Ontario Psychiatric Association
DIALOGUE
THE NEWSLETTER OF THE ONTARIO PSYCHIATRIC ASSOCIATION/UNE PUBLICATION DE L'ASSOCIATION DES PSYCHIATRES DE L'ONTARIO
SEPTEMBER
2002

MESSAGE FROM THE PRESIDENT

It is hard to believe that more than half my term as OPA President has passed! I hope all OPA members and their families had a pleasant and relaxing summer in spite of heavy workloads.

I would like to take this opportunity to thank Dr. Pauline Pytka for her valuable contributions to the OPA. Dr. Pytka served on the OPA Council both as a Council member, and, more recently as Secretary, but is unable to complete her term with us. Dr. Federico Allodi has kindly agreed to be Secretary, and Dr. Ann Thomas has been appointed as a Council Member until January 2004. Dr. Thomas will continue in her very valuable role as Chair, Continuing Education Committee. We are very appreciative of Dr. Allodi's and Dr. Thomas' hard work and dedication.

In June, I had the pleasure of attending the 50th Anniversary Banquet of the Canadian Mental Health Association, Ontario Division, on behalf of the OPA. Awards were given to some very dedicated and deserving citizens of Ontario who have contributed time and energy helping individuals with mental health needs.

The OPA has been involved in a number of activities in the last several months which I will briefly touch on - The OPA has opened discussions with the Ontario College of Family Physicians (OCFP) with respect to their Shared Mental Health Care initiative and future collaboration with the OPA. Dr. Nick Kates attended the OPA Council meeting in June and provided excellent information on shared care, both nationally and provincially. Dr. Kates also agreed to provide information to OPA members on this topic; his article is featured in this issue of *Dialogue.* Further discussion will take place at the OPA Council meeting in September with Janet Kasperski, Executive Director, OCFP.

We are aware that some of the Regional Mental Health Implementation Task Forces have completed their deliberations and final reports are being compiled and/or have been submitted. The OPA will continue to follow this issue diligently in order to ensure that individuals with mental health problems are adequately served in Ontario. Dr. Keith Anderson has been instrumental in assisting the OPA to understand all of the issues that the task forces are addressing. Dr. Anderson and other OPA representatives attended the AGHPS planning day, held in June, to discuss Regional Mental Health Authorities.

The Section Task Force, appointed by Council, to develop the roles and goals of Sections, completed a draft discussion paper that was presented to the OPA Council on June 14, 2002. OPA has decided to focus on the following six Sections: Child and Adolescent, Community, Consultation-Liaison, Geriatric, Psychotherapy, and Residents. Many thanks to Elizabeth Leach, Khrista Boylan, Jane Howard, Rosemary Meier, Don Pearsall and Lorraine Taylor who have continued to work diligently on this project. The Council made a number of suggestions on the draft document. We are aiming to have a final draft completed in the fall of 2002, for implementation to begin in the New Year. Anyone who may have an interest in being actively involved in any of these Sections, please contact either myself or Lorraine Taylor at the OPA office.

Some of you may not be aware that the Coroner's Office sends out the Verdict of the Coroner's Jury and explanation to OPA on a routine basis. OPA Council, at their last meeting, decided to have the Advocacy Committee take on the role of reviewing summary information and reporting back to Council to ensure that:

1) Council responds in a timely manner when a specific response has been requested;
2) Council is alerted to patterns in the inquests, as they relate to psychiatry;
3) key inquest topics are incorporated in the Annual Meeting, and;
4) key reports are identified, to be summarized, for the benefit of all OPA members, in *Dialogue.*

Please plan on attending OPA's 83rd Annual Meeting - "Psychiatry Across the Life Span". Scheduled topics include delirium, neuroleptic malignant syndrome, Tourette's Syndrome, andropause, and attachment, to name but a few. We would also like to encourage you to present a poster to display research that is happening provincially. Please mark the dates on your calendar - January 30, 31 and February 1, 2003. Many thanks to Dr. Thomas and the Continuing Education Committee for their excellent work and enthusiasm.

I would like to continue to thank my colleagues on the OPA Council, Elizabeth Leach and Lorraine Taylor for their dedication and hard work. If you have any questions or comments about the OPA please feel free to contact me. I look forward to hearing from you.

Dr. Margaret Steele, HBSc, MD, FRCP(C)
President, Ontario Psychiatric Association

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Council Members can be contacted through the OPA Head Office.

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From THE EDITOR

FIRST THINGS FIRST – this issue of *Dialogue* has a new look. Hope you like it, although we know the tinkering with *Dialogue* will never really end; there is always more to do and more to include. Past cover logos have been included in this issue so you can see how the cover has changed over the years. The inside of *Dialogue* has been changing as well. New columns are being introduced into each issue, as part of the ongoing experimental process to figure out what OPA members want to read about. Information is gathered from different and varied sources to provide you with the latest on current issues in psychiatry and mental health, in addition to news about what OPA is doing now and planning for the future. Your voice, the voice of the reader, is always a welcome addition to the mix. If you'd like to try your hand at writing, give us a call.

In this issue we introduce a "Guest Column" in order to give you a different perspective on the care and treatment of people with mental health problems. Dr. Weir sums up what RBRVS says in their final report. Dr. Kates tells us how shared mental health care is developing across the country. And, Dr. Pain provides her perspective on what life is like one year after the attacks of September 11. While it is easy to keep up with the news on terrorism and combating terrorism, I found myself turning my attention to the recent special issue of Scientific American, which deals with Time, and all of its complexities, and found that perspective - "None of us really can account for how much we have left" and "There is time for every purpose under heaven, but there is never enough" - to somehow mesh very well with Dr. Pain's viewpoint. What do you think ?

Thank you to everyone who filled out the *Dialogue* Readership Survey. The results are included in this issue for you to review. The online version resulted in more feedback to us; and, we will be reviewing the results and your suggestions and comments.

We continue to provide articles on legal topics and national news from the Canadian Psychiatric Association. Information on Children's Mental Health Ontario has been delayed but will appear in the next issue.

Elizabeth Leach
Editor

Dialogue will be featuring telepsychiatry in the future.
We would be pleased to receive your submissions on this topic.

Please forward any submissions to the Editor by email at opa@bellnet.ca or by fax: 905-469-8697

HOW THE DIALOGUE HAS EVOLVED OVER THE PAST TEN YEARS

Dialogue

Ontario Psychiatric Association Executive and Council

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Winter 1992
The newsletter of the Ontario Psychiatric Association
Une publication de l'Association des psychiatres de l'Ontario

Inside

A Preview of the Program of the Upcoming 73rd Annual Meeting

1992 Annual Report

Letter to the Editor

Meeting the Challenge: Eliminating the Sexual Abuse of Patients in the Health Care Field

Residents' Forum

You Should Know

OPA 73rd Annual Meeting

"Consultation and Collaboration"

January 28-30, 1993
Delta Chelsea Inn, Toronto

Dialogue

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"PSYCHIATRY UNITE" DECEMBER 1993

Focus: Participating in Mental Health Reform

Since the Graham Report in 1988, the provincial government has been moving towards reform of the mental health system. The Ministry of Health's 10 year plan was put forth in June, 1993 in the document "Putting People First" (available at the government bookstore for any of you who have not seen it.) The plan stated that the government's priority will be the needs of people with severe and persistent mental illness. In order to meet these needs, the system for delivery of mental health services, and the financial resources to pay for them will be gradually reallocated to reflect this priority.

The "bottom line" is that resources now used to support provincial psychiatric hospitals, general hospital psychiatric units, community mental health clinics, Homes for Special Care, consumer initiatives and OHIP payment for mental health services, will be eventually realigned where necessary to reflect a coordinated, community based system revolving around the consumers'/patients' mental health needs. I can the term mental health actively to remind all of us that while the focus of psychiatry is mental illness, and we have a very important contribution to make to the treatment/ amelioration of psychiatric disorders, there are many other contributions to mental health that the government also plans to prioritize under the same funding envelope (e.g. psychosocial and vocational rehabilitation, consumer initiatives, crisis intervention, various levels of supported housing, etc.)

The OPA and the OMA Section of Psychiatry, as well as many other professional groups, have responded to the Government document "Putting People First" to try to address the problems that may be caused by such a shift in priorities. A summary of the main points of the OPA response is included on page 3.

Many, if not most of us, will be affected in one way or another by

The "bottom line" is that resources now used to support provincial psychiatric hospitals, general hospital psychiatric units, community mental health clinics, Homes for Special Care, consumer initiatives and OHIP payment for mental health services, will be eventually realigned where necessary to reflect a coordinated, community based system revolving around the consumers'/patients' mental health needs.

this process of mental health reform. I would like to suggest a few things that each of us could do in order to be full participants in the process towards change and to ensure that our patients' needs continue to be met in an appropriate fashion:

- We can realize the "consumer" revolution is here and start to recognize ways in which we can be more effective partners with our patients in a way that empowers them. After all, "consumers" are just our patients who want to be respected as equal human beings and who can happen to have a psychiatric disorder.
- We can spend more time outside our offices. By doing so, we can find out how best to address community needs.
- We can volunteer to do some public education about our effective and well researched treatments for psychiatric disorders.
- We can set aside a bit more time to do urgent and/or emergency consultations for our medical colleagues so that they and their patients know we will try to be there when they need us most.

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DIALOGUE

WINTER 1998

Ontario Psychiatric Association

ANNUAL REPORT OF THE PRESIDENT

by Lois Hutchinson, M.D.

Year In Review

1998 began very sadly with the death of Jane Gnanadesikan, OPA Executive Director. Her leadership was greatly missed by the Executive and OPA Council during the past year.

1998 also saw a forging of a closer relationship with the OMA Section on Psychiatry through the Coalition of Ontario Psychiatrists. Two documents, "Putting Care First" and "Meeting the Challenge" were presented to the Ministry of Health to advocate for an improved community mental health treatment system. Meetings were also arranged with Ministry of Health officials expressing concerns about the crisis in general hospitals, the lack of adequate sessional funding to do the kind of work necessary in light of PPB cleaves and the problems with current mental health legislation. Discussions were also held with both the Ministry of Health and the Ministry of Community and Social Services regarding Children's Mental Health Services. The two organizations agreed to work together in compliment each others activities by the ongoing meetings of the two executives as well as regular combined OMA Section on Psychiatry/OPA Council meetings.

The organization also began discussions regarding the hiring of a new Association Manager. Hopefully, a person will be in place in the New Year.

Planning occurred throughout the year for the annual scientific meeting, promoting the theme "Ethics in Psychiatry: Who Is Responsible?". This was felt to be a timely theme in light of psychiatry's role in advocating for changes in mental health legislation and systems design, planning as well as the challenge of providing quality care in times of financial constraints.

I would like to thank the Executive and Council of the OPA for their support this past year and especially Lorraine Tudor, our Executive Assistant, for her day to day work overseeing the operating of the organization and, in particular, organizing this year's Annual Meeting.

Respectfully submitted
Lois Hutchinson, M.D.
1998 President
Ontario Psychiatric Association

Elections Committee

ELECTIONS TO EXECUTIVE:

President-Elect	Dr. Blake Woodside
Treasurer	Dr. Margaret Eisen
Secretary	Dr. Jane Howard

ELECTIONS TO COUNCIL:

Dr. Judy Hamilton
Dr. Donald Pharisall
Dr. Robert Swinson
Dr. Todd Tomlin – Resident Representative

Ontario Psychiatric Association

DECEMBER 2000

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

DIALOGUE

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CALENDAR OF EVENTS

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

Ontario Psychiatric Association 2002 Council Meetings

Toronto – Friday, November 15
Space is limited, please contact Lorraine Taylor, OPA Executive Assistant, for locations or further details; (905) 827-4659, email: opa@bellnet.ca

Institute for the Advancement of Self Psychology

September 2002
The Institute offers a four-year training program in the psychoanalytic theory and clinical techniques of self-psychology.
Contact information: IASP, 416 690-3722; e-mail rosemary.adams@sympatico.ca

World Forum on Drugs and Dependencies

September 22 - 27, 2002
Montreal
Sponsored by the Canadian Centre on Substance Abuse.
More than 3000 delegates from 60 countries, representing such areas as public policy, social services, academia, the legal system, community services, law enforcement, education and health are expected to attend. The mission is to find solutions to the ever-growing problem of illicit drugs, licit substances (such as alcohol and tobacco), compulsive gambling and other forms of dependencies.
Contact information: Bureau des Congrès Universitaires 6600, Chemin de la Côte-des-Neiges, Suite 215 Montreal (Quebec) H3S 2A9 Tel.: (514) 340-4550 Fax: (514) 340-4440 website: http://www.worldforumdrugs-dependencies.com

Reaching Higher, Growing Stronger

Royal College of Physicians and Surgeons.
September 26 - 28, 2002
Ottawa
Annual Conference on Achieving Quality Health Care through Education, Professional Development and Research. Dedicated as we are to ensuring the highest standards and quality of healthcare, the Royal College makes important contributions and collaborates with other organizations in the areas of medical education, continuing professional development, research and the development of health policy that supports quality in Canadian health care. And so it is that our Annual Conference is once again focused on these key areas for 2002. The Conference will also continue to offer quality programming in generic aspects of specialty medicine that are important to the practicing physician such as biomedical ethics, the history of medicine and medico legal topics.
Contact information http://rcpsc.medical.org/english/meetings/

Eye Movement Desensitization and Reprocessing (EMDR) – Level I

September 26 – 28, 2002
Toronto
An initial 18-hour programme consisting of: history and theory of EMDR; efficacy of EMDR: research findings; how to use EMDR as a form of psychotherapy; client selection criteria and cautions; how to do the EMDR procedure: eight phases of treatment; applications of EMDR including personal use; seven hours of practice using EMDR. The participants will be required to have used EMDR for at least 25 sessions with clients before proceeding to the next level of training. In addition, the participants will participate in a two-hour consultation/supervision session during this interval to ensure that they are applying the EMDR procedure correctly. Participants must possess a Master's Degree in a counselling discipline and be licensed or registered with a profession organization. The cost is $550.00 per person.
Contact information: Sue Fraser, MSW, RSW, Certified Trauma Specialist, Fraser Counselling Services, 1-877-392-7954 email: sue@frasercounselling.com website: www.frasercounselling.com.

First International Conference on Symptom, Diagnostic and Disability Validity: Improving Patient Outcomes

September 26 - 29, 2002
Markham -Toronto
Canada Symposium Website: www.icpro.org
Associated Post Conference Workshop: Clinical Assessment of Malingering and Deception September 30, 2002, Markham-Toronto, Ontario, Canada
Contact information: Physical Medicine Research Foundation, Suite 204, 856 Homer Street, Vancouver, BC V6B 2W5, Toll Free (800) 872-3105, Fax (604) 684-6247 E-mail: pmrf@icpro.org; www.icpro.org

Infant Observation Seminar

October 2002 - May 2003
Presented by the Toronto Child Psychoanalytic Program for adult psychoanalytic trainees and graduates, and other mental health practitioners.
There will be 22 sessions (October through May) on Thursday evenings, 6:30 to 8:00 pm. The seminars are being held at the Hincks-Dellcrest Institute.
Leader: Elizabeth Tuters, MSW, Child and Adult Psychoanalyst.
Contact information: Donna or Janice, at woodhouse@golden.net, or Tel: 416-288-8689.

Youth and Mental Health Problems: Clinical and Community Approaches

October 1 – 2, 2002
CAMH - Toronto
This interactive two-day workshop explores clinical skills and community service models for treating common mental health problems occurring in childhood and adolescence. The course focuses on interventions and treatments for prevalent mental health conditions, including substance use.
Contact information: CAMH, Education & Training Services, 33 Russell Street, Toronto, M5S 2S1, phone: 1-800-661-1111 or 416-595-6059, email: marketing@camh.net, website: www.camh.net

Association of Academic Psychiatry 2002 Annual Meeting: Advances in Psychiatric Education, "The Exemplary Educator: Getting There and Getting the Recognition You Deserve"

October 2 - 5, 2002
Toronto
Chair: Dr. Deborah Klaman, Keynote Speaker, Richard Tiberius.
Contact information: http://www.hsc.wvu.edu/aap/2002_annual_meeting.htm

Shifting Abuse-Related Internalizations: Treating Childhood Trauma

October 4 - 5, 2002
R.A. Centre, Ottawa, Ontario
The Centre for Treatment of Sexual Abuse & Childhood Trauma presents their 10th Anniversary Conference for psychologists, psychological associates, psychiatrists, social workers, youth workers, child protection workers and other mental health professionals. Featuring Dr. Sandra Wieland, this workshop will provide both the novice and advanced clinician with a clear conceptual framework, her Internalization Model, to improve clinical effectiveness.
Contact information: Centre for Treatment of Sexual Abuse & Childhood Trauma phone: 613-233-4929

Mental Illness Awareness Week

October 6 – 12, 2002
This year's campaign will focus on suicide prevention, early detection and treatment of depression and dual disorders.
Contact information: Canadian Psychiatric Association, (613) 234-2815, fax: (613) 234-9857, email: miaw@cpa-apc.org, website: www.cpa-apc.org

Treating Addictions in Special Populations Conference

October 7 - 8, 2002
Binghamton, NY, United States
This large-scale conference will be addressing the multidimensional treatment issues that have emerged among special populations affected by substance-related disorders and process addictions. Presentations will address distinct and common treatment issues specific to these special populations as well as evaluated treatment programs that have been found to be effective.
Contact Information: Jane Angelone - angelone@binghamton.edu
tel: 607-777-4447 - fax: 607-777-6041

From Survival to Recovery: The relationship between childhood trauma and adult mental illness

October 9, 2002
George Brown College
St. Lawrence Hall, The Great Hall (3rd floor), 157 King St. East, Toronto, Ontario
An educational forum in celebration of World Mental Health Day. Dr. Pain will explore the relationship between childhood trauma and neglect and adult mental illness.
Contact information: Carolyn Grayston; phone: 416-415-5000 ext. 4791, fax: 416-415-4796, email: training@gbrownc.on.ca

Post-Traumatic Stress Disorder (PTSD and New Canadians: Exploring the Implications)

October 9 – 10, 2002
CAMH – Toronto
Participants will; identify challenges experienced by this unique population; recognize diagnostic criteria for and symptoms of PTSD; understand assessment methods used for PTSD; identify and understand a variety of treatment options for PTSD; understand the relationship between PTSD and addiction.
Contact information: CAMH, Education & Training Services, 33 Russell Street, Toronto, M5S 2S1, phone: 1-800-661-1111 or 416-595-6059, email: marketing@camh.net, website: www.camh.net

Psychopharmacology

October 11 - 13, 2002
Westin Hotel, Copley Place, Boston, MA
Course Directors: Jerrold F. Rosenbaum, M.D.; Maruizio Fava, M.D.; John B. Herman, M.D.
This course, presented by Massachusetts General Hospital, Department of Psychiatry, is designed for clinicians wishing to retool and refine their knowledge of state of the art practice in order to deliver the best care to patients they treat everyday.
Contact information: Harvard MED-CME, P.O. Box 825, Boston, MA, 02117-0825; phone: 617-384-8600, fax: 617-384-8686, website: www.cme.hms.harvard.edu

Tenth Annual Santa Fe Symposia for Mental Health Professionals

October 11 – 27, 2002
Santa Fe, New Mexico
The tenth Annual Santa Fe Symposia provides psychologists, psychiatrists, psychiatric social workers, psychiatric nurses, and allied mental health professionals with an outstanding opportunity to combine a stimulating symposium with an enjoyable vacation in the beautiful southwest. Presentations include among others: Psychopharmacology for the Therapist; Angry & Aggressive Behaviour: A Life-Span Treatment Approach; Mindfulness Cognitive Therapy; Spirituality: The Missing Dimension in Therapy.
Contact Information: New England Educational Institute, 92 Elm Street, Pittsfield, MA 01201, Tel: 413-499-1489, Fax: 413-499-6584, email: educate@neei.org web: www.neei.org

Narrative Therapy – Folk Psychology and the Scaffolding of Therapeutic Conversations

October 18 – 19, 2002
Toronto, Ontario
In this workshop, Michael White, a pioneer in the field of family therapy and highly acclaimed therapist, teacher and workshop trainer, will link narrative practices to longstanding traditions of folk psychology. Therapeutic conversations can provide a context for the renewal of these traditions, and when they do a world of options becomes available to therapists in their work with the people who consult them.
Contact information: Hincks-Dellcrest Institute, 114 Maitland Street, Toronto, ON, M4Y 1E1, phone: 416-972-1935, fax: 416-924-9808, email: training@hincksdellcrest.org

49th Annual Meeting of the American Academy of Child and Adolescent Psychiatry

October 22 – 27, 2002
Hilton San Francisco Towers, San Francisco, CA.
Contact information: http://www.aacap.org/meeting/index.htm

Innovations in Recovery and Rehabilitation: The Decade of the Person

October 24 - 26, 2002
Park Plaza Hotel, 64 Arlington Street, Boston, MA
Sponsored by Boston University's Centre for Psychiatric Rehabilitation, this conference is oriented toward administrators, researchers, educators, and consumers of mental health services.
Contact information: Blanca Yanulis, phone 617-353-3549 website: www.bu.edu/cpr/conference/registration

Second Canadian Inter-Professional Conference on Spirituality & Health Care

October 25 – 27, 2002
Mt. Sinai Hospital & University of Toronto
Health professionals of diverse specialty and training and spiritual leaders of all affiliations are becoming increasingly interested in ways of integrating spirituality with health-care. The health benefits of specific spiritual therapeutic modalities and spiritual practices are now beginning to be documented by research studies. The purposes of this conference are to: enable participants to network with others who are working to bridge spirituality and health care in their professional work; introduce participants to different therapeutic modalities for integrating spirituality into health care; showcase cutting edge models of clinical programs, research and interdisciplinary work in spirituality and health care; make participants aware of resources relating to spirituality in health; encourage the development of further research in this field; foster dialogue in a non-aligned multi-faith atmosphere, honouring all faiths and spiritual traditions; provide a forum for inter-professional bridging, collaboration and learning, to foster mutual understanding and respect.
Contact information: Conference Secretariat at: Office of Continuing Education, Faculty of Medicine, University of Toronto, 500 University Avenue, Suite 650, Toronto, Ontario M5G 1V7 PH: 416.978.2719 Fax: 416.971.2200
Toll-Free: 1.888.512.8173

Certificate in Trauma Counselling for Front-Line Workers

October 29-30; November 12-13; November 26-27; December 10-11, 2002
Hincks-Dellcrest Institute, Toronto, Ontario
This 8-day course is designed for front-line workers who provide short-term counselling contact with vulnerable populations in community based settings such as hospitals, community health centres, rape crisis centres, battered women's shelters, homeless shelters, addiction services, crisis phone lines and short-term counselling centres.
The program is designed for persons with a minimum of 2 years full-time employment working with vulnerable and/or traumatized populations.
Contact information: Hincks-Dellcrest Institute, 114 Maitland Street, Toronto, ON, M4Y 1E1, phone: 416-972-1935, fax: 416-924-9808, email: training@hincksdellcrest.org

Canadian Psychiatric Association 52nd Annual Meeting

October 31 – November 3, 2002
Fairmont Banff Springs Hotel
Contact information: www.cpa-apc.org

Addictions: Bet I Can Take the Edge Off

November 5, 2002
McMaster Centre for Gerontological Studies
Royal Botanical Gardens, Burlington, Ontario
This one-day workshop will focus on addressing the challenges associated with addictions in older adults, including alcohol/substance abuse and gambling.
Contact Information: McMaster Centre for Gerontological Studies; Phone: 905-525-9140 ext. 24440, Fax: 905-525-4198; email: gercntr@mcmaster.ca

Schizophrenia 2002: Clinical Update

November 6 - 9, 2002
Toronto Marriott Eaton Centre
Plenary sessions in the mornings, on substance abuse, compliance in schizophrenia, psychosocial intervention, family intervention, future directions in the management of schizophrenia and workshops in the afternoons.
Contact information: Science & Medicine Canada Inc., 50 McIntosh Dr., Suite 100, Markham, ON, L3R 9T3, phone: 905-513-1171, fax: 905-513-1174; e-mail, info@scimedcan.com

Interpersonal Psychotherapy Advanced Research and Training Day (IPT) 2002

November 8 - 9, 2002
Toronto
Presenter: Dr. Ellen Frank. The Research Half-Day will begin with a plenary address by Dr. Frank followed by two hours of research presentations with Dr. Frank and the audience providing commentary. The Advanced Workshop will include 6 hours of educational programming intended to dive into the fine points and challenges of clinical work in IPT.
Contact information: 416 535-8501 x 6638; fax, 416 595-6644; e-mail melissa_leaist@camh.net

Roots to Recovery: Mind Annual Conference

November 12 – 14, 2002
St. David's Hall & Cardiff Marriott Hotel, Cardiff, UK
The Mind Annual Conference is the major event in the UK mental health calendar and attracts over 900 participants every year. Concentrating on the theme for this year's Annual Conference – Roots to Recovery – we will look at how social networks, family, cultural and personal identity, can be rediscovered and reclaimed to aid recovery.
Contact information: Mind Conference and Training Unit; Phone: 020822196731/1 Fax: 02082219681; email: conference@mind.org.uk

Eye Movement Desensitization and Reprocessing (EMDR) – Level II

November 14 – 16, 2002
Toronto
This second 18- hour EMDRIA-approved training program teaches advanced EMDR techniques to Level 1-trained EMDR Therapists.
Topics include: a review of the EMDR procedure; how to use EMDR with a variety of clinical problems; how to handle looping, resistance and other problems; additional strategies to handle incomplete sessions and abreactions; specialty applications of the EMDR protocol; eight hours of practice using EMDR. This second 18-hour program will be a review of the material presented in the first program and will also cover the material presented in remaining chapters of Shapiro's text. The participants will participate in a two-hour consultation/ supervision session within 2 months of completing this program to ensure that they are applying the procedures appropriately. A certificate of completion will be issued at this time. Participants must possess a Master's Degree in a counselling discipline and be licensed or registered with a profession organization.
Contact information: Sue Fraser, MSW, RSW, Certified Trauma Specialist, Fraser Counselling Services, 1-877-392-7954 email: sue@frasercounselling.com website: www.frasercounselling.com

CMHA National Conference 2002- People Policy & Passion - New conversations about mental health

November 16 - 19, 2002
Ottawa, Ontario
Crowne Plaza Hotel
The CMHA National Conference is one of Canada's largest mental health conferences attracting health care professionals, public educators, policy makers, community groups, consumers, families and concerned citizens. The goal of this year's conference is to create new conversations and opportunities for CMHA to learn about and work with others in the community and government to achieve common goals.
Contact information: Canadian Mental Health Association, 2160 Yonge, 3rd floor, Toronto, ON M4S 2Z3, Tel./Tél.: (416) 484-7750, Fax: (416) 484-4617,Email: national@cmha.ca; web: www.cmha.ca

Ontario Hospital Association Convention & Exhibition

November 18, 19, 20, 2002
Metro Toronto Convention Centre
OHA's Annual Convention & Exhibition will afford participants opportunities to explore the identified topics in detail. They represent the "umbrella" phrases for the development of OHA Feature Theme, General and Allied Group sessions for convention delegates. The Convention Preview which features educational sessions, speakers, registration details and confirmed exhibitors to date is now available on the OHA website at www.oha.com/convention
Contact Information: Educational Services at 416-205-1361

Introduction to Emerging Psychotherapies: IPT, DBT, CBT and Mindfulness

December 4 – 5, 2002
This interactive two-day course gives a thorough orientation in IPT, DBT, CBT and Mindfulness. Participants will learn the theoretical framework of these therapies, and will use exercises and case studies to enhance their clinical skills and learn practical tools and strategies for working with clients.
Contact information: CAMH, Education & Training Services, 33 Russell Street, Toronto, M5S 2S1, phone: 1-800-661-1111 or 416-595-6059, email: marketing@camh.net, website: www.camh.net

Ontario Psychiatric Association 83rd Annual Meeting, "Psychiatry Across the Life Span"

January 30, 31, February 1, 2003
Toronto Marriott Eaton Centre Hotel, 525 Bay St., Toronto
Contact information: Lorraine Taylor, OPA Office, 905-827-4659, email: opa@bellnet.ca

Mental Illness Awareness Week

By Tanya Baglole & Francine Knoops, Canadian Psychiatric Association

Reach out to prevent suicide. Care and treatment save lives.

That is the theme for this year's Mental Illness Awareness Week, the Canadian Psychiatric Association national public education campaign, which runs from Oct. 6-12. The focus is on identifying suicide as an important public health issue, and what can be done to reduce its impact on population health.

"This year's theme is intended to highlight that mental illness is almost always a factor in suicides and that there are strategies that can reduce rates," said Dr. Pierre Beauséjour, CPA board chair. "I hope this year colleagues will make a special effort to reach out to their own communities by offering to speak about mental illness or helping to organize a public education event", he added.

"While suicide results from a complex set of biological, psychological and social factors, it causes considerable suffering and emotional pain for people," said David Masecar, president of the Canadian Association for Suicide Prevention. His group is one of 16 national organizations who are not only endorsing this year's MIAW campaign, but also helping to distribute the messages through posters and postcards that stress suicide is preventable and care and treatment can make a difference.

"Reaching out to prevent suicide is possible in that we know much more now about how to respond to a suicidal crisis, and treat many of the contributing factors," said Masecar.

The annual MIAW campaign, created in 1992, reinforces the objectives of the CPA, the Canadian Alliance on Mental Illness and Mental Health and the Canadian Association for Suicide Prevention that Canada adopt a national strategy on mental illness and mental health.

"In spite of the lack of a federal initiative, Canada has many excellent leaders in the study of suicide, many prominent advocates working to prevent suicide and many frontline health care professionals working with individuals at risk for suicide. The MIAW activities demonstrate that the nation stands ready to do more to prevent suicide," said Dr. Paul Links, Arthur Sommer Rotenberg Chair in Suicide Studies at the University of Toronto. Dr. Links, along with Dr. Alain Lesage of Montreal, offered their expertise as part of this year's reference group for the campaign.

The 2002 MIAW theme poster will be in the September Canadian Journal of Psychiatry polybag. Posters, postcards and the guidebook for planning events are available from the CPA at 613-234-2815 and more information is available at its web site: http://www.cpa-apc.org/MIAW/MIAW.asp ■

Editor's Note: See "Suicide in Physicians: Toward Prevention by Dr. Michael Myers, OPA Dialogue, September 2001, page 10-11; Resources on suicide and suicide prevention, page 13; "The Map is Not the Territory - Trends in Youth Suicidality", page 14.

AGENDA OPA Council June 14, 2002

1.0 Remarks from the President
Approval of Agenda
2.0 Approval of Minutes of April 5, 2002 OPA Council
3.0 Old Business
3.1 Coroner's Reports
3.2 AGHPS – Perspective Document
3.3 CPSO Draft Guidelines Response
3.4 Report of the Sections Task Force
3.5 Ontario College of Family Physicians
3.6 Consent & Capacity Board – Rules of Practice
4.0 Treasurer's Report
5.0 Reports of Task Forces and Committees
5.1 Advocacy
5.2 Communications Committee
5.3 Continuing Education Committee
5.4 Finance/Audit Committee
5.5 Member Services Committee
6.0 Standing Reports
6.1 OMA Tariff/RBRVS
6.2 CPA Report
6.3 Working Group on Mental Health Services
6.4 Coalition
6.5 Council of Provinces
6.6 Alliance for Mental Health Services
6.7 JPPC Psychiatric Working Group
7.0 New Business
7.1 Guest Speaker: Dr. Nick Kates – Shared Care Initiative
7.2 Streamlining Access to Mental Health Services & Supports
7.3 Honourary Membership
7.4 AGHPS June 1st Planning Day
7.5 National Symposium on Gaps in Mental Health Services for Seniors in Long-term Care

MEMBERS ON THE *MOVE*

Dr. John Copen relocated from Ottawa to London for a yearlong Fellowship in Telemedicine and Addiction Psychiatry and has now moved on to Lakehead Psychiatric Hospital (as Medical Director of Telepsychiatry) Thunder Bay effective November 1, 2002. Dr. Copen can be reached at 807-343-4394 and 807-343-5019 or by email at john.copen@dreamhorizons.ca.

Dr. Rod Lough left The Royal Ottawa Hospital, Forensic Services, to work at St. Joseph's Healthcare Centre, Hamilton, where his two major responsibilities are Staff Psychiatrist for Community Liaison inpatient services (effective May 2002) and Acting Clinical Director of Emergency Psychiatric Services (effective August 2002). Dr. Lough can be reached at 905-522-1155-6775 or by email at rlough@stjosham.on.ca

Dr. Brenda Yim relocated from Ottawa to London to work in a Community Child Mental Health Agency and has now moved on to Thunder Bay Regional Hospital and Lakehead Regional Family Centre (as Director of Child and Adolescent Psychiatry), Thunder Bay, effective November 1, 2002. Dr. Yim can be reached at 807-343-4394 and 807-343-5019 or by email at brenda.yim@dreamhorizons.ca

To get your new appointment in "Members on the Move", send us the following information – your name, position, date of appointment, the organization you were with and the new organization (if applicable), your email, phone number and address. We will run these announcements as we receive them, and as space in the *Dialogue* allows. Please forward your items in writing to the OPA Office, 1141 South Service Rd. W., Oakville, ON, L6L 6K4 or by email to: opa@bellnet.ca or fax to : 905-469-8697.

ATTENTION MEMBERS!

The OPA needs your vitality and expertise to continue to provide a strong leadership for Ontario Psychiatrists.

Do you know of someone who would make a good OPA Council Member? Are you interested in being a Council Member? Nominations for the 2003 OPA Elections are now being accepted. Term of office is January 2003 to January 2006. Meetings are held in Toronto in January, March, June, September and November. Three Full Members and one Member-in-Training are required to join the OPA Council beginning January 2003. Council Members function within the mandate of the OPA Constitution and By-laws, and are responsible, collectively, to govern and lead the Association by:

- Determining the vision, mission, values or beliefs of the Association;
- Setting and approving goals and objectives including overall operating and financial plans designed to achieve certain goals and objectives;
- Recruiting and evaluating staff;
- Identifying and managing any and all risks to the Association;
- Verifying the integrity of internal control and management information systems;
- Ensuring cost-effective, efficient operations within legal requirements, ethical and quality standards;
- Monitoring communications within and outside the Association;
- Recruiting, orienting and training new Council members; and,
- Adopting a strategic planning process to determine short term and long term goals and objectives for the Association.

Council members serve for a three-year term, may serve for two consecutive terms and are not eligible for re-election for a period of three years following the end of their second term and then may only serve one additional term. Two Council members shall be Members-in-Training, elected for a term of two years, one Member-in-Training to be elected in each succeeding year. A complete Role Description and Nomination Forms can be obtained by contacting the OPA Office by phone; 905-827-4659 or by email; opa@bellnet.ca. Completed nomination forms must be signed by the nominee and received by the OPA by November 14, 2002.

Please contact Dr. Keith Anderson, OPA Past President ***by November 1, 2002*** *at KeithAndersonMD@aol.com or (613) 725-2284 for further information on this exciting opportunity.* ■

Meet A Council Member:

An Interview with Khrista Boylan, M.D.

Dr. Khrista Boylan is currently a Resident, Department of Psychiatry, McMaster University

OPA: What is your current position on the OPA Council and on what committee do you serve?

Khrista: I am a Council member, one of two Member-in-Training OPA Council members. I also serve on the Advocacy and the Member Services Committees.

OPA: Tell us a bit about your background.

Khrista: I'm a Nova Scotian. I completed my BSc. in Biology and Psychology at Dalhousie University. I taught piano for many years and was always busy writing and studying how to bring "art" into clinical care during medical school. I was also preoccupied with chronicling the experience of becoming a doctor, and these days, a psychiatrist. As a psychiatric resident at McMaster, I have been involved in advocating for resident well-being through PAIRO and in our department. My current research activities involve comorbidity and phenomenology in bipolar disorder and gender differences in first episode of mood disorders.

OPA: When did you join the OPA and why?

Khrista: I joined in my second year of residency so that I could become informed about issues that might affect my training and transition to practice in Ontario. I hope that I can stimulate discussion and change about these issues with fellow resident OPA Council member, Krishna Balachandra, through the OPA Council and the new Residents Section.

OPA: What has been your most valuable experience as an OPA member?

Khrista: Learning from more experienced psychiatrists from all over Ontario- about how they structure their practice, maintain their interests in non-clinical aspects of the profession- has been a very rich opportunity that I could not have found any other way. The sense of collegiality has been invaluable at this early stage in my career.

OPA: What do you think is important for psychiatrists to be aware of in the 21st century?

Khrista: My early stage of training biases me to be concerned about our profession's identity and in what ways we are different from other MDs and various other mental health care providers. I think it is important to advocate for what makes us unique from our non-psychiatrist colleagues and also from each other (without losing our cohesion) as our styles of practice and modalities of treatment continue to advance and diversify.

OPA: What kind of career would you like to pursue?

Khrista: It is difficult for me to make a decision right now because I have enjoyed working with every patient group so far in my rotation. One theme that I always come back to is recognizing the phenomenology of, and treating those who have severe mood disorders. Since I like to work in more than one place, I could envision myself working with a mobile research team for mood disorders.

OPA: If you weren't a psychiatrist, what other professional endeavor would you be pursuing?

Khrista: I would be a jazz pianist, a talk show host or an anthropologist.

OPA: If you had 3 wishes for the profession of psychiatry, what would they be?

Khrista: I wish depression could be as commonly discussed as cholesterol levels.
I wish psychiatrists could be paid to do mental health prevention, and paid more.
I wish more residents and psychiatrists would be interested in seeing kids or teens as part of their outpatient practices, or, would start talking about why this doesn't happen.

OPA: If you had 3 wishes, what would they be?

Khrista: I wish there were more funding for children's education.
I wish housing was more affordable.
I wish we all would work 4 days a week.

OPA CONFERENCE AND ANNUAL MEETING:

By: Dr. Ann Thomas, Continuing Education Committee Chair

Psychiatry ACROSS THE LIFE SPAN

Your Continuing Education Committee is looking forward to presenting an outstanding lineup of presentations at the OPA Annual Meeting in Toronto at the Toronto Marriott Eaton Centre Hotel on January 30, 31 and February 1, 2003.

Here are just a few of the titles you can expect; Dr. Phillip Sarrel of Yale University - "The Psychiatric Significance of Ovarian Hormones"; Dr. Jon G. Allen of the Menninger Clinic in Kansas - "Finding and Losing Your Mind in Attachment Relationships" and "Stressful Impact of Treating Trauma"; Dr. Raj Velamoor of London, Ont. - "Neuroleptic Malignant Syndrome (NMS) Across the Life Span" and Dr. Michael Robinson of Kingston, Ont. - "Delirium Across the Life Span".

As well, you will be able to expand your knowledge on the following subjects; Anorexia Nervosa, Tourette's Syndrome, Cognitive Behaviour Therapy, Post Traumatic Stress Disorder, Andropause and many others.

As the OPA attempts to empower the Sections, a new addition to this year's meeting will be the OPA Section Luncheons planned for Saturday, February 1, 2003. Delegates will have the opportunity to attend one of the four luncheon symposia offered in the following Sections; 1) Residents, 2) Child & Adolescent, 3) Psychogeriatrics and 4) Community & Psychotherapy (combined). Dr. Mamta Gautam of Ottawa will address the Resident Section and discuss "Setting Up a Psychiatric Practice". Dr. Kenneth Shulman, Professor, Department of Psychiatry, Sunnybrook & Women's Health Centre, University of Toronto and inaugural recipient of the Richard Lewar Chair in Geriatric Psychiatry at Sunnybrook & Women's, University of Toronto, will be presenting "Geriatric Psychiatry and the Future of Clinical Neurosciences" to the Psychogeriatric Section. Speakers for the Child & Adolescent and Community & Psychotherapy Sections are presently under negotiation.

The recipient of the T.A. Sweet Award is Lt. General (Ret.) Roméo D'Allaire. We look forward to his attendance at the President's Dinner/Dance on Friday, January 31, 2003. One Dinner/Dance ticket is included with your Annual Meeting registration. Be sure to attend this event – it's a great dinner with a live band and a wonderful way to spend a relaxing evening with old and new friends.

Thanks again to the Continuing Education Committee; Krishna Balachandra, Mamta Gautam, Jane Howard, Roumen Milev, Margaret Steele and Elizabeth Leach for all their time and valuable input.

As always, I look forward to your comments on both past and upcoming Annual Meetings. Please email them to my attention at opa@bellnet.ca or send them by fax to 905-469-8697.

We look forward to seeing you in January! ■

INNOVATIVE LEARNING, family focus at CPA Annual Meeting

By Katie Hardy, Canadian Psychiatric Association

Cloning and Canadian law, care of the terminally ill and personal digital assistants are among sessions to be offered at the Canadian Psychiatric Association's 52nd Annual Meeting. The meeting will be held in the heart of the Rocky Mountains at the Fairmont Banff Springs Hotel from Oct. 31 - Nov. 3, 2002.

"This year, we've tried to introduce some innovative programming as well as incorporate more psychotherapy-related sessions into the meeting," said Dr. Susan Abbey, Annual Meeting program committee chair.

A seven-hour seminar on stress in daily life and clinical practice that touches on cognitive-behavioural interventions, time management, yoga and meditation will be offered for the first time.

A social program has been planned to accommodate delegates and their families. A Halloween-themed welcome reception and western fun night will offer activities geared to children. A day-care service during the president's banquet will allow attendees to relax and enjoy the best of Albertan cuisine.

Dr. Cornelia Wieman, chair of the CPA's native mental health section, will deliver the inaugural Clare Brant Memorial Lecture. It is titled, "For Seven Generations: Remembering the Past While Planning for the Future." Dr. Wieman works with Aboriginal peoples on the Six Nations of the Grand River reserve in Ohswehen, Ont., and was the second Aboriginal to train as a psychiatrist in Canada. Dr. Clare Brant was the first Aboriginal psychiatrist in Canada. He was a founding member of the Native Mental Health Association and the Native Physicians' Association and raised awareness of Aboriginal mental health issues throughout his career.

Delegates can also take advantage of the subspecialty academy meetings scheduled at The Fairmont Banff Springs. The Canadian Academy of Psychiatry and the Law will meet Oct. 31; the Canadian Academy of Geriatric Psychiatry is slated to meet Nov. 4; and the Canadian Academy of Child Psychiatry meeting is scheduled for Nov. 3-5. The Canadian Academy of Psychiatric Epidemiology will meet Oct. 31 at the Banff YMCA close to the hotel. ■

Federal agency overhauls disability tax credit form

By Katie Hardy & Francine Knoops, Canadian Psychiatric Association

The Canadian Customs and Revenue Agency (CCRA) consulted during the summer months with national professional and disability advocacy groups to redesign the forms used to assess eligibility for the disability tax credit (DTC).

The consultation process stems from a March 2002 report issued by the House of Commons' Subcommittee on the Status of Persons with Disabilities. Dr. Carolyn Bennett, MP (St. Paul's Riding, Toronto) chairs the subcommittee.

The subcommittee made a series of recommendations for administrative changes, including that a revised DTC assessment form provide more space to elaborate on the applicant's medical condition. Any changes to the form by the CCRA must adhere to existing Income Tax Act legislation.

As noted in submissions by mental health groups during the subcommittee hearings, including that of the Canadian Psychiatric Association, those with a mental illness have rarely been deemed eligible for the credit due to the episodic nature of mental illnesses. The subcommittee also recommended a broad consultation on inequities that may require changes to the Income Tax Act. While this process has not yet begun, the CCRA decided to proceed with the administrative improvements within the confines of existing legislation anyway.

Following separate consultations in August with advocacy and professional groups, that included psychology, psychiatry and the CMA, the CCRA drafted and circulated a revised form to both groups. Mental health groups tried to help CCRA staff better understand the nature of disability associated with severe mental illnesses. "Whether or not the new form will open the door for more individuals with severe mental illness to become eligible for this benefit remains to be seen", says Dr. Pierre Beauséjour, who attended one of the meetings on behalf of the CPA.

Professional groups insisted the CCRA change its deadlines to give each organization more time to review the form. Comments on the redesigned form had to be received in the early fall so the CCRA could make a new form available in time for 2002 tax returns.

The DTC is a non-refundable tax credit intended to help offset the disability-related costs of persons with a severe disability. Applicants must have a qualified professional complete a disability tax credit certificate (form T2201) to be considered for the credit. This certificate is then reviewed by trained staff at the CCRA, who make the final decision on eligibility.

For more information about the initiative to reform the DTC, please visit www.disabilitytaxcredit.com. ■

SET MINIMUM STANDARDS FOR MENTAL HEALTH CARE SERVICES, COMMISSION TOLD

By Tanya Baglole & Francine Knoops, Canadian Psychiatric Association

The federal government must adopt national goals to lower mortality, morbidity and disability arising from mental illness. That was one recommendation the Canadian Psychiatric Association (CPA) made in June to the Commission on the Future of Health Care in Canada.

The CPA urged the Commission to pay special attention to mental health in its final report. It noted that it is time Canada adopts a national strategy on mental illness and mental health, and stipulated that a national strategy should include:

- minimum standards for mental health care services so Canadians know what to expect
- strategies that address the unique range of needs for children, elderly, incarcerated, Aboriginal peoples, visible minorities, people living with chronic and serious mental illnesses and people living with moderate mental illnesses
- a surveillance program to monitor achievement of national goals
- strategies that address long waiting lists for specialized mental health care services, the shortage of psychiatrists, including advancing shared mental health care
- mental health goals within all federal, social, health and justice policies

The CPA also urged the commission to recommend that the federal government establish appropriate levels of annual funding for mental health research, including base funding that corresponds more closely to the burden of mental disorders.

A human resources paper, prepared by the CPA Council of Provinces that examines the shortage of psychiatrists in Canada, which is only expected to worsen, was submitted to the commission.

The commission, which has been scrutinizing the sustainability of Canadian health care since May 2001, is expected to release its final report later this fall. ■

The Ontario Psychiatric Association is pleased to welcome the following new members up to June 14, 2002

Sarwat Hanna-Dief
Sylvia Hidvegi
Bill Mah
Poonam Sharma
Valerie Taylor
Giovanni Villella
Nadim Y. Zamar

Wanted: Book Reviewers

Do you know of book that should be reviewed for the *Dialogue?* Would you like to be a book reviewer? Are you aware of a website that would be of interest to our Members? If so, please contact the Editor.

OPA *DIALOGUE* 2002 SURVEY RESULTS

Congratulations to Dr. Marino Battigelli of Burlington who won $100.00 off his 2003 Annual Meeting Registration Fee.

SURVEYS SENT: 368 EMAIL/ 717 BY MAIL • 58 RESPONSES RECEIVED: 50 EMAIL/ 8 FAXES

1. Do you read *Dialogue* on a regular basis?

all the time	23
most of the time	18
sometimes	12
not too often	4
not at all	1

2. Do you pass on *Dialogue* to others?

all the time	2
most of the time	0
sometimes	9
not too often	12
not at all	35

3. Do you think *Dialogue* tells you about what is happening in psychiatry?

all the time	5
most of the time	27
sometimes	22
not too often	3
not at all	1

Membership Category

Full	48
Associate	1
Member in Training	3
Life	6

4. Should *Dialogue* continue to offer? Y/N

Do you read? A all the time B most of the time C sometimes D not too often E not at all

	Y	N	N/A	A	B	C	D	E	N/A
Message from the President	55	3		28	11	14	4	1	
From the Editor	48	10		29	9	12	6	1	1
Calendar of Events	58	0		40	9	5	3	1	
OPA Council Meeting Agenda	50	8		33	6	10	5	3	1
Council Highlights	54	4		33	10	8	4	2	1
Meet a Council Member	44	14		21	3	19	7	5	3
Members on the Move	45	13		28	7	14	2	4	3
Resident's Review	53	5		23	10	12	7	3	3
Coalition news	54	4		28	12	12	4	1	1
AGHPS news	45	8	5	25	10	16	5	2	
OPDPS news	41	12	5	25	8	13	6	4	2
OMA Section on Psychiatry news	56	1	1	33	11	11	1	1	1
RBRVS information	52	5	1	25	14	10	6	3	
CTC information	50	7	1	29	5	18	3	2	1
Book Reviews	44	12	2	28	9	13	4	2	2
RAI-MH information	34	20	4	21	3	15	10	7	2
Government news	49	6	3	29	7	15	2	4	1
General Mental Health Information	45	11	2	28	6	14	5	3	2
Mental Health Resources	50	6	2	29	5	15	5	2	2
Legal issues/topics	54	2	2	35	4	16	1	0	2
Pharmaceutical Advertisements	27	26	5	29	2	7	9	8	3
Other Advertisements	31	21	6	28	3	11	6	7	3
Classified ads from Members	40	13	5	32	4	11	7	3	1
Classified ads from Non-Members	26	27	5	29	2	5	12	7	3

5. What other topics would you like to see covered in *Dialogue*?

- You're doing a great job.
- Need to get a broader perspective. Too narrow. Same influence all the time.
- I really enjoy reading the *Dialogue*, it is the only publication that keeps me informed on Ontario psychiatry/psychiatrists.
- APA news.
- Issues related to private practice
- Explanation of the structure of the Ontario Ministry of Health and Long Term Care with further explanation of how mental health is governed.
- Perhaps statements from the Assistant Deputy Ministers explaining their mandate and the process of decision making. Updates on the work of the mental health restructuring task forces.
- Thanks for your efforts in doing this.

6. Other comments or suggestions

None.

SHARED MENTAL HEALTH CARE

By: Nick Kates, CPA Co-Chair of the Canadian Psychiatric Association and College of Family Physicians of Canada Collaborative Working Group on Shared Mental Health Care in Canada

In almost every Canadian community the family physician plays a key role in delivering mental health care. Almost forty percent of people who receive mental health care receive it only from their family physician. In addition, while seventy two percent of individuals with mental health problems receive no care over the course of the year, the majority of these individuals will visit their family physician. And many individuals with serious medical problems also have co-morbid psychiatric problems, predominately depression and anxiety. Few of these individuals are referred to mental health services, but the majority receive regular treatment from their family physician. For these reasons, primary care may be the optimal setting to detect problems at an early stage. Quite simply, the family physician is uniquely placed to initiate treatment and monitor progress.

Although primary care continues to be an important part of a community mental health system, family physicians and psychiatrists have identified many problems in the relationship between the two specialties. These include problems in accessing mental health services, poor communication and a lack of personal contacts. Family physicians also often feel unsupported as providers of mental health care and do not always feel that mental health providers treat this role with respect.

This suggests that psychiatry needs to rethink its relationship with family medicine. We need to see the two sectors as complimentary parts of a continuum, encouraging easy movement progress between different services. We also need to look at ways in which psychiatry can provide a range of supports that will optimize the care patients receive in primary care settings and ensure they get rapid access to psychiatric services when they need it.

Achieving this requires a shift in attitude as well as in clinical practice. We need to start thinking about a new kind of partnership where responsibilities for care can be shared rather than remaining the exclusive property of one or other disciplines.

The term "shared care" describes patterns of collaboration between providers from different services or disciplines who share the responsibility for the care an individual receives. Working together, these providers are able to pool their resources, according to the needs of an individual client, service availability and their respective skills. In doing so they will attempt to ensure an individual reaches the services they need when they need them, improve communication and personal contacts between providers from different sectors, enhance continuity of care and provide mutual support. Shared care models also have the potential to address resource shortages and build system capacity, as the provision of back up and support for primary care providers can enable them to handle a broader range of cases.

While there are many possible ways in which care can be shared, including making intake processes more user friendly, developing rapid access consultation services, conducting discharge appointments in the family physician's office or integrating mental health services in primary care settings, it is important that shared care is based upon the following principles:

- All services are part of an interdependent care delivery system.
- No single service or provider can deliver every service an individual needs.
- There needs to be clarity about roles and responsibilities.
- While one provider may be playing a leading role, other providers/services need to remain involved and be willing to reactivate care quickly, when required.
- Collaborative relationships are based upon mutual respect and trust.
- Shared care models need to be adapted to resource availability and respective skills and comfort of partners.
- Providers are able to provide each other with mutual support and share resources.
- The key to successful collaboration is good personal contact between providers from different sectors and clear and regular communication.

Over the last five years, it has been encouraging to watch the rapid expansion of shared care projects across Canada and the extent to which the principles of shared care are now being accepted and adopted by planners and administrators of health systems as well as by clinicians. In part this has been stimulated by the project between the Canadian Psychiatric Association and the College of Family Physicians of Canada who have produced a joint position paper and followed this up by establishing a Collaborative Working Group to facilitate better collaboration between psychiatrists and family physicians across Canada.

Amongst the new projects are new models of clinical service delivery, including the integration of mental health care providers within primary care settings in a number of communities across Canada. Others have included innovative training experiences for residents, creative continuing education programs; administrative links to facilitate shared care and a small but expanding number of research projects. The range and diversity of these activities have been captured in a compendium of shared mental health care projects, which has recently been produced by the Conjoint Working Group and is available from both organisations. Three very successful national conferences on shared care have been held, with a fourth being planned for Halifax for next June; two meetings of researchers have been organised to develop a national agenda for research and a strong network of interested colleagues has been established.

If shared care is to move forward, three other ingredients need to be in place. The first is an emphasis on the training of future practitioners who will incorporate these ideas into their daily practice. This has spurred the Working Group to survey family medicine and psychiatry residency program directors to develop recommendations for curricula for training family medicine and psychiatry residents.

The second is to ensure that new projects are based, as much as possible, on existing evidence about what works, what hasn't worked and the practical lessons which can be drawn from these projects. And the third is to make sure that all shared care projects be evaluated, using common evaluation methods and instruments. With this in mind, Marilyn Craven and Roger Bland have developed a comprehensive annotated bibliography on shared mental health care projects. This includes an extensive review of the research and evaluation literature relevant to shared mental health care as well as recommendations for a common framework for the evaluation of shared care projects.

Other directions for shared care over the coming years include exploring ways in which shared care models can be adapted to meet the needs of individuals in rural communities, and other underserved populations, such as new immigrants or the homeless. There is also a need to strengthen provincial networks of colleagues and to continue to work with planners and funders to look at how the principles and concepts of shared care can be incorporated in federal and provincial health reforms. Finally, the national working group is meeting with representatives of psychology, nursing, occupational therapy, social work and the Canadian Mental Health Association to look at how these partnerships can be broadened to include providers from other disciplines.

It promises to be an exciting time for shared care and many of the ideas discussed in this article can be adapted to any community in Ontario. For further information on any of the activities of the working group, including its publications, or to get on our mailing list, please contact Nick Kates, CPA Co-Chair at nkates@mcmaster.ca. ■

(Editor's Note: For more information you may also refer to "The Collaborative Mental Health Care Network" in the OPA Dialogue, March 2002, page 14 and "Psychiatry Referral Service" in OPA Dialogue, June 2002, page 20).

One Year After September 11th: **A PERSPECTIVE**

By: Dr. Clare Pain, Clinical Director Psychological Trauma Assessment Clinic,
Assistant Professor of Psychiatry, University of Toronto, Mount Sinai Hospital, Centre for Addiction and Mental Health.

America braces for a painful resurgence of memories as the anniversary of September 11th 2002 approaches. Returning to normal after the attack on the World Trade Centre and the Pentagon has taken some time. There has been a gradual unfreezing… a slow end to a kind of traumatic paralysis…. following the shock of the events one year ago.

I remember asking a New York cab driver how he and New York were doing three weeks after Sept 11th – he said drivers in downtown New York were beginning to use their horns again.

The CNN no longer has its 'war on terrorism' footer. The May 30th - June 5th 2002 Guardian Weekly had an article commenting on the welcome return of dissent to American politics.

While work at Ground Zero progressed actively, America united against threat. Fear disrupted routines from ongoing threats, and rumors of additional threats kept the country in bipartisan consensus. Every porch few a flag, the President's ratings were off the chart, and to question Bush's administrative war against terrorism was seen as unpatriotic for months. Newspapers continue to address the political fallout following the events of September 11th. But for most of us not directly involved, it's not articles on US foreign policy failures, or even possible missed intelligence warnings that remind us of that exquisitely beautiful early fall morning.

What were you doing on Tuesday September 11th 2001? It's easy to remember, like the day Kennedy was shot. You were probably working, seeing patients, doing clinics, or in a meeting until the television claimed you - to watch as events unrolled in real time. Then, we all watched as the towers were hit and burned and collapsed over and over again, until we believed it. It is the combination of the usually indistinguishable daily routines, disrupted by the magnitude of those events, and consequently remembered, that provides the path back to the emotions we experienced.

For me, the specific emotional connection with that time is not the visual images so much as the poignant snippets of cell phone conversation we heard or read about. They were from workers trapped in the WTC offices to the spouses they had left at breakfast an hour before. From passengers in the hijacked flight that crashed in Pennsylvania and an airline flight attendant reporting the seat number of the hijacker on her doomed flight. The calls were calm or they were tearful, but over and over again we heard how "I love you", corny and overused as it can be, was the message that had to be given. These cell phone conversations became an empathic window into the highjacked planes, into the upper floors of the WTC where there were no cameras.

For the first time, we heard descriptions of the particular experiences through the voices of the victims as it was happening. In other tragedies, there have been war photographers or artists, and statements, long after the events had occurred, by politicians or reporters or poets to help us shape our emotional response. On Sept 11th it was perhaps the ordinariness of the conversations that was so moving. It was possible to identify immediately with the caller's description, panic or heroism; but perhaps most of all with their need to connect authentically before they faced the end.

The tragedy of these strangers also made our own past suddenly newly available to us. In a workshop earlier this year to Canadian doctors on acute psychological trauma, the majority described their reaction to Sept 11th as abruptly breathing emotional life and pain back into events in their past. They reported experiencing again, or more acutely, the grief and sadness and sometimes anger and outrage for losses in their lives; for emigration from a country of origin, for a recent hysterectomy, for the death of a grandmother, for a past unfairness or cruelty.

Of all the innumerable thoughts and feelings that September 11th caused, it is this inevitability of the need for human connection that continues to hold my attention. In our need to empathetically connect to others, we are led back to ourselves. The sudden emotional link I felt to the ordinary people killed on that day, and to their family and friends, because of their cell phone calls, caused the unexpected chance to re-work and re-view personal past losses and grief.

I am struck too by the way life does return again to normal, how the waters of time fold over even these most extreme events. Mostly it is as though it never happened, at least for those of us who did not lose anyone. Even the emotional connection to that day weakens with repeated telling. But learning again, that the need for continued authentic personal connectedness continues to link us to others, and to ourselves, and persists, despite all and to the end, is somehow heartening. ■

Editor's Note: For additional reading see: The Guardian Year 2001 Ed: Katz, I. Atlantic Books, 2001. In addition, Rosalie Moscoe, a professional speaker and nutritional consultant suggests five strategies to reduce stress:

1. Make a list of what's bothering you. Are you doing too much? Are relationships at the base of your problems? Is your workload too great or do you hate many things about your job? Are you a workaholic, or a procrastinator? Are you disorganized? Is poor money management your problem? Or is it too much coffee? Are you doing what you want to be doing in life? Make a simple plan for each item taking steps to do something about it. You can start your New Year's resolutions a month early! b) Make a list of what's going well in your life. Read each list over and over until you feel you have a better perspective.

2. Just stop and take a couple of deep breaths- right down to your belly. Do the "Ten Second Break". Take in a deep belly breath to the count of four. Hold your breath to the count of four. Breathe out to the count of four. As you exhale, imagine something warm coming over your body from your head to your toes and repeat to yourself "I am calm". Repeat a few times throughout the day.

3. Use positive self-talk to replace old negative messages that often rumble through our heads, causing psychological and emotional stress. Use messages like "I'm a worthy person", I'm doing the best that I can". "Look how far I've progressed and I'm still moving forward". "I can remain calm with this difficult person". "I can get through this". "This too will pass".

4. Get rid of the bound energy that lurks in muscles causing many physical problems. Put some form of physical activity into your life on a regular basis. Even 14 minutes on a treadmill or a brisk walk around the block can reduce anxiety, banish stress and fatigue.

5. Feed your nervous system with quality foods. Reduce junk food; coffee, pizza, muffins, cakes, pastries, and other white flour products. Increase water, fruits, vegetables, whole grain products and low fat protein sources such as chicken, fish and lean cuts of meats. Use raw almonds, raw sunflower and/or pumpkin seeds as snacks and most importantly, replace supermarket oil with cold pressed olive oil. Since stress can deplete vitamins (especially the B's) and minerals as well as depress our immune system, investigate supplementation such as a good quality vitamin and mineral formula. Vitamin C can lower stress hormone levels. In a study at the University of Alabama, in 1999, vitamin C fed rats showed lower stress hormone levels as well as fewer incidences of typical stress indicators, such as weight loss and enlarged adrenal glands. ■

Responding to Complaints: *Don't Make Matters Worse*

By: Bernard C. LeBlanc

One of the most stressful experiences for anyone, particularly professionals, is responding to a complaint. Virtually all regulators report that the numbers of complaints that are being registered against professionals in all areas are increasing. There are two particular, recurring areas that can make matters worse when responding to a complaint.

The first area concerns the manner in which a professional responds to a complaint. When responding to a complaint, a professional should make sure that he or she has a clear grasp of the issues raised by the complainant and responds to those issues. The "flip side" of this advice is to avoid expanding the nature of the dispute.

While responding to complaints is stressful enough, it is unfortunately not uncommon that professionals will include disparaging remarks about the complainant that do not relate directly to the complaint or the issues raised in the complaint. For example, comments about a complainant's psychological or psychiatric status, either real or perceived, their ethnicity, racial background, or other personal characteristics will almost inevitably create more problems for the professional than it solves. Professionals sometimes try to paint the complainant as hysterical or otherwise unreasonable. However, all practitioners must recognize that the work they do is very important in the lives of their clients, and their clients therefore often have a tremendous emotional investment in the services offered by the professional. It is therefore not unusual for a client to become quite emotional if he or she becomes upset with the services provided. Pointing this out to the regulator does not help the investigating body to determine the merits of the complaint.

Worse still, if the professional's response is sufficiently belligerent, the professional may himself or herself be faced with additional allegations of unprofessional conduct for the manner in which they respond to the complaint. While these sorts of proceedings are very unusual, it cannot be in the professional's interest to expand the scope of the investigation by making an already volatile situation worse.

The best advice, then, is to restrict your response as much as possible to the actual facts of the case and only expand the scope of the investigation if it is an absolutely integral part of your defense. However, it can rarely, if ever, be useful to make disparaging or personal remarks about the complainant.

The other issue that sometimes causes concern for professionals is when the nature of the allegations against the professional expands beyond the scope of the original complaint.

While it is generally accepted that a regulator cannot investigate a member for matters beyond the scope of the complaint, most regulators have the authority to commence further proceedings if, during the course of investigating one complaint, it learns about significant problems in other areas.

Accordingly, while professionals should always be concerned about the manner in which they practice their professions, it is probably useful to review all aspects of one's practice if one receives a complaint. First, if there is merit to the complaint, other areas of the professional's practice may have led to the actual issue that is the source of the complaint. However, investigators sometimes visit the offices of practitioners during the course of investigating one complaint, and it is always in the professional's interest to ensure that his or her office is run efficiently to avoid a situation where an investigator reports additional problems to the regulator, thereby potentially raising additional concerns.

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RBRVS

Commission Finds Psychiatric Fees Are Undervalued Relative to Other Services

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

The Resource Based Relative Value Schedule Commission of Ontario was established by agreement between the Ontario Medical Association (OMA) and the Ministry of Health and Long Term Care (MOHLTC) in May 1997 (and renewed in the OMA/MOHLTC 2000 Agreement) with a mandate to recommend a Resource Based Relative Value Schedule (RBRVS) that assigns each OHIP service code a relative value, expressed in units. The Commission submitted its report to its principals in July 2002.

Psychiatric services are identified in the Final RBRVS Report as being inadequately compensated.

The Executive of the OMA Section on Psychiatry has made numerous submissions to the RBRVS Commission and with the support of the Coalition of Ontario Psychiatrists engaged appropriate experts to help prepare the submissions and to understand the various documents the Commission has produced in the last 5 years. The members of the Executive of the OMA Section on Psychiatry have received the Final Report and are studying it thoroughly.

The Final Report consists of two main documents - the final report and statistical tables. The Commission also included its suggestions for RBRVS transition and future fee schedule maintenance. The complete package is several hundred pages in length. The report is available on the RBRVS Commission Web site (www.rbrvs.on.ca). Materials will also be posted on the OMA Members' Home Page (www.oma.org). Those psychiatrists who do not have Internet access will be able to obtain a copy of the report from the Commission by calling 416-201-5205 or 1-866-744-5244.

All Ontario physicians will have received a newsletter from the RBRVS Commission with a summary of the final report, along with an explanation of the approach and methodology of the Commission. In that newsletter, Dr. John Wade, Chair of the RBRVS Commission reminds the profession that the reason the RBRVS Commission was established was due to a widespread perception, within the profession, that the existing fee schedule has significant inequities requiring redress and that a more equitable and rational approach for evaluating and compensating medical services was required.

Dr. Wade says also that it is vital to understand what the RBRVS does not provide or solve. The RBRVS does not determine the size of the physician fee-for-service funding pool. It is not a tool for physician recruitment and retention, and it is not designed to address fiscal, policy or system issues of the day. That is its strength. These issues, outside the scope of service relativity, must be addressed in other arenas. Quite simply, the RBRVS provides a sustainable methodology for evaluating the relative value of a service based on the resources required by the physician to deliver that service. Other issues such as physician recruitment and distribution are important but must be addressed outside of the RBRVS methodology to preserve its relevance and to ensure that relativity can be maintained even in the context of other changes in the health care system.

Background

Psychiatric services have been identified in previous reports over the last 20 years as being under-valued. In 1982 the MacKenzie Study identified Psychiatry as being under-valued. In 1987 the Thorne-Ernst-Whinney Study concluded that psychiatric services were under-valued. In 1991 the Committee on Economics recognised that Psychiatry relative to other Sections was under-valued. Previous efforts to address the fee inequities have been stopped by Sections who feared their incomes would go down.

From 1992 to 1997 the OMA Department of Economics engaged in a relativity process which was scuttled because of complaints by the OMA Sections who anticipated what they viewed as negative results similar to the B.C. and the U.S.A. relativity exercises. The complaint then was that more consultation was necessary, and, as a result of fighting amongst the Sections, that process stalled and was eventually given up when the present Commission grew out of the OMA/MOHLTC Agreement in 1997.

Much as we are today hearing criticisms of the RBRVS process, previous efforts to address fee inequities also were subject to a similar response. In the past, reports that identified under-valued services or Sections have been shelved and no remedial actions taken. Generally the outcome was further study which led to yet another long process to evaluate fee inequities. The Commission was supposed to finish its work by January 1998. The Commission was proclaimed to be a quick solution to the deadlock in the OMA RBRVS process. Five years later, this report cannot go the way of previous studies. This time the medical profession must work together to find a way to implement the findings of the Commission and correct the fee inequities that have been identified repeatedly over the last 20 years.

RBRVS Final Report and Psychiatric Services

A cost-neutral implementation of RBRVS would cause a relocation or shift of payments amongst physicians and across Specialties. An increase in the weighted average fees of services provided by psychiatrists, of 11.95%, under RBRVS cost-neutral implementation, would result in an increase in payments of $30 million to psychiatrists, assuming the same volume and mix of services. That amounts to $17,183, on average, per psychiatrist. Since the effect is an average this means that some psychiatrists would experience a larger increase while others would experience a smaller increase. See Tables 1 and 2 for detailed information about how this would affect other Sections.

TABLE 1: RBRVS Cost Neutral Implementation Estimated Overall Effect by Specialty - 2000/01 Weighting

This table shows the weighted average change to OHIP benefits by Section if RBRVS is implemented on a cost-neutral basis. Actual effect on individual physicians will depend on the services provided.

OHIP SPECIALTY CODE	SPECIALTY	DRAFT REPORT SECTION INCREASE	FINAL REPORT SECTION INCREASE
00	General Practice	1.35%	3.36%
01	Anaesthesia	-4.70%	-10.28%
02	Dermatology	-2.57%	-4.27%
03	General Surgery	-2.31%	-8.01%
04	Neurosurgery	26.70%	11.66%
05	Community Medicine	na	55.64%
06	Orthopaedic Surgery	9.59%	0.70%
07	Geriatrics	36.88%	48.07%
08	Plastic Surgery	-5.78%	-6.68%
09	Thoracic & Cardiovascular Surgery	3.97%	10.63%
12	Emergency Medicine	16.02%	33.81%
13	Internal Medicine	1.88%	-2.71%
18	Neurology	6.79%	3.60%
19	Psychiatry	12.79%	11.95%
20	Obstetrics & Gynaecology	7.28%	-2.89%
22	Genetics	47.80%	12.50%
23	Ophthalmology	-25.93%	-22.14%
24	Otolaryngology	-5.30%	-6.56%
26	Paediatrics	13.19%	11.57%
28	Lab Medicine	-12.05%	1.72%
29	Microbiology	na	27.33%
30	Clinical Biochemistry	na	62.31%
31	Physical Medicine & Rehab	8.18%	4.10%
33	Diagnostic Radiology	-33.46%	-23.20%
34	Therapeutic Radiology	-13.74%	-2.25%
35	Urology	-10.36%	-6.82%
41	Gastroenterology	-0.44%	-6.97%
47	Respiratory Diseases	11.12%	5.56%
48	Rheumatology	13.73%	5.36%
60	Cardiology	-10.58%	-14.39%
61	Haematology	4.65%	2.49%
62	Clinical Immunology	9.68%	7.58%
63	Nuclear Medicine	-50.76%	-41.03%
64	General Thoracic Surgery	1.64%	-5.00%
99	Grand Total	0.05%	0.00%

TABLE 2: RBRVS Cost Neutral Implementation Estimated Reallocation of Payments
2000/01 Weighting, Impact by Specialty

A cost-neutral implementation of RBRVS would cause a relocation or shift of payments amongst physicians and across Specialties. Psychiatry accounts for $251 million or 6.3% of payments for the provision of professional services. An increase in the weighted average fees of services provided by psychiatrists, of 11.95%, under RBRVS cost-neutral implementation, would result in an increase in payments to psychiatrists assuming the same volume and mix of services, of $30 million. That amounts to $17,183 on average, per psychiatrist. Since the effect is an average, some psychiatrists would experience a larger increase while others would experience a smaller increase. Estimates are provided by the Department of Economics, Ontario Medical Association based on the RBRVS Final Report.

SPECIALTY	# MDs	Total OHIP Professional Fee Payments	Final RBRVS Change	Reallocation of $$$	Reallocation of $$$ per MD Pre	Pre RBRVS Average Gross OHIP Fee Payments per MD	Average Gross OHIP Fee Payments per MD after Reallocation
Clinical Biochem	6	$197,769	62.31%	$123,224	$20,537	$32,961.57	$53,498.95
Lab Medicine	251	$9,484,871	1.72%	$162,929	$649	$37,788.33	$38,437.45
Genetics	8	$315,669	12.50%	$39,453	$4,932	$39,458.63	$44,390.27
Geriatrics	44	$3,920,105	48.07%	$1,884,572	$42,831	$89,093.30	$131,924.48
Therapeutic Rad	126	$11,692,890	-2.25%	-$263,504	-$2,091	$92,800.71	$90,709.41
Emergency Med	93	$9,556,749	33.81%	$3,231,177	$34,744	$102,760.74	$137,504.59
Haematology	62	$8,540,138	2.49%	$212,455	$3,427	$137,744.17	$141,170.86
Psychiatry	1,745	$250,877,067	11.95%	$29,983,700	$17,183	$143,769.09	$160,951.73
Phys Med & Rehab	134	$20,377,816	4.10%	$836,073	$6,239	$152,073.26	$158,312.60
Rheumatology	41	$6,610,094	5.36%	$354,426	$8,645	$161,221.81	$169,866.35
General Practice	10,283	$1,692,540,572	3.36%	$56,931,747	$5,536	$164,595.99	$170,132.48
Paediatrics	762	$128,193,734	11.57%	$14,832,161	$19,465	$168,233.25	$187,698.02
Neurology	225	$43,200,767	3.60%	$1,553,076	$6,903	$192,003.41	$198,905.97
Clinical Immunology	6	$1,198,606	7.58%	$90,879	$15,146	$199,767.60	$214,914.04
Anaesthesia	844	$178,897,837	-10.28%	-$18,387,819	-$21,787	$211,964.26	$190,177.75
Internal Medicine	1,663	$360,159,137	-2.71%	-$9,743,592	-$5,859	$216,571.94	$210,712.90
Plastic Surgery	167	$37,538,731	-6.68%	-$2,509,369	-$15,026	$224,782.82	$209,756.66
Resp Diseases	92	$21,681,328	5.56%	$1,205,082	$13,099	$235,666.61	$248,765.32
General Surgery	652	$165,806,876	-8.01%	-$13,289,420	-$20,383	$254,305.02	$233,922.48
Gen Thoracic Surg	24	$6,281,383	-5.00%	-$314,155	-$13,090	$261,724.28	$248,634.50
Orthopaedic Surgery	414	$108,707,147	0.70%	$756,812	$1,828	$262,577.65	$264,405.70
Neurosurgery	71	$18,764,657	11.66%	$2,187,495	$30,810	$264,290.95	$295,100.73
Dermatology	190	$50,594,352	-4.27%	-$2,162,422	-$11,381	$266,286.06	$254,904.89
Obstetrics & Gyn	663	$178,264,869	-2.89%	-$5,145,283	-$7,761	$268,876.12	$261,115.52
Otolaryngology	224	$61,424,986	-6.56%	-$4,028,664	-$17,985	$274,218.69	$256,233.58
Nuclear Medicine	42	$12,010,266	-41.03%	-$4,928,268	-$117,340	$285,958.71	$168,619.01
Urology	224	$65,167,936	-6.82%	-$4,442,786	-$19,834	$290,928.29	$271,094.42
Diagnostic Rad	775	$251,597,989	-23.20%	-$58,379,281	-$75,328	$324,642.57	$249,314.46
Cardiology	277	$92,675,496	-14.39%	-$13,334,899	-$48,140	$334,568.58	$286,428.15
Ophthalmology	413	$139,633,528	-22.14%	-$30,919,801	-$74,866	$338,095.71	$263,229.36
Gastroenterology	99	$35,190,222	-6.97%	-$2,451,817	-$24,766	$355,456.79	$330,690.96
Thoracic & Card Surg	74	$30,978,324	10.63%	$3,292,541	$44,494	$418,626.00	$463,119.79
Grand Total	20,694	$4,002,081,913	0.00%	$0	$0	$193,393.35	$193,393.35

Table 3 shows the estimated fees for specific psychiatric services calculated from the RBRVS Final Report on a cost-neutral basis. As you can see from Table 3 the fees of numerous psychiatric services would increase substantially and the Commission's recommendations correct these undervalued fees. However, there are some recommendations that are problematic.

Code	Description	RBRVS Fee	2002 OHIP Fee	% Difference from OHIP 2002
A193	Specific assessment	$89.86	$57.10	57.4 %
A194	Partial assessment	$32.55	$24.65	32.0 %
A195	Consultation	$180.85	$122.00	48.2 %
A196	Repeat consultation	$109.79	$73.85	48.7 %
A197	Consultation on behalf of disturbed child - consultative interview with parents	$187.90	$107.20	75.3 %
A198	Consultation on behalf of disturbed child - consultative interview with child	$172.00	$107.20	60.4 %
C192	In-Patient Services - Subsequent visits - up to five weeks - per visit	$16.38	$18.25	-10.2 %
C193	Hospital In-Patient Services - Specific assessment	$99.20	$57.10	73.7 %
C194	Hospital In-Patient Services - Specific re-assessment	$67.35	$41.15	63.7 %
C196	Hospital In-Patient Services - Repeat consultation	$109.79	$73.85	48.7 %
C197	Hospital In-Patient Services - Subsequent visits - 6th-13th wks inclusive (max. of 3/wk) - per visit	$16.38	$18.25	-10.2 %
C198	Hospital In-Patient Services - Concurrent care	$18.09	$18.25	-0.9 %
C199	Hospital In-Patient Services - Subsequent visits - after 13th wk (max. of 6/mth) - per visit	$16.38	$18.25	-10.2 %
C895	Hospital In-Patient Services - Consultation	$219.64	$134.25	63.6 %
K190	Individual in-patient psychotherapy	$57.71	$54.15	6.6 %
K191	Family psychiatric care, in-patient	$66.02	$61.40	7.5 %
K192	Individual Hypnotherapy	$64.66	$54.15	19.4 %

The Section Executive met February 15, 2002 with the Commission. At that time we argued that the RVUs for K202, Group psychotherapy, in-patients 6-12 people and K205, Group psychotherapy, out-patients created fees for groups of 6-12 did not reflect clinical reality. The reason for this was that the Commission assumed the typical number in these groups was 9, whereas it was the experience of psychiatrists doing group psychotherapy that most of the time the average of such groups is more commonly 7. The Commission did not accept that argument and as a result the fees for K202 and K205 would be $7.73 in a cost-neutral implementation of RBRVS, a 19.1% decrease from the 2002 OHIP fee of $9.55.

A second problem is that in the Final RBRVS Report ECT is a B1 Type Code, i.e., a code fitted to an evaluated survey code based on clinical equivalency or relativity. ECT is given a code number of Z458 in the Final RBRVS Report, which was the services code until April 2002. In April 2002 the code was revised and is now two codes:

# G478 - in-patient	54.15
# G479 - out-patient	59.80

This was the result of a presentation to OMA Central Tariff Committee which agreed to two new codes, ECT in-patient, which was seen as being equivocal to K198 which currently has a fee of $54.15 and ECT out-patient, which was seen as being equivocal to K199 which currently has a fee of $59.50. In a cost-neutral implementation of RBRVS, ECT (Code # Z458) has a new fee of $34.39 which is a result of using the much lower fee for the old ECT code.

Another problem is with K007 GP Individual psychotherapy, which in a cost-neutral implementation of RBRVS would be given a new fee of $59.44. That compares to K197 Psychiatric individual outpatient psychotherapy, which in a cost-neutral implementation of RBRVS would be given a new fee of $57.71. Psychiatric individual outpatient psychotherapy in the RBRVS data was rated as more intense than GP Individual psychotherapy (see Table 4) however, because Gen./Family Practice percentage practice costs are much greater than psychiatry the final RVUs and the final fee for K007 was 3% higher than K197.

The above problems would hopefully be corrected if RBRVS were implemented.

TABLE 4: Comparing GP Psychotherapy and Psychiatric Psychotherapy in the RBRVS Final Report.

Key: KJ = Knowledge and Judgment; CI = Communications and Interpersonal Skills; TS = Technical Skills; PW RVU = Physician Work Relative Value Units (physician work comprises the average time required for a service and the average intensity required (as expressed in intensity units). The total is expressed as the number of physician work RVUs for that service); PC% = Practice Cost Percentage derived from Revenue Canada Income and Cost of Practice Data.

SOB CODE	SCHEDULE OF BENEFITS CODE LABEL	KJ	CI	TS	RS	Intensity Rating g	Intensity Units	TIME	PW RVU	PC%	PRACTICE COST UNITS	TOTAL UNITS	2002 RBRVS FEE	APRIL 2002 OHIP SOB FEE (UB)	% DIFFERENCE FROM OHIP 2002
K007	GP - Ind Psychotherpy	4.1	5.3	1.0	2.9	13.3	14.10	30.0	423.00	45.3%	339.70	762.70	$59.44	$50.45	17.82%
K197	Psyc - Individual out-patient psychotherapy	4.7	6.1	1.0	3.4	15.2	17.20	30.0	516.00	33.3%	224.50	740.50	$57.71	$54.15	6.57%
K004	GP - Family Psychotherapy	4.2	5.3	1.0	3.1	13.6	14.60	30.0	438.00	45.3%	303.70	741.70	$57.80	$54.75	5.57%
K195	Psyc - Family out-patient therapy	4.8	6.2	1.0	3.4	15.4	17.60	30.0	528.00	33.3%	229.80	757.80	$59.05	$61.40	-3.83%

The Executive of the OMA Section on Psychiatry encourages all psychiatrists to avail themselves of the contents of the final report. Further deliberations by the OMA Board and Council will occur in the next few months. We would be interested in your comments and would encourage you to write to your representatives on the OMA Board of Directors and let them know your opinion on this issue. It is important that psychiatrists let their representatives know that the fee inequities identified in this report must be addressed.

DEPERSONALIZATION

By: Elaine Hunter Psychologist ; M. L. Phillips Senior Lecturer and Consultant Psychiatrist; M. Sierra Research Worker; M V. Lambert Lecturer and Specialist Registrar in Psychiatry; N. Medford Senior House Officer in Psychiatry; C. Senio Research Worker; A.S. David Professor and Consultant Psychiatrist

Focus of research about dissociative disorders can be different among various countries depending on the points of view of the clinicians. Depersonalization disorder has been of little interest in North America compared to more complex dissociative disorders. In North America, the disorder is considered mainly a symptom or part of a more complex dissociative disorder. As an example of the European view on depersonalization disorder, here is a report by colleagues at the Depersonalisation Research Unit at the Institute of Psychiatry in London, United Kingdom. - Vedat Sar, M.D., International Director, ISSD, Professor of Psychiatry, Istanbul University, Istanbul Medical Faculty, e-mail: vsar @ istanbul.edu.tr

Depersonalization was described clinically over 100 years ago, yet there has been little research into this interesting but distressing psychiatric disorder. The symptom of depersonalization can occur alone or in the context of other psychiatric and neurological illnesses and is characterised by the experience of detachment from one's senses and the outside environment, and may be present for several years without remission. Three years after the establishment of the depersonalization research unit at the Institute of Psychiatry in London, UK, we report on current neurobiological and clinical research findings, including functional magnetic resonance imaging, psychophysiology and neuroendocrinology and progress regarding the development of effective treatments. The remit of the unit is: (a) research into depersonalization disorder; (b) the development of treatments, both pharmacological and psychological; and (c) to increase awareness and knowledge of the condition. Since 1998 we have established a national depersonalization research clinic that takes referrals from within the local NHS trust, throughout the UK and even internationally. This is currently funded from grants thanks to the generosity of the Pilkington Family Charitable Trusts, who first proposed such a unit, with some additional funding for specific research projects from the Medical Research Council. To date, approximately 120 cases have been given a full assessment. The DPD unit has a website that receives up to 1,000 hits per month and we have sent information leaflets to over 300 callers.

Patients are given a thorough evaluation and offered the chance to participate in research and future treatment trials. A full report is sent to the patient's general practitioner. Using data collected from the patients attending the clinic and those contacted through the DPD unit website, we have examined the demographic, clinical and neuropsychological features of DPD. Our findings indicate that the disorder is experienced equally by men and women, with a mean age of onset of 21 years and a mean illness duration of 16 years, which is mostly chronic and continuous.

Although many patients are unable to recall an initial precipitant at onset, 30% of our sample have reported the experience of a traumatic event, and other important factors including social and relationship problems and substance misuse (e.g., Ecstasy). Many patients also report that physical factors, including tiredness and migraine, and situational factors such as bright lights and noise, have contributed to the onset of symptoms.

In this sample other psychiatric illnesses were present, in particular depression (47%) and generalised anxiety (30%). The results are in line with data from a specialised clinic at the Mount Sinai Hospital, New York (Simeon et al, 1997). Rating and quantifying the phenomenology and severity of the disorder has been improved by refinements in various scales such as items from the Dissociative Experiences Scale (see Simeon et al, 1998a; Sierra & Berrios, 2000). We have found that it is probably not possible to distinguish primary and secondary depersonalization on these grounds alone and that some level of depression and anxiety is frequently observed even in primary cases (Lambert et al, 2001a).

Investigation of the neuropsychological features of the disorder is underway. A main focus of the research of the unit has been the investigation of the neurobiological basis of DPD. We have been able to employ functional magnetic resonance imaging (fMRI) to demonstrate abnormal neural responses to presentation of emotional stimuli in patients with depersonalization.

Patients suffering from the disorder fail to activate brain regions associated with perception of emotion (e.g., the insula) during presentation of scenes depicting unpleasant events and objects. Furthermore, our findings have indicated that in

these patients the "emotion centres" appear to be inhibited by activation of other brain regions (e.g., prefrontal cortex) associated with the performance of executive functions.

We have also been able to confirm that patients suffering from DPD do not demonstrate the normal pattern of increased skin conductance response [first discovered by Lader (1975)] during the viewing of these emotionally salient stimuli, but instead demonstrate a flattened response reminiscent of the normal skin conductance response to neutral stimuli. This occurs in the face of intact recognition of the emotion in question.

The results of these studies are compelling evidence for the presence in DPD of an inhibition of the normal neural response to emotion. Further studies employing fMRI and skin conductance measures are underway to investigate these findings and their specificity in more detail.

Finally, in collaboration with colleagues at Newcastle University School of Medicine we have carried out a pilot study of diurnal cortisol secretion using salivary samples in patients suffering from DPD. Preliminary results suggest a pattern of hypocortisolaemia, quite unlike depression but similar to disorders such as posttraumatic stress disorder (Yehuda, 1998).

A central aim of the depersonalization research unit is to develop effective therapeutic interventions for the treatment of depersonalization disorder. Many treatments have been tried but few have been consistently successful. Fluoxetine has been prescribed with limited success (Hollander et al, 1990) and the only controlled trial to date showed that clomipramine was effective in some patients (Simeon et al, 1998b). Lamotrigine, an anticonvulsant that blocks voltage-dependent sodium channels and inhibits glutamate release, is useful not only in the treatment of epilepsy, but also resistant bipolar disorder.

Furthermore, lamotrigine has largely been demonstrated to reduce the intensity of depersonalization-like symptoms induced by sub-anaesthetic doses of ketamine, a N-methyl-D-aspartate reception antagonist that also induces glutamate release (Anand et al, 2000). Given this background, we have conducted a placebocontrolled, double-blind treatment trial with lamotrigine in 12 patients suffering from DPD. Results will be reported shortly. Open clinical use has yielded promising results with a combination of lamotrigine and antidepressant medication. We have also attempted to develop non-pharmacological interventions. Published clinical research in this area has largely been limited to case studies of psychodynamic psychotherapy and behaviour therapy that claimed some success in alleviating symptoms.

Cognitive-behaviour therapy (CBT) has been found to be highly effective in the treatment of a wide variety of psychiatric disorders, but to our knowledge no studies of CBT have been conducted with DPD. A study is currently being conducted with patients who have been referred to the unit to assess the efficacy of CBT for this disorder. In the majority of cases the depersonalization has resulted in unemployment, social avoidance and low mood. In the initial phase of treatment, techniques are employed that are nonspecific to the depersonalization, but which aim to increase activity, motivation and mood (e.g.,activity scheduling, graded exposure to social situations and challenging negative automatic thoughts through the use of cognitive diaries). Comorbid disorders, such as panic or obsessive-compulsive disorders, are addressed during this initial phase.

The final phase of therapy involves the use of more specific interventions. In many patients depersonalization seems to develop as a coping mechanism to avoid painful negative emotions, which may have arisen from a variety of traumatic or aversive situations. The resulting avoidance of emotional arousal appears to lead to a global blunting of emotional response. Many sufferers state that a major goal of treatment is to regain the ability to experience emotions. Treatment involves enabling the patient to gain confidence in experiencing negative emotions by the grading of exposure to emotional arousal.

A second intervention, attention training (Wells et al, 1997), specifically addresses alterations in attentional focus that are apparent in depersonalization, and that may act as maintaining factors. Attention training consists of exercises in switching, dividing and selecting attention to encourage control and focus to external, rather than internal, stimuli. This outward shift in attention may also improve the sense of connection to the external world, which people suffering from depersonalization often lack.

Preliminary results appear promising, with improvements in general functioning and depersonalization severity. The establishment of the depersonalization research unit clinic has served to focus a multi-disciplinary research effort towards this under-researched psychiatric disorder. In particular, we are now in a position to report research findings that further our understanding of the neurobiological basis of the disorder and the control and subjective experience of emotional responses in general. We are also beginning to be able to offer specific treatments for patients suffering from one or more of the symptoms of depersonalization, which will soon be amenable to controlled evaluation.

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BEST PRACTICES PERTAINING TO CONCURRENT DISORDERS

Two new publications on concurrent disorders have recently been posted on the Health Canada website. "Best Practices: Concurrent Mental Health and Substance Use Disorders," provides an updated synthesis of the research information and offers specific recommendations for the screening, assessment, and treatment/support of this population. It is intended to be a resource for managers and staff of mental health, substance abuse, and integrated mental health/substance abuse services, as well as for individual practitioners in the community who are faced with the challenges of providing good quality service to people presenting with concurrent mental health and substance use disorders. It can be found at
http://www.hc-sc.gc.ca/hppb/cds-sca/cds/pdf/concurrentbestpractice.pdf

"National Program Inventory: Concurrent Mental Health and Substance Use Disorders" is a national inventory of specialized concurrent disorders programs and serves as a companion to the first document. It contains information from 37 agencies that provide services to individuals with concurrent disorders, including geographic area served, services provided, types of interventions, fee for service and inclusion/exclusion criteria and can be found at
http://www.hc-sc.gc.ca/hppb/cds-sca/cds/pdf/e522_hc_proginventory-e.pdf ■

Guest Column: The Effect of a Son's Mental Illness on a Family

By: Ann Howarth-Wiles

Five years ago, at the age of fifteen, our son tried to take his life. So began a four-year journey into the world of mental illness: meetings with psychiatrists and psychologists, weeks and months spent on the adolescent psychiatric ward, encounters with the confusing world of medications; and a journey into our own self awareness and identities.

As parents of four older children all of whom had gone through typical adolescent problems, my husband and I were nevertheless unprepared for this situation. My first reaction was one of guilt- what had I, as a mother, done that would make my child think that life was so worthless? Perhaps my son had been traumatized as a child while in daycare or at school and was now suffering from post-traumatic stress? Maybe I hadn't parented him properly because my job had involved a lot of travel and several assignments in different countries? This guilt was reinforced by my extended family. With little knowledge of mental illness, their only answer was simply to blame the mother. Or perhaps the blame should be with the child himself? Perhaps there was something the matter with him? "All teenagers get depressed." I thought, "I should just tell him to pull himself up by his boot straps!"

Later, guilt turned to anger-— kids whom I had seen professionally in refugee camps had undergone indescribable horrors but nevertheless clung to life- how could my son, my son who had everything, reject life?

There were no easy answers. Or, perhaps we didn't know what questions to ask?

Few of the professionals consulted with us on our son's background or past health history. He was sent home after one attempt with medication, with no direction as to what we should do. Within days he was re-admitted; he had overdosed on the medication. Thus began a series of "experiments" as chemical answers were sought to the mystery of his depression. I had never taken more than an Aspirin myself, so I was frightened by the potential negative impact of all of the medications. We were told at the time that this was the only answer – we would lose him if we didn't take this route.

As my son took the various drugs, we watched him gain forty pounds in a month, need support because "the floors were moving", or become totally apathetic and passive.

Concurrently, as an inpatient, he attended group sessions with other kids on the psychiatric ward. Among them, many were also severely psychologically disturbed (several having been sexually or otherwise abused, others suffering from first episodes of schizophrenia). I thought at the time that if anything would convince my son that life was not worth living –this exposure to the dark side would.

The most difficult times for us were when hospital staff seemed to blame our parenting skills and when they would restrict our visits. Given the ultimate diagnosis, I really believe that this attitude was inappropriately negative and added to our family's stress, at a time when our son needed his family the most.

On those few occasions when he was sent home for day passes, we felt as if we had been handed a ticking time bomb. We were not given much notice of the day passes and often we felt that time at home for our son was for hospital convenience. We were fortunate though in that both parents were available and our financial situation permitted me to, eventually, resign my job. We spent countless days on suicide watch, sometimes taking him back to the hospital because he felt "unsafe." There was no respite. When you have a severely ill child, it is normally a time that you can expect friends and family to rally around – I felt as if my child was dying- but how do you explain to people that "chemical depression" (the diagnosis at that time) is just as much a critical illness as cancer? Our sense of impotence was reinforced by his total rejection of us. We were told to keep hanging on – that this was his attempt to separate from everything important which would keep him alive.

We continued to get many different and conflicting messages and very little recognition that we, as a family, had a major role to play in the successful treatment of our son.

We became as educated as is possible for laypersons – every new medication was carefully researched on Medscape, all the psychiatric journals and conferences were reviewed for the latest information. We reviewed information from "Centers of Excellence" for treating youth mental illness. Our questions were not always well received by some of the treating doctors. They seemed to feel undermined by our need to know, rather than to accept that we were trying to be responsible and educated supporters of our child. We were encouraged to agree to ECT, and our son by this time was willing to do anything to get better but, in the end, we refused the ECT and insisted on an alternative consultation.

Three years after the initial suicide attempt, our son was diagnosed as Bipolar 2. Following this diagnosis various new drug protocols were attempted until finally he was stabilized. Although there were many difficulties, we believe that without the dedication of many of the healthcare professionals (and there were many who went beyond the necessary) he would not be alive today.

Today when people ask how he is doing, we say fine…. for now. We know he has a chronic illness. He is starting university, having overcome the years when he was unable to attend regular school, or even read because of the effects of various drugs and the pervasive desire to die. For now, we have every confidence in his ability to manage his illness.

Our experience with youth mental illness has changed our lives radically. Constant care of a suicidal youth can destroy marriages, financially undermine a family, and cause serious problems for siblings. I believe strongly that parents of children and youth facing chemical brain illness need as much support as those facing other life threatening physical illness, perhaps more, because society still stigmatizes mental illness. This is why I formed Parents Lifelines of Eastern Ontario (PLEO).

Our aim is to help families deal with the challenges of mental illness and give them some hope. We help to identify the (extremely limited) support available within the community, to advocate and work cooperatively with health professionals for improved care, and ultimately to contribute to strengthening the family unit in order that these children can be cared for at home and do not end up on the street or in the penal system. We believe that some positive changes have already begun to take place.

While we recognize the need for confidentiality between a patient and medical professional we strongly believe that treating psychiatrists have a crucial role to play in ensuring that the child/youth receives the full benefit of a supportive

continued on page 24

See an anxiety disorder. Look for depression. And vice versa. You'll find up to 70% of patients could have a comorbid condition.[1-3] Which can make treatment more difficult.[4] Relapse more likely.[5] And an appropriate choice of therapy, very important. PAXIL®. No other antidepressant has more indications.[6] Look for The PAXIL® Spectrum in every patient. When you treat one, treat them all. PAXIL®. See why it's the #1 prescribed SSRI in Canada.[7]

PAXIL® is indicated for the symptomatic relief of Depression (benefits observed for up to six months in moderate to moderately severe patients); Panic Disorder (with or without agoraphobia); Generalized Social Anxiety Disorder (persistent fear; anxious anticipation or avoidance of multiple social situations and/or performance situations) – this diagnosis should not be made unless symptoms interfere significantly with a person's routine, job or social life or cause marked distress; Obsessive-Compulsive Disorder – the obsessions or compulsions must be experienced as intrusive, markedly distressing, time consuming or significantly interfering with the person's social or occupational functioning and Generalized Anxiety Disorder (the anxiety causes significant distress in patients).

PAXIL® shares the tolerability profile of other SSRIs with nausea, somnolence and asthenia being the most common adverse effects. For elderly patients or patients with renal/hepatic impairment, dosage should be restricted to the lower ranges.

PAXIL® is contraindicated in patients currently receiving an MAO inhibitor or within 2 weeks of discontinuing an MAO inhibitor. PAXIL® is also contraindicated in patients receiving thioridazine. Please consult the product monograph for full prescribing information.

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Paxil® Once a day paroxetine HCl

Finding a way out

Paroxetine Hydrochloride Tablets
paroxetine 10 mg, 20 mg and 30 mg
Therapeutic Classification:
Antidepressant – Antiobsessional – Antipanic – Anxiolytic Agent – Social Phobia (Social Anxiety Disorder) – Posttraumatic Stress Disorder Therapy

CLINICAL TRIALS: Generalized Anxiety Disorder: The effectiveness of PAXIL® in the treatment of Generalized Anxiety Disorder (GAD) (DSM IV) was demonstrated in two 8-week, multicenter, placebo-controlled studies. One trial was a flexible dose (20-50 mg/day) study while the other was a multiple fixed dose (20 or 40 mg/day) study. In both studies PAXIL® demonstrated statistically significant superiority over placebo on the primary outcome measure – the Hamilton Rating Scale for Anxiety (HAM-A) total score, and on a number of secondary outcomes including the HAM-A anxiety and tension items, the Clinical Global Impression (CGI) responder criterion and the Sheehan Disability Scale (SDS). An additional 8-week flexible dose study did not demonstrate a significant difference between PAXIL® (20-50 mg/day), and placebo on the primary outcome measure. However, PAXIL® (20-50 mg/day) was more effective than placebo on many secondary study outcomes. **Posttraumatic Stress Disorder:** The efficacy of PAXIL® in the treatment of Posttraumatic Stress Disorder (PTSD) was demonstrated in two 12-week, multicenter placebo-controlled studies (Study 1 and Study 2) in adult patients who met the DSM-IV criteria for PTSD. Study outcome was assessed by (i) the Clinician Administered PTSD Scale Part (CAPS-2) score and (ii) the Clinical Global Impression Global Improvement Item (CGI-I). The CAPS-2 is a multi-item instrument that measures the three PTSD diagnostic symptom clusters of: reexperiencing/intrusion, avoidance/numbing and hyperarousal. The two primary outcomes for each trial were (i) change from baseline to endpoint on the CAPS-2 total score (17 items), and (ii) proportion of responders on the CGI-I, where responders were defined as patients having a score of 1 (very much improved) or 2 (much improved).Study 1 was a 12-week study comparing fixed paroxetine doses of 20 mg or 40 mg/day to placebo. PAXIL® 20 mg and 40 mg were demonstrated to be significantly superior to placebo for the CAPS-2 total score, and on proportion of responders on the CGI-I. Study 2 was a 12-week flexible-dose study comparing paroxetine (20 mg to 50 mg daily) to placebo. PAXIL® was demonstrated to be significantly superior to placebo for the CAPS-2 total score, and on proportion of responders on the CGI-I. The majority (66-68%) of patients in these trials were women. Subgroup analyses did not indicate differences in treatment outcomes as a function of gender. There were an insufficient number of patients who were 65 years or older or were non-Caucasian to conduct subgroup analyses on the basis of age or race, respectively.

INDICATIONS AND CLINICAL USE: Depression: PAXIL® (paroxetine) is indicated for symptomatic relief of depressive illness. Clinical trials have provided evidence that continuation treatment with PAXIL® in patients with moderate to moderately severe depressive disorder is effective for at least 6 months. **Obsessive-Compulsive Disorder:** PAXIL® (paroxetine) is indicated for the symptomatic treatment of obsessive-compulsive disorder (OCD). The obsessions or compulsions must be experienced as intrusive, markedly distressing, time-consuming, or interfering significantly with the person's social or occupational functioning. **Panic Disorder:** PAXIL® (paroxetine) is indicated for the symptomatic treatment of panic disorder, with or without agoraphobia. **Social Phobia (Social Anxiety Disorder):** PAXIL® is indicated for the symptomatic relief of generalized social phobia (social anxiety disorder), a disorder characterized by marked and persistent fear, anxious anticipation, or avoidance of multiple social situations (e.g. interacting with strangers, attending social gatherings, dealing with authority figures) and/or performance situations (e.g. eating, writing, working while being observed, or public speaking). A diagnosis of social phobia/social anxiety disorder should not be made unless the fear, anxious anticipation, or avoidance of social and/or performance situations interferes significantly with the person's normal routine, occupational functioning, or social life, or causes marked distress. **Generalized Anxiety Disorder:** PAXIL® is indicated for the symptomatic relief of anxiety causing significant distress in patients with Generalized Anxiety Disorder (GAD). **Posttraumatic Stress Disorder:** PAXIL® is indicated for the symptomatic treatment of posttraumatic stress disorder (PTSD). PTSD as defined by DSM-IV requires exposure to a traumatic event that involved actual or threatened death or serious injury, or threat to the physical integrity of self or others, and a response which involves intense fear, helplessness, or horror. Symptoms that occur as a result of exposure to the traumatic event include reexperiencing of the event in the form of intrusive thoughts, flashbacks or dreams, and intense psychological distress and physiological reactivity on exposure to clues to the event; avoidance of situations reminiscent of the traumatic event, inability to recall details of the event, and/or numbing of general responsiveness manifested as diminished interest in significant activities, estrangement from others, restricted range of affect, or sense of foreshortened future; and symptoms of autonomic arousal including hypervigilance, exaggerated startle response, sleep disturbance, impaired concentration, and irritability or outbursts of anger. A diagnosis of PTSD requires that the symptoms are present for at least one month and that they cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. **Long-term use of PAXIL®:** The effectiveness of PAXIL® in long-term use (i.e. more than 8 weeks for GAD and 12 weeks for other indications) has not yet been established in controlled trials for OCD, panic disorder, social phobia (social anxiety disorder) generalized anxiety disorder and posttraumatic stress disorder. Therefore, the physician who elects to use PAXIL® for extended periods in these indications should periodically re-evaluate the long-term usefulness of the drug for individual patients.

Table 3 Treatment-Emergent Adverse Events in Short Term Flexible Dose Placebo-Controlled Clinical Trials in Depression[1]

Body System	Preferred Term	Paroxetine (n=421)	Placebo (n=421)
Body as a whole	Headache	17.6%	17.3%
	Asthenia	15.0%	5.9%
	Abdominal Pain	3.1%	4.0%
	Fever	1.7%	1.7%
	Chest Pain	1.4%	2.1%
	Trauma	1.4%	0.5%
	Back Pain	1.2%	2.4%
Cardiovascular	Palpitation	2.9%	1.4%
	Vasodilation	2.6%	0.7%
	Postural Hypotension	1.2%	0.5%
Dermatological	Sweating	11.2%	2.4%
	Rash	1.7%	0.7%
Gastrointestinal	Nausea	25.7%	9.3%
	Dry Mouth	18.1%	12.1%
	Constipation	13.8%	8.6%
	Diarrhea	11.6%	7.6%
	Decreased Appetite	6.4%	1.9%
	Flatulence	4.0%	1.7%
	Vomiting	2.4%	1.7%
	Oropharynx Disorder[2]	2.1%	0.0%
	Dyspepsia	1.9%	1.0%
	Increased Appetite	1.4%	0.5%
Musculoskeletal	Myopathy	2.4%	1.4%
	Myalgia	1.7%	0.7%
	Myasthenia	1.4%	0.2%
Nervous System	Somnolence	23.3%	9.0%
	Dizziness	13.3%	5.5%
	Insomnia	13.3%	6.2%
	Tremor	8.3%	1.9%
	Nervousness	5.2%	2.6%
	Anxiety	5.0%	2.9%
	Paresthesia	3.8%	1.7%
	Libido Decreased	3.3%	0.0%
	Agitation	2.1%	1.9%
	Drugged Feeling	1.7%	0.7%
	Myoclonus	1.4%	0.7%
	CNS Stimulation	1.2%	3.6%
	Confusion	1.2%	0.2%
Respiration	Respiratory Disorder[3]	5.9%	6.4%
	Yawn	3.8%	0.0%
	Pharyngitis	2.1%	2.9%
Special Senses	Blurred Vision	3.6%	1.4%
	Taste Perversion	2.4%	0.2%
Urogenital System	*Abnormal Ejaculation†	12.9%	0.0%
	*Male Genital Disorders[4]	8.0%	0.0%
	Urinary Frequency	3.1%	0.7%
	Urination Impaired[5]	2.9%	0.2%
	*Impotence	2.5%	0.5%
	*Female Genital Disorders[6]	1.8%	0.0%

1 Events reported by at least 1% of patients treated with PAXIL® are included. * Percentage corrected for gender Placebo: male, n=206 female, n=215 Paroxetine: male, n=201 female, n=220 †Primarily ejaculatory delay. In a trial of fixed doses of paroxetine, the incidence of ejaculatory disturbance in males with 20 mg per day of paroxetine was 6.5% (3/46) versus 0% (0/23) in the placebo group. 2 Includes mostly lump in throat and tightness in throat. 3 Includes mostly cold symptoms or URI. 4 Includes anorgasmia, erectile difficulties, delayed ejaculation/orgasm sexual dysfunction and impotence. 5 Includes difficulty with micturition and urinary hesitancy. 6 Includes anorgasmia and difficulty reaching climax/orgasm.

CONTRAINDICATIONS: Hypersensitivity: PAXIL® (paroxetine) is contraindicated in patients who are known to be hypersensitive to the drug or any of its components. **Monoamine Oxidase Inhibitors:** In patients receiving another serotonin reuptake inhibitor drug in combination with a MAO inhibitor, there have been reports of serious, sometimes fatal, reactions including hyperthermia, rigidity, myoclonus, autonomic instability with possible rapid fluctuations of vital signs, and mental status changes that include extreme agitation progressing to delirium and coma. These reactions have also been reported in patients who have recently discontinued that drug and have begun treatment on a MAO inhibitor. Some cases presented with features resembling neuroleptic malignant syndrome. Therefore, PAXIL® should not be used in combination with MAO inhibitors or within 2 weeks of terminating treatment with MAO inhibitors. Treatment with PAXIL® should then be initiated cautiously and dosage increased gradually until optimal response is reached. MAO inhibitors should not be introduced within 2 weeks of cessation of therapy with PAXIL®. **Thioridazine:** Thioridazine administration alone produces prolongation of the QTc interval, which is associated with serious ventricular arrhythmias, such as torsade de pointes-type arrhythmias, and sudden death. This effect appears to be dose-related. An *in vivo* study suggests that drugs which inhibit P450 IID_6, including certain SSRI's such as paroxetine, fluoxetine and fluvoxamine, will elevate plasma levels of thioridazine. Therefore, PAXIL® should not be used in combination with thioridazine.

PRECAUTIONS: Suicide: The possibility of a suicide attempt is inherent in depression and may persist until remission occurs. Therefore, high risk patients should be closely supervised throughout therapy with appropriate consideration to the possible need for hospitalization. In order to minimize the opportunity for overdosage, prescriptions for PAXIL® (paroxetine) should be written for the smallest quantity of drug consistent with good patient management. Because of the well established comorbidity between depression and other psychiatric disorders, the same precautions observed when treating patients with depression should be observed when treating patients with other psychiatric disorders. **Epilepsy:** As with other antidepressants, PAXIL® should be used with caution in patients with epilepsy. **Seizures:** During clinical trials, the overall incidence of seizures was 0.15% in patients treated with PAXIL®. However, patients with a history of convulsive disorders were excluded from these studies. Caution is recommended when the drug is administered to patients with a history of seizures. The drug should be discontinued in any patient who develops seizures. **Activation of Mania/Hypomania:** During clinical testing in depressed patients, approximately 1% of PAXIL®-treated patients experienced manic reactions. When bipolar patients were considered as a sub-group the incidence of mania was 2%. As with other Selective Serotonin Reuptake Inhibitors (SSRIs), PAXIL® should be used with caution in patients with a history of mania. **Discontinuation of Treatment with PAXIL®:** When discontinuing treatment, regardless of the indication for which PAXIL® is being prescribed, patients should be monitored for symptoms which may be associated with discontinuation (e.g. dizziness, abnormal dreams, sensory disturbances (including paresthesias and electric shock sensations), agitation, anxiety, nausea, vomiting and sweating or other symptoms which may be of clinical significance, see ADVERSE REACTIONS). A gradual reduction in the dose rather than abrupt cessation is recommended whenever possible. If intolerable symptoms occur following a decrease in the dose or upon discontinuation of treatment, dose titration should be managed on the basis of the patient's clinical response. (See ADVERSE REACTIONS and DOSAGE and ADMINISTRATION). **Occupational Hazards:** Although paroxetine did not cause sedation or interfere with psychomotor performance in placebo-controlled studies in normal subjects, patients should be advised to avoid driving a car or operating hazardous machinery until they are reasonably certain that PAXIL® does not affect them adversely. **Use in Patients with Concomitant Illness: General:** Clinical experience with PAXIL® in patients with certain concomitant systemic illnesses is limited. Caution is advisable in using PAXIL® in patients with diseases or conditions that could affect metabolism or hemodynamic responses. **Cardiac Conditions:** PAXIL® has not been evaluated or used to any appreciable extent in patients with a recent history of myocardial infarction or unstable heart disease. The usual precautions should be observed in patients with cardiac conditions. **Electroconvulsive Therapy (ECT):** The efficacy and safety of the concurrent use of PAXIL® and ECT have not been studied. **Use in Elderly:** Administration of PAXIL® to the elderly is associated with increased plasma levels and prolongation of the elimination half-life relative to younger adults. Elderly patients should be initiated and maintained at the lowest daily dose of paroxetine which is associated with clinical efficacy. Approximately 800 elderly patients (≥65 years) have been treated with PAXIL® in worldwide premarketing clinical trials. The pattern of adverse experiences in the elderly was comparable to that in younger patients. **Children:** The safety and effectiveness of PAXIL® in children under 18 years of age have not been established. **Pregnancy and Lactation:** Although animal studies have not shown any teratogenic or selective embryotoxic effects, the safety of PAXIL® in human pregnancy has not

Table 4 Treatment-Emergent Adverse Experience Incidence in Placebo-Controlled Clinical Trials for Obsessive-Compulsive Disorder, Panic Disorder, Social Phobia (Social Anxiety Disorder), Generalized Anxiety Disorder and Posttraumatic Stress Disorder .[1]

		Obsessive-Compulsive Disorder		Panic Disorder		Social Phobia (Social Anxiety Disorder)		Generalized Anxiety Disorder		Posttraumatic Stress Disorder	
Body system	Preferred Term	PAXIL® (n=542)	Placebo (n=265)	PAXIL® (n=469)	Placebo (n=324)	PAXIL® (n=425)	Placebo (n=339)	PAXIL® (n=735)	Placebo (n=529)	PAXIL® (n=676)	Placebo (n=504)
Body as a Whole	Headache	25.3%	29.1%	25.4%	25.3%	22.4%	21.8%	16.9%	14.0%	18.9%	19.2%
	Asthenia	21.8%	13.6%	13.6%	4.6%	22.4%	13.6%	14.3%	6.4%	11.8%	4.2%
	Infection	5.4%	4.9%	5.3%	6.8%	3.8%	5.9%	5.6%	3.4%	4.9%	3.8%
	Abdominal Pain	4.8%	4.9%	4.3%	3.1%	2.1%	4.7%	4.5%	3.6%	4.3%	3.2%
	Chest Pain	2.8%	1.9%	2.3%	3.1%	0.7%	0.3%	1.0%	0.6%	1.2%	0.8%
	Back Pain	2.4%	4.9%	3.2%	2.2%	1.6%	4.1%	2.3%	3.6%	3.4%	3.4%
	Chills	2.0%	0.8%	2.3%	0.6%	0.2%	0.3%	1.0%	0.0%	0.1%	0.4%
	Trauma	3.1%	3.8%	3.6%	3.7%	2.6%	0.9%	2.6%	3.4%	5.8%	5.2%
	Vasodilation	3.9%	1.1%	2.1%	2.8%	1.4%	0.6%	2.7%	0.8%	2.2%	1.2%
Cardiovascular	Palpitation	2.0%	0.4%	2.3%	2.5%	1.2%	1.8%	1.1%	1.1%	1.0%	0.8%
Dermatologic	Sweating	8.9%	3.0%	14.3%	5.9%	9.2%	2.1%	6.3%	1.5%	4.6%	1.4%
	Rash	3.1%	1.9%	2.3%	1.5%	0.7%	0.3%	1.5%	0.9%	1.5%	2.0%
Gastrointestinal	Nausea	23.2%	9.8%	22.8%	17.3%	24.7%	6.5%	20.1%	5.3%	19.2%	8.3%
	Dry Mouth	18.1%	8.7%	18.1%	10.8%	8.9%	2.9%	10.9%	4.7%	10.1%	4.8%
	Constipation	15.7%	6.4%	7.9%	5.2%	5.4%	1.8%	10.5%	1.7%	5.5%	3.4%
	Diarrhea	10.3%	9.8%	11.7%	6.5%	8.5%	5.9%	9.1%	6.6%	10.5%	5.4%
	Decreased Appetite	9.0%	3.4%	7.0%	2.8%	7.8%	1.5%	5.2%	1.1%	5.9%	2.6%
	Dyspepsia	3.9%	6.8%	3.8%	6.8%	4.0%	2.4%	4.5%	4.9%	4.6%	3.4%
	Flatulence	3.0%	4.2%	1.7%	2.8%	4.0%	2.4%	1.4%	2.1%	1.0%	1.0%
	Increased Appetite	4.2%	3.0%	2.1%	0.6%	1.2%	1.8%	0.4%	1.1%	1.5%	1.0%
	Vomiting	2.2%	3.4%	1.9%	1.5%	2.4%	0.6%	2.7%	2.5%	3.0%	2.0%
	Myalgia	3.1%	3.8%	2.3%	3.4%	4.0%	2.7%	2.9%	2.6%	1.8%	1.8%
Musculoskeletal	Somnolence	24.4%	7.2%	18.8%	10.8%	21.6%	5.3%	15.4%	4.5%	16.0%	4.6%
Nervous System	Insomnia	23.8%	13.2%	17.9%	10.2%	20.9%	15.9%	10.7%	7.9%	11.8%	11.3%
	Dizziness	12.4%	6.0%	14.1%	9.9%	11.3%	7.1%	6.1%	4.5%	6.1%	4.6%
	Tremor	10.5%	1.1%	8.5%	1.2%	8.7%	1.2%	4.6%	0.8%	4.3%	1.4%
	Nervousness	8.5%	8.3%	7.9%	8.3%	7.5%	6.5%	3.9%	2.8%	3.0%	4.4%
	Libido Decreased	7.2%	3.8%	8.5%	1.2%	11.5%	0.9%	9.4%	1.5%	5.2%	1.8%
	Anxiety	4.1%	6.8%	4.5%	4.0%	4.7%	4.1%	1.6%	0.9%	3.8%	4.0%
	Abnormal Dreams	3.9%	1.1%	2.8%	3.4%	1.9%	1.5%	0.5%	1.1%	2.5%	1.6%
	Myoclonus	3.3%	0.4%	3.2%	1.5%	2.1%	0.9%	1.6%	0.6%	1.0%	0.6%
	Concentration Impaired	2.8%	1.5%	1.1%	0.9%	3.5%	0.6%	1.1%	0.6%	1.5%	1.0%
	Depersonalization	2.6%	0.4%	1.7%	2.2%	0.7%	0.9%	0.7%	0.0%	0.9%	0.2%
	Amnesia	2.2%	1.1%	0.6%	0.0%	0.5%	0.3%	0.4%	0.6%	1.3%	1.0%
	Hyperkinesia	2.2%	1.5%	0.9%	0.9%	1.2%	0.0%	0.8%	0.0%	1.3%	0.2%
	Agitation	1.7%	2.3%	4.7%	3.7%	2.6%	0.9%	1.8%	1.1%	1.9%	3.2%
	Pharyngitis	3.7%	4.9%	3.2%	3.1%	3.8%	2.1%	2.3%	2.1%	2.4%	2.2%
Respiratory System	Rhinitis	1.5%	3.4%	2.6%	0.3%	1.2%	3.2%	1.5%	1.1%	1.0%	2.0%
	Sinusitis	1.5%	4.9%	5.8%	4.6%	2.1%	2.4%	3.5%	3.4%	3.8%	4.4%
	Yawn	1.7%	0.4%	1.9%	0.0%	4.9%	0.3%	4.2%	0.2%	2.1%	0.2%
	Cough Increased	1.1%	1.9%	2.3%	1.5%	0.7%	0.9%	0.8%	0.8%	1.2%	0.6%
	Respiratory Disorder[1]	–	–	–	–	–	–	6.8%	5.1%	3.3%	1.0%
Special Senses	Abnormal Vision	3.7%	2.3%	3.0%	2.8%	4.0%	0.3%	2.2%	0.6%	0.3%	0.0%
	Taste Perversion	2.0%	0.0%	1.1%	0.6%	0.7%	0.6%	0.7%	0.8%	0.7%	0.8%
	Abnormal Ejaculation[2]	23.3%	1.3%	20.5%	0.9%	27.6%	1.1%	24.7%	2.0%	12.6%	1.6%
Urogenital System	Dysmenorrhea[2]	1.4%	1.9%	2.0%	2.3%	4.6%	4.4%	1.3%	1.2%	1.6%	1.3%
	Impotence[2]	8.2%	1.3%	5.4%	0.0%	5.3%	1.1%	4.2%	3.0%	9.2%	0.5%
	Female Genital Disorders[1,3]	3.3%	0.0%	8.9%	0.5%	8.6%	0.6%	4.4%	0.6%	4.8%	0.6%
	Urinary Frequency	3.3%	1.1%	2.1%	0.3%	1.6%	1.8%	1.0%	0.6%	1.0%	0.2%
	Urination Impaired	3.3%	0.4%	0.4%	0.3%	1.9%	0.0%	1.0%	0.0%	0.6%	0.0%
	Urinary Tract Infection	1.5%	1.1%	2.1%	1.2%	0.2%	1.2%	1.2%	1.1%	0.6%	0.8%

1 Events reported by at least 2% of either OCD, Panic Disorder, Social Phobia (Social Anxiety Disorder), Generalized Anxiety Disorder or Posttraumatic Stress Disorder PAXIL®-treated patients are included, except the following events which had an incidence on placebo ≥ PAXIL®: [OCD]: depression, paraesthesia, and respiratory disorder. [Panic Disorder]: flu syndrome, depression, paraesthesia, respiratory disorder. [Social Phobia (Social Anxiety Disorder)]: depression, respiratory disorder. [Generalized Anxiety Disorder]: not applicable, [Posttraumatic Stress Disorder]: depression, respiratory disorder. 2 Incidence is gender-corrected. OCD: Placebo: male, n=158; female, n=107 Paroxetine: male, n=330; female, n=212 PANIC: Placebo: male, n=111; female, n=213 Paroxetine: male, n=166; female, n=303 SOCIAL PHOBIA (SOCIAL ANXIETY DISORDER): Placebo: male, n=180; female, n=159 Paroxetine: male, n=228; female, n=197 GENERALIZED ANXIETY DISORDER: Placebo: male, n=197; female, n=332 Paroxetine: male, n=283; female, n=452 POSTTRAUMATIC STRESS DISORDER: Placebo: male, n=190; female, n=314 Paroxetine: male, n=238; female, n=438. 3 Includes anorgasmia and difficulty reaching climax/orgasm.

been established. PAXIL® should not be used during pregnancy unless the potential benefit to the patient outweighs the possible risk to the fetus. The concentrations of paroxetine detected in the breast milk of lactating women are similar to those in plasma. Lactating women should not nurse their infants while receiving paroxetine unless in the opinion of the treating physician, breast feeding is necessary, in which case the infant should be closely monitored. **Renal Impairment:** Since PAXIL® is extensively metabolized by the liver, excretion of unchanged drug in urine is a minor route of elimination. However, single dose pharmacokinetic studies in subjects with clinically significant renal impairment suggest that plasma levels of paroxetine are elevated in such subjects. Paroxetine should therefore be used with caution and the dosage restricted to the lower end of the range in patients with clinically significant renal impairment. **Hepatic Impairment:** Pharmacokinetic studies of PAXIL® in subjects with clinically significant hepatic impairment suggest that prolongation of the elimination half-life and increased plasma levels can be expected in this patient group. PAXIL® should be used with caution and dosages restricted to the lower end of the range in patients with clinically significant hepatic impairment. **Hyponatremia:** Several cases of hyponatremia have been reported. The hyponatremia appeared to be reversible when PAXIL® was discontinued. The majority of these occurrences have been in elderly individuals, some in patients taking diuretics or who were otherwise volume depleted. **Abnormal Bleeding:** There have been several reports of abnormal bleeding (mostly ecchymosis) associated with paroxetine treatment, including a report of impaired platelet aggregation. While a causal relationship to paroxetine is unclear, impaired platelet aggregation may result from platelet serotonin depletion and contribute to such occurrences. Skin and mucous membrane bleedings have been reported following treatment with paroxetine. Paroxetine should therefore be used with caution in patients concomitantly treated with drugs that give an increased risk for bleeding (e.g. anticoagulants, nonsteroidal anti-inflammatories and ASA) and in patients with a known tendancy for bleeding or those with predisposing conditions. **Glaucoma:** As with other SSRIs, PAXIL® infrequently causes mydriasis and should be used with caution in patients with narrow angle glaucoma. **Neuroleptic Malignant Syndrome:** As with other SSRIs, PAXIL® should be used with caution in patients already receiving neuroleptics, since symptoms suggestive of Neuroleptic Malignant Syndrome cases have been reported with this combination.

Drug Interactions: Monoamine Oxidase Inhibitors: See CONTRAINDICATIONS. **Thioridazine:** See CONTRAINDICATIONS. **Drugs Metabolized by Cytochrome P450(CYP2D6):** Like some other selective serotonin reuptake inhibitors, paroxetine inhibits the specific hepatic cytochrome P450 isozyme CYP2D6 which is responsible for the metabolism of debrisoquine and sparteine. Poor metabolizers of debrisoquine/sparteine represent approximately 5-10% of Caucasians. The median C_{min}(ss) for PAXIL® (20 mg daily) at steady state in poor metabolizers (n=8) was almost triple that reported for extensive metabolizers (n=9). Although the full clinical significance of this effect has not been established, inhibition of CYP2D6 can lead to elevated plasma levels of co-administered drugs which are metabolized by this isozyme. In two studies, daily dosing of PAXIL® (20 mg qd) under steady state conditions increased the following mean pharmacokinetic parameters for a single (100 mg) dose of *desipramine* in extensive metabolizers: C_{max} (2 fold), AUC (6 fold), and $T_{1/2}$ (3-5 fold). Concomitant steady-state PAXIL® treatment did not result in any further impairment of *desipramine* elimination in poor metabolizers. Insufficient information is available to provide recommendations on the necessary dosage adjustments for tricyclic antidepressants or PAXIL®, if these drugs are to be used in combination. Plasma tricyclic antidepressant concentrations may need to be monitored in such instances. Concomitant use of PAXIL® with other drugs metabolized by CYP2D6 has not been formally studied but may require lower doses than usually prescribed for either PAXIL® or the other drug. Drugs metabolized by CYP2D6 include certain tricyclic antidepressants (e.g. *nortriptyline, amitriptyline, imipramine and desipramine)*, selective serotonin reuptake inhibitors (e.g. *fluoxetine*), phenothiazine neuroleptics (e.g. *perphenazine*) Type IC antiarrhythmics (e.g. *propafenone, and flecainide*) and metoprolol. Due to the risk of serious ventricular arrhythmias and sudden death potentially associated with elevated plasma levels of thioridazine, PAXIL® and thioridazine should not be co-administered (see CONTRAINDICATIONS). **Drugs Metabolized by Cytochrome P450 (CYP3A4):** An *in vivo* interaction study involving the co-administration under steady state conditions of PAXIL® and *terfenadine*, a substrate for CYP3A4, revealed no effect of PAXIL® on *terfenadine* pharmacokinetics. In addition, *in vitro* studies have shown *ketoconazole*, a potent inhibitor of CYP3A4 activity, to be at least 100 times more potent than paroxetine as an inhibitor of the metabolsim of several substrates for this enzyme, including *terfenadine, astemizole, cisapride, triazolam* and *cyclosporin*. Based on the assumption that the relationship between paroxetine's *in vitro* Ki and its lack of effect on *terfenadine's in vivo* clearance predicts its effect on other CYP3A4 substrates, paroxetine's extent of inhibition of CYP3A4 activity would not be expected to be of clinical significance. **Serotonergic Drugs:** As with other SSRIs, co-administration with serotonergic drugs (e.g. MAO inhibitors (see CONTRAINDICATIONS), L-tryptophan) may lead to an incidence of 5–HT associated effects (Serotonergic Syndrome; see ADVERSE REACTIONS). **CNS Drugs:** Experience in a limited number of healthy subjects has shown that PAXIL® does not increase the sedation and drowsiness associated with *haloperidol, amylbarbitone or oxazepam*, when given in combination. Since the effects of concomitant administration of PAXIL® with neuroleptics have not been studied, the use of PAXIL® with these drugs should be approached with caution. **Food/Antacids:** The absorption and pharmacokinetics of PAXIL® are not affected by food or antacids. **Cardiovascular Drugs:** Multiple dose treatment with PAXIL® 30 mg/day has little or no effect on the steady-state pharmacokinetics of *digoxin* (0.25 mg qd) or *propanolol* (80 mg bid). **Microsomal Enzyme Inhibition/Induction:** The metabolism and pharmacokinetics of PAXIL® may be affected by the induction or inhibition of drug metabolizing enzymes. Steady state levels of PAXIL® (30 mg daily) were elevated by about 50% when *cimetidine* (300 mg tid), a known drug metabolizing enzyme inhibitor, was co-administered to steady-state. Consideration should be given to using doses of PAXIL® towards the lower end of the range when co-administered with known drug metabolizing enzyme inhibitors. **Anticonvulsants:** In a limited number of patients with epilepsy on long-term treatment with anticonvulsants (carbamazepine 600-900 mg/day, n=6; phenytoin 250-400 mg/day, n=6; sodium valproate 300-2500 mg/day, n=8) the co-administration of PAXIL® (30 mg/day for 10 days) had no significant effect on the plasma concentrations of these anticonvulsants. In healthy volunteers, co-administration of paroxetine with *phenytoin* has been associated with decreased plasma levels of paroxetine and an increased incidence of adverse experiences. However, no initial dosage adjustment of PAXIL® is considered necessary when the drug is to be co-administered with known drug metabolizing enzyme inducers (e.g. carbamazepine, phenytoin, sodium valproate) and any subsequent dosage adjustment should be guided by clinical effect. Co-administration of PAXIL® with anticonvulsants may be associated with an increased incidence of adverse experiences. **Alcohol:** The concomitant use of PAXIL® and alcohol has not been studied and is not recommended. Patients should be advised to avoid alcohol while taking PAXIL®. **Tryptophan** can be metabolized to serotonin. As with other serotonin reuptake inhibitors, the use of PAXIL® together with tryptophan may result in adverse reactions consisting primarily of headache, nausea, sweating and dizziness as well as serotonin syndrome. Consequently, concomitant use of PAXIL® with tryptophan is not recommended. Chronic daily dosing with *phenobarbital* (100 mg qid for 14 days) decreased the systemic availability of a single 30 mg dose of paroxetine in some subjects. The AUC and $T_{1/2}$ of PAXIL® were reduced by an average of 25% and 38% respectively compared to PAXIL® administered alone. The effect of PAXIL® on *phenobarbital* pharmacokinetics was not studied. No initial PAXIL® dosage adjustment is considered necessary when co-administered with phenobarbital; any subsequent adjustment should be guided by clinical effect. **Anti-cholinergic Drugs:** PAXIL® has been reported to increase significantly the systemic bioavailability of procyclidine. Steady state plasma levels of procyclidine (5 mg daily) were elevated by about 40% when 30 mg paroxetine was co-administered to steady-state. If anti-cholinergic effects are seen, the dose of procyclidine should be reduced. **Drugs Highly Bound to Plasma Protein:** Paroxetine is highly bound to plasma protein, therefore administration of PAXIL® to a patient taking another drug that is highly protein bound may cause increased free concentrations of the other drug, potentially resulting in adverse events. Conversely, adverse effects could result from displacement of paroxetine by other highly bound drugs. In a study of depressed patients stabilized on *lithium*, no pharmacokinetic interaction between paroxetine and lithium was observed. However, since there is limited experience in patients, the concurrent administration of PAXIL® and lithium should be undertaken with caution. A multiple dose study of the interaction between PAXIL® and *diazepam* showed no alteration in the pharmacokinetics of PAXIL® that would warrant changes in the dose of PAXIL® for patients receiving both drugs. The effects of PAXIL® on the pharmacokinetics of *diazepam* were not evaluated. **Sumatriptan:** There have been rare postmarketing reports describing patients with weakness, hyperreflexia, and incoordination following the use of a selective serotonin reuptake inhibitor (SSRI) and the $5HT_1$ agonist, sumatriptan. If concomitant treatment with sumatriptan and an SSRI (e.g., fluoxetine, fluvoxamine, paroxetine, sertraline) is clinically warranted, appropriate observation of the patient is advised. The possibility of such interactions should also be considered if other $5HT_1$ agonists are to be used in combination with SSRIs. **Theophylline:** Reports of elevated theophylline levels associated with PAXIL® treatment have been reported. While this interaction has not been formally studied, it is recommended that theophylline levels be monitored when these drugs are concurrently administered. **St. John's Wort:** In common with other SSRI's, pharmakodynamic interactions between paroxetine and the herbal remedy St. John's Wort may occur and may result in an increase in undesirable effects.

ADVERSE REACTIONS: Commonly Observed: The most commonly observed adverse experiences associated with the use of PAXIL® (paroxetine) in clinical trials and not seen at an equivalent incidence among placebo-treated patients were: nausea, somnolence, sweating, tremor, asthenia, dizziness, dry mouth, insomnia, constipation, diarrhea, decreased appetite and male sexual dysfunction. (See Tables 3 and 4). **Adverse Events Leading to Discontinuation of Treatment:** Twenty-one percent of over 4000 patients who received PAXIL® in worldwide clinical trials in depression discontinued treatment due to an adverse experience. In obsessive-compulsive disorder, panic disorder, social phobia (social anxiety disorder), generalized anxiety disorder and posttraumatic stress disorder studies, 11.8% (64/542), 9.4% (44/469), 16.1% (84/522) 10.7% (79/735), and 11.7% (79/676), respectively, of patients treated with PAXIL® discontinued treatment because of adverse events. The most common events leading to discontinuation (reported by 1% or more of subjects) included: asthenia, headache, nausea, somnolence, insomnia, agitation, tremor, dizziness, constipation, impotence, abnormal ejaculation, sweating and diarrhea. **Adverse Events following Discontinuation of Treatment (or Dose Reduction): Clinical Trials:** The following adverse events have been reported at an incidence of 2% or greater for PAXIL® and were at least twice that reported for placebo: abnormal dreams (2.3% vs 0.5%), paresthesias (2.0% vs 0.4%), and dizziness (7.1% vs 1.5%). The majority of these events were mild to moderate, self-limiting and did not require medical intervention. These adverse events were noted in GAD and PTSD clinical trials employing a taper phase regimen for discontinuation of treatment. This regimen involved an incremental decrease in the daily dose by 10 mg/day at weekly intervals. When a daily dose of 20 mg/day was reached, patients were continued on this dose for 1 week before treatment was stopped. **Post-Marketing:** There have been spontaneous reports of adverse events upon the discontinuation of PAXIL® (particularly when abrupt), including but not limited to the following: dizziness, sensory disturbances (including paresthesias and electric shock sensations), agitation/restlessness, anxiety, nausea, vomiting, sweating, headache, and sleep disturbance. These events are generally self-limiting. Symptoms associated with discontinuation have been reported for other selective serotonin reuptake inhibitors. Patients should be monitored for these or any other symptoms when discontinuing treatment, regardless of the indication for which PAXIL® is being prescribed. If intolerable symptoms occur following a decrease in the dose or upon discontinuation of treatment, dose titration should be managed on the basis of the patient's clinical response (see PRECAUTIONS and DOSAGE and ADMINISTRATION). **Clinical Trial Experience:** Multiple doses of PAXIL® were administered to 4126 subjects in clinical trials for depression, 542 subjects in clinical trials for OCD, 469 subjects in clinical trials for panic disorder, 522 subjects in clinical trials for social phobia (social anxiety disorder) and 735 subjects in clinical trials for generalized anxiety disorder and 676 subjects in clinical trials for posttraumatic stress disorder. Untoward experiences associated with this exposure were recorded by clinical investigators using descriptive terminology of their own choosing. Consequently, it is not possible to provide a meaningful estimate of the proportion of individuals experiencing adverse experiences without first grouping similar types of untoward experiences into a limited (i.e., reduced) number of standardized experience categories. **Table 3** lists adverse experiences that occurred at an incidence of 1% or higher in short term (6-week) flexible dose (20-50 mg/day) placebo-controlled trials in depression. (An additional 460 patients participated in a fixed-dose placebo-controlled study). **Table 4** enumerates adverse events that occurred at a frequency of 2% or more among patients on PAXIL® who participated in placebo-controlled OCD trials of 12-weeks duration in which patients were dosed in the range of 20-60 mg/day, in placebo-controlled panic disorder trials of 10-12-weeks duration in which patients were dosed in the range of 10-60 mg/day, in placebo-controlled social phobia (social anxiety disorder) trials of 12-weeks duration in which patients were dosed in a range of 20 to 50 mg/day and in placebo-controlled generalized anxiety disorder trials of 8-weeks in which patients were dosed in a range from 10-50 mg/day and in pacebo-controlled posttraumatic stress disorder trials of 12-weeks in which patients were dosed in a range from 20-50 mg/day. The prescriber should be aware that these figures cannot be used to predict the incidence of side effects in the course of usual medical practice where patient characteristics and other factors differ from those which prevailed in the clinical trials. Similarly the cited incidences cannot be compared with figures obtained from other clinical investigations involving different treatments, uses and investigators. The cited frequencies do however provide the prescribing physician with some basis for estimating the relative contribution of drug and non-drug factors to the side effect incidence rate in the population studied. Reported adverse experiences were classified using a COSTART-based Dictionary terminology for the depression trials and an ADECS (a modified COSTART dictionary) for OCD and panic disorder trials. **MALE AND FEMALE SEXUAL DYSFUNCTION WITH SSRIs:** Although changes in sexual desire, sexual performance and sexual satisfaction often occur as manifestations of a psychiatric disorder, they may also be a consequence of pharmacologic treatment. In particular, some evidence suggests that selective serotonin reuptake inhibitors (SSRIs) can cause such untoward sexual experiences. Reliable estimates of the incidence and severity of untoward experiences involving sexual desire, performance and satisfaction are difficult to obtain, however, in part because patients and physicians may be reluctant to discuss them. Accordingly, estimates of the incidence of untoward sexual experience and performance cited in product labeling are likely to underestimate their actual incidence. In placebo-controlled clinical trials involving more than 3,200 patients, the ranges for the reported incidence of sexual side effects in males and females with major depressive disorder, OCD, panic disorder, social anxiety disorder, GAD and PTSD are displayed in Table 5 below. There are no adequate and well-controlled studies examining sexual dysfunction with paroxetine treatment. Paroxetine treatment has been associated with several cases of priapism. In those cases with a known outcome, patients recovered without sequelae. While it is difficult to know the precise risk of sexual dysfunction associated with the use of SSRIs, physicians should routinely inquire about such possible side effects. **DOSAGE AND ADMINISTRATION: General:** PAXIL® should be administered once daily in the morning and may be taken with or without food. The tablet should be swallowed rather than chewed. **Dose Adjustments:** Based on pharmacokinetic parameters, steady-state paroxetine plasma levels are achieved over a 7-14 day interval. Hence, dosage adjustments in 10 mg increments should be made at 1-2 week intervals or according to clinician judgment. **Maintenance:** During long term therapy for any indication, the dosage should be maintained at the lowest effective level. **Discontinuation of Treatment:** Symptoms associated with the discontinuation of PAXIL® have been reported in clinical trials and post marketing. Patients should be monitored for these and other symptoms when discontinuing treatment, regardless of the indication for which PAXIL® is being prescribed. (See PRECAUTIONS and ADVERSE REACTIONS). A gradual reduction in the dose rather than abrupt cessation is recommended whenever possible. If intolerable symptoms occur following a decrease in the dose or upon discontinuation of treatment, dose titration should be managed on the basis of the patient's clinical response. (See ADVERSE REACTIONS). **DEPRESSION: Usual Adult Dose:** The administration of PAXIL® (paroxetine) should be initiated at 20 mg daily. For most patients, 20 mg daily will also be the optimum dose. The therapeutic response may be delayed until the third or fourth week of treatment. **Dose Range:** For those patients who do not respond adequately to the 20 mg daily dose, a gradual increase in dosage up to 40 mg daily may be considered. The maximum recommended daily dose is 50 mg. **OBSESSIVE-COMPULSIVE DISORDER: Usual Adult Dose:** The administration of PAXIL® (paroxetine) should be initiated at 20 mg/day. The recommended dose of PAXIL® in the treatment of OCD is 40 mg daily. **Dose Range:** For those patients who do not respond adequately to the 40 mg daily dose, a gradual increase in dosage may be considered. The maximum recommended

Table 5 Incidence of Sexual Adverse Events in Controlled Clinical Trials

	PAXIL*	Placebo
n (males)	**1446**	**1042**
Decreased Libido	6-15%	0-5%
Ejaculatory Disturbance	13-28%	0-2%
Impotence	2-9%	0-3%
n (females)	**1822**	**1340**
Decreased Libido	0-9%	0-2%
Orgasmic Disturbance	2-9%	0-1%

daily dose is 60 mg. **PANIC DISORDER: Usual Adult Dose:** The recommended starting dose of PAXIL® (paroxetine) in the treatment of panic disorder is 10 mg/day. The recommended dose of PAXIL® in the treatment of panic disorder is 40 mg daily. **Dose Range:** For those patients who do not respond adequately to the 40 mg daily dose, a gradual increase in dosage may be considered. The maximum recommended daily dose is 60 mg. **SOCIAL PHOBIA (SOCIAL ANXIETY DISORDER): Usual Adult Dose:** The recommended initial dosage is 20 mg/day. No clear dose-relationship has been demonstrated over 20 to 60 mg/day dose range. **Dose Range:** Some patients not responding adequately to a 20 mg dosage may benefit from gradual dosage increases, in 10 mg/day increments, up to a maximum of 50 mg/day. **GENERALIZED ANXIETY DISORDER: Usual Adult Dose:** The recommended initial dosage is 20 mg/day. **Dose Range:** Some patients not responding adequately to a 20 mg dosage may benefit from gradual dosage increases, in 10 mg/day increments, up to a maximum of 50 mg/day. **POSTTRAUMATIC STRESS DISORDER: Usual Adult Dose:** The recommended starting dosage is 20 mg/day. **Dose Range:** Some patients not responding adequately to a 20 mg/day dosage may benefit from gradual dosage increases, in 10 mg/day increments, up to a maximum of 50 mg/day. **Special Patient Populations: For any indication: Elderly:** The recommended initial dose is 10 mg/day for elderly and/or debilitated patients. The dose may be increased if indicated up to a maximum of 40 mg daily. **Children:** The use of PAXIL® in children under 18 years of age is not recommended as safety and efficacy have not been established in this population. **Renal/Hepatic Impairment:** PAXIL® should be used with caution in patients with renal or hepatic impairment. The recommended initial dose is 10 mg/day in patients with clinically significant renal or hepatic impairment (See Precautions). A maximum dose of 40 mg should not be exceeded. **AVAILABILITY OF DOSAGE FORMS:** PAXIL® (paroxetine) is available as film coated, oval biconvex tablets containing paroxetine hydrochloride equivalent to 10 mg (yellow tablets), 20 mg (pink tablets), 30 mg (blue tablets) paroxetine free base. The tablets have the product name engraved on one side and strength engraved on the other side. The 20 mg tablets are bisected.

Available in package sizes of:
10 mg - Bottles of 30's
20 mg - Bottles of 100's and 500's, Cartons of 6 PAXIL® *cp* blister cards (each containing 30 tablets for depression)
30 mg - Bottles of 30's

Full Prescribing Information available to Health Practitioners upon request.

Please Contact: GlaxoSmithKline Inc., 7333 Mississauga Rd. N., Mississauga ,Ontario, L5N 6L4

1. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders,* 4th ed., Text Revision, American Psychiatric Association, Washington DC, 2000. 2. Van Ameringen M *et al.* Relationship of social phobia with other psychiatric illness. *J Affective Disorders* 1991;21:93-99. 3. Rasmussen SA, Eisen JL. The epidemiology and differential diagnosis of Obsessive Complusive Disorder. *J Clin Psychiatry* 1992;53(suppl 17):4-10. 4. Ballenger JC *et al.* Consensus statement on Social Anxiety Disorder from the International Consensus Group on Depression and Anxiety. *J Clin Psychiatry* 1998;59(suppl 17):54-60. 5. Joffe RT, Levitt AJ. Conquering Depression: A Guide to Understanding Symptoms, Causes and Treatment of Depressive Illness. Hamilton (ON): Empowering Press;1998,p.15.65-69. 6. Product Monograph of PAXIL® (paroxetine HCl), GlaxoSmithKline Inc. 2002. 7. IMS Canada: IMS Canadian Compuscript, MAT March 2002.

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family. This means educating the family on the illness and working as a team in identifying the diagnosis and ensuring the appropriate treatment. We also believe that general practitioners need to be better educated on youth mental illness in order to help in the identification of serious problems, which could lead to suicide, and to refer parents to appropriate professionals for follow-up.

Within our group we have tragically lost some of our children to suicide or to the streets and penal system. We believe that by working together with healthcare professionals we can avoid some of these tragedies in the future.

Ann Howarth-Wiles is founder and co-director of "Parents Lifelines of Eastern Ontario"; a not for profit organization based in Ottawa whose aim is to support the families of children and youth suffering from severe mental illness. For more information, you can reach Ann at inovasol@sprint.ca or (613) 248- 8332 or Cynthia Clark (co-director) at cclark@trican.com or 613 737 7370 or visit the PLEO website at www.pleo.on.ca. ■

Editor's Note: Thank you to Dr. Derek Puddester for suggesting this topic and Ann Howarth-Wiles in particular. If you have suggestions for other topics or contributors for our Guest Column, please let us know. Your comments on this column are welcome at any time.

THE COMMUNITY MENTAL HEALTH EVALUATION INITIATIVE

The Community Mental Health Evaluation Initiative (CMHEI) Newsletter offers the latest findings from evaluation studies currently being conducted in Ontario. To read the newsletter, visit:
http://www.ontario.cmha.ca/content/information_and_links/cmhei/newsletter_Spring2002.pdf

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http://www.adobe.com/products/acrobat/readstep2.html

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ONTARIO INVESTS MORE THAN $1 MILLION FOR SUBSTANCE ABUSE TREATMENT PROGRAMS

TORONTO, July 2 /CNW/ - Ontario Health and Long-Term Care Minister Tony Clement, today announced $1.033 million in capital grants to agencies providing substance abuse treatment.
This funding will provide one-time grants to substance abuse agencies to support the extension of current programs such as withdrawal management and Methadone treatment programs.
"This further financial commitment allows our substance abuse partners to provide even higher quality services to the people who need them the most," said Clement.
The government's total contribution to substance abuse programs for this year is $118 million.
Recently, the minister also announced more than $570,000 in one-time funding to substance abuse agencies across the province for the new Drug and Alcohol Treatment Information System (DATIS) software. DATIS collects information used for planning, monitoring and assessing the cost and health outcomes of addiction treatment services. ■

Housing Guide Available from the Centre for Addiction and Mental Health

A Comprehensive Guide to Housing Programs for Clients of Mental Health and Addiction Services (192 pages) is a concise information resource that lists comprehensive housing options and resources for clients of mental health and addiction services. It is intended to help workers, clients and family members in locating and accessing housing in the community and can be used to develop both short-term and long-term housing goals. The Housing Guide lists many social housing programs in the City of Toronto, such as boarding homes, emergency housing, and other supportive housing programs including community –based residential treatment and transitional and long-term housing programs (addiction specific). A housing program profile includes a brief description of the housing program, cost, capacity, restrictions, application procedure and access. It is available, free of charge by contacting:

Community Support and Research Unit
Centre for Addiction and Mental Health
1001 Queen Street West
Toronto Ontario M6J 1H4
Tel: (416) 535-8501 ext. 2068
E-mail: housingguide@camh.net

The print version of the Housing Guide will be updated when there have been changes within the housing sector in Toronto. An electronic version is available on the Internet and can be found as a link from the Centre's Web site, which will be updated monthly, and can be accessed by going to http://info.camh.net/housing ■

Editor's Note: The Toronto District Health Council estimated that in the year 2001 between 8,430 to 16,861 adults in Toronto have a serious mental illness. Using benchmarks from the Ministry of Health and Long-Term Care, which establishes that housing supports should be made available to approximately one-third of people with severe mental illness, the Toronto District Health Council concluded that there should be between 2,782 and 5,564 housing units, with supports, for this population. The Toronto District Health Council published the "Toronto Mental Health Housing Study" in September 2001; this survey states that there is a lack of affordable and supportive housing units, an insufficient supply and range of housing supports and insufficient financial assistance for people with serious mental illness. To access this document go to www.tdhc.org-public-pdf-TorontoMentalHousingStudy-Sept.2001.pdf