



MESSAGE FROM THE PRESIDENT

As you know, we are in the midst of a provincial election campaign. This means that decisions regarding a number of current mental health issues will be deferred to whichever party wins

the election. For example, the Minister received reports from the nine Mental Health Implementation Task Forces and the Forensic Mental Health Expert Advisory Panel at the end of last year, but the government has not provided any information on implementing the recommendations from these groups. And, the current government, in its March 2003 budget of \$250 million over five years, proposed establishing a Premier's Council on Mental Health and the divestment of the Provincial Psychiatric Hospitals in Whitby and North Bay, although details were not provided.

Penetanguishene remains the only hospital where divestment and costs are still to be determined. Whichever party comes to power, your association will continue to represent psychiatry and your interests to the government and the Ministry of Health and Long Term Care.

Statistics Canada recently released data from its Canadian Community Health Survey on the prevalence of mental illness in the Canadian population - 4.5 % of people (5.5% of women and 3.4% of men) interviewed in the survey reported having experienced symptoms associated with major depression, as compared to 5% with diabetes and 5% with heart disease. One out of every ten Canadians, age 15 and over (about 2.6 million people) reported symptoms of one of the five mental disorders assessed by the survey or alcohol and illicit drug dependence. Despite the distress associated with the experience of mental illness, only 32% of those with symptoms consistent with the surveyed mental disorders or substance dependencies sought professional help. Teens and young adults were least likely to use mental health resources despite having higher prevalence rates.

One out of five people who suffered from a mental disorder or substance abuse reported a perceived unmet need. Reasons for not seeking help included a preference to manage themselves, a fear of asking for help, and being afraid to ask for help. This survey illustrates that we have much to do to reduce the stigma associated with mental illness.

The theme for our annual meeting in January is destigmatizing mental illness. I can report with assurance that Dr. Ann Thomas and her committee are again planning a terrific annual meeting, which you will want to make sure you attend.

I have appreciated receiving your comments by e-mail and look forward to continuing to hear from you about any important issues that you wish to bring to my attention.

*Robert Buckingham, MD, FRCPC
2003 OPA President*

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IN DECEMBER 2003
• A Brief History of Mental Health Reform in Ontario
• Mental Illness and Developmental Disabilities
• Mental Health and Aging
• Look for the Resident's Review In the December issue of Dialogue! "Detecting Malingered Memory Impairment in Neuropsychiatry: Part 1"



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

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

Production Co-ordinator: Lorraine Taylor

Design & Production: Smashing Design & Advertising Inc.

The OPA reserves the right to refuse requests for advertising.

The views expressed in this newsletter do not necessarily reflect the views of the OPA Council.

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From THE EDITOR

There is no question that this summer has been trying for all of us in Ontario. The preparation of this issue of *Dialogue* was affected by the 2003 Blackout since the due date for articles fell on Friday August 15th. However, the most important event that occurred, which changed which articles the September 2003 issue of *Dialogue* would contain, was not SARS-related, nor was it the power outage; it was the Supreme Court of Canada decision on *Starson v. Swayze*, which occurred on June 6, 2003. This decision changed what the plan had been for the September issue. A new plan was drawn up, one that concentrated on obtaining articles on legal and forensic issues.

Three articles, from three different perspectives, detail the unique aspects of the *Starson* case and provide you with the implications for psychiatric practice. A variety of forensic mental health articles are also included in this issue. In addition, there is news from the Coalition of Ontario Psychiatrists – the recent increase in sessional fees – and a broad range of information, from various sources, about people with mental illness and services for them, and related tidbits. The December 2003 issue will publish articles on mental health and aging and Dr. Drew Moulden will discuss malingering in the first of two articles, and if planning continues as it should, there will also be three articles dealing with issues related to persons with developmental disabilities and mental illness. Should you have an interest in these areas and wish to contribute, we would like to hear from you.

I want to take this opportunity to thank both regular and first-time contributors for sending in their submissions, in spite of Blackout 2003, as soon as they could, so that this issue could get to you on time.

The *Dialogue* welcomes your comments, your feedback and any points that you would like to make on any aspect of the publication. The results of the 2002 and the 2003 *Dialogue* Surveys are included in this issue for your information.

Elizabeth Leach

Editor

**THE ONTARIO PSYCHIATRIC
ASSOCIATION IS PLEASED TO
WELCOME**

the following new Associate members up to June 20, 2003

Bonnie Madonik • Caroline Wright

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.

New Two Year Training Program in Psychotherapy.

September 2003

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

Contact information: Rosemary Adams 416-690-3722/
rosemary.adams@sympatico.ca

Brief Therapy with Families, Couples and Individuals

September 2003 – June 2004

Brief and Narrative Therapy Extern Program

(Level 1) A Year-Long Intensive Training Program

Advanced Brief & Narrative Therapy Extern Program

(Level 2) An Advanced Level Year-Long Training and Research Project

These two intensive brief therapy extern programs offer a comprehensive training experience in the latest, up-to-date theory and practice of brief therapies in supportive and encouraging learning environments.

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

CMA Leadership Programs

Physician Manager Institute

The CMA's Physician Manager Institute (PMI) has been helping physicians become better leaders for over 20 years. PMI delivers highly interactive workshops designed to equip physicians with the leadership and management skills needed to lead effectively in the ever-changing health care environment. The five level PMI series offers skill development in the areas of: negotiation, conflict management, team development, performance management, funding, facilitation, situational leadership, and planning and managing change.

Fall 2003:

PMI I: Sept. 21-23/PMI II: Sept. 24-26, Fairmont Queen Elizabeth, Montreal, QC

PMI Refresher: Oct. 24-26, Westin Prince Hotel, Toronto, ON

PMI III: Nov. 2-4/PMI IV: Nov. 5-6, Sutton Place Hotel, Vancouver, BC

Registration for the fall PMIs has begun. Call now as registration is limited!

Brochures for PMI 2004 will be available in November 2003.

Contact information: 1-800-663-7336

Area 1 APA Council (business) meeting,

September 20, 2003

Delta Chelsea, 33 Gerrard St. W., Toronto, M5G 1Z4

OPA members who are also APA members are welcome to attend but space is limited. Please contact Ray Freebury at 416-961-6360 if you wish to attend.

Centre for Addiction and Mental Health

5th Anniversary Celebration Events

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

Contact information: CAMH, Queen Street Site, 1001 Queen St. West, Toronto, Ontario M6J 1H4, (416) 535-8501 ext. 6076 Website: www.camh.net

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

September 21 - 23, 2003

Toronto Hilton Hotel

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

Workplace Psychiatry is featured at the OEMAC 21st annual conference in Toronto. This is a unique opportunity to learn from leading psychiatrists about the practical assessment and accommodation of mental disability, mental health and productivity, and how to appropriately evaluate the risk of workplace violence. Psychiatric presentations include: Mental Health and the Workplace - Productivity Drain or Productivity Weapon, Dr. Sam Ozerskey, Consulting Psychiatrist, UHN and Founder, Medra Health Care, Dr. Ronald J. Walsh, Occupational Medicine Consultant, Proctor and Gamble Inc.; Mental Illness, Psychiatric Disabilities and Workplace Accommodation, Dr. Brian Hoffman, Chief of Psychiatry, NYGH; Workplace Violence Risk Assessment: Organizational Variables and Individual Differences, Dr. Philip Klassen, Director, Workplace Violence Risk Assessment Clinic, CAMH, Dr. Roohi Qureshi, Chief Resident in Occupational Medicine, U of T. The Science and Business of Occupational Medicine: Practical Approaches to Fundamental Issues is the theme for main presentations focused on workplace accommodations in relation to pregnancy, cardiac events, diabetes, multiple sclerosis and epilepsy, and sessions on the disability paradigm in daily practice, fitness to drive, SARS and a variety of other topics and practical pre-conference workshops.

Contact information: www.oemac.org

Family-to-Family Education Evening Program

September 22 - December 8, 2003 (12 weeks), 6:30 to 9:30 pm. Toronto ON

Organized by: Toronto Chapter, Schizophrenia Society of Ontario

A twelve-week evening course, developed for the National Alliance for the Mentally Ill (www.nami.org) for family caregivers of people with severe mental illness. Taught by trained family members, the course will include sessions on handling crises and relapses, listening and communication techniques, problem-solving, learning how to deal with chronic worry and stress, connecting with community services, fighting discrimination and advocating for services.

There is no charge for participants. For more information, call 416 975-1630 or email rzinch@schizophrenia.on.ca

There are plans to offer a similar course in the Halton area in 2004.

Contact information: 905 842-1161 or email sso_oakville@canada.com

Treating Emotional and Behavioural Problems in Children and Adolescents

September 24, 2003

Led by Donald Meichenbaum, this workshop will teach you how to conceptualize, assess and treat children and adolescents with both internalizing and externalizing problems. Specific practical interventions that can be used with parents, teachers and by children and adolescents themselves will be examined. Individualized treatment for those young people with a history of victimization will also be discussed. Specific intervention skills for managing depression, suicidal behaviors, anxiety, avoidance behaviours, and PTSD in children and adolescents, as well as ways to conduct parent and teacher training will be discussed. A major focus will be on enhancing the generalization of the treatment effects. How cognitive-behavioural and community-based interventions can be employed on both a treatment and preventative basis will be explored (see www.melissainstitute.org for examples).

Contact information: Leading Edge Seminars, 88 Major Street, Toronto, ON, M5S 2L1 Phone: (416) 964-1133, toll free: 1-888-291-1133,

Fax: (416) 964-7172, Email: info@leadingedgeseminars.org

Parenting for Change -Steps to Solutions With Difficult & Challenging Teens

September 24, 2003, Oshawa ON

Organized by: Canadian Mental Health Association, Durham Region
An Interactive Evening with Bob Bertolino, Ph.D.
Contact information: cmha@cmhadurham.org

Breaking All the Rules - The Next Generation of Collaborative, Change-Oriented Therapy with Challenging Clients

September 24-25, 2003, Oshawa ON

Organized by: Canadian Mental Health Association, Durham Region Branch
A 2-day intensive workshop with Bob Bertolino, Ph.D.
Contact information: cmha@cmhadurham.org

Making Gains: Research, Recovery and Renewal in Mental Health and Addictions

September 28 to October 1, 2003

Hilton Niagara Falls Hotel, Niagara Falls, Ontario
CMHA Ontario Division, CAMH, OFCMHAP, ADRAO

Four of the leading organizations in mental health, addictions and substance abuse in Ontario are hosting a major conference to talk about the newest developments in mental health and addictions.

Conference streams will focus on the following topics: Recovery, Dual Diagnosis, Organizational Strategies in Times of Change, Evidence Based Practices in Mental Health and Addictions, Concurrent Disorders and Addictions.

Contact Information: Rachel Gillooly, Phone: 705-454-8107, Fax: 705-454-9792
website: www.ontario.cmha.ca

28th International Congress on Law and Mental Health

September 28 - October 3, 2003, Sydney, Australia

Organized by: International Academy of Law and Mental Health
Please visit the Congress website: www.ialmh.org for full details

Health Privacy

September 29 - 30, 2003

Metropolitan Hotel, Toronto

Privacy is a critical issue for the health sector today. The growth of electronic networks, the impact of epidemics, the improvements in research technology, the funding imperative and the myriad other pressures on the system all impact the way in which the health sector collects, uses or discloses personal information. The Personal Information Protection and Electronic Documents Act (PIPEDA) will apply to all organizations in the health sector in Ontario on January 1, 2004 and will impose strict requirements on how such organizations may collect, use and disclose personal health information. In addition, several provinces have or are expected to introduce privacy legislation this year and the collective impact of these new laws will fundamentally change the Canadian health privacy landscape for all organizations.

Are you prepared? At Insight's 2003 Health Privacy Conference, you will hear from and meet experts in the fields of privacy and healthcare who will discuss many of the critical privacy issues in today's healthcare environment. They will provide suggestions and models for meeting compliance challenges moving forward. Speakers will also address the dilemmas that arise when organizations try to balance individual privacy rights with the health sector's legitimate need for free-flowing and rapidly available information. Don't miss this opportunity to learn how the existing and proposed legislation will affect you, your organization and your clients. Contact information: Insight Information Co., 214 King Street West, Suite 300, Toronto, Ontario, Canada M5H 3S6, Tel: 1-888-777-1707 or 416-777-2020, Fax: 1-866-777-1292 or 416-777-1292, E-mail: order@insightinfo.com Website: insightinfo.com

Self-Help Awareness Week

September 29-October 4, 2003, Ontario

Organized by: Self-Help Resource Centre

Families Caring for Each Other is the theme for this year's Self-Help Awareness Week in Ontario. Contact information: www.selfhelp.on.ca

Association for Academic Psychiatry 2003 Annual Meeting

Best Evidence Medical Education: How Well Does Psychiatry Measure Up?

October 1 - 4, 2003

Courtyard Marriott Hotel Philadelphia, PA

As evidence-based medicine is sweeping the country, educators have increasingly been asking themselves, "What evidence can I provide that the curriculum/

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

2003 World Congress for Psychiatric Genetics

October 4-8, 2003, Quebec City, QC

Organized by: International Society for Psychiatric Genetics. Plenary lectures, workshops, invited symposia, free communications and poster sessions will be the forum for exchange of information and interaction between scientists, physicians and colleagues from around the world.

Contact information: www.ispg.net

Mental Illness Awareness Week (MIAW) 2003

October 5 - 11, 2003

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

MIAW offers an excellent backdrop to organize an event that helps raise awareness about mental illness. Together we can do something to turn around the persistent stigma surrounding mental illness. We already know about some exciting events that are tied into the MIAW 2003 campaign. On October 7, the newly expanded Canadian Alliance of Mental Illness and Mental Health (CAMIMH) will host the "CAMIMH Champions of Mental Health Luncheon on the Hill" at the National Arts Centre in Ottawa. This Parliamentary Luncheon will inaugurate a new honour: the CAMIMH Mental Health Champion Awards. An interdepartmental Federal Government Employee Assistance Program (EAP) Conference will take place on October 1 and the MIAW 2003 message will play a role in this important event. More details about these, and other events can be found on the MIAW website at www.cpa-apc.org/MIAW/MIAW.asp, in the Calendar of Events section. While you're there, take a moment to tell us about your MIAW event! The more events we post—the stronger the message we send. To help you with your event, the CPA can provide you with MIAW 2003 campaign materials, including theme posters, bookmarks and a guidebook for planning. Check online to order these materials, to nominate a colleague or community member for raising awareness about mental illness, or for more info. First launched by the CPA in 1992, MIAW aims to destigmatize mental illness by providing information on mental illnesses and their treatments, as well as promoting public discussion and informed decision-making about mental illness issues. MIAW is led by the CPA in partnership with CAMIMH. This alliance includes the Canadian Psychiatric Association, Canadian Alliance on Mental Illness & Mental Health, the Autism Society of Canada, the Canadian Association of Occupational Therapists, the Canadian Association of Social Workers, the Canadian Association for Suicide Prevention, the Canadian Coalition for Seniors Mental Health, the Canadian Federation of Mental Health Nurses, the Canadian Medical Association, the Canadian Mental Health Association, the Canadian Psychiatric Research Foundation, Canadian Psychological Association, the Mood Disorders Society of Canada, the National Network for Mental Health, the Native Mental Health Association of Canada, and the Schizophrenia Society of Canada.

Together Against Stigma, Second International Congress on the Stigma of Mental Illness

October 8 - 11, 2003

Kingston, Ontario at Queen's University

The theme for the congress will be "Stigma Across the Life Span" in order to highlight special problems faced by children and youth, and the elderly. The congress will be hosted on behalf of the World Psychiatric Association's Open the Doors global program to fight stigma and discrimination because of schizophrenia.

Contact information: Ms. Debbie Ball, Department of Psychiatry, Rm 546, Brock 5, Hotel Dieu Hospital, 166 Brock Street, Kingston, Ontario, K7L 5G2, tel: (613) 544-3400 ext. 2519, fax: (613) 547-1501, e-mail: balld@hdh.kari.net website: [_http://meds.queensu.ca/medicine/psychiatry/locate.htm](http://meds.queensu.ca/medicine/psychiatry/locate.htm)

World Mental Health Day

October 10, 2003

World Mental Health Day (www.wmhd.net) is an initiative of the World Federation for Mental Health (WFMH) and is co-sponsored by the World Health Organization. WMHD takes place on 10 October each year, and within Australia WMHD coincides with National Mental Health Week. The World Mental Health Day theme set by the WFMH for 2003 is the "Emotional & Behavioural Disorders of Children & Adolescents".

Promotional material for WMHD, including posters, postcards, bookmarks, stickers and fact-sheets are available from the Mental Health Council of Australia. Please call Neil Wildman (02) 6285 3100 or email: wmhd@mhca.com.au.

Santa Fe Symposia

October 10 – 26, 2003

Santa Fe, New Mexico

The 11th 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. Among others, presentations include: Mindfulness Meditation: Exploring the Self; Angry and Aggressive Behaviour: A Life-Span Treatment Approach; The Nature of Autism and Asperger's Disorder: From Diagnosis to Treatment.

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

American Academy of Child & Adolescent Psychiatry, 50th Annual Meeting

October 14 – 19, 2003

Fontainebleau Hotel, Miami Beach Florida

Plan to attend AACAP's 50th Anniversary Meeting, October 14-19, 2003, at the Fontainebleau Hilton Resort in Miami Beach, the Riviera of the Western Hemisphere. In addition to our rich scientific meeting, Miami Beach offers terrific shopping, the glitz and glamour of Ocean Drive, Art Deco architecture, and the powerful and moving Holocaust Memorial. The Program Committee met this April to review submissions for this fall's Annual Meeting. At the end of our meeting, only 69% of the submissions had been accepted. The 50th Anniversary Meeting program consists of 7 Institutes, 71 Symposia, 40 Workshops, 13 Media Theater, 11 Clinical Consultation Breakfasts, 15 Special Interest Study Groups, and a Clinical Practicum. Contact information: AACAP, 3615 Wisconsin Avenue, N.W., Washington, D.C. 20016-3007, phone (202) 966.7300, fax (202) 966.2891, meetings@aacap.org

2003 CMA Leaders' Forum

October 19-20, 2003

Westin Hotel in Ottawa

150 new and experienced physicians will gather at the 2003 CMA Leaders' Forum in Ottawa to learn the theory and skills to be effective leaders, to be inspired by the example of other leaders, and to renew their sense of the value and importance of physician leadership.

Contact information: leadersforum@cma.ca

Marketing Madness: How Pharmaceutical Companies Shape The Way We Think

October 22, 2003

Toronto ON

Organized by: Redirection Through Education, George Brown College
Dr. David Healy will discuss the changing nature of mental health - from mental illness services to mental health services to mental risk services. A panel discussion, moderated by Elizabeth Gray (former CBC host) will follow.
Contact information: Program Secretary: Maureen Griffenham. Tel: 416-415-2315 ; Co-ordinator: Rosalind Gilbert. Tel: 416-415-2641

2nd Annual Conference on Police/Mental Health Systems Liaison – Psychiatrists in Blue: Collaboration and Learning

October 26 – 27, 2003

Delta Bessborough, Saskatoon, Saskatchewan

Organized by: Canadian National Committee for Police/Mental Health Liaison
As police services move to a 'community policing' model, the need for collaboration, experience, learning, education and understanding about people experiencing severe mental illnesses is important. This Conference will focus on ways that we can teach, train, learn and work together effectively.

Contact information: Lisa Cyrenne, Phone: 306-694-7658, Fax: 306-693-2167, Email: lcyrenne@city.moose-jaw.sk.ca or Lori Anderson, Email: landerson@city.moose-jaw.sk.ca or www.pmhl.ca

Canadian Psychiatric Association 53rd Annual Meeting

October 30 – November 2, 2003

Halifax, Nova Scotia

The Canadian Psychiatric Association's 53rd Annual Meeting will be held at the World Trade and Convention Centre (WTCC) and two conference hotels, the Deltas Barrington and Halifax.

The presidential theme, "Under One Roof: A Tapestry of Families" provides the opportunity for us to explore the wide range of families to which we belong and to celebrate with our psychiatric family. As in past years, the meeting offers a myriad of continuing professional development opportunities in the form of courses, symposia and workshops, and discussions with experts. Invited lecturers at this year's meeting include Dr. Jock Murray (A History of Marijuana as Therapy), Dr. Zindel Segal (Sequencing Pharmacological Remission with Psychological Prophylaxis in Major Depression), the Honourable Mr. Justice Richard D. Schneider (Mental Health Court), and Dr. Richard Swinson, Chair of the Department of Psychiatry at McMaster University will give the distinguished member lecture.

The Canadian Psychiatric Association's 2003 Annual General Meeting (AGM) promises a superior occasion to network with colleagues and offers diverse learning prospects: new, multiple learning formats (including networking discussion groups as well as an attempted murder mystery—a team-based game that will teach you about the medical complications of psychiatric medications), expanded paper and posters sessions, Maintenance of Certification (MOC) credits, the latest research, and, features a special policy symposium chaired by Dr. David Goldbloom. Senator Michael Kirby, Chair of the Senate Committee on Social Affairs, Science and Technology joins Drs Elliot Goldner, Pierre Beauséjour and Pamela Forsythe to discuss the need for a National Mental Health Policy in Canada. Senator Kirby will speak to the mental health study currently underway by his Committee.

For more information on the meeting contact the Meeting Coordinator, Heather Cleat at 613-234-2815 (242). For registration information call the Registration Coordinator, Scott Kettles at 613-234-2815 (231). You can also register online at www.cpa-apc.org.

Accommodations can be booked at the Delta Barrington and Delta Halifax conference hotels by downloading a pdf form from <http://www.cpa-apc.org/Abstracts/intro.asp>.

Anxiety Disorders: Comprehensive Strategies for Assessment and Treatment

October 30 and 31, 2003

Led by Dr. Martin M. Antony, this workshop provides in-depth training in evidence-based techniques for helping people who suffer from anxiety disorders. Proven strategies for treating panic disorder with and without agoraphobia, social anxiety disorder, specific phobias, obsessive-compulsive disorder, generalized anxiety disorder, and posttraumatic stress disorder will be provided, and related disorders such as hypochondriasis and body dysmorphic disorder will also be discussed.

Contact information: Leading Edge Seminars, 88 Major Street, Toronto, ON, M5S 2L1 Phone: (416) 964-1133, toll free: 1-888-291-1133, Fax: (416) 964-7172, Email: info@leadingedgeseminars.org

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

November 3, 4 & 5, 2003

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

New Directions in the Treatment of Post Traumatic Stress: The Revised Self-Trauma Model

November 7 - 8, 2003

National Gallery of Canada, 380 Sussex Drive, Ottawa, Ontario

Organizer: Centre for Treatment of Sexual Abuse & Childhood Trauma Event Details:

This workshop is intended for psychologists, psychological associates, psychiatrists, social workers, youth workers, child protection workers, and other mental health professionals.

Contact information: Centre for Treatment of Sexual Abuse & Childhood Trauma, Phone: 613-233-4929, Fax: 613-233-4947, Email: centrefortreatment@yahoo.com

Centre for Addiction and Mental Health

5th Anniversary Celebration Events

November 12 - 16 - Rendezvous with Madness Film Festival

Contact information: CAMH, Queen Street Site, 1001 Queen St. West, Toronto, Ontario M6J 1H4, (416) 535-8501 ext. 6076 Website: www.camh.net

Ontario Psychiatric Association 2003 Council Meeting

Toronto - Friday, November 14, 2003; Space is limited, please contact the OPA for further details; (905) 827-4659, email: opa@bellnet.ca

10th Annual Conference: The Science & Art of Pain and Symptom Management

November 14 - 15, 2003

The Old Mill, 21 Old Mill Road, Toronto, Ontario

Sponsored by Oncology Continuing Education, University of Toronto

A conjoint effort of: Rapid Response Radiotherapy Program at the Toronto Sunnybrook Regional Cancer Center and Department of Radiation Oncology, University of Toronto The Division of Palliative Medicine of the Department of Family and Community Medicine, University of Toronto Conference Directors:

Drs. Edward Chow and Russell Goldman Contact information: Continuing Education, Faculty of Medicine, University of Toronto 500 University Avenue, Suite 650, Toronto ON M5G 1V7, Tel: 416.978.2719 Fax: 416.971.2200, Email: ce.med@utoronto.ca Website: www.cme.utoronto.ca

ADHD in Children and Adolescents: Nature and Management

November 24, 2003

Led by Russell Barkley, this workshop will provide detailed, current information on the nature of ADHD in children. A new theory of ADHD will be presented which provides a much more enriching, comprehensive, and dignifying view of the disorder than does the current clinical conceptualization of ADHD as an attention deficit. This view also has a number of important implications for the home and classroom management of ADHD children. Dr. Barkley will discuss these exciting implications and the most effective treatment strategies, focusing particularly on home and classroom management.

Contact information: Leading Edge Seminars, 88 Major Street, Toronto, ON, M5S 2L1. Phone: (416) 964-1133, toll free: 1-888-291-1133, Fax: (416) 964-7172, Email: info@leadingedgeseminars.org

Mindfulness-Based Cognitive Therapy for Depression

November 27, 2003

Led by Zindel Segal. The chronic, recurrent nature of depression presents an enormous challenge to sufferers and treatment providers. Mindfulness-Based Cognitive Therapy is an innovative, clinically proven treatment that encourages patients to play an active role in preventing the return of depression by integrating elements of Mindfulness-Based Meditation with Cognitive Therapy. It draws upon recent findings from psychological research to show how sustaining recovery from depression depends upon learning how to keep mild states of sadness from spiralling out of control.

This type of learning is experiential in nature and often involves developing a capacity to allow distressing feelings, thoughts and sensations to occupy awareness, but to reduce one's reactivity to them. Training in mindfulness fosters a 'de-centered' relationship to experience in which depression-inducing thoughts or feelings can be viewed from a wider perspective as passing events in the mind, rather than as 'self' or as necessarily true. Dr. Segal will illustrate the core elements of this approach using lecture, experiential and video presentations.

Contact information: Leading Edge Seminars, 88 Major Street, Toronto, ON, M5S 2L1. Phone: (416) 964-1133, toll free: 1-888-291-1133, Fax: (416) 964-7172, Email: info@leadingedgeseminars.org

A Day of Mindfulness for Mental Health Professionals

November 28, 2003

Led by Zindel Segal

9:00 a.m. to 4:30 p.m.

Mindfulness-Based Cognitive Therapy requires that the self-knowledge gained through sustained meditative practice be brought to bear on our own work with clients in emotional distress. This Day of Mindfulness is offered as a way of grounding this inquiry in the formal and systematic practice of mindfulness of the body, of the breath, of feelings, and of thoughts and emotions. This day will alternate between periods of silence, practice and discussion, featuring the core practices taught in MBCT - Eating Meditation, Body Scan, Sitting Meditation, Mindful Walking, and Mindful Stretching. This workshop will be limited to 60 participants in order to permit meaningful interaction and contact among a fairly large number of people. Mats will be provided. Some experience with MBCT or mindfulness-based clinical care is recommended. Contact information: Leading Edge Seminars, 88 Major Street, Toronto, ON, M5S 2L1. Phone: (416) 964-1133, toll free: 1-888-291-1133, Fax: (416) 964-7172, Email: info@leadingedgeseminars.org

CMA Leadership Workshop for Medical Women

November 28-29, 2003

The CMA will be offering the ninth annual CMA Leadership Workshop for Medical Women. The workshop is designed to address the needs of women physicians who are involved or interested in involvement in leadership roles. Leaders from the fields of medicine, business and politics will deliver plenary and small group sessions on topics that include: leadership challenges, project development, situational leadership, communications, dealing with stress, and balancing career and family demands. The workshop will be held at the Crowne Plaza in Toronto. Registration is limited.

Contact information: 1 800 663-7336/ (613) 731-8610 extension 2319 or LeadershipPrograms@cma.ca.

Current Legal Issues - What Mental Health Professionals Need to Know

December 5, 2003

Led by Torkin Manes Group

Healthcare professionals face difficult legal issues on a daily basis. Recent high profile cases have highlighted the potential for legal liability when therapists either ignore or misunderstand their legal obligations. In this fast-paced and information-filled seminar, four leading practitioners from Toronto's prestigious Torkin Manes Cohen Arbus law firm will teach you what you need to know about recent developments in four key areas: Records, Confidentiality and Reporting; Avoiding Lawsuits and Professional Discipline; The Role of the Therapist in Sexual Assault Cases; Recent Developments in Family Law.

Contact information: Leading Edge Seminars, 88 Major Street, Toronto, ON, M5S 2L1. Phone: (416) 964-1133, toll free: 1-888-291-1133, Fax: (416) 964-7172, Email: info@leadingedgeseminars.org

Ontario Psychiatric Association 84th Annual Meeting - Destigmatizing Mental Illness

January 29, 30 and 31, 2004

Pre-conference, one-day Cognitive Therapy Workshop - Wednesday, January 28, 2004.

Toronto Marriott Eaton Centre Hotel, Toronto

Contact information: phone: 905-827-4659, email: opa@bellnet.ca (see article on page 11 for detailed information)

9th Annual CAPL/Forensic Section Winter Meeting

February 28 - March 3, 2004

Fairmont Chateau Lake Louise, Alberta

Paper and poster submission deadline: January 15, 2004

Contact information: Dominique Bourget, ph: 613-722-6521 ext. 6366, fax: 613-595-8971, email: thira@sympatico.ca

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

AGENDA OPA Council June 20, 2003

1.0 Remarks from the President

Approval of Agenda

2.0 Approval of Minutes of April 4, 2003

3.0 Business Arising

- 3.1 Mental Health Implementation Task Forces/Authorities
- 3.2 Review of OPA Liaison - nominations for CPA director-in-training
- 3.3 Child Psychiatry Task Force

4.0 Treasurer's Report

5.0 Reports of Task Forces and Committees

- 5.1 Advocacy Committee
- 5.2 Communications Committee
- 5.3 Continuing Education Committee
- 5.4 Finance/Audit Committee
- 5.5 Member Services Committee

6.0 Standing Reports

- 6.1 OMA Tariff/RBRVS
- 6.2 CPA Report
- 6.3 Working Group on Mental Health Services
- 6.4 Coalition
- 6.5 Council of Provinces
- 6.6 Alliance for Mental Health Services
- 6.7 CPA Standing Committee on Education
- 6.8 Section Reports

7.0 New Business

- 7.1 Strategic Planning and Governance
- 7.2 Review of Role Descriptions
- 7.3 Guest: Dr. D. Blake Woodside, President, CPA
- 7.3 Guest for September Council Meeting

Guest for November Meeting: R. John Harper, Chair & CEO of Consent & Capacity Board

Meet A Council Member

Adrian Hynes, M.B., FRCP(C)



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

Adrian: I am a Council member, Chair of the Communications Committee (whose role includes being the Publisher of *Dialogue*) and a member of the Advocacy Committee.

OPA: Tell us a bit about your background.

Adrian: I was born and raised in Ireland. I attended medical school and did my internship in Dublin. I trained as a family doctor in Maidstone, Kent in England and then moved to Northern Manitoba where I practiced for one year and received my landed immigrant status. I then went to Winnipeg, which is considered to be "south" in Manitoba. There I practiced family medicine, first as a solo practitioner, then as a full-time academic teacher, and then once again as a solo practitioner. While teaching family medicine, I was designated as the physician to develop and teach the addictions component of family medicine. Over time, I became increasingly interested in addictions and the routinely associated psychiatric illnesses. I finally decided to bite the bullet and did a psychiatry residency in Winnipeg and an addiction psychiatry fellowship in Minneapolis. After this, I went to Thunder Bay where I have remained for many years, helping to develop a concurrent disorders program. In the summer of 2003, I moved to London to lead the concurrent disorders program there. A new adventure! Outcome – who knows?

OPA: When did you join the OPA and why?

Adrian: I joined the OPA soon after I arrived in Ontario. Joining was suggested to me by one of my colleagues so as not to become isolated while in Thunder Bay.

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

Adrian: The connection with other psychiatrists in a discipline that I am new to.

OPA: In what ways have you seen the OPA change over the last 10 years?

Adrian: In the six years I have been a member, my perception is that the OPA has been progressively trying harder to reach out to its members and be involved in the issues important to the profession and the discipline.

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

Adrian: I think that every psychiatrist should be almost as interested and attentive to addictions as I am! Joking aside, I believe that psychiatrists need to increase their awareness of the addictions as treatable mental illnesses.

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

Adrian: Well, I have already tried and enjoyed family practice, both solo and as an academic. When I was a Roman Catholic monk for 2 years in the dim distant past, I became very interested in philosophy. This interest has remained, so, I might consider becoming a professional philosopher or ethicist.

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

Adrian: Being a totally unselfish physician, I can't wish for unlimited wealth, happiness and health. So instead, on behalf of the world, I wish for a reduction in the American need for empire building, the reform of institutions, like the International Monetary Fund, that are further impoverishing the third world, and a change in the type and/or extent of globalization, that is also impoverishing the third world, and even many in the first world.

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

Adrian: 1) Ongoing integration of brain science and psychodynamic psychiatry.
2) Seeing psychiatry become fashionable again so that we might have less difficulty filling our residency quotas and attracting the best brains to our profession.
3) Income structures that are more likely to attract and retain people in our discipline.

OPA Dialogue 2002-2003 Survey Results

Congratulations to Dr. William M. Davies of Toronto who won \$100.00 off his 2004 Annual Meeting Registration Fee for returning his completed 2003 Dialogue survey prior to July 31, 2003.

Surveys sent: 2002 – 368 email/717 mail
2003 - 379 email/ 693 by mail

Responses received: 2002 – 50 email/8 fax
2003 – 1 email/5 fax/mail

1. Do you read Dialogue on a regular basis?			2. Do you pass on Dialogue to others?			3. Do you think Dialogue is informative/ provides useful information? **			4. Do you think Dialogue tells you about what is happening in psychiatry?		
	2002	2003		2002	2003		2002	2003		2002	2003
all the time	23	2	all the time	2	0	all the time	2		all the time	5	1
most of the time	18	3	most of the time	0	0	most of the time	3		most of the time	27	4
sometimes	12	1	sometimes	9	0	sometimes	0		sometimes	22	1
not too often	4	0	not too often	12	3	not too often	0		not too often	3	0
not at all	1	0	not at all	35	3	not at all	1		not at all	1	0

5. 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

	2002			2003			2002		2003		2002		2003		2002		2003	
	Y	N	N/A	Y	N	N/A	A	B	C	D	E	N/A	A	B	C	D	E	N/A
Message from the President	55	3	0	2	1	3	28	4	11	1	14	1	4	0	1	0	0	0
From the Editor	48	10	0	2	1	3	29	4	9	1	12	1	6	0	1	0	1	0
Calendar of Events	58	0	0	3	0	3	40	1	9	3	5	3	3	0	1	0	0	0
OPA Council Meeting Agenda	50	8	0	2	0	3	33	1	6	0	10	3	5	1	3	0	1	1
Council Highlights	54	4	0	3	0	3	33	1	10	1	8	3	4	1	2	0	1	0
Meet a Council Member	44	14	0	3	0	3	21	1	3	2	19	1	7	2	5	0	3	0
Members on the Move	45	13	0	3	0	3	28	1	7	2	14	2	2	1	4	0	3	0
Resident's Review	53	5	0	2	0	4	23	1	10	1	12	2	7	2	3	0	3	0
Coalition Updates	54	4	0	2	1	3	28	2	12	2	12	2	4	0	1	0	1	0
AGHPS updates	45	8	5	2	1	3	25	0	10	2	16	4	5	0	2	0	0	0
OPDPS updates	41	12	5	2	1	3	28	2	8	1	13	2	6	0	4	0	2	1
OMA Section on Psychiatry news	56	1	1	3	0	3	33	2	11	2	11	2	1	0	1	0	1	0
CPA updates**	0	0	0	3	0	3	0	1	0	3	0	2	0	0	0	0	0	0
APA updates**	0	0	0	2	1	3	0	1	0	1	0	2	0	2	0	0	0	0
RBRVS information	52	5	1	2	1	3	25	0	14	2	10	2	6	1	3	0	0	1
CTC information	50	7	1	3	0	3	29	1	5	3	18	0	3	2	2	0	1	0
Government news	49	6	3	3	0	3	29	2	7	3	15	1	2	0	4	0	1	0
Book Reviews	44	12	2	3	0	3	28	0	9	4	13	2	4	0	2	0	2	0
General Mental Health Info	45	11	2	3	0	3	28	1	6	3	14	2	5	0	3	0	2	0
Mental Health Resources	50	6	2	3	0	3	29	1	5	4	15	0	5	1	2	0	2	0
Legal issues/topics	54	2	2	3	0	3	35	2	4	3	15	1	1	0	0	0	2	0
Pharmaceutical Advertisements	27	26	5	2	1	3	29	0	2	1	7	2	9	1	8	1	3	1
Positions available**	0	0	0	2	1	3	0	0	0	1	0	0	0	2	0	3	0	0
Other classified ads	31	21	6	1	2	3	28	0	3	1	11	0	6	2	7	2	3	1
Classified ads from Members*	40	13	5	0	0	0	32	0	4	0	11	0	7	0	3	0	1	0
Classified ads from Non Members*	26	27	5	0	0	0	29	0	2	0	5	0	12	0	7	0	3	0
RAI-MH information*	34	20	4	0	0	0	21	0	3	0	15	0	10	0	7	0	2	0

6. What other topics would you like to see covered in Dialogue? 2002/2003

- 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.
- There are others?

7. Other comments or suggestions

None.

Membership Category

	2002	2003
Full	48	2
Associate	1	0
Member- in –Training	3	1
Life	6	3

* 2002 Survey only

** New for 2003

Guidelines for Clinical Practice and Facility Standards – Psychotherapy

The Coalition of Ontario Psychiatrists (OPA-OMA Section on Psychiatry) provided comments to the College of Physicians and Surgeons regarding the most recent draft of the Guidelines for Clinical Practice and Facility Standards on June 23, 2003. This submission indicated that the “Standards and Guidelines for the Psychotherapies” (1998) is the clearest and most comprehensive guidelines for

the psychotherapy practice for psychiatrists. The submission also provided comments indicating that the CPSO document requires extensive revision.

For a copy of the complete submission, please contact the OPA office at (905) 827-4659 or by email: opa@bellnet.ca

28 October 2002



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

Dear Minister:

Re: Mental Health Reform

I am writing on behalf of the Ontario Psychiatric Association (OPA) with serious concerns regarding recent developments in the reform of mental health services.

The OPA is very supportive of the goals of mental health reform. One of the goals is to create local systems of care that will ensure that people with mental illness and their families have access to a broad range of community-based services and supports. Our Association supports this goal; however, we are concerned about the proposed governance structure to achieve these local systems of care, that is, the implementation of regional mental health authorities/boards. To hive off mental health from health, we believe, is not advantageous to people with mental health and (other) health problems. Our understanding is that Alberta and New Brunswick had to reverse their mental health authority process. Best practices have not been established in the area of governance and evidence based research shows that mental health authorities have not had a positive impact on clinical outcomes.

By the end of this year, the nine Mental Health Implementation Task Forces will have finalized their recommendations. We believe that the Task Forces are to be congratulated for all of the important work that they have done and for taking the opportunity to consult with thousands of people in the mental health field. We believe that all of the Task Forces have done excellent work and have made many very positive recommendations with respect to improving access to and utilization of community mental health services. All of these recommendations can be implemented without the establishment of regional mental health governing boards or authorities. We urge you to act as quickly as possible to invest in, and implement, the much needed service delivery reforms.

We are concerned too that provincial organizations, such as the OPA, have not been given sufficient opportunity to provide their views on how this important endeavor can be implemented. Our Association met with Michael Wilson, Chair of the Toronto-Peel Task Force, at his invitation, on September 20th and we attended the invitational information session hosted by the Provincial Forum on September 23rd. The question and answer period following the session indicated that a variety of common concerns had not been adequately addressed as yet.

If we want to ensure that there will be a greater range of, and improved access to, mental health services in the community, tailored to specific individual needs, and that those 'best practice' services are linked, such that those individuals with mental illness can move seamlessly within the system, there needs to be dialogue with provincial organizations. The recent letter from OMA President Dr. Elliot Halparin suggests that treatment be removed from this phase of the reform agenda, and we believe this suggestion should be explored further. We feel that it will be important to ensure that psychiatrists can support the implementation of those recommendations approved by government. As a provincial Association, we expect to play a lead role in educating our members regarding the implementation of the recommendations.

We would be pleased to provide additional information or comment and to discuss this important matter with you. Please contact Dr. Keith Anderson directly at 613-725-2284.

Sincerely,

Margaret Steele, HBSc, MD, FRCP(C)
OPA 2002 President

cc. Elliott Halparin, MD, CCFP, FCFP, Ontario Medical Association President

Ministry of Health
and Long-Term Care

Office of the Minister

10th Floor, Hamilton Block
50 Grosvenor Street
Toronto ON M7A 2C4
Tel: 416 327-4318
Toll: 416 228-1871
www.gov.on.ca/health

Ministère de la Santé
et des Soins de longue durée

Bureau du ministre

10^e étage, édifice Hamilton
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Tél. : 416 327-4318
Toll : 416 228 1871
www.gov.on.ca/santé



Ontario

W. J. Stabile, M.D., C.M., F.R.C.P.(C).
65 Thomas Street
Port Hope, ON, L1A 3H5

March 28th, 2003

Dr. Robert Buckingham, President
Ontario Psychiatric Association
1141 South Service Road West
Oakville, ON, L6L 6R4

Dear Bob,

In the March 2003 issue of Dialogue, you invited comments on the paucity of young psychiatrists at the Annual Meetings. In this, my 10th year of official retirement, I feel I must bestir myself and try to contribute something on this subject.

What I have noticed for the last many years is the absence of the leaders of psychiatry from the many teaching hospitals and departments of psychiatry. This contrasts greatly with the way things were when I moved from McGill to Toronto in 1955. For many years the Chairmen and senior psychiatrists were enthusiastic promoters of the OPA. They encouraged the younger psychiatrists and residents to present papers and participate in panels and workshops. It would have been unthinkable to not cancel various Grand Rounds and other meetings so that staff and residents could attend the OPA.

For several of us 'old hands' it is enjoyable to meet once a year at the Annual Meeting. At the last meeting my wife, Jean, and I enjoyed dinner with Ian and Charlotte Hector, and I enjoyed chatting with Quentin Rae-Grant, Andy Zajac, Ed Kingstone, Ed Rzascki and Bettu O'Brien among others. I am sure we will continue to attend as long as we can.

Good luck to you and your Council.

Sincerely,

Bill

9/1/03
Dr. Margaret Szele
President

Ontario Psychiatric Association
1141 South Service Road West
Oakville ON L6L 6K4

Dear Dr. Szele:

Thank you for your October 28, 2002 letter regarding the Mental Health Implementation Task Forces (MIITFs). I am pleased to note that your organization supports many of the initial directions that the MIITFs have identified regarding the implementation of mental health reform. I apologize for the delay in responding.

As indicated in your letter, you have had the opportunity to participate in an individual meeting with Michael Wilson, vice-chair of the Provincial Forum as well as the larger presentation by the Provincial Forum in September. I understand that many issues were discussed at both meetings and that the dialogue was very productive in addressing several concerns. In terms of detailed recommendations such as governance structures, no decisions will be made until we have reviewed the final Task Force reports and developed a government strategy to address their recommendations.

The final Mental Health Implementation Task Force reports have been submitted, and my ministry is undertaking a thorough analysis of the recommendations to chart the next steps in implementing Making It Happen, our policy framework for mental health systems in Ontario. As you can appreciate, I am not in a position to comment until we have had the opportunity to review and analyse the final reports.

Again, I want to thank you for sharing your views, and I would like to acknowledge your commitment to mental health reform and the important role your organization plays. Your comments are invaluable as we move forward with important reforms to our health care system.

Yours very truly,

Tony Clement
Minister

MIN 0203

200-01188

MIN 0203

CORRECTIONAL FACILITY TO PROVIDE PSYCHIATRIC TREATMENT

Construction of the St. Lawrence Valley Correctional and Treatment Centre, on the site of the Brockville Psychiatric Hospital, began in June 2001 and will be completed in late 2004.

The Centre is considered a leading-edge model in the management and treatment of mentally ill offenders. The target population for the secure treatment unit is male provincial offenders with psychiatric problems who pose a risk to the community and themselves. Mentally ill offenders will have access to appropriate treatment while in custody and will be provided with continuous care - well-established links and services in the community - when they are released. Because provincial offenders are in the correctional system for a short period of time (up to two years less a day), it is critical that connections are established with the right resources in the community to reduce the risk of re-offending.

The first phase of construction, which includes a 100-bed secure treatment unit, for mentally ill offenders, and a renovated 44-bed forensic treatment unit, for patients who have been found not criminally responsible, is complete and occupancy is anticipated to begin in the next several months.

The second phase of construction consists of a 300-bed correctional treatment unit for sex offenders and offenders with behavioural and addiction problems. This treatment unit will replace the Ontario Correctional Institute in Brampton. The second phase also includes a 54-bed remand unit for prisoners awaiting bail or trial and replaces the 160-year old Brockville Jail.

The Ministry of Public Safety and Security and the Ministry of Health and Long-Term Care will engage in a partnership for treatment services with the Royal Ottawa Health Care Group during the first phase of the program. While it is intended that the hospital will provide treatment services to the secure treatment unit, key principles of containment and security will be reflected in the day-to-day operations.

For additional information please contact: Marilyn Tomkinson, Deputy Superintendent/Treatment, St. Lawrence Valley Correctional and Treatment Centre, (613) 341-2888

Report of the Continuing Education Committee

by Ann Thomas, Chair, Continuing Education Committee

Planning continues for the 2004 Annual Meeting. The theme for the meeting, as chosen by our President, Dr. Robert Buckingham, will be "Destigmatizing Mental Illness".

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

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

The June issue of *Dialogue* reported on confirmed speakers: Dr. Donald L. Nathanson of the Silvan S. Tomkins Institute and Clinical Professor of Psychiatry at Jefferson Medical College in Pennsylvania, who will be giving the theme address entitled "Stigma and the Compass of Shame", as well as a workshop entitled "When Stigma Explodes: Managing Shame to Prevent Violence"; Dr. Charles Schulz of the University of Minnesota, on the use of atypical antipsychotic agents in disease states other than schizophrenia; Dr. Michael Robinson of Queen's University on delirium; and Dr. Susan Abbey of Toronto General Hospital on "Fibromyalgia and Chronic Fatigue: An update focusing on how psychiatrists can help"; Dr. Bryan King of Dartmouth Medical School in Hanover, N.H. presents "Psychopharmacological Issues in Developmental Disabilities", and Dr. Mamta Gautam will discuss "Stigma In the Culture of Medicine".

New this year! In conjunction with The Ontario College of Family Physicians, we will be offering a Pre-conference one-day Cognitive Therapy Workshop on Wednesday, January 28, 2004. We are pleased that Dr. Christine Padesky,

Distinguished Founding Fellow of the Academy of Cognitive Therapy and a Co-Founder of the Center for Cognitive Therapy in California has agreed to present this workshop entitled "Cognitive Therapy for Panic Disorder".

We are also working on a three-hour workshop covering the aspects of dementia. Registration will be limited for this workshop, so be sure to book early!

There will also be a symposium on Independent Medical Examinations. Dr. John Mount will address the business and risk management aspects of conducting IMEs. Dr. Erhard Busse, psychiatric consultant at ATF-Oncidium Health Group Inc. will discuss the various needs of employers, insurers, and treatment providers. This presentation will focus on the politics and strategic considerations involved.

Two luncheon symposia will be offered this year. One luncheon presentation is being organized by CANMAT and will address the treatment of bipolar depression. Speakers at that luncheon will be Dr. Diane Whitney of University of Toronto, Dr. Roumen Milev of Queen's University and Dr. Lawrence Martin.

The second luncheon will cover the topic of chronic pain. Dr. Peter Moran will give an overview of the current concepts of chronic pain; Dr. Harvey Moldofsky of University of Toronto will speak on sleep in chronic pain conditions and Dr. Doug Gourlay will bring us up to date on the current use of opioids in the management of non-malignant chronic pain.

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

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

NEW FEDERAL REGULATIONS FOR NATURAL HEALTH PRODUCTS

The Honourable Anne McLellan, Minister of Health, recently announced the adoption of the Natural Health Products Regulations. Previously, natural health products (NHPs) have been sold as either drugs or foods under the Food and Drugs Act and Regulations, since there is no other category in which they can be classified. The new Regulations call for improved labelling, good manufacturing practices, product and site licensing, and provisions for a full range of health claims that will be supported by evidence. There will be a transition period for the Regulations that will span from 2 to 6 years - 2 years for site licensing and 6 years for products with drug identification numbers (DINs) - to allow manufacturers, labellers, packagers, importers and distributors time to meet the new requirements. During the phase-in period, Health Canada will provide support to industry, and undertake a comprehensive public education and outreach program to ensure that the Regulations are well understood.

The products that fall within the new Regulations include herbal remedies, homeopathic medicines, vitamins, minerals, traditional medicines, probiotics,

amino acids and essential fatty acids (such as Omega-3).

All natural health products in Canada will now require a product licence before being marketed. Obtaining a license will require detailed information on the product submitted to Health Canada, including medicinal ingredients, source, potency, non-medicinal ingredients and recommended use. Once a product has been assessed by Health Canada, the product label will bear a product licence number preceded by the distinct letters NPN, or, in the case of a homeopathic medicine, by the letters DIN-HM. The product licence number on the label will inform consumers that the product has been reviewed and approved by Health Canada for safety and efficacy.

Labels will be required to specify directions for use, the recommended use or purpose (health claim), medicinal and non-medicinal ingredients, and any cautions, contra-indications or known adverse reactions associated with the product.

Child and Youth Health Report, Northern Ontario

The Northern Ontario Child and Youth Health Report, published in June 2003, by the Northern Health Information Partnership (www.nhip.org) contains information regarding a variety of mental health conditions in children and youth in Northern Ontario, as compared to children and youth in Ontario. For example, the report indicates that hospitalizations for mental health issues in Northern Ontario occur at approximately 160% of the provincial rate, for those aged 14-19 years. Death, due to intentional self-injury, is also approximately three times more frequent in

Northern Ontario as in the rest of the province, and, while both provincial hospitalization and death rates, due to suicide attempts, have been decreasing over the past decade, both rates are increasing in Northern Ontario.

The full report is available from: website:
<http://www.nhip.org/child/The%20Northern%20Ontario%20Child%20and%20Youth%20Health%20Report.pdf>

Attention Members !

Call for Nominations to Council

The OPA needs your ideas, enthusiasm 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 2004 OPA Elections are now being accepted. Council Meetings are held in Toronto in January (during the OPA Annual Conference), March, June, September and November.

We are looking for a President Elect, Treasurer, Secretary, three Council Members (Full Members) and one Member-in-Training beginning January 2004. Term of office for Secretary, Treasurer and Council members is January 2004 to January 2007, January 2004 to January 2005 for President Elect and January 2004 to January 2006 for Member-in-Training.

A Full Member is a legally qualified practitioner who is licensed to practice medicine in Ontario and is:

- (a) Registered as a specialist in psychiatry by the Royal College of Physicians and Surgeons of Canada, and is in active practice, or,
- (b) Teaching psychiatry in a university or other senior psychiatric position.

A Member-in-Training is a person who is registered in an approved, psychiatric, post-graduate training programme, or, in an undergraduate medical programme, in Ontario.

A Life Member (any Member who has reached the age of 65 and whose years of age and years of Full membership total 80 in the Association) retains all the rights and privileges of a Full Member.

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.

A President-Elect serves for one year prior to becoming President. 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. A Member-in-Training is elected for a term of two years. There are two Council members who are Members-in-Training, elected for a term of two years, one Member-in-Training is elected in each succeeding year.

Role Descriptions 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 Friday November 28, 2003. For further information please contact Dr. Margaret Steele, OPA Past President, by telephone: (519) 667-6671 or by email: margaret.steele@lhsc.on.ca.

Ontario Drug Strategy Review

On May 23, 2003, the Ontario Psychiatric Association submitted comments on the Drug Strategy Review of the Ontario Ministry of Health and Long-Term Care, on behalf of its members. In the submission, the OPA commented on the short timeframe for response and asked that the Drug Strategy Review Steering Committee seek additional input from psychiatrists about drugs prescribed to people with mental illness. The OPA submission stated that:

- Recent discussions and reports regarding a National Pharmacare Program should be reviewed by the Ontario Ministry;
- The Ontario Drug Benefit (ODB) program should be more aware of the needs of people with mental illness, who receive the medications, and the statistics regarding this population, in order to better plan for drug utilization in the area of mental illness, in the future;
- Access to medications is critical to the ability of people with mental disorders to be able to live and work in the community, and, access to medications which are best suited to the individual patient, and which minimize side effects, will assist in improving the health outcomes of people with mental illness;
- There are additional challenges in terms of types of drugs and dosages required, when prescribing for children or adolescents, as opposed to adults;
- The variability in drug regimen amongst patients, common in mental health prescribing, should be acknowledged within the various approval processes. For example, under the Section 8 process, changes in dosages should be accepted without the further need for approvals and continued submissions by psychiatrists. Delays in approval, and re-approvals, prevent the timely delivery

of medication therapies to patients who rely on medication to function on a day-to-day basis;

- Education, regarding best practices in prescribing, current research, guidelines, and clinical experience, achieved through peer education, are all effective ways to promote optimal drug prescribing and use;
- Patients and their families want better access to psychiatrists who can help them to understand the need for their medications, the disorder that is being treated, and how families can support the individual with mental illness. Patients often have to cope with various drug regimens until the best drug protocol can be discerned, often with side effects that may require other medications. Patients need regular monitoring to ensure that they continue to take their medication, often on a long-term basis;
- It would be helpful to further reduce the number of medications used in the treatment of mental illness, which are currently under Limited Use or require Section 8 approval, to reduce the need (and the administrative burden to psychiatrists) for approvals for changes which are common place for this population (for example, dosage changes or annual approvals for medications which are required for long term use);
- Access to new and existing drugs must be streamlined in order to allow psychiatrists to prescribe the best possible medication for their patients, given their individual situation;
- During the time in which various drug regimens are being considered, bulk buying, to reduce co-payments, results in drug wastage. People with mental illness are more likely to have to pay more co-payments as compared to other

patient populations, where the drug regimens are more clearly delineated. This is unfair for this patient population that struggles to put their lives together and often have few financial resources available to them;

- Faster approvals will enable patients with mental illnesses to benefit from new drugs on the market that may, as compared to older drugs, have fewer side effects. Often it is the side effects of the medication that convinces patients to stop taking their medication, resulting in decompensation;
- The involvement of psychiatrists on the Drug Quality and Therapeutics Committee and for expert opinion when new psychotropic drugs are being

considered would assist in providing needed information regarding the types of patients that psychiatrists see, as well as the types of medication that people with mental illness require;

- Psychiatrists should be notified of any changes to policy or the program directly, including changes that could impact on their patient's ability to pay for their medications, which may result in medication avoidance and therefore, increased risks to their patients of decompensation and suicide.

For a copy of the submission in its entirety please contact the OPA office.

Drug Strategy Review
10th Floor, 1075 Bay St.
Toronto, Ontario
M5S 2B1
Telephone: (416) 212-4685
Facsimile: (416) 212-3799

Révision de la stratégie relative aux médicaments
1075, rue Bay, 10^e étage
Toronto, Ontario
M5S 2B1
Téléphone: (416) 212-4685
Télécopieur: (416) 212-3799

May 26, 2003.

Dr. Robert Buckingham
Ontario Psychiatric Association
1141 South Service Road West
Oakville, ON
L6L 6K4

Dear Dr. Buckingham:

Thank you for your recent response to our request for submissions to the Drug Strategy Review (DSR). We are delighted that you have contributed to this important initiative. Your input will be reviewed by the Steering Committee and Working Groups prior to submission of the DSR Steering Committee's report to the Minister of Health and Long-Term Care.

As you know, the DSR is reviewing the Ontario Drug Benefit Program and developing a strategy to achieve improved pharmaceutical care for Ontarians through a more effective, patient-focused and sustainable program. We believe that the involvement of our stakeholders in the Review process is essential to the success of this initiative.

Once the interim report has been completed, you will have the opportunity to provide further input into the process, as the DSR plans to hold sectoral consultations at that time. In this way, the DSR expects that all interested stakeholders will have the opportunity to provide input to the Steering Committee's final recommendations.

I would like to thank you for your interest and participation in this review.

Yours sincerely,

Original signed by

Bill Blundell
Chair, Drug Strategy Review

NEW INITIATIVES TARGETING YOUTH AND MENTAL ILLNESS

To raise awareness about schizophrenia among youth, between the ages of 15 and 24, and to reduce the stigma associated with this disorder, the Schizophrenia Society of Canada and the Schizophrenia Society of Ontario recently launched "Reaching Out", a teen-oriented educational program that will provide educators with tools to effectively communicate key information that will help promote the early diagnosis and treatment of schizophrenia among young people.

The resource kit, which is available at no cost to educators, includes a professionally produced video docu-drama that highlights the experiences of people who are successfully living with schizophrenia. Other resource materials include recommended lesson plans, FAQs, suggested role-playing scenarios, as well as several web links and referral sources. The resource kit is being offered to approximately 6,000 high school and selected middle school principals across Canada. In addition, the program will be available to download at www.schizophrenia.ca.

The Schizophrenia Society of Ontario, in partnership with Scadding Court Community Centre, also launched their youth awareness program, which consists of a Website (www.ssoaware.com) geared specifically to young people. The Website has information to help raise awareness of schizophrenia, promote early identification, provide links to intervention and treatment services, and aid in eliminating the misunderstanding and stigma surrounding this disorder. A 30-second public service announcement for television was produced in English, French, Cantonese and Italian and can be viewed online.

Addiction and Mental Health Treatment Sites May Be Merged at CAMH Site

An article in the Toronto Star on July 10, 2003 suggested that a \$328 million dollar plan to amalgamate four Toronto addiction and mental health treatment sites — with help from the private sector — is being considered by the Centre for Addiction and Mental Health (CAMH). Part of the plan may be for the private sector to rebuild, equip and lease back the existing 27-acre Queen Street facility to the Ontario government. The rebuilt Queen St. site would incorporate services currently offered at the Donwood site (137 Brentcliffe Rd.), the Clarke site (250 College St.) and the Addiction Research Foundation site (33 Russell St.). Several proposals are being considered including selling the Donwood site, and making

way for a Loblaws, Tim Hortons or a drycleaners on the redeveloped Queen Street site.

The province has already approved plans for the involvement of the private sector in hospitals in Brampton and Ottawa and the Tory re-election platform talks about using "innovative partnerships with the private sector" to build or expand hospitals, such as the Peterborough Regional Hospital and the Markham-Stouffville Hospital. Potential partnerships with the private sector include, but are not limited to, having the private sector build and equip hospitals, and then leasing them back to the public sector.



23 June 2003

Dr. Bonita Porter
Deputy Chief Coroner - Inquests for Ontario
Office of the Chief Coroner
25 Grenville Street
Toronto Ontario M7A 2G9
Dear Dr. Porter:

I am writing to you to provide comment regarding the recommendations of the jury serving in the inquest into the death of Paola Rosales.

The Council of the Ontario Psychiatric Association (OPA) has reviewed recommendation 10 and Reason as quoted below:

We recommend the federal and provincial Ministries of Health allocate additional resources for:

- The establishment of both inpatient and community-based psychiatric programs for youths.
- The number of applicants for psychiatric residency programs doubles the number of positions available. We recommend additional funding to hospitals and universities so as to permit a greater number of adolescent psychiatrists to be trained and qualified in the province.
- In the case of children in the care of a children's aid society, we recommend the compensation child psychiatrists for their attendance at case plan or case conference meetings.

Reason: In the Mental Health system at present, there is a dearth of both inpatient and outpatient psychiatric services for adolescents in this province. If adolescent suicide is to be prevented, it is imperative this deficiency be rectified as soon as possible.

The Ontario Psychiatric Association is in support of recommendation 10. We support increasing the number of psychiatric residency positions and increased funding for the training of child and adolescent psychiatrists.

The Canadian Academy of Child and Adolescent Psychiatrists and the Royal College of Physicians and Surgeons of Canada recommend one child psychiatrist per 16,000 population, or about one for every 4,000 children. No jurisdiction has anywhere near this coverage. There are not enough funded positions.

We note that recommendation 10 refers to the federal and provincial Ministries of Health and wanted to bring to your attention the fact that the Ministry of Community, Family and Children's Services (MCFCS) provides funding for training positions for child and adolescent psychiatrists as well. In addition, we are aware that the Canadian Psychiatric Research Foundation has published a brief guide, entitled, "When Something is Wrong", that helps educators to identify depression, schizophrenia, and anxiety, eating and impulse-control disorders in students. Services to assess and treat those children and youth, identified by educators, simply will not be available. Left untreated, many psychiatric disorders in children and youth will persist into adulthood.

I trust that this information will be helpful to your office.

I would like to take this opportunity to thank the Office of the Chief Coroner for continuing to send the Verdict of Coroner's Jury and explanation to our Association. We appreciate the opportunity to review and share the information and recommendations with our members.

If you require any additional information please do not hesitate to contact me.

Sincerely

Robert Buckingham, MD, FRCPC
2003 OPA President

c.c. Honourable Tony Clement, Minister of Health and Long-term Care, Hepburn Block, 10th Floor, 80 Grosvenor St., Queen's Park, Toronto, ON, M7A 2C4
Luc Morin, President, Canadian Academy of Child & Adolescent Psychiatry, c/o Douglas Hospital, 7070 boulevard Champlain, Verdun, QC, H4H 1A9
Honourable Brenda Elliott, Minister of Community, Family and Children's Services, Hepburn Block, 6th Flr, 80 Grosvenor St, Toronto ON M7A 1E9
Dr. Richard Swinson, Chair of the Specialty Committee for Psychiatry, Royal College of Physicians and Surgeons, The Royal College of Physicians and Surgeons of Canada, 774 Echo Drive, Ottawa, ON, K1S 5N8
Dr. Blake Woodside, President, Canadian Psychiatric Association, 260-441 Maclaren, Ottawa, ON, K2P 2H4
Dr. James Clarke, President, Canadian Association for Interns & Residents, 151 Slater St., Suite 412, Ottawa, ON, K1P 5H3

Sessional Fee Rates Increase 15% OMA Section on Psychiatry – UPDATE

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

Effective November 6, 2002, sessional fee rates in Provincial Psychiatric Hospitals increased 15% as a result of the settlement reached between Management Board and the Association of Ontario Physicians and Dentists in Public Service (OPDPS). The Coalition of Ontario Psychiatrists started lobbying to have the sessional fee increase extended to other programs as soon as the OPDPS completed their negotiations in November 2002.

The Honourable Tony Clement, Minister of Health and Long-Term Care has sent out a letter announcing that the Ministry of Health and Long-Term Care is extending this increase to all agencies that receive a psychiatric sessional fee allocation. In 2001/02 Community Mental Health Agencies, Children Mental Health Institutional Programs and General Hospital Psychiatric Departments received more than \$20 million in sessional funds. This 15% increase is retroactive to November 2002 and will increase the sessional pool by \$3 million annually.

The new rates are:

General Practitioners \$231 increasing to \$266

Psychiatrists \$311 increasing to \$358

Sessional funding is a mechanism to pay for a variety of 'indirect' psychiatric services provided by psychiatrists/physicians in Community Mental Health Agencies,

Children Mental Health Institutional Programs and General Hospital Psychiatric Departments. In most cases, a multidisciplinary team, which includes a psychiatrist, delivers psychiatric services in these settings. Sessional funding compensates these physicians for participating in indirect case management and for consulting with other professionals to plan, monitor and evaluate care. The sessional rate has remained unchanged for over 10 years at \$311 per session, a minimum of three hours and a maximum of four hours (about \$104 - \$77 per hour) since before 1993. Psychiatrists cannot bill OHIP for services during the time they are being paid a sessional fee.

In 1993, the NDP government unilaterally cut sessional funds by 25%, keeping the rate the same but cutting the total funds available. Since that time various unsuccessful efforts have been made by the Section on Psychiatry and other professional psychiatric organizations to engage the MOH and the government in solving the crisis. In 2000, as a result of lobbying by the Coalition of Ontario Psychiatrists and as part of the OMA/MOHLTC negotiations, the current government restored the sessional funds back to their 1993 level but left the sessional rate unchanged. Psychiatrists representing the OMA Section on Psychiatry, the OPA, the Association of General Hospital Psychiatric Services (AGHPS) and the OPDPS worked together to at last bring about the increase to the sessional fund rate.

COALITION RETREAT A SUCCESS

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

In the spring of 1997 the Coalition was an idea that a group of psychiatrists had to unite Ontario psychiatrists. The Coalition of Ontario Psychiatrists is a formal partnership of the Ontario Psychiatric Association and the Section on Psychiatry of the Ontario Medical Association. The Coalition represents the more than 1700 psychiatrists in Ontario. The Coalition brings together the leadership not only of the OMA Section on Psychiatry and the OPA, but also the representatives of the Association of General Hospital Psychiatric Services (AGHPS) and the Association of Ontario Physicians and Dentists in Public Service (OPDPS). The Coalition Executive consists of the Chair (yours truly), Past-Chair (Dr. Gerry McNestry) and Vice Chair (Dr. Michael O'Mahony) of the OMA Section on Psychiatry; the President (Dr. Bob Buckingham), Past-President (Dr. Margaret Steele) and President Elect (Dr. Doug Wilkins) of the OPA (one of those three is a member of the OMA Section on Psychiatry Executive – currently this is Dr. Bob Buckingham) and a member at large who currently is also a member of the OMA Section on Psychiatry (Dr. Barry Gilbert).

Since its inception, the Coalition has held retreats attended by the Executive of the OMA Section on Psychiatry, the OPA Council Members, and representatives of the AGHPS and the OPDPS. The most recent retreat was held on Saturday, June 21, 2003. This year, Dr. Karen Hand was our invited guest, as the representative of the ACT psychiatrists.

The Coalition retreat was a success. We heard a number of excellent presentations that generated useful discussions. Invited guests included: Mr. George Boddington and Mr. Peter Regenstreif, from Policy Concepts, who have worked with the Coalition as political lobbyists and advisors on government relations and communications; Dr. Larry Erlick, OMA President; Dr. Chris McKibbin, Co-Chair Physician Services Committee; Dr. Steven Harrison, Advisor, Health Policy for the OMA; and Mr. Bruce Light, who has advised us about negotiations.

At the end of the day, participants were asked their views on what the priorities should be for 2003-2004. In summary, when asked to rank first, second, third, and other objectives that should be priorities for the Coalition in the next year, "correcting fee inequities" was identified as the top priority. The next three priorities identified were: "communicating with our members"; "getting our message out to the Liberals and Conservatives before the next election"; and, "preparing for the 2004 OMA/MOHLTC negotiations".

In future issues of *Dialogue*, notices regarding "Positions Available/Practices for Sale/Persons Seeking Employment/Positions Sought" will be published for OPA Members free of charge. Non-Members will be charged a fee. Please email your notice to: opa@bellnet.ca fax: 905-469-8697 or mail to Ontario Psychiatric Association, 1141 South Service Rd. W., Oakville, ON, L6L 6k4

PSYCHIATRY REFERRAL SERVICE IN OTTAWA: PSYCHIATRISTS HELPING FAMILY PHYSICIANS AND THEIR PATIENTS.

by Dr. Keith Anderson

The Ottawa Academy of Medicine established a Psychiatry Referral Service a little over one year ago. With the recent approval of funding, from the Ministry of Health and Long-Term Care, for a second fiscal year, the Service will be able to continue to assist family physicians to more easily access psychiatric consultation. The Service is currently getting between 90 and 100 requests per month from family physicians although we are only able to provide 70-75 consultations per month right now.

More than 350 family physicians have accessed the service so far. We are receiving very good feedback from the family physicians, health care administrators and the Ministry. In particular, people are impressed by the fact that over 50 community based psychiatrists (out of 135) have volunteered their services to help address a problem that was identified by primary care physicians.

Each psychiatrist provides at least one consultation per month. All the family physician has to do is call the Academy of Medicine and provide the particulars regarding the needed consultation. The Academy then gives the family physician the names of two psychiatrists who are available. The family physician then contacts

the psychiatrist who sets up an appointment in their usual manner for a consultation with the patient. The family physician is expected to notify the Academy of the arrangements so that the psychiatrist's name is taken off the availability list until the next month.

The consultation can be a one shot effort with a report, part of a shared care service, or, it may lead to ongoing treatment, depending on what the family physician and psychiatrist work out between themselves.

It is exciting that so many community based psychiatrists have joined the service. We hope that in the future, many more psychiatrists will be able to join this voluntary service. The Psychiatry Referral Service is just one example of how physicians are responding to the needs of their community.

For more information please contact Jennifer Valentino at the Academy of Medicine of Ottawa 613-733-2604 or Dr Keith Anderson 613-725-2284 or email: KeithAndersonMD@aol.com

The recent Supreme Court of Canada *Starson v Swayze* decision was covered extensively in the media. The following three articles provide information on what the judgement means for psychiatrists, from different vantage points:

Implications for Psychiatrists of the Supreme Court of Canada *Starson v. Swayze* Decision

By: S.A. Brooks, MB, FRCPC¹, R.L. O'Reilly, MB, FRCPC², J.E. Gray, PhD³

Owing to the nature of the media reports of the *Starson v. Swayze* judgement (2003; SCC 032), the CPA Board of Directors invited the above-named experts to prepare an advisory that would better inform members of the actual implications of the judgement on psychiatric practice.

What is the *Starson v. Swayze* Decision?

Scott Starson is a highly intelligent man with an interest in physics. In 1998, an Ontario Court found him to be not criminally responsible on account of mental disorder of uttering death threats. Later, while confined to a mental hospital, he was found to be incapable of consenting to or refusing treatment. The Ontario Consent and Capacity Board (CCB) reviewed his case and confirmed the finding of treatment incapacity. Subsequently, three courts, including the Supreme Court of Canada (June 6, 2003, in a split decision) overturned the finding of incapacity. The courts' decisions were partly based on the opinion that insufficient evidence had been presented to the CCB. The courts also noted that the CCB appeared to have been overly influenced by what it saw as Mr. Starson's best interests rather than with a strict interpretation of the law.

The Supreme Court lowered the standard of evidence required to confirm incapacity to the "balance of probabilities" rather than the enhanced standard previously used in Ontario.

What the *Starson v. Swayze* Decision Does Not Change

The Supreme Court did not change the specific elements required to make a finding of treatment incapacity in Ontario or other jurisdictions. Under the Ontario Health Care Consent Act (HCCA), it remains possible to treat an incapable patient against his or her will with the consent of a substitute decision maker, as long as the finding of incapacity can be proven on a balance of probabilities by appropriate evidence. However, the HCCA does not permit even involuntary patients to be treated if their informed refusal is deemed to be a capable one. The *Starson v. Swayze* case did not deal with any constitutional or Charter challenge to the HCCA and leaves intact the laws of a number of other Canadian jurisdictions that do not permit an involuntary patient, regardless of capacity, to refuse needed psychiatric treatment.

Implications of the *Starson v. Swayze* Decision

The Supreme Court ruled that Mr. Starson's physicians did not establish that he lacked the capacity to make a decision on his own treatment. The Court opined that it was unclear whether Mr. Starson had been informed that the absence of treatment would likely lead to deterioration (the consequences of nontreatment), among several other issues. Psychiatrists should continue to assess a patient's capacity to make a treatment decision based on the specific requirements in their jurisdiction's legislation. The major clinical implication of the *Starson v. Swayze* decision is to emphasize the importance of documenting that the specific elements of the test have been addressed and then to ensure that this evidence is provided at any subsequent review board hearing.

In Ontario, the "enhanced standard of proof" for making a determination of incapacity has been lowered by the Supreme Court to a simple balance of probabilities. For other provinces, there appear to be no implications for the process of, or standard for, determining treatment capacity.

The *Starson v. Swayze* decision may be found at:
www.lexum.umontreal.ca/csc-scc/en/rec/html/2003scc032.wpd.html

¹Assistant Professor, Department of Psychiatry, Dalhousie University, Halifax, Nova Scotia; Chair, Professional Standards and Practice Committee, CPA, Ottawa, Ontario.

²Associate Professor, Department of Psychiatry, The University of Western Ontario, London, Ontario.

³Adjunct Professor, Department of Psychiatry, The University of Western Ontario, London, Ontario.

First published in the Canadian Psychiatric Association Bulletin, Vol 35, No 4, August 2003, Ottawa. The OPA thanks the CPA for their permission to reprint this article in *Dialogue*.

SCOTT STARSON: What was the Supreme Court Thinking ?

By: Michael Bay, Juris Doctor

“Professor Scott Starson” is neither a real professor nor is his real name Scott Starson. He is profoundly mentally ill and a long-standing, if unwilling, resident of the Oakridge maximum-security division of the Penetanguishene Mental Health Centre. In spite of all of this, a majority of the members of the Supreme Court of Canada recently decided that he is legally entitled to make his own treatment decision.

It is more than a little tempting to critique the court for its interpretation of the facts surrounding the case. That, however, would not be a useful exercise. Nothing is ever gained by second guessing the court. When studying a court case for lessons to apply to the future, the correct approach is to accept the factual findings of the court as a given and then to examine the legal principles that the court applied to those facts. That is what I will do in this article. I will also quote extensively from the court’s decision because the judges in the case have been precise and eloquent in setting out their expectations of practitioners.

The court makes the following important observations:

- The right to refuse unwanted medical treatment is fundamental to a person’s dignity and autonomy. This right is equally important in the context of treatment for mental illness.
- The right, knowingly, to be foolish is not unimportant; the right to voluntarily assume risks is to be respected. The state has no business meddling with either. The dignity of the individual is at stake.
- The wisdom of a patient’s decision has no bearing on the determination of his or her capacity.
- The presence of a mental disorder must not be equated with incapacity. The presumption of capacity can be displaced only by evidence that the patient lacks the requisite elements of capacity as set out in the Health Care Consent Act.

The court reminds the reader that the Health Care Consent Act describes capacity in terms of the ability to understand the information relevant to making a decision about the treatment, and, able to appreciate the consequences of a decision or lack of a decision. It then carefully sets out the legal principles that must be applied when evaluating the capacity to consent to treatment.

The court points out that a patient is entitled to hold a “dissident interpretation of the information” and “need not agree with the diagnosis of the attending physician.” It goes on to say, however, that if the patient has a “mental condition,” he or she, “must be able to recognize that he is affected by that condition.” The court makes the point that “mental condition” in this context refers to the “broader manifestations of the illness rather than the existence of a discrete diagnosable pathology.”

The court makes the point that - “the word ‘condition’ allows the requirement of understanding to focus on the objectively discernible manifestations of the illness rather than the interpretation that is made of these manifestations. As a result, a patient is not required to describe his mental condition as an ‘illness’, or to otherwise characterize the condition in negative terms. Nor is a patient required to agree with the attending physician’s opinion regarding the cause of that condition. Nonetheless, if the patient’s condition results in him being unable to recognize that he is affected by its manifestations he will be unable to apply the relevant information to his circumstances and unable to appreciate the consequences of his decision.”

The court notes that “the Act requires a patient to have the ability to appreciate the consequences of a decision. It does not require actual appreciation of those consequences.” The court declares that, “In practice, the determination of capacity should begin with an inquiry into the patient’s actual appreciation of the parameters of the decision being made: the nature and purpose of the proposed treatment; the foreseeable benefits and risks of treatment; the alternative courses of action available; and the expected consequences of not having the treatment. If the patient shows an appreciation of these parameters -- regardless of whether he weighs or values the information differently than the attending physician and disagrees with the treatment recommendation -- he has the ability to appreciate the decision he makes.” ...

“However, a patient’s failure to demonstrate actual appreciation does not inexorably lead to a conclusion of incapacity. The patient’s lack of appreciation may derive from causes that do not undermine his ability to appreciate consequences. For instance, a lack of appreciation may reflect the attending physician’s failure to adequately inform the patient of the decision’s consequence. ... Accordingly, it is imperative (to) inquire into the reasons for the patient’s failure to appreciate consequences. A finding of incapacity is justified only if those reasons demonstrate that the patient’s mental disorder prevents him from having the ability to appreciate the foreseeable consequences of the decision.”

The comments of the court can be summarized as follows:

- Paternalism and subjectivity must not play any role in the evaluation of capacity.
- The presumption of capacity is important, clear evidence is required to displace it.
- Capable people have the right to be wrong, even catastrophically wrong.
- Neither bad decision-making nor the presence of a disorder should automatically be equated with incapacity.
- Rejection of a diagnosis should not automatically be equated with incapacity.
- A patient is entitled to interpret information differently from the physician so long as the patient is able to recognize that he is affected by the manifestations of the condition.
- Patients are not required to have actual understanding and appreciation of the relevant facts, only the ability to understand and appreciate. For example, a patient would not be incapable if the physician failed to educate or inform the patient.

The simple lesson from the case is that physicians must:

- Understand the test,
- Administer it objectively and properly,
- Carefully record the process they followed, their reasoning, and their conclusions.

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

SCOTT STARSON: A TRAGIC LIFE

By: Dr. John Bradford, Clinical Director of the Integrated Program of Forensic Psychiatry, University of Ottawa and Deputy Head of the Integrated Program of Forensic Psychiatry, Royal Ottawa Health Care Group

The recent decision in the case of Scott Starson is a disturbing reflection of the Supreme Court's understanding of the rights of a person to refuse treatment. Mr. Starson, aged 47, was recently diagnosed with schizophrenia, after many years of psychosis, and refusing treatment, based on his belief that medication would dull his intelligence and creativity. In what must have been a painful 6-3 decision, the Supreme Court of Canada determined that Starson could not be given medication or treatment against his will, and, that he had the capacity, in spite of his advanced illness, to provide informed consent.

It is not uncommon for a person with a mental illness to be deemed incapable of making a rational decision and disagreeing with mental health professionals about their care and treatment. With mental illness, side effects of medication can be as uncomfortable as estrangement of the illness. Safeguards, such as the Ontario Consent and Capacity Board, are in place to ensure that the rights of the individual are balanced with the best interests of that individual and society.

If someone were physically ill with a brain tumor that clouded his or her judgement, treatment would be provided. However, if the person has a mental illness, which would cloud his or her judgement, it is more important, according to the Supreme Court of Canada, to uphold an individual's right to decide, regardless of that individual's capacity. This is a stunning example of society's misguided insight into mental illness - a nasty leftover of a stigma associated with lunatic asylums and straightjackets.

I believe the critical question to be considered is - Will this recent decision become a standard that must be followed?

I believe that this decision will be an anomaly because the Starson case is unique and because Mr. Starson is unique. There is no doubt that he is an intelligent man and well educated. He has an intimidating personality that may have led to his being transferred to several different mental health facilities. Some may have felt that he is an exceptional person and deserving of a different type of treatment.

Mr. Starson has a very complex mental illness, earlier thought to be a bi-polar disorder, but now more likely a schizo-affective disorder. Mr. Starson's psychosis has most likely caused a severe cognitive disability and this will worsen over time without medical interventions.

While his behaviour is bizarre, making it impossible for Mr. Starson to function in society, he is not physically violent. Most people with a similar level of psychosis would become violent without treatment and would end up in the justice system with treatment forced upon them. While Mr. Starson has threatened to kill many times, he has only been assaultive to a minor degree.

Mr. Starson strongly affirms that the medication used to treat bi-polar disorder diminishes his cognitive abilities. However, it is clear that Mr. Starson does not understand that withholding treatment for bi-polar, for which he was first diagnosed, has different and less severe consequences than withholding treatment for schizophrenia.

The Starson case cannot be allowed to become the norm in Canada's mental health and justice systems; if the Supreme Court's decision meant that everyone who is mentally ill would retain the right to refuse treatment, the consequences would be significant and serious.

If all those diagnosed with a mental illness could refuse treatment, but could clearly not live or function in the community, because they were threatening to themselves or to others, we would have to build hospitals, jails, or institutions in which to house them. Essentially, we would have to bring back the asylum that would cloister or warehouse the mentally ill from the rest of society. This would be reminiscent of the times prior to the 1950s and the advent of anti-psychotic medication that has made it possible for so many people to live in the community, with various levels of support, as functioning members of society.

Sadly, left untreated, severe mental illness often leads to premature death through suicide or lifestyle choice, violence, incarceration and a lowered quality of life. In my view, the Starson case begs another, more important question – What really went wrong for this sad, lonely individual ?

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Physician Health and Well-being

The Canadian Medical Association published "The CMA Guide to Physician Health and Well-Being" in April, 2003, to raise awareness of illness among physicians. The guide features articles by experts, advice and resources for Canadian physicians, and, directories of physician support programs across the country. In August, 2003, the CMA launched the CMA Centre for Physician Health and Well-being. The Centre will serve as the national resource for promoting and protecting the health and well-being of physicians, physicians in training and their families. The Centre will function as a clearinghouse and coordinating body and will focus initially on four key areas:

- health promotion and disease prevention;
- awareness and education;
- advocacy and leadership, and;
- research and data collection.

CMA surveys reveal that almost 50 per cent of Canadian physicians were dissatisfied with their chosen profession and 46% are in an advanced phase of burnout, characterized by emotional exhaustion, cynicism, and a sense of depersonalization in relationships with co-workers, patients, or both. Physicians

have over twice the suicide rate of the general Canadian population. 21% of physicians reported seeking help for emotional problems. As a comparison, the 'Sources of Workplace Stress' in the Statistics Canada publication 'Perspectives on Labour and Income', June 2003, (www.statcan.ca) indicate that long working hours and heavy job demands are the main sources of work stress. Statistics Canada also reported that self-employed and full-time workers were more likely to feel that job demands or hours at work were stressful, compared to employees and part-time workers. Women were more likely to cite stress from job demands and working hours, while men were more likely to cite the risk of accident or injury on the job.

The resources of the Centre for Physician Health and Well-being can be accessed through the CMA website at: www.cma.ca and by calling 1-877 CMA 4 You. In Ontario, the Physician Health Program of the Ontario Medical Association provides telephone support, counseling referrals, case management, advocacy and other services for physicians and their families. See www.phpoma.org for more information. PHP's confidential toll free line: 1 (800) 851-6606.

ONTARIO'S FORENSIC MENTAL HEALTH SYSTEM: THE NEEDS OF THE MENTALLY DISORDERED OFFENDER

By: Dennis Helm* and Jim Cyr*

Introduction

Service needs of the mentally disordered offender have traditionally been viewed as a separate or distinct component of the mental health system. The result has been the marginalization of this population. There continues to be a significant challenge in integrating service needs of this population into the broader mental health and health care system of Ontario. Central to this integration is the role and success of the Psychiatric Patient Advocate Office.

Historical Overview of the Forensic System

The provision of forensic services to mentally disordered offenders (MDOs) is a federally mandated service for which provincial health ministries have historically accepted responsibility. In addition to addressing the mental health needs of offenders, forensic services contribute directly to the safety of the community by reducing the risk posed by the mentally ill offender through effective assessment, treatment, and rehabilitation.

MDOs are a very heterogeneous population from a clinical perspective. Diagnoses include psychoses, personality disorders, acquired brain injuries, and the developmentally handicapped. The term "forensic" is very much a legal label, acquired through involvement with the criminal justice process, where the presence or suspicion of a mental disorder causes an accused person to be directed for psychiatric assessment or treatment.

Legal Context

Currently, Ontario's forensic mental health system is directed by the Mental Disorder provisions of the Criminal Code of Canada.¹ These provisions spell out a range of options for dealing with an accused person appearing before a court and who has (or is thought to have) a mental disorder.

The two aspects of the recent Mental Disorder Amendments, presenting the greatest challenge to both the health care provider and advocates, are compulsory treatment and the enumerated factors to be considered by the court or Ontario Review Board (ORB) when making a disposition. The factors to be considered by the court or ORB in determining dispositions are:

- 1) the need to protect the public from dangerous persons;
- 2) the mental condition of the accused;
- 3) the reintegration of the accused into society; and
- 4) the other needs of the accused.

The disposition made must be the least onerous, least intrusive, and least restrictive. In these instances, we are confronted with the concept that the individual's needs or wishes are not the primary considerations. The concept of making a disposition or providing treatment without the consent of the client raises complex questions. It is also contrary to the Psychiatric Patient Advocate Office's (PPAO) belief in an individual's right to self-determination. Both the Ministry of Health and Long-Term Care (MOHLTC) and the PPAO staff have worked together on educational initiatives to ensure the provision of the best service to our clients.

As a result of the Criminal Code amendments, both the MOHLTC and the PPAO have experienced an increased demand for service from the forensic population. The MOHLTC has increased the number of beds designated as forensic and has developed provincial implementation plans. According to the 2001 PPAO Annual Report, of the 2,113 files opened, 35.3% were deemed to be "forensic" and "detained under the Criminal Code of Canada." This represents an increase of 124 cases since 1999. The PPAO has developed an InfoGuide entitled "Appealing an Ontario Review Board Decision" and the PPAO Patient Advocates are advised of pending appeals in which clients

are unrepresented. At that point, the Patient Advocate speaks with the client to ensure the client wishes to proceed without counsel. If the client would like counsel, the Patient Advocate assists in locating a lawyer and applying for Legal Aid.

In addition, the Code specifies that, where detention in custody is necessary to address assessment and treatment requirements, the accused may only be detained in a hospital designated by the Minister of Health and Long-Term Care. The designated hospitals provide services to mentally disordered offenders in the following ways:

1. by undertaking assessments of accused persons;
2. by detaining and treating individuals who have been found unfit to stand trial or not criminally responsible (NCR); and
3. by admitting and treating offenders from the correctional system where their condition is acute enough to warrant care in a mental health facility.

Forensic Treatment/Care Approaches

The major areas of required expertise for assessment, treatment, and rehabilitation are:

- *Biological Therapies* – physical and pharmacological therapies;
- *Cognitive Therapies and Knowledge Deficits* – cognitive approaches to risk management;
- *Behaviour Therapies and Skills Acquisition* – behavioural approaches to the treatment of risk factors and/or practical skill acquisition; and
- *Risk Assessment* – use of clinical and situational factors together with actuarial risk information to form opinions of risk and strategies to prevent future violent or criminal conduct.

The majority of forensic clients exhibit the same symptoms of mental disorder and the same clinical needs as clients in the general psychiatric population. From a quality of life point of view, as well as the significant staff costs associated with operating forensic beds, it is desirable that specialized inpatient services be used only when absolutely necessary.

Expectations of Ontario's forensic system include the following:

- forensic services should function as part of a coordinated system;
- forensic services will provide a continuum of care;
- there will be a cascading system whereby clients move to progressively lower or higher levels of security or integrated mental health settings; and
- there will be coordination at both the point of entry and the point of discharge.

Client Involvement and Rights

Two decades of unprecedented changes in mental health service delivery have elapsed since the first 11 advocates of the PPAO were appointed. These changes have been driven by amendments to existing legislation, such as the *Mental Health Act*² and the *Criminal Code*, as well as the introduction of new legislation such as the *Substitute Decisions Act*,³ *Consent to Treatment Act*,⁴ *Advocacy Act*,⁵ *Health Care Consent Act*,⁶ and the creation of the *Mental Health Reform* agenda.

The Mental Disorder Amendments to the *Criminal Code*, enacted on February 4, 1992, were the first major changes to the way in which the criminal law dealt with the mentally disordered accused since the introduction of the *Criminal Code* in 1892. The amendments included such

new departures as expanded court powers to order psychiatric assessments, compulsory treatment for the purpose of making persons fit to stand trial, new special verdict of not criminally responsible on account of mental disorder, flexible dispositions by courts and review boards, and the mandatory creation of review boards with decision-making powers (eliminating the role of the Lieutenant Governor) with right of appeal to the Court of Appeal.

The revisions to these amendments impacted on the provision of service to forensic clients by the PPAO and the MOHLTC. As a result, the PPAO addressed the significant implications to its mandate, operations, staff, and the delivery of advocacy and rights protection services to this population. This proactive stance continues. In 2002, the PPAO provided a written submission to the Standing Committee on Justice and Human Rights on their Issue Paper involving a Review of the Mental Disorder Provisions of the *Criminal Code of Canada*. During this same period, a number of initiatives to address forensic needs were undertaken by the MOHLTC, not the least of which was the Human Services and Justice Coordination Project⁷ and the *Range of Forensic Services in Ontario*.⁸

The provision of efficient and effective services to ensure that Ontario's mental health system best meets the needs of all people with serious mental illness is integral to mental health reform. The reformed mental health system includes people, commonly identified as forensic clients, who have multiple and complex overlapping needs relating to aggression, legal status, and clinical/risk management. Due to the nature of these multiple and complex needs, health, social service, and judicial systems work cooperatively to meet the Ministries' shared goals of achieving healthy and safe communities and recognize that solutions are a joint responsibility. The PPAO continues to be active in helping to shape mental health reform by highlighting issues that need to be addressed from a client-centered and client-first perspective.

Advocacy must be considered an essential component of mental health reform and it must be available to all individuals with a mental illness regardless of where or from whom they receive their care and treatment. The PPAO was recently an active player in ensuring that the Mental Health Implementation Task Forces and the Forensic Mental Health Services Expert Advisory Panel considered advocacy as an essential and integral component of mental health reform.

Ontario's Forensic Strategy

The *Provincial Forensic System Strategic Directions Report* (1997) outlines corporate strategic directions concerning the operation of forensic mental health services, including the vision, goals, and principles that should guide the provision of services, and the description and role of the key services comprising the provincial forensic system. This document continues to provide the policy/implementation framework for the Ontario system.

Vision

A system of care for mentally disordered offenders should be provided where:

- 1) People will not be stigmatized or discriminated against on account of mental disorder;
- 2) Mentally disordered offenders will be integrated within broader mental health programs and services, consistent with level of risk and needs;
- 3) The lives of offenders with a mental disorder can and will improve;
- 4) Mentally disordered offenders will have a voice in the ways they choose to live, learn, work, and relax – taking into account the need to protect;
- 5) A comprehensive service delivery system will be established that is accessible to mentally disordered offenders and which is consumer-focused, quality-driven, equitable, respectful of diversity, integrated, and accountable;

- 6) Community acceptance and tolerance of mentally disordered offenders will be strengthened through active and dynamic public education activities; and
- 7) The Ministry will cooperate with our partners in the criminal justice, correctional, and social services systems in developing strategies to reduce crime, implement appropriate alternatives to criminal justice prosecution and incarceration, protect public safety, and provide for the welfare and well-being of individual mentally disordered clients.

Goals

The goals of a system of care for mentally disordered offenders are:

- 1) To balance the rehabilitation and reintegration needs of forensic clients with the need to protect public safety;
- 2) To work within the required legal parameters, and provide for the successful and least restrictive assessment, treatment, rehabilitation, and safe reintegration of clients into their community;
- 3) To provide resources proportionate to regional needs and priorities, with access to services occurring at the lowest security level and as close to home as possible;
- 4) To conduct forensic-focused research and provide education; and
- 5) To communicate effectively and coordinate mental health services with the criminal justice, correctional, and social services systems.

Principles

Principles in relation to serving this population include:

- 1) Treatment, care and support will be accessible, equitable, and developed with consumer and family input;
- 2) Services will be designed to meet the special needs of mentally disordered offenders, and will be sensitive to gender, culture, and race, etc.;
- 3) Programs will be quality driven and evidence-based;
- 4) Legal status must not serve as a barrier to mentally disordered people in accessing clinically appropriate services;

- 5) Most intensive services will be targeted to individuals of the highest need;
- 6) Services provided in the system will be flexible, adaptable, and responsive;
- 7) Services will respect the values and capabilities of families and other support or service networks; and
- 8) Services will be planned according to the provincial mental health policy framework.

To assist with the effective implementation of a restructured forensic service system, a review of forensic mental health services policy was conducted from March to May 2000. The review included:

- Targeted consultations with key stakeholders;
- A summary of existing interministerial and MOHLTC forensic policy, specific questions addressed, and comments of participants recorded; and
- A review of past Ontario reports and reports of other jurisdictions' experiences with forensic services.

The following issues were identified as requiring MOHLTC attention:

- 1) Interministerial coordination of forensic services, with focused leadership;
- 2) The need to consolidate and clarify existing MOHLTC forensic policy; and
- 3) Processes to improve services for forensic clients.

The following recommendation was made to address the above issues:

- Creation of a time-limited provincial Forensic Mental Health Services Expert Advisory Panel to provide advice on the interministerial coordination and implementation of existing forensic policy.

Provincial Forensic Mental Health Services Expert Advisory Panel

The Forensic Mental Health Services Expert Advisory Panel was established in January 2001 by the Minister of Health and Long-Term Care and ended on December 31, 2002, with the submission of a final report to the Minister.

The Forensic Expert Panel identified the following five categories of issues and, based on its review of those issues, made 40 recommendations for the Minister's consideration:

- 1) Leadership and Accountability;
- 2) Information and Data;
- 3) Concepts and Definitions;
- 4) System Capacity and Integration; and
- 5) Interministerial Issues.

Conclusion

Recent work internal and external to the Ministry has reinforced the direction of Ontario's implementation strategy and has articulated specific implementation strategies that should be followed. Strategic implementation strategies will continue to be developed.

Central to the success of developing a reformed mental health system and, in particular, the establishment of an effective and integrated provincial forensic system, is "the recognition of advocacy as an essential and integral component of a reformed mental health system".⁵

¹ R.S.C. 1986, c. C-48 (Criminal Code).

² R.S.O. 1990, c. M.7 (MHA).

³ Substantive Decisions Act, 1992, S.O. 1992, c. 30 (SDA).

⁴ S.O. 1992, c. 31 (CTA), repealed by S.O. 1996, c. 2, s. 2.

⁵ S.O. 1992, c. 38, repealed by S.O. 1994, c. 2, s. 1.

⁶ Health Care Consent Act, 1996, S.O. 1996, c. 2, Sched. A (HCCA).

⁷ Human Services and Justice Coordination Project (1997). A Provincial Strategy to Coordinate Human Services and Criminal Justice Systems in Ontario.

⁸ Ontario Ministry of Health and Long-Term Care (2002). Range of Forensic Services in Ontario.

⁹ Vade Kohagan, Director, Psychiatric Patient Advocate Office, PPAD Annual Report 2001.

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CONDITIONS IN ONTARIO PROVINCIAL PRISONS: A TROUBLING PICTURE

By: Paula Osmok*

Much has been written about the deinstitutionalization of the mentally ill that began in the 1970s and has continued to the present day. Generally, the stories have focussed on the woefully inadequate resources that were set up in communities to deal with the needs of people returning to their community and coping with mental illness.

But it can also be argued that the process of deinstitutionalization is more apparent than real. What has occurred is not so much a movement of people from institutional to community settings but rather, for a significant number of men, women and children, a movement from one institution to another - specifically from mental health facility to prison.

Evidence from mental health organizations and our own experience working with people in provincial correctional facilities seems to confirm the figure noted in the Provincial Auditor's report¹ of the proportion of inmates in provincial prisons with mental health problems (15% - 20%). Research suggests that individuals with mental health disorders are more vulnerable to arrest and detention for nuisance offences, more likely to be remanded into custody for these minor offences and spend more time on remand and awaiting a sentencing disposition.² With what we know about the effect of pre-trial detention on sentencing, it would stand to reason that mentally disordered individuals are also more likely to be given a sentence of imprisonment. Also, given what we know about the treatment of other

disadvantaged groups, they would be less likely to be granted conditional release.

The John Howard Society of Ontario would suggest that there are a number of reasons for this. The social and economic barriers of the mentally ill disadvantage them at all stages in the criminal justice process. Swelling numbers and greater visibility in the community of those who exhibit behaviour that is either a nuisance or 'scary' has led to less tolerance and less understanding. Combine this with unfair stereotypes of the mentally ill, particularly of their risk of violence towards others, and the pressure to get them off our streets seems inevitable. With appropriate alternatives in short supply or, in some areas, non-existent, either through community care or psychiatric facilities, criminal justice solutions become the only way to manage the problem.

The Society believes, and it would appear that both Ontario's Provincial Auditor and Provincial Ombudsman share this view, that mentally disordered individuals are being treated unfairly, especially with respect to the use of imprisonment. Treatment is extremely limited and correctional staff are not trained to handle inmates with mental disorders. Furthermore, prisons are often not equipped to provide even the basics of decent accommodation, never mind meet any special needs of already vulnerable inmates. Being exposed to lengthy lock-downs, lack of recreation, overcrowding, violence,

non-smoking, high stress and serious health risks can only exacerbate mental health issues. The undue reliance on criminal justice solutions, particularly the use of imprisonment, to deal with mental health problems is ineffective, unjust and inhumane.

Conditions in provincial prisons were the key concern of the Ontario Ombudsman as he presented his annual report for the 2001-2002 year.³ The job of the Ontario Ombudsman is to investigate complaints about provincial government organizations. During the year 2001/02, the Ombudsman's office received 21,186 complaints and inquiries. Those from inmates in provincial correctional facilities comprised the largest percentage - 36% of total complaints. The 7,697 complaints received about corrections far exceeded any others, followed next by the Family Responsibility Office about which the Ombudsman received 1,135 complaints. Case examples described in the report relating to the (then) Ministry of Correctional Services included ones such as this:

[A] mentally ill, hearing-impaired young woman, heard screaming and yelling through the heavy doors of the segregation cell where she was held for most of the two months she spent in prison, and lacking regular access to showers and daily fresh air, as required by Ministry policy.⁴

Working to change this scenario demands first an

acceptance of the principle of restraint in the use of the criminal law and its powers, particularly that of imprisonment. Currently, however, government rhetoric and action seems to reflect the opposite. The John Howard Society of Ontario believes that no significant action with respect to reducing the needless and inappropriate incarceration of mentally disordered individuals will happen unless the government and its ministries operate on the basis of the principle of restraint. As well, significant change cannot happen through actions instituted by the Corrections Division of the Ministry of Public Safety and Security (MPSS) alone. For example, the police, who are often accepted as being the 'gatekeepers' of the criminal justice system, are often the first encounter that mentally disordered individuals have with the system. These individuals end up in prison because of decisions made first by the police. Sometimes, people end up in prison because the alternatives for diversion are not pursued by either the police or the Crown Attorney.

And, as with any suspects deemed to be vulnerable, the mentally ill face increased disadvantage, not only because of their increased propensity to answer questions, but often the evidence they do provide may be unreliable or substantially incorrect and may later be used to incriminate them¹. Changes in this regard require the involvement of the Ministry of Attorney General and the Policing Services Division of the MPSS to ensure that:

- Police are supported in their decisions to use alternatives to the laying of a charge (through guidelines for the use of police discretion not to charge, and through training and evaluation);
- Crown Attorneys are supported in their decisions to divert minor offenders (through guidelines, a screening process and provision of alternatives to the formal court process);
- there is greater consideration of the use of specialized courts for the mentally disordered accused,² and,
- bail conditions are set appropriately and alternatives to pre-trial detention are developed.

Our provincial government, as most are aware, has embarked on what is called an 'Infrastructure Renewal Project'. This includes closing many of the smaller community jails and building of three large mega-jails. Remanded prisoners will be detained at even greater distances from the location of the alleged crime, legal representation, family and other supports. The effects of being remanded in custody can be severe. Many individuals lose their jobs, experience increased health problems,³ endure relationship stress, and most disturbing, experience higher rates of suicide than sentenced prisoners.⁴

Unlike health care and education, there has been little public debate about the long-term wisdom of the course set for corrections by the current provincial government. Where our correctional system is headed, however, should be a concern for all Ontarians. The changes implemented and proposed reflect a clear direction that relies on harsher sentences and prison environments to deter crime, and continues to promote the primacy of incarceration as a means of achieving public protection. If we want a system that contributes to the reduction of re-offending, is cost effective, treats people fairly and follows basic principles of restraint in the use of incarceration, then we need to take a very serious look at the direction in which our system is headed.

The John Howard Society of Ontario supports the recommendation of the Provincial Auditor regarding the need for the Ministry to expedite efforts to deal with mentally disordered prisoners. In furtherance of this objective, we specifically propose that the Ministry ensure that:

- Community mental health professionals are involved in case management in the prisons and are integral to the process of developing plans for release with those on remand as well as those sentenced;
- an assessment process is in place to identify mentally disordered inmates upon admission and, where a placement in a psychiatric facility is warranted, the transfer takes place as quickly as possible;
- there is greater use of conditional release mechanisms to support the use of community care programs;
- there is ongoing feedback to the Ministry of the Attorney General and the Policing Services Division of the Ministry of Public Safety and Security about the trends with respect to mentally disordered inmates, and ongoing inter-ministerial dialogue about strategies to reduce their numbers; and,
- there is an over-arching plan and targets for reducing the number of minor offenders in prison who could safely and more effectively be managed in the community.

One last point seems almost too obvious to state: there will be limited success in reducing the numbers of mentally disordered individuals in prison if the mental health resources and other support services, such as housing and welfare assistance, do not exist, or are inadequate. The government must make the necessary investments in these areas. A prison, no

matter what programs it offers, is not a therapeutic environment.

The Society maintains the important principle that the sentence is, in and of itself, the punishment, and that a person should not be further punished by the conditions of their incarceration or their treatment at the hands of the criminal justice system. It is discouraging indeed that international standards adopted by the United Nations,⁵ and officially endorsed by a number of countries - including Canada - are being violated or ignored. As a province of Canada, Ontario shares in these commitments and, therefore, has an obligation to ensure that its policies and practices comply with the UN. These include basic principles that address discrimination, treatment of unconvicted prisoners and prison conditions. Even with improvements in these areas, alternatives to incarceration, including community treatment of mentally ill offenders, offer the best means to protect everyone's interests.

¹ Provincial Auditor of Ontario, Special Report on Accountability and Value for Money, Toronto: Queen's Printer for Ontario, 2000.

² Fuzopinski, F.J. and L. Munkit, *The Prison Careers of Offenders with Mental Health Disorders*. Ottawa: Correctional Services of Canada, 1992.

³ Report of the Ombudsman (Ontario), Toronto: Queen's Printer for Ontario, 2002.

⁴ *Ibid.*

⁵ Palfrey, C. (1996) *90% Vulnerable After All These Years*. *Can. L. Rev.*, September, 1996, v. 663-94.

⁶ As recommended in the Report of the Criminal Justice Review Committee (Ontario), February 1999.

⁷ Harwood, G. *The Effects of Remand*. *Prison Services Journal* (1985), v. 80-19.

⁸ Casellas, P. and Gilson, B. *Ball, The Law, Best Practice and the Debate*. Winchester: Waterside Press 1993.

⁹ The Standard Minimum Rules for the Treatment of Prisoners was adopted by the United Nations in 1955 and officially endorsed by Canada in 1975.

¹⁰ Paula Omsick, Executive Director, John Howard Society of Ontario.

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The Canadian Institute for Health Information (CIHI) Report on Hospital Mental Health Services In Canada

By: Carolyn Pullen, Consultant, Health Resources Information, CIHI

In August 2003, the Canadian Institute for Health Information (CIHI) released the first Report on Hospital Mental Health Services in Canada. The report will contain highlights of national, provincial and regional-level data analysis using inpatient hospital data from fiscal year 2000/2001 of the national Hospital Mental Health Database.

The focus of the report is on hospital services utilization indicators calculated using the only national, standardized mental health data available. Indicators include separation (discharge) rates, length of stay, and suicide rates, to name a few. Through the analysis of the indicators, CIHI is able to highlight the range of information that can be gleaned from the national mental health data, and discuss the meaning and limitations of the data. Through a discussion of the results for each indicator, CIHI hopes to promote dialogue and raise awareness about the nature of the data, the range of possibilities and special studies for analysis using

hospital mental health services data, and the availability of the data to researchers. The report is available through the CIHI website at www.cihi.ca and is accompanied by an electronic, web-based capability that allows users to view the indicator results using age, gender and diagnosis variables.

For more information, or to access a copy of the report, please visit the CIHI website or contact the CIHI Mental Health Team directly:
Mental Health and Addiction Services, Canadian Institute for Health Information, 200-377 Dalhousie Street, Ottawa, Ontario K1N 9N8, Tel: 613-241-7860, Fax: 613-241-8120, e-mail: mentalhealth@cihi.ca <<mailto:mentalhealth@cihi.ca>>
Web: <http://www.cihi.ca>

Advocacy in Ontario's Mental Health System

By: *Vahe Kehyayan**

Twenty years ago, the Ontario government introduced the Psychiatric Patient Advocate Office (PPAO) to safeguard the rights and privileges of patients in the provincial psychiatric hospitals by providing clients with instructed advocacy. Over the years, the PPAO also played a significant role in systemic advocacy efforts by preparing countless position papers and submissions on a wide variety of issues affecting clients' rights and entitlements. Such systemic efforts included the Weisstub Report (1990) on treatment incapacity, health information privacy legislation, and playing a pivotal role in the development and implementation of a provincial rights advice program in Schedule 1 facilities. In addition, the PPAO has worked diligently to raise public awareness of issues affecting patients' rights and supported voting rights for individuals with mental illness.

Today, a wide variety of formal and informal advocacy programs and services exist at both the local and provincial levels. These services are fragmented and lack provincial co-ordination, integration, and accountability. The PPAO believes that a mechanism of advocacy and rights protection, one that is properly designed, implemented and coordinated, is required in Ontario's reformed mental health system. Such a mechanism could play an essential role in Ontario's comprehensive mental health system with benefits to the individual, service providers and policy makers.

For the individual, advocacy would contribute to the person's recovery process. It would afford them quality of life and care and, at times, prompt access to required services. It would also increase their successful integration into the community.

For service providers, advocacy would serve as a catalyst to promote a culture of recovery, and bring about change and greater understanding of patient rights issues. Advocacy, through early issue identification and intervention, serves as risk avoidance for health care professionals and facility administrators. Service providers would benefit from an expert resource about mental health legislation and patients' rights for their risk management initiatives.

For the Ministry of Health and Long-Term Care, as social policy maker and primary funding source of the mental health system, a provincial advocacy and rights protection mechanism would serve:

- as a key leverage point for creating a culture of recovery in Ontario;
- to break apart silos, such that there is equitable service to all;
- as a single source of contact for taking the pulse of the community in terms of services provided and outcomes sought by consumers;
- as a vehicle for the Ministry to achieve a balanced system of accountability, and,
- as a quality check for the Ministry.

By having an appropriate mechanism in place, the Ministry would have the opportunity to hear of alleged incidents, breaches of Ministry legislation and policy in areas of rights and entitlements, or potential deviations from desired standards of care and services. Such a mechanism would act as the proverbial "canary in a mine" for the Ministry, and through its systemic checks and balances, would provide tools for the Ministry to assess the availability, accessibility and quality of mental health services.

A provincial advocacy mechanism would be characterized by being independent of service providers. It would have both a local and regional presence so that the services are accessible to those who will utilize them, regardless of where and from whom they are receiving service. The envisioned provincial advocacy model would complement and supplement other existing mechanisms, and not duplicate them. Advocacy services would be driven from the client's perspective. Clients would have a choice of advocacy services, which would be delivered in partnership with stakeholders, consumer-survivor organizations, families and caregivers. Such a service delivery model would allow for the pooling of local and provincial talents and resources.

The functions of a provincial mechanism would include:

- training and certification of advocates and rights advisers;
- setting standards of practice and conduct for advocates;
- developing public education material and conducting education to the general public and professionals about mental health legislation and patients' rights;
- providing individual advocacy services;
- conducting regional or provincial systemic advocacy; and
- providing rights advice in psychiatric facilities and in the community.

The PPAO views mental health reform as a great opportunity for further advancement of patients' rights, the inclusion of the patient as an equal partner in the treatment process and the involvement of patients in all decisions that affect their care, life and treatment. As a progressive society we must find new and creative ways to provide mental health care and treatment in an environment that is supportive, understanding and accepting of mental illness and that affords dignity and respect to all, regardless of their illness. We must begin to talk about "wellness and recovery" and to support individuals in their full participation in society.

As we embrace the future, we need to make advocacy and rights protection services an integral component of mental health services in Ontario. While in the past 20 years the PPAO has made significant advancements in patients' rights, we need to continue to offer advocacy services to vulnerable persons with mental illness to help them navigate the system on their road to recovery. We need to continue our collective efforts in advancing patients' rights beyond where they are today. It would take collaboration of all stakeholders to create a system that has a client-centred philosophy, to make the mental health system more accountable to the people it serves, to create a community that is accepting, inclusive and understanding of mental illness, and, to give persons with mental illness a greater but equal voice in all aspects of mental health service delivery.

*Vahe Kehyayan has been the director of the Psychiatric Patient Advocate Office since August 1996. For further information please contact the PPAO at: (416) 327-7000 or 1-800-578-2343

Look for the Resident's Review In the December issue of Dialogue!
"Detecting Malingered Memory Impairment in Neuropsychiatry: Part 1"
by Drew J.A. Moulden, M.D., Ph.D., OPA Council Member, will be featured.



IMPORTANT DRUG SAFETY INFORMATION
Until further information is available,
PAXIL® (paroxetine hydrochloride) should
not be used in children and adolescents under 18 years of age

Further information can be found at http://www.hc-sc.gc.ca/hpfb-dgpsa/tpd-dpt/paxil_e.html

Any questions from health care professionals may be directed to Medical Information via GlaxoSmithKline Customer service at 1-800-387-7374.

Any suspected adverse reactions can also be reported to: Canadian Adverse Drug Reaction Monitoring Program (CADRMP) Marketed Health Products Directorate HEALTH CANADA Address Locator: 0201C2 OTTAWA, Ontario, K1A 1B9 Tel: (613) 957-0337 or Fax: (613) 957-0335 Toll free for consumers and health professionals: Tel: 866 234-2345, Fax: 866 678-6789 cadrmpp@hc-sc.gc.ca The AR Reporting Form and the AR Guidelines can be found on the TPD web site or in The Canadian Compendium of Pharmaceuticals and Specialties.

Drug Treatment Courts Receive Additional Funding

The Canadian Drug Treatment Courts received news of additional funding at the end of May, 2003 from the Federal Government. One of the Drug Treatment Courts, the Toronto Drug Treatment Court (TDTC), is currently in its fifth year of operation.

The TDTC was the first Drug Treatment Court outside of the United States and has developed a model of service delivery that has been replicated by numerous other countries including Australia, Bermuda, Brazil, Ireland, Jamaica, New Zealand and Scotland.

The TDTC is a voluntary program that provides court-supervised treatment for people who are addicted to cocaine or heroin and who have become involved in drug-related criminal activity to support their addiction. The majority of clients have a long history of involvement with drugs and the criminal justice system. The program consists of a combination of regular court appearances, judicially supervised treatment, and an extensive community based support network. Its primary objective is to increase public safety by reducing drug addiction and the crimes committed to support a drug habit, through a combination of treatment and court monitoring. Clients who complete the program receive a non-custodial sentence instead of the incarceration that they would normally be facing.

New Research Shows Primary Care for Mentally Ill Reduces Hospital Stays

by Barbara Everett, PhD.

The Windsor Branch of the Canadian Mental Health Association (CMHA) has released new data on their innovative primary care program which shows that access to a nurse practitioner reduces visits to emergency rooms and crisis centres as well as hospitalizations. This data supports the case for funding from the Ministry of Health and Long-Term Care for additional primary care programs being proposed by CMHA branches throughout Ontario.

In 2000, CMHA Windsor received funding to hire a nurse-practitioner (NP) to provide primary care services to more than 800 clients within the primary care clinic, consult with physicians and collaborate with CMHA staff.

Eighty-eight percent of those served by the primary care clinic are seriously mentally ill. CMHA Windsor's data shows that the number of hospital stays among those using the clinic has been reduced by 75% over the past year. The number of days spent in hospital has been reduced by 79%.

Primary care reform in Windsor has had the same positive impact on the region's overwhelmed emergency wards. For those clients who had made hospital emergency room visits prior to using the clinic, 84% reported a decrease in their emergency room visits after beginning to use the CMHA clinic for primary care. Seventy-five percent reported a decreased use of crisis centres. The reductions in emergency room visits and hospitalizations also benefit the larger community since Windsor is one of the most under-served regions in Ontario, and everyone has felt the pressure of doctor and hospital bed shortages.

Barbara Everett, Ph.D. is the Chief Executive Officer, Canadian Mental Health Association, Ontario

Niagara District Health Council Studies Suicide

According to data from Statistics Canada, suicide is the leading cause of death for Canadian men age 25 to 44, and Canadian women age 25 to 34. For youth age 15 to 24, suicide is second only to motor vehicle accidents as the leading cause of death.

To help plan for future suicide prevention and mental health programs in their region, the Niagara District Health Council (www.niagaradhc.on.ca) analyzed statistical data on suicide deaths and inpatient hospitalizations, due to suicide attempts in the Niagara population, in the age group 15 years and over. In their

report, entitled, "Analysis of Suicide Deaths and Hospitalizations Due to Suicide Attempt for Residents of Niagara" (<http://www.niagaradhc.on.ca/Suicidereport2003.pdf>), the Niagara District Health Council noted that overall, the rates of suicide deaths in the Niagara Region are comparable to international, national and provincial rates. Some municipalities within the region, however, have higher than average rates of suicide deaths and attempts, while others are significantly lower. The report concluded that further analysis is needed to better understand Niagara population patterns and trends.

THE DIVESTMENT OF LAKEHEAD PSYCHIATRIC HOSPITAL TO ST. JOSEPH'S CARE GROUP

On Monday, June 23, 2003 St. Joseph's Care Group assumed governance and management of Lakehead Psychiatric Hospital. St. Joseph's Care Group is owned and operated by the Sisters of St. Joseph of Sault Ste. Marie and managed by a volunteer Board of Directors. The divestment of the region's provincial psychiatric facility is the result of a directive issued by the Health Services Restructuring Commission in 1996 and supports the efforts of mental health reform in Ontario. In a June 17, 2003 press release, Carl White, President, St. Joseph's Care Group was quoted as saying that "Many people confuse divestment or change in governance with the immediate closing of the facility. I would like to stress that it's business as usual and, until the appropriate facilities are developed in the community and at St. Joseph's Care Group, the building will remain open." The change in governance and management will allow Administration and the Board of St. Joseph's Care Group to actively advocate and expand services for mental health clients in Northwestern Ontario, when needed. The June press release also stated that the Care Group is committed to providing

programs and services in complex care, rehabilitation, long-term care, supportive housing, addictions and mental health to meet the needs of the residents of the districts of Thunder Bay and Kenora-Rainy River. During and following the divestment process, quality mental health services will continue to be provided to Lakehead Psychiatric Hospital clients and their families. Mental health services will be provided by a local health care organization under the direction of a volunteer Board of Directors. The transfer of governance and management will not impact the current levels of care and service delivery - inpatient, outpatient and community based services will continue to be provided. In keeping with the principles of mental health reform in the Province of Ontario, enhanced community-based mental health services will be provided to support clients and their families.

For more information, call Carl White, President, St. Joseph's Care Group, (807) 768-4440

High-Tech Project to Target At-Risk Youth in the Ottawa Area

The Canadian Advanced Technology Alliance, a high-tech association, recently announced a new project that will combine technology with mental health programs to help prevent crime among at-risk youth in the Ottawa area. Partners include S4Potential, a company that combines psychological methods with interactive multimedia to promote well-being, and Youth Services Bureau (YSB), a children's mental health centre. YSB will be responsible for quality assurance and field testing, including a small-scale outcomes study. The project will develop e-learning products to teach the psychological skills needed to avoid situations that may lead to inappropriate behaviour, including

crime. The e-tool will use youth-friendly graphics, images and music. The computer program will respond to the user and engage in 'back and forth' exchanges and will deliver preventive behavioral health interventions directly to under-served youths who are at risk for violence. The project is funded by the National Crime Prevention Centre, Business Action Program on Crime Prevention, Department of Justice Canada.

For more information, see "Program to Develop a Crime Prevention E-program for High Risk Youth" at www.s4potential.com.

Acute Care Hospitalizations for Mental Illness and Suicide Attempts in Southwestern Ontario

A recently published report provides a snapshot of the characteristics of patients utilizing the Southwestern Ontario acute care hospital system due to mental illness and suicide attempts. The report highlights the following information:

- mental illness and suicide attempts account for a great deal of the use of acute care facilities;
- relatively high numbers of re-admissions are for the same issues (more than one in four patients who were subsequently readmitted returned to an acute care facility within ten days of discharge, and almost half returned within thirty days);
- relatively high numbers of patients (just over 6%) are signing themselves out against medical advice, although the majority of individuals were formally discharged following a hospital stay for mental illness; and,
- lengths of stay are relatively low – mean acute length of stay was less than eleven days, while the modal length of stay was one day.

During fiscal year 1999/2000 there were 9,121 separations (hospital discharges) for mental illness from hospitals in this region. Slightly more than half of all the separations were to females. Those in the age group 80 years and older had the highest age-specific rates, although they were relatively small in terms of absolute numbers. The next highest age-specific rate was 30 to 49 years. Affective psychoses was the most common diagnosis, followed by depressive disorders and schizophrenia.

During the three-year period encompassing fiscal years 1998/99 to 2000/01, there were 4,030 hospital separations involving a suicide attempt with the majority having a diagnosis of mental illness, the most frequent being affective psychoses and depressive disorders. More females than males were hospitalized for suicide attempts. The highest age-specific rates were for those aged 20 to 49 years. The most common method for suicide attempts, by far, was poisoning. The report noted that:

- just 1% of those who attempted suicide died while in hospital;
- almost 7% discharged themselves against medical advice;
- mean length of stay was 7.5 days, modal length of stay was one day; and,
- over 16% of patients had more than one hospital separation for a suicide attempt within the three year period.

For more information see: Sarkella, J. (2003). Acute Care Hospitalizations for Mental Illness and Suicide Attempts in Southwestern Ontario. London, Ontario: Southwest Region Health Information Partnership. Contact: Dr. Iris Gutmanis, Director, SRHIP 115-100 Colip Circle, London, Ontario, N6G 4X8, Tel: (519) 858-5081, Fax: (519) 858-5082, e-mail: igutmanis@srhip.on.ca The full report (64 pages) is available from: website: <http://www.srhip.on.ca>

CAMH Launches On-Line Support For People Dealing with the Stress of SARS

An online web-assisted support group for people dealing with the stress of SARS, www.sarssupportcentre.net, was launched on June 16, 2003 by the Centre for Addiction and Mental Health (CAMH). The target audience is people who have been personally affected by SARS, such as those who are in quarantine, patients in isolation who have SARS, but who are well enough to use a computer and who have little support, because contact is limited due to restrictions, and members of the public who have questions and concerns about the illness and want to educate

themselves on ways to cope with the stress.

The site will have a section for health care providers and another for the general public with a confidential password protected online support group which will be moderated by a trained health care professional. The support group will be anonymous and free for anyone to use. Initially, it will be offered in English only; translation is being explored.
