizations and treatment teams. The presentations are designed to examine issues from the perspective of the client in the context of an advocacy framework.

4. www.agingincanada.ca

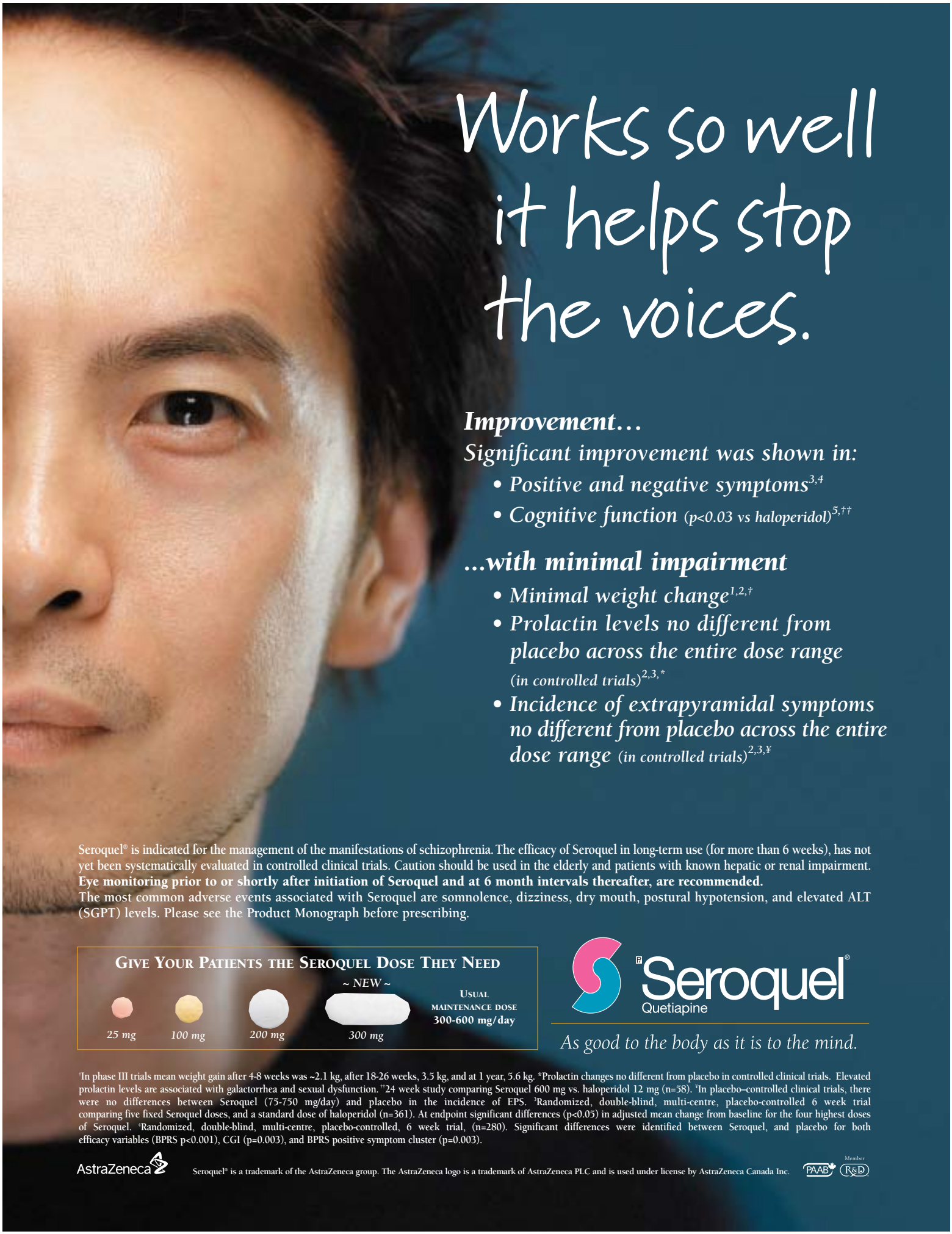
This website focuses on Canadian alcohol treatment program for older adults but has lots of other information on it as well. It is from the Gerontology Research Centre at Simon Fraser University, Vancouver, B.C.

5. www.dementiaeducation.ca

The Ontario College of Family Physicians and the Physician Education Initiative of the Ontario Strategy for Alzheimer Disease and Related Dementias launched this new website, Dementia Education for Medical Professionals, in March 2004. The website offers up-to-date information on dementia and features web conferencing, e-mail, surveys, and boardroom capabilities. Physicians, residents and medical students will be able to access curriculum materials, continuing education programs and updates on the latest research and advances in care, e-mail or participate in an online discussion forum.

6. www.virtual-party.org

Virtual Party is an educational, interactive web site for teenagers which was developed and written by teenagers. The site simulates a party situation, offers a harm reduction approach to the use of alcohol and other drugs and provides information on a number of topics. The site has music and describes the exploits of two characters as they become involved with a variety of drugs and address emotional and mental health issues such as depression and low self-esteem. The site also provides information about the risks of mixing alcohol with antidepressants, host liability, dating, sex, binge drinking and drinking and driving. The web site is sponsored by the Centre for Addiction and Mental Health in partnership with the Peterborough County-City Health Unit.



Works so well it helps stop the voices.

Improvement…

Significant improvement was shown in:

- *Positive and negative symptoms*[3,4]
- *Cognitive function* (*p<0.03 vs haloperidol*)[5,††]

…with minimal impairment

- *Minimal weight change*[1,2,†]
- *Prolactin levels no different from placebo across the entire dose range* (*in controlled trials*)[2,3,*]
- *Incidence of extrapyramidal symptoms no different from placebo across the entire dose range* (*in controlled trials*)[2,3,¥]

Seroquel® is indicated for the management of the manifestations of schizophrenia. The efficacy of Seroquel in long-term use (for more than 6 weeks), has not yet been systematically evaluated in controlled clinical trials. Caution should be used in the elderly and patients with known hepatic or renal impairment. **Eye monitoring prior to or shortly after initiation of Seroquel and at 6 month intervals thereafter, are recommended.** The most common adverse events associated with Seroquel are somnolence, dizziness, dry mouth, postural hypotension, and elevated ALT (SGPT) levels. Please see the Product Monograph before prescribing.

GIVE YOUR PATIENTS THE SEROQUEL DOSE THEY NEED

~ *NEW* ~

25 mg *100 mg* *200 mg* *300 mg*

USUAL MAINTENANCE DOSE
300-600 mg/day

℗ Seroquel®
Quetiapine

As good to the body as it is to the mind.

†In phase III trials mean weight gain after 4-8 weeks was ~2.1 kg, after 18-26 weeks, 3.5 kg, and at 1 year, 5.6 kg. *Prolactin changes no different from placebo in controlled clinical trials. Elevated prolactin levels are associated with galactorrhea and sexual dysfunction. ††24 week study comparing Seroquel 600 mg vs. haloperidol 12 mg (n=58). ‡In placebo–controlled clinical trials, there were no differences between Seroquel (75-750 mg/day) and placebo in the incidence of EPS. ¥Randomized, double-blind, multi-centre, placebo-controlled 6 week trial comparing five fixed Seroquel doses, and a standard dose of haloperidol (n=361). At endpoint significant differences (p<0.05) in adjusted mean change from baseline for the four highest doses of Seroquel. ¶Randomized, double-blind, multi-centre, placebo-controlled, 6 week trial, (n=280). Significant differences were identified between Seroquel, and placebo for both efficacy variables (BPRS p<0.001), CGI (p=0.003), and BPRS positive symptom cluster (p=0.003).

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