Ontario Psychiatric Association
DIALOGUE
THE NEWSLETTER OF THE ONTARIO PSYCHIATRIC ASSOCIATION/UNE PUBLICATION DE L'ASSOCIATION DES PSYCHIATRES DE L'ONTARIO
SEPTEMBER
2004

MESSAGE FROM THE PRESIDENT

Our phantom summer is coming to an end and fall is starting to show itself in the air and in the trees. The CPA Annual Meeting is around the corner and I expect that many OPA members will be attending. The OPA Psychotherapy Section Fall Conference is scheduled for October 2nd and the speaker is Christopher Bollas. I would advise anyone interested in attending to complete the registration form and return it to the OPA office. Dr. Cinda Dyer, Psychotherapy Section Chair, and her organizing committee deserve a great deal of credit for all of the time and effort they have contributed towards this event.

The OPA Annual Meeting is scheduled for January 27th - 29th, 2005 and I would hope that people are blocking off their calendars now. The theme is " The Times: Are They Changing? " and with all of the uncertainty and focus on health care currently it is quite appropriate and timely. The upcoming talks between the Federal and Provincial Governments appear less promising than initially hoped for. It appears very unlikely we will see the "fix" to the system initially touted by the federal Liberals. The provincial Liberals are talking of health care transformation and regional networks to address the problems. There is very little known about what they are proposing but certainly there are changes coming that will affect the mental health system. Negotiations continue between the MOH and the OMA. Psychiatrists are very fortunate to have Dr. Doug Weir on the OMA negotiating team. We should know shortly if there will be an agreement in the near future.

I recently met with the new Chair of the Consent and Capacity Board, Mr. Ted Nemetz. I had an opportunity to review the concerns expressed by many OPA members. He has organized a round table discussion involving numerous stakeholders to look at all of the issues. The OPA, AGHPS and the OMA Section on Psychiatry will all be represented at this meeting on September 15th. This is a wonderful opportunity to try and affect positive change.

There have been changes at the OPA over the past several months. Both Lorraine Taylor, the OPA Executive Assistant and Elizabeth Leach, OPA Director of Policy and Planning have left the organization to pursue new opportunities. Lorraine has been with the OPA since Feb 1997 and has been invaluable to Executive, Council and members. She has managed the OPA office and all OPA Presidents have depended on her immensely. She has done all of the practical organization for the Annual Meetings and many of you would have met her at the registration desk. I would like to thank her for her contributions to the OPA and wish her the best in the future.

Elizabeth has been our Director of Policy and Planning for 5 years. Her past experience in mental health, her knowledge of the health care system and her connections with other mental health organizations as well as the MOH have greatly benefited the OPA. She has co-ordinated strategic planning, advised on organizational structure and provided guidance on understanding often confusing Government policy. She fostered relations with key constituencies and often represented the OPA at meetings with ministry officials and other organizations. She also served as Editor of the OPA *Dialogue*. I wish her success in her new position as Executive Director, Ontario Public Health Association.
The OPA has contracted with June Hylands and Associates Inc. to provide management services to the organization. June has extensive experience in working with mental health organizations in Ontario and will be able to provide not only management but also policy and strategic support to the OPA. Members will be notified regarding change of OPA address etc. in the near future.

Finally, I would like to welcome Dr. Toba Oluboka from North Bay to OPA Council. Dr. Oluboka will be completing the term of Dr. Derek Puddester who is now the Treasurer of the OPA.

Please feel free to contact me or any member of Council if you have questions, concerns or comments. We value you input.

Doug Wilkins, MD, FRCPC
2004 OPA President

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Ontario Psychiatric Association Executive and Council

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Dr. Richard O'Reilly

Dr. Oleg Savenkov

Dr. Bob Swenson

Council Members can be contacted through the OPA Head Office.

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

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Bob Swenson, OPA Council Member
Ann Thomas, Chair, Continuing Education Committee
Doug Wilkins, OPA President

From THE EDITOR

This issue marks the 22nd newsletter that I have edited for the Ontario Psychiatric Association. It shall also be my last as I bid farewell for new adventures. My unwritten rule has been that everything in this newsletter must be interesting and informative to OPA members. The intent was that the content also be useful to you. It will now be up to the new Editor to make changes and improve on what has been provided these last five years.

This issue continues with Interesting Websites For You To Explore, introduces you to Dr. Richard O'Reilly, a new Council member (in "Meet a Council Member"), additional information on the topic of Mental Health and the Workplace, as well as the intentions of the Minister of Health with respect to community mental health in this province, as presented in the legislature.

As in every issue, a description of some community-based services are presented – the Lance Krasman Centre and programs administered by CMHA-National. This issue also brings you up to date on what is happening with collaborative/shared mental health care in Ontario and Canada, includes three advisories that Health Canada has published since the last issue of *Dialogue*, and presents a report on the process in South Western Ontario by various ministries to develop a comprehensive system of mental health care for children and youth, which is to include highly specialized services and supports. Dr. Drew Moulden continues with Part 2: The Efficacy of Transcranial Magnetic Stimulation in Treating Depression.

The *Dialogue* welcomes your comments, feedback and any point that you would like to raise on any aspect of this publication.

Elizabeth Leach
Editor

CALENDAR OF EVENTS

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

ONTARIO PSYCHIATRIC ASSOCIATION EVENTS

Ontario Psychiatric Association 2004 Council Meetings
MEMBERS WELCOME !

Friday, October 1. Space is limited, please contact the OPA office for locations or further details; (905) 827-4659, email: opa@bellnet.ca

Ontario Psychiatric Association Psychotherapy Section Fall Meeting
Free Association…a day with Christopher Bollas

Saturday, October 2, 2004

Mount Sinai Hospital Auditorium, 600 University Ave., Toronto

Christopher Bollas will discuss what he terms 'The Freudian Pair'— that partnership composed of the freely associating analysand and the evenly suspended attentive psychoanalyst. He will examine this object relation in a wide context that begins by regarding it as a seminal moment in the history of western culture. This 'Freudian Pair' is arguably the most sophisticated form of unconscious thinking we possess and, as Christopher Bollas argues, has far more wide-ranging implications than we ever imagined. He will also discuss the technical implications for working with free association— especially what Freud called 'the logic of sequence'— and he will provide clinical vignettes to illustrate his argument.

Contact information: Ontario Psychiatric Association, 1141 South Service Rd. W., Oakville, ON, L6L 6K4, Phone: 905-827-4659, fax: 905-469-8697, email: opa@bellnet.ca or Dr. Cinda Dyer at 416-922-6699/Dr. Doron Almagor at 416-482-8900

Ontario Psychiatric Association Annual Meeting
The Times: Are They Changing?

January 27 – 29, 2005

OPA Annual General (Business) Meeting Friday, January 28, 2005 (Breakfast meeting - time to be confirmed), Toronto Marriott Eaton Centre Hotel, 525 Bay St., Toronto. Attendance at the AGM is free to all OPA members.

Contact information: OPA Office, phone: (905) 827-4659, fax: (905) 469-8697, email: opa@bellnet.ca

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

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

Diagnosis & Treatment of Sexual Issues: Counter-Intuitive Approaches
September 23, 2004
Toronto, Led by Marty Klein
Participants will learn why helping clients feel more sexually "normal" is an insufficient clinical goal, almost guaranteeing treatment failures. Instead, participants will learn to reframe clients' goals so that when reached they enhance, rather than limit, clients' satisfaction and growth. As a result, participants will be able to empower clients to make better sexual choices, function more as they would like to, and better integrate eroticism into their relationships. Participants will learn: How to notice and effectively challenge clients' assumptions about sexuality & intimacy; Myths about sexual desire & desire discrepancies; How myths about the differences in male and female sexuality undermine couples counselling; Strategies for working with cybersex, commercial sex, and non-traditional sexual expression; Sexual aspects of health issues, including aging, illness, & medications; Effective history-taking & home assignments; How our sexual values affect our work - and often disempower our clients. Contact information: Leading Edge Seminars Inc., 88 Major St., Toronto, ON, M5S 2L1, toll-free at 1-888-291-1133 (in Toronto 416-964-1133), Website: http://www.leadingedgeseminars.org/register.html

Treating Complicated Couples: Successful Approaches to Challenging Cases
September 24, 2004
Toronto, Led by Marty Klein
Participants will learn the inaccurate assumptions behind many popular clinical models; acquire strategies to help individual partners make progress within the couple's sessions; and learn ways of working with boundaries, intimacy, and risk-taking that make couples therapy deeper and more satisfying for therapist and couples alike. Participants will learn: How to contain, work with, and become more comfortable with couples' anger; How to diagnose and defuse power struggles; Developmental stages in trust, commitment, and communication problems; How to use an existential perspective in understanding and treating couples' dynamics; How to help clients bring historical hurts & betrayals to a close; How to productively use the experience of couples ganging up on the therapist; How therapists unwittingly collude with clients' disempowerment
Contact information: Leading Edge Seminars Inc., 88 Major St., Toronto, ON, M5S 2L1, toll-free at 1-888-291-1133 (in Toronto 416-964-1133), Website: http://www.leadingedgeseminars.org/register.html

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

Anger Management: Behavioral, Cognitive, and Affective Intervention

September 27 – 28, 2004

Participants will be able to: Identify and plan treatment for clients with a wide range of anger problems as varied as anger avoidance to chronic anger and resentment; gain treatment materials that facilitate client change in four distinct areas: cognitive, behaviour, affect and existential meaning/spirit; utilise three separate anger assessment tools; implement one of three separate 12 week anger management programs, utilising materials at the seminar; describe practical approaches to working with angry families, children, adolescents and couples; identify how specific adult attachment styles interact with anger problems to increase the probability for domestic violence as well as treatment suggestions in this sphere.

Contact information: Edythe J. Nerlich, Hinks-Dellcrest Centre, Gail Appel Institute, 114 Maitland Street, Toronto, ON M4Y 1E1, Telephone: 416-972-1935, Fax :416-924-9808

Narrative Therapy: When All the Time you Have is Now

September 27 – 28, 2004

Participants will learn; therapist posture – ways of being with people in time sensitive conversations; useful pre-session questions; setting the agenda – ways to determine focus that differs from goal setting; a Narrative therapy "map" that guides time limited therapy; engaging people in deeply meaningful therapeutic conversation; getting to know the person away from the problem; developing thick, rich stories of what is "other than" the problem; finding and making use of outsider witnesses within and outside of the session; in-session note taking and creation of therapeutic documents.

Contact information: BTTC-I, The Hincks-Dellcrest Centre - Gail Appel Institute Telephone: (416) 972-1935 ext. 3345, Fax: (416) 924-9808, email: enerlich@hincksdellcrest.org

The 4th International Conference on Early Psychosis – Translating the Evidence

September 28 – October 1, 2004

Vancouver Convention and Exhibition Center, 999 Canada Place, Vancouver, British Columbia

Organized by: International Early Psychosis Association (IEPA)

The Conference will highlight rapid progress across the full spectrum of biological, epidemiological, psychological and sociological research into early psychosis. This broad perspective will aid the translation of new evidence into clinical advances that will enhance early detection, expert clinical care and sustained recovery.

Contact Information: Venue West Conference Services, Phone 604-681-5226, Fax: 604-681-2503

Email: congress@venuewest.com website: www.venuewest.com/2004/iepa

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

September 30 & October 1, 2004

With the use of popular film and documentary videos participants will examine how early attachment patterns and early childhood trauma can predispose some individuals to develop debilitating adult coping mechanisms. A conceptual framework for understanding and guiding your work with complex individuals will be outlined.

Contact information: The Hincks-Dellcrest Centre - Gail Appel Institute, 114 Maitland Street, Toronto, Ontario, Canada M4Y 1E1, Telephone: (416) 972-1935, Fax: (416) 924-8208, e-mail: institute@hincksdellcrest.org, website: http://www.hincksdellcrest.org

Royal College of Physicians and Surgeons of Canada Annual Conference Informed by our past, focused on our future

September 30 – October 2, 2004

Ottawa

The goal of the conference is to be a forum for activities that reflect the mission and core functions of the College, and assist Fellows with their professional development by promoting quality health care through education, research, sound health and public policy, ethics, and other generic topics related to specialty medicine.

Contact information: Meetings and events, RCPSC, phone 613-730-6231 or 1-800-668-3740 ext. 231 Fax: 613-730-8252, email: meetings@rcpsc.edu, web: www.rcpsc.medical.org/meetings/

Creative Interventions for Troubled Children & Youth

October 1, 2004

Ottawa, Led by Liana Lowenstein

Through activity demonstrations, audio-visual presentations, and small group exercises, participants will learn: Creative interventions to assess and treat children, youth, and families; Innovative techniques to manage challenging client behavior; How to select interventions appropriate to the distinct needs of clients; How to integrate interventions to make individual, group, and family counselling sessions meaningful and effective; How to make and create therapeutic games; How to engage resistant clients in counselling

Contact information: Leading Edge Seminars Inc., 88 Major St., Toronto, ON, M5S 2L1, toll-free at 1-888-291-1133 (in Toronto 416-964-1133), Website: http://www.leadingedgeseminars.org/register.html

Effective Approaches for Assessing and Treating Anxiety Disorders

October 1, 2004

Ottawa, Led by Dr. Martin M. Antony

This workshop provides an over-view of evidence-based techniques for helping people who suffer from anxiety disorders. The workshop will include a discussion of the anxiety disorders, their key features, their causes, and a detailed presentation of strategies for assessment. You will learn about effective psychological strategies for treating anxiety-based problems. In particular, step by step guidelines regarding cognitive and behavioural techniques for treating anxiety disorders will be provided.

Participants will learn: How to distinguish among various types of anxiety disorders; How to develop a comprehensive assessment plan; ;Which medications work for anxiety-related problems; Which psychological treatments work for particular anxiety disorders; Practical strategies for using cognitive therapy with individuals suffering from anxiety disorders; Step-by-step methods for treating anxiety disorders using exposure-based therapies.

Contact information: Leading Edge Seminars Inc., 88 Major St., Toronto, ON, M5S 2L1, toll-free at 1-888-291-1133 (in Toronto 416-964-1133), Website: http://www.leadingedgeseminars.org/register.html

The Anti-Depressant Intensive

October 1, 2004

Harbourfront, Toronto, Ontario

Organized by: International Academy of Cognitive Therapy

This one-day intensive teaches the state-of-the-art management of common depressive disorders. Cognitive therapy is widely recognized as the most effective psychotherapy for the various forms of depression. Profound breakthroughs have taken place over the 25 years since Aaron Beck field-tested an early version of cognitive therapy for depression. For example, ca. 2004 cognitive therapy combined with medication helps a full three-quarters of truly chronic depressives improve by 50% or more.

This intensive teaches new approaches to major depression, dysthymic disorder, bipolar disorder, post-partum depression and suicidality, as well as the dreaded 'post-depression anxiety' and other significant relapse prevention issues. Participants learn to integrate modern cognitive therapy techniques into their existing practice styles. The net result is a relief for those suffering from depression.

Contact information:

Visit the website at:www.cbt.ca or phone Sara at 416-410-6699

Ontario Psychiatric Association Psychotherapy Section Fall Meeting Free Association…a day with Christopher Bollas

October 2, 2004

Mount Sinai Hospital Auditorium, 600 University Ave., Toronto

Christopher Bollas will discuss what he terms 'The Freudian Pair'— that partnership composed of the freely associating analysand and the evenly suspended attentive psychoanalyst. He will examine this object relation in a wide context that begins by regarding it as a seminal moment in the history of western culture. This 'Freudian Pair' is arguably the most sophisticated form of unconscious thinking we possess and, as Christopher Bollas argues, has far more wide-ranging implications than we ever imagined. He will also discuss the technical implications for working with free association— especially what Freud called 'the logic of sequence'— and he will provide clinical vignettes to illustrate his argument.

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Oakville, ON, L6L 6K4, Phone: 905-827-4659, fax: 905-469-8697, email: opa@bellnet.ca or Dr. Cinda Dyer at 416-922-6699/Dr. Doron Almagor at 416-482-8900

2004 Annual Meeting of the Canadian Academy of Child and Adolescent Psychiatry

October 3 – 5, 2004
Montreal
This year's Annual Meeting will be held in Montreal from Sunday, October 3rd through to Tuesday, October 5th, 2004 at the Fairmont Queen Elizabeth Hotel. The Academy meeting will be held separately from the Annual Meeting of the Canadian Psychiatric Association (CPA) due to scheduling challenges that resulted when the CPA changed their original dates from November to mid-October. If CACAP preceded the CPA it would conflict with Thanksgiving and if held after would run close to the American Academy of Child and Adolescent Psychiatry (AACAP) Annual Meeting.
Contact information: Canadian Academy of Child and Adolescent Psychiatry, Ms. Elizabeth Manson, Administrator, 555 University Avenue, Toronto, ON M5G 1X8, Ph.: 416-813-6540; Fax: 416-813-6200, E-mail: elizabeth.manson@sickkids.ca, website: www.canacaed.org

Making Gains in Mental Health and Addictions: Knowledge, Integration, Action Second Annual Making Gains Conference

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

Health Privacy: New Compliance Requirements and Best Practices

October 4 – 5, 2004
The Fairmont Palliser Hotel, Calgary AB
Insight Information has brought together a distinguished faculty of senior privacy regulators, legal experts and health and technology leaders to provide you with up-to-date and comprehensive information on the most pressing issues as well as practical strategies for meeting the new standards. Given the pressures in the current health care environment, the risk of privacy breaches is real and the stakes are high. Don't miss this opportunity to gain valuable knowledge and insights that will help you meet these challenges and contain the attendant risks.
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: talk@insightinfo.com , website: www.insightinfo.com

Mental Illness Awareness Week

October 4, 2004 to October 10, 2004
Planning for Mental Illness Awareness Week (MIAW) is underway, and once again help is needed to ensure that we reach as many Canadians as we can with important messages about mental illness. Too few Canadians know about the burden of mental illness on our society, and too few sufferers seek help when they need it. Through your assistance in the past, we have opened the eyes of many Canadians to the reality of mental illness.
New this year
Since its launch in 1992, MIAW has been coordinated by the Canadian Psychiatric Association (CPA), with help from many partners. This responsibility has transitioned to the Canadian Alliance on Mental Illness and Mental Health (CAMIMH), with CPA still playing a strong role. Fundamental to our success in 2004 will be our ability to actively engage our supporters to help ensure that our public education campaign reaches more people than ever before.
MIAW 2004
The theme of this year's campaign is Face Mental Illness. This theme will build in future years in order to strengthen the MIAW brand and reinforce awareness year-over-year.
The core elements of the 2004 campaign will include: a grassroots public education initiative; a nationally-distributed poster and bookmark series; and the 2nd Annual Champions of Mental Health Awards luncheon on October 5 in Ottawa. The luncheon is a component of a new education initiative being undertaken with federal Members of Parliament, both in their home ridings and on Parliament Hill. The MIAW poster and bookmark series will feature photographs of people who live with or have lived with mental illness. The posters will tell their stories and encourage Canadians to face the reality of mental illness by learning more about it. These stories will also be featured on our new website, along with lots of information on mental illnesses and their impacts on individuals, families and communities.
Contact information: Canadian Alliance on Mental Illness and Mental Health at www.miaw.ca

Association for Academic Psychiatry Annual Meeting - Leadership in Academic Psychiatry: Preparing, Becoming, and Being Leaders for our Profession

October 6 - 9, 2004
Albuquerque, New Mexico
Contact information: Carole Berney, AAP Executive Office, Suite 4200,725 Concord Avenue, Cambridge, MA 02138, Phone: 617-661-3544, Fax: 617-661-4800 http://www.hsc.wvu.edu/aap/home.htm

The World Mental Health Day Project: The Relationship between Physical and Mental Health: Co-occurring mental and physical disorders A Global Mental Health Education Campaign of the World Federation for Mental Health

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

7th Biannual IAPSRS Ontario Conference - Pathways to Recovery: From Foundation to Innovation

October 12, 2004 to October 15, 2004
Hamilton Convention Centre, Hamilton, Ontario
Contact information: International Association of Psychosocial Rehabilitation Services Ontario Chapter, e-mail psrconf@stjosham.on.ca or call Jodi Younger at 905-522-1155 ext. 6267. The complete event brochure is available online at http://www.psrrpscanada.ca/new_events.htm

Certificate in Trauma Counselling for Front-Line Workers An Eight Day Course

October 12 & 13, 26& 27, 2004
November 9 & 10, 23 & 24, 2004
Toronto
Participants will be given the most current information on the biopsychosocial phenomenon of psychological trauma, an examination of how workers and organizations are affected by and respond to working with traumatized individuals and training in how to assess and respond ethically and appropriately to clients given the parameters of the workplace.
Contact information: The Hincks-Dellcrest Centre - Gail Appel Institute, 114

Maitland Street, Toronto, Ontario, Canada M4Y 1E1, Telephone: (416) 972-1935, Fax: (416) 924-8208, e-mail: institute@hincksdellcrest.org, website: http://www.hincksdellcrest.org/institute/

Harm Reduction Psychotherapy (HRP)

October 14, 2004
Toronto, Led by Patt Denning
Participants will learn: The principles of HRP; The Stages of Change Model; Specific clinical techniques to use in assessment, treatment planning and the evaluation; The Multidisciplinary Assessment Profile; HRP treatment protocols; Working with transference, ambivalence and resistance; Countertransference; The role of Substance Use Management to reduce alcohol and drug related harm.
Contact information: Leading Edge Seminars Inc., 88 Major St., Toronto, ON, M5S 2L1, toll-free at 1-888-291-1133 (in Toronto 416-964-1133), Website: http://www.leadingedgeseminars.org/register.html

Therapy in the Trenches: Strategies for Working with "Difficult" Cases

October 14 & 15, 2004
Toronto
Participants will learn: how to decide whom is best to include in the session; how to think about and define a problem; what is a useful contract and how to negotiate one; how to work with clients to develop goals; how to think about and do direct and non-direct intervention; how to plan therapy in crisis versus non-crisis cases; how to close therapy cases for the best prognosis.
Contact information: The Hincks-Dellcrest Centre - Gail Appel Institute, 114 Maitland Street, Toronto, Ontario, Canada M4Y 1E1, Telephone: (416) 972-1935, Fax: (416) 924-8208, e-mail: institute@hincksdellcrest.org, website: http://www.hincksdellcrest.org/institute/

Canadian Psychiatric Association 54th Annual Meeting
Culture and Mental Health: Not a Minor Matter

October 14 – 17, 2004
Montreal, Quebec
The cultural mosaic of Canada presents a multi-faceted dimension for psychiatry that is often underappreciated. Canadians are immigrants. They are the children of immigrants. They are native born of culturally diverse families. They are also native born of relatively homogenous parents. Each of us may be born into a cultural context but as we grow and develop we are altered by the surrounding culture—we become a sum of the parts. These are complex interactions. Also, the influence brought to bear by our culture and our patients' culture cannot be underestimated. It affects how they see us, how we see them and how they perceive their problems.
Contact information: The Canadian Psychiatric Association, 260-441 MacLaren Street, Ottawa, Ontario, K2P 2H3, Telephone: 613-234-2815, Fax: 613-234-9857 email: agm@cpa-apc.org, website: www.cpa-apc.org

Single Session Therapy: The catalyst of change

October 15, 2004
Toronto
Participants will learn: The unique scaffolding of a single session conversation; Effective brief and single session techniques that you can use in your work immediately; How to focus the conversation with lines of inquiry that elicit concrete, achievable goals that set the stage for change in the first five minutes; How to utilize client feedback in the process to shape and orient the session towards successful outcomes; How to elicit and sustain motivation; The role of the team in Single Session Consultation.
Contact information: The Hincks-Dellcrest Centre - Gail Appel Institute, 114 Maitland Street, Toronto, Ontario, Canada M4Y 1E1, Telephone: (416) 972-1935, Fax: (416) 924-8208, e-mail: institute@hincksdellcrest.org, website: http://www.hincksdellcrest.org/institute/

Harm Reduction Psychotherapy (HRP) with Clients who have Concurrent Disorders

October 15, 2004
Toronto, Led by Patt Denning
Participants will learn about: Major mental disorders and their neurobiological impact; Neurobiological effects of street drugs or alcohol; Biological and emotional sequelae of physical illnesses and interaction with various drugs; Differential diagnosis; Co-existent of personality disorders or traits; Recommendations for integrated treatment of co-existing disorders.
Contact information: The Canadian Psychiatric Association, 260-441 MacLaren Street, Ottawa, Ontario, K2P 2H3, Telephone: 613-234-2815, Fax: 613-234-9857 email: agm@cpa-apc.org, website: www.cpa-apc.org

12th Annual Santa Fe Symposia

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

Canadian Academy for Geriatric Psychiatry – 2004 Annual Scientific Meeting
Culture and Ageing

October 18, 2004
Fairmont The Queen Elisabeth Hotel, Montréal, Québec
Objectives: To provide a forum to explore issues in geriatric psychiatry. Lectures and workshops will focus on different aspects of clinical practice and research and will allow for discussion of clinical and research challenges. Participants: The content will be of particular interest to psychiatrists and physicians who are treating the elderly in a variety of settings. Students and residents, as well as other health care professionals are welcome.
Contact information: Dr. Francois Rousseau at 418-663-5781, or Shelly Haber at s.haber@sympatico.ca, website: www.cagp.ca

Canadian Association for Suicide Prevention Conference - Planning for Action: Building Momentum for Suicide Prevention

October 20, 2004 to October 23, 2004
Shaw Conference Centre, Edmonton, Alberta
To learn, network, advocate, support and advise in hopes of reducing suicide and minimizing the harmful effects of suicidal behaviour. Conference Objectives: 1.Provide support, information and opportunities for continued dialogue and collaboration to build a better understanding of suicide, the effects of suicide and suicide prevention strategies. 2. Support networking between survivors, researchers, policy makers, advocates, front-line workers and clinicians. 3 Facilitate efforts to build and sustain momentum and motivation toward a national strategy on suicide prevention.
Contact information: Alberta Mental Health Board and Canadian Association for Suicide Prevention (CASP) www.buksa.com/casp, BUKSA Conference Management and Program Development, Suite 307, 10328 - 81 Avenue NW, Edmonton, Alberta T6E 1X2

EFT Couples Therapy Training Program

October 21, 2004 to October 23, 2004
York University, Toronto, Ontario
A three-day Emotion Focused Couples Therapy Training Program with Les Greenberg, Ph.D. EFT for couples was developed by Dr.'s Les Greenberg and Sue Johnson in the 1980s. The evidence-based modality consists of widely-acclaimed techniques for enhancing the emotional bonds between partners. The program focus is in-depth skills training through a combination of lecturettes, video demonstrations, skills modeling, role-playing practice, and the supervision of cases. Enrollment is strictly limited to 27 participants.
Contact Information: Emotion Focused Therapy wwwemotionfocusedtherapy.org, Phone: 416-410-6699

Dialectical Behaviour Therapy: Clinical Tools for Difficult Patients

October 21 and October 22, 2004
Toronto, Led by Shelley McMain & Lorne Korman
Participants in this workshop will have an opportunity to role-play difficult therapeutic situations, view videotape, and apply treatment strategies to specific clinical cases provided by the group.
Participants will learn: To conceptualize borderline personality disorder from

DBT's biosocial theory; To identify the functions and modes of DBT; Strategies for increasing commitment and engagement; To balance validation and change strategies; To describe the two core strategies in Dialectical Behaviour Therapy; To conduct behavioural and solution analyses of problem behaviours like self-harm and substance abuse; To utilize dialectical strategies to address extreme behaviours.
Contact information: Leading Edge Seminars Inc., 88 Major St., Toronto, ON, M5S 2L1, toll-free at 1-888-291-1133 (in Toronto 416-964-1133), Website: http://www.leadingedgeseminars.org/register.html

Psychopharmacology

October 21 – 23, 2004
The Westin Copley Place, 10 Huntington Avenue, Boston, MA 02116
Now in its twenty-eighth year as the pacesetter in psychiatry education, this renowned Massachusetts General Hospital and Harvard Medical School course once again gathers a premier teaching faculty of clinician-researchers to present a comprehensive three-day curriculum. The course is designed for clinicians wishing to retool and refine their knowledge of state-of-the-art practice in order to deliver the best possible care to their patients
Contact information: Harvard MED-CME, P.O. Box 825, Boston, MA 02117-0825, phone: (617) 384-8600, e-mail: hms-cme@hms.harvard.edu., website: http://cme.med.harvard.edu.

Rational Emotive Behaviour Therapy (REBT) Workshop

October 22, 2004
Donald Gordon Centre, Queen's University, Kingston
Participants will learn: ABCs of REBT; how to help clients make the distinction between appropriate and inappropriate, functional and dysfunctional responses; various styles of disputing dysfunctional cognitions; three domains of intervention: somatic, cognitive and behavioural; how to integrate EBT with associated intervention strategies; how to help clients differentiate between stress, distress and eustress; cognitive underpinnings of anxiety, panic, depression, and anger; how to help clients dispute their dire need for certainties and guarantees; usefulness of FID scales; how to develop appropriate homework assignments.
Contact information: Doreen Hoekstra, PCCC, Mental health Services, 752 King St. W., Kingston, phone (613) 548-5567 ext. 5713 or e-mail hoekstrd@pccchealth.org

Addiction Medicine: Evidence-Based Strategies

October 22 – 23, 2004
Radisson Hotel Boston, 200 Stuart Street, Boston, MA 02116
In October of each year, the Division on Addictions at Harvard Medical School hosts a course in Addiction Medicine. The primary focus of the 2004 course is "Evidence-Based Strategies." This course imparts information on methods of diagnosis and protocols for intervention and management of patients with substance abuse and dependence. Our expert faculty provides a unique forum for dialogue and participant interaction. Participants will increase their understanding of: The status of substance abuse treatment effectiveness; How to medically manage detoxification; New methods of managing substance abusing patients in an outpatient setting; How to manage patients who suffer from co-occurring substance use disorders and psychiatric illness; The role of neurobiology in the development of addictive disorders and the implications for assessment and treatment; Strategies for treating patients with nicotine-related problems.
Contact information: Harvard MED-CME, P.O. Box 825, Boston, MA 02117-0825, phone: (617) 384-8600, e-mail: hms-cme@hms.harvard.edu., website: http://cme.med.harvard.edu.

Tools for Transforming Trauma: Ericksonian & Solution Oriented Approaches for Treating Survivors of Trauma and Abuse

October 28 & 29, 2004
Toronto, Robert Schwarz, PhD
Contact information: The Hincks-Dellcrest Centre - Gail Appel Institute, 114 Maitland Street, Toronto, Ontario, Canada M4Y 1E1, Telephone: (416) 972-1935, Fax: (416) 924-8208, e-mail: institute@hincksdellcrest.org, website: http://www.hincksdellcrest.org/institute/

Challenges for Inpatient Mental Health Units: Striving for Best Practices in the 21st Century

October 29, 2004
Sponsored By: St. Michael's Hospital Mental Health Service and the Association of General Hospital Psychiatric Services
This conference is intended for all who are involved and interact with Inpatient programs. Keynote speakers include Dr. Hugh Griffiths and Dr. Cindy Peternelj-Taylor, and there will be a panel discussion with consumer survivors on inpatient experiences. Program & Registration form will be circulated by September 2004.
Contact information: Jeff Loudermilk, Mental Health Service Tel:(416) 864-6060 ext 6481 Fax:(416) 864-5480 e-mail: loudermilkj@smh.toronto.on.ca

Treating Couples

October 29 – 30, 2004
Royal Sonesta Hotel, 5 Cambridge Parkway, Cambridge, MA 02142
The objective of this course is to present couple therapy from clinical, theoretical, and research perspectives in order to broaden the thinking and improve the skills of practitioners. Challenging issues will include how to look at the tensions between love and desire; how to achieve dialogue; how to explore and communicate expectations; how to restore intimacy; how to forgive; and how to establish greater self-reflection and awareness in couples. Additional topics to be considered are working with couples in the context of recovery, physical illness and infertility, and the influence of race and culture on the couple relationship. Treatment approaches will include cognitive behavioral, psychodynamic, systemic, and feminist theories. The course is intended for all mental health clinicians, marriage and family therapists, and others interested in couples and couple therapy.
Contact information: Cambridge Health Alliance Physicians Organization - Continuing Education, PO Box 398075-Inman Square, Cambridge, MA 02139. Phone: (617) 503-8445, FAX: (617) 503-8460, email: cme@challiance.org; or web: www.cambridgecme.org

Creative Interventions for Troubled Children & Youth

October 29, 2004
Toronto, Led by Liana Lowenstein
Through activity demonstrations, audio-visual presentations, and small group exercises, participants will learn: Creative interventions to assess and treat children, youth, and families; Innovative techniques to manage challenging client behavior; How to select interventions appropriate to the distinct needs of clients; How to integrate interventions to make individual, group, and family counselling sessions meaningful and effective; How to make and create therapeutic games; How to engage resistant clients in counselling.
Contact information: Leading Edge Seminars Inc., 88 Major St., Toronto, ON, M5S 2L1, toll-free at 1-888-291-1133 (in Toronto 416-964-1133), Website: http://www.leadingedgeseminars.org/register.html

Taming Dragons: Play Therapy for Anger Management

October 30, 2004
Presented by: Leading Edge Seminars and the Canadian Association for Child & Play Therapy
Toronto, Led by Neil Cabe
In community mental health agencies, anger is the single greatest referral symptom for children. Teaching children to manage anger, and learning how to treat it with play therapy, are issues of great importance for therapists. However, anger is a secondary emotion, and underneath it usually lurk hurt and fear. Discovering those hurts and fears, and working with them, will allow the therapist to walk with a child toward healing. Dr. Cabe will explore with his audience some of the potential sources for anger in children, and will present guidelines for differentiating simple angry outbursts and tantrums from more disabling difficulties. Participants will actively engage in at least 17 practical play therapy anger management techniques. The presented techniques are inexpensive and treatment tested. In addition, participants will leave this workshop with a tool kit packed with things to use during their very next workday. The workshop can get messy, so casual clothing is highly recommended.
Participants will learn: To identify anger and its correlates in child clients; To engage in and be able to demonstrate a large number of practical play therapy techniques for anger management; To relate anger management to the powers of play; To identify six characteristics of a playful mind; To engage a child in the

therapy process in less than three minutes!; To identify anger "pay offs" and five types of aggression.
Contact information: Leading Edge Seminars Inc., 88 Major St., Toronto, ON, M5S 2L1, toll-free at 1-888-291-1133 (in Toronto 416-964-1133), Website: http://www.leadingedgeseminars.org/register.html

Dimensions of Suicide
November 4, 2004
Presented by: Waterloo Region Suicide Prevention Council
Keynote Speaker: Dr. Gustavo Turecki (Neuroscience of Suicide)
Workshops: Bipolar Disorder in Children & Adolescents - Dr. Margaret Steele/ Building Community Capacity of Suicide Prevention - David Masecar/ Models of Intervention in High Risk Patients - Al Copland/ Living with Someone Who is Suicidal - Maureen Garner and Subaida Hanifa
Contact information: Pauline Potzold, Grand River Hospital, 519-749-4300, pauline.potzhold@grhosp.on.ca

Cognitive Therapy Pearls
November 5, 2004
Harbourfront, Toronto, Ontario
Organized by: International Academy of Cognitive Therapy
Following a (fun)damentals review, this acclaimed intensive provides CBT-derived 'pearls' in the treatment of over 20 common disorders. Whether your orientation is psychodynamic, experiential, eclectic or already cognitive-behavioral, you'll come away with many new pearls for a broad range of disorders. Dr. Dubord's treatment tips begin with the common anxiety disorders, covering chronic worry, panic disorder, agoraphobia, social phobia, obsessive-compulsive disorder, health anxiety, and the so-called 'simple' phobias (e.g., the fear of flying; West-Nile-o-Phobia). He then addresses the common depressive disorders, including major depression (with anti-suicide pointers), dysthymia, bipolar disorder and post-partum depression. Next are severe and persistent problems, such as borderline personality disorder and schizophrenia. Much more follows, ranging from anorexia, bereavement and CFS, all the way to terrorism fears and xenophobia. Participants leave with a long & shiny 'string of pearls' from the evidence-based cognitive therapy tradition.
Contact Information: Visit the website at:www.cbt.ca or phone Sara at 416-410-6699

Traumatized Attachment Disordered Children: "Understanding & Changing Behaviour, Beliefs & the Brain"
November 5, 2004
Toronto
This workshop will present information on attachment theory and brain development and the impact on child maturation. The training will include practical methods of treating such challenging children.
Contact information: The Hincks-Dellcrest Centre - Gail Appel Institute, 114 Maitland Street, Toronto, Ontario, Canada M4Y 1E1, Telephone: (416) 972-1935, Fax: (416) 924-8208, e-mail: institute@hincksdellcrest.org, website: http://www.hincksdellcrest.org/institute/

Treating Bipolar Disorder: From Childhood to Adulthood
November 5 – 6, 2004
Boston Park Plaza Hotel, 64 Arlington Street, Boston, MA 02116
The objective of this course is to present the latest clinical, theoretical, and research findings on bipolar disorder in children, adolescents, adults and their families. The focus is on assessment and treatment, differential diagnosis, misdiagnosis, and comorbidity. Other topics include juvenile onset, neurological findings, and the lifecycle issues of pregnancy and ageing. Biological, psychological, cultural and sociological factors effecting treatment and outcome will be considered. Approaches to treatment include cognitive-behavioral, psychodynamic and psychopharmacologic. The course is intended for clinicians, researchers and others interested in bipolar disorder.
Contact information: Cambridge Health Alliance Physicians Organization - Continuing Education, PO Box 398075-Inman Square, Cambridge, MA 02139. Phone: (617) 503-8445, FAX: (617) 503-8460; email: cme@challiance.org; or web: www.cambridgecme.org

Toronto Child Psychoanalytic Program 25th Annual Symposium
November 6, 2004
The Canadian Association of Psychoanalytic Child Therapists, in association with the Toronto Child Psychoanalytic Program, will be holding its 25th Annual Symposium in Toronto with guest speaker Dr. Daniel N. Stern.
Contact information: rosemary.adams@sympatico.ca or call 416-690-5464.

Effective Approaches for Assessing and Treating Anxiety Disorders
November 8, 2004
Toronto, Led by Dr. Martin M. Antony
This workshop provides an over-view of evidence-based techniques for helping people who suffer from anxiety disorders. The workshop will include a discussion of the anxiety disorders, their key features, their causes, and a detailed presentation of strategies for assessment. You will learn about effective psychological strategies for treating anxiety-based problems. In particular, step by step guidelines regarding cognitive and behavioural techniques for treating anxiety disorders will be provided.
Participants will learn: How to distinguish among various types of anxiety disorders; How to develop a comprehensive assessment plan; Which medications work for anxiety-related problems; Which psychological treatments work for particular anxiety disorders; Practical strategies for using cognitive therapy with individuals suffering from anxiety disorders; Step-by-step methods for treating anxiety disorders using exposure-based therapies.
Contact information: Leading Edge Seminars Inc., 88 Major St., Toronto, ON, M5S 2L1, toll-free at 1-888-291-1133 (in Toronto 416-964-1133), Website: http://www.leadingedgeseminars.org/register.html

The Effective Facilitator
November 11, 2004
Toronto, Led by Ruth Armstrong
Participants will learn: The role and functions of a facilitator; The stages of facilitation; The dynamics of group work; To encourage participation; To manage group conflict; Effective decision-making; Meeting management. This practical workshop is for you if: You lead groups in problem-solving and decision-making; You support or coach others in a facilitating role. You want to enhance your own facilitation skills.
Contact information: Leading Edge Seminars Inc., 88 Major St., Toronto, ON, M5S 2L1, toll-free at 1-888-291-1133 (in Toronto 416-964-1133), Website: http://www.leadingedgeseminars.org/register.html

Habit Control: Integrative Approaches to Entrenched Problems
November 11 & 12, 2004
Toronto, Jeffrey K. Zeig, PhD
This workshop will provide: tools for conducting an action assessment; an overview of the phenomenology of addiction; how to determine stages of treatment and effective task assignment; clear and effective training demonstrations; principles for intervening with patients regarding habit control; strategies for intervening with patients regarding habit control; an integrative model for effective habit control.
Contact information: The Hincks-Dellcrest Centre - Gail Appel Institute, 114 Maitland Street, Toronto, Ontario, Canada M4Y 1E1, Telephone: (416) 972-1935, Fax: (416) 924-8208, e-mail: institute@hincksdellcrest.org, website: http://www.hincksdellcrest.org/institute/

Different Ways of Grieving - Different Ways of Healing: Practical Counselling Tools and Techniques
November 12, 2004
Toronto, Led by Douglas C. Smith
Here is a practical and applicable workshop offering tools and techniques you can use the very next day!
Participants will learn to: Describe ways to start conversation with people who are experiencing loss and grief, and how to start a counselling relationship with them; Identify ways of assessing a person's own grieving style and language, as well as assessing a person's own psycho-social and psycho-spiritual grief resources; Discuss the differences between "Intuitive Grievers" (feeling oriented people) and

"Instrumental Grievers" (cognitive/action oriented people); Identify tools and techniques that address gender similarities and differences in the grieving process; Explain tools and techniques for addressing psycho-social and psycho-spiritual needs of people experiencing loss and grief.
Contact information: Leading Edge Seminars Inc., 88 Major St., Toronto, ON, M5S 2L1, toll-free at 1-888-291-1133 (in Toronto 416-964-1133), Website: http://www.leadingedgeseminars.org/register.html

Aggressive, Resistant and Delinquent Youth
Meeting the Treatment Challenge

November 12 – 14, 2004
The Fairmont Copley Plaza Hotel, 138 St. James Avenue, Boston, MA 02116
Organized by: Massachusetts General Hospital, Department of Psychiatry
The longstanding, intractable difficulties of aggressive, noncompliant and delinquent youth present significant challenges to professionals in the fields of mental health, social services, juvenile justice, and education. Effective treatment of such youth requires an awareness of the most current research regarding characterization, etiology and intervention. In recent years advances in research have greatly enhanced our understanding of these youth. Likewise our ability to effectively intervene has dramatically improved. This groundbreaking course – now in its second session - gathers a distinguished faculty of leading experts from the Massachusetts General Hospital, Harvard Medical School, and around the country to translate the latest research into practical approaches and effective treatment in schools, outpatient clinics, inpatient units, and residential and juvenile detention facilities. A comprehensive syllabus is provided.
Contact information: Harvard MED-CME, P.O. Box 825, Boston, MA 02117-0825, phone: (617) 384-8600, e-mail: hms-cme@hms.harvard.edu., website: http://cme.med.harvard.edu.

Ontario Hospital Association Convention: Advancing Leadership & Accountability

November 15, 16, 17, 2004
Metro Toronto Convention Centre, North Building
This year, OHA HealthAchieve2004 will feature 350 prestigious speakers, over 70 educational sessions and over 300 exhibitor booths.
Contact information: Ontario Hospital Association, 200 Front St. W, Suite 2800, Toronto, ON, M5V 3L1, phone: 416-205-1362, fax: 416-205-1340, website: www.ohahealthachieve.com

Understanding and Managing Vicarious Traumatization in Work with Survivors of Trauma

November 19, 2004
Toronto, Led by Carolyn Knight
Techniques and strategies that assist clinicians in managing vicarious traumatization also will be presented. Throughout the workshop, case examples, including the presenter's practice with adult survivors of childhood sexual abuse, will be integrated, as will relevant empirical and theoretical literature. Participants will be encouraged to share their own experiences, questions, and concerns regarding their practice. Participants will learn to: Understand the nature of trauma and traumatic stress; Recognize the treatment needs of trauma survivors; Identify the causes of vicarious traumatization; Recognize the manifestations of vicarious traumatization in yourself and others; Identify and utilize techniques to minimize vicarious traumatization in yourself and others; Adopt strategies of self-care to minimize the effects of working with survivors of trauma.
Contact information: Leading Edge Seminars Inc., 88 Major St., Toronto, ON, M5S 2L1, toll-free at 1-888-291-1133 (in Toronto 416-964-1133), Website: http://www.leadingedgeseminars.org/register.html

Preventative Strategies & Therapeutic Justice

November 24 & 25, 2004
Conference of the Human Services and Justice Coordination Network, Kingston, ON
The conference will provide learning and discussion opportunities to explore successful methods of intervention as well as emerging trends in the field of human services and justice. It is designed for people who are involved in human service and justice coordination initiatives, mental health and forensic professionals, people working within the criminal justice system and other community health care providers.
Contact information: Carol Blake, cblake@fcmhs.ca, website: meds.queensu.ca/medicine/psychiatry/HSJCN.doc

Mindfulness-Based Cognitive Therapy for Depression

November 25 and 26, 2004
Ottawa, Led by Zindel Segal
Participants will learn: The types of thinking and feeling loops that increase the risk of depression returning; The differences between bringing a 'doing' versus a 'being' frame of mind to your problems; The core tasks negotiated by patients in the 8 week MBCT program; The rationale behind intentionally facing and moving into difficulties and discomfort with an open and acceptant mode of responding; Practice three forms of mindfulness training utilized in MBCT, the Body Scan, Mindfulness of the Breath, and Three Minute Breathing Space; Learn about outcomes from a multi-centre randomized trial of MBCT for the prevention of depressive relapse.
Contact information: Leading Edge Seminars Inc., 88 Major St., Toronto, ON, M5S 2L1, toll-free at 1-888-291-1133 (in Toronto 416-964-1133), Website: http://www.leadingedgeseminars.org/register.html

Breaking Free From Depression & Anxiety: Interpersonal and Narrative Approaches

November 26, 2004
Toronto
Participants will be introduced to: Ways of understanding depression and anxiety through interpersonal and Narrative ideas and practices; The structure of storyline and re-authoring therapeutic conversations; Externalizing conversations as a gateway to preferred stories; Micro-maps for exploring the effects of the problem on identity; How to upload significance into pivotal events and moments in peoples' lives; The use of note taking in capturing alternate stories.
Contact information: The Hincks-Dellcrest Centre - Gail Appel Institute, 114 Maitland Street, Toronto, Ontario, Canada M4Y 1E1, Telephone: (416) 972-1935, Fax: (416) 924-8208, e-mail: institute@hincksdellcrest.org, website: http://www.hincksdellcrest.org/institute/

The Effective Facilitator

November 26, 2004
Ottawa, Led by Ruth Armstrong
With the trend towards increased participation in decision-making, and the accompanying accountability for results within short time frames, many of us are finding the facilitation of teams, meetings and focus groups more challenging than ever. Participants will learn; The role and functions of a facilitator; The stages of facilitation; The dynamics of group work; To encourage participation; To manage group conflict; Effective decision-making; Meeting management. This practical workshop is for you if: You lead groups in problem-solving and decision-making; You support or coach others in a facilitating role; You want to enhance your own facilitation skills.
Contact information: Leading Edge Seminars Inc., 88 Major St., Toronto, ON, M5S 2L1, toll-free at 1-888-291-1133 (in Toronto 416-964-1133), Website: http://www.leadingedgeseminars.org/register.html

Treating PTSD and Complex Psychological Trauma: Recent Advances

November 29 and 30, 2004
Toronto, Led by John Briere
The workshop attendee will be able to: List the types and known long-term effects of psychological trauma; Outline the general principles of the Self-Trauma Model for treating trauma-related distress; Explain why titrated (as opposed to prolonged) exposure may be necessary with some clients; Outline the rationale for process-based affect regulation skills development; Describe why the therapeutic relationship is critical to treating complex posttraumatic outcomes.
Contact information: Leading Edge Seminars Inc., 88 Major St., Toronto, ON, M5S 2L1, toll-free at 1-888-291-1133 (in Toronto 416-964-1133), Website: http://www.leadingedgeseminars.org/register.html

Mindfulness-Based Cognitive Therapy for Depression

December 2 and 3, 2004
Toronto, Led by Zindel Segal
The participant will learn: the types of thinking and feeling loops that increase the risk of depression returning; The differences between bringing a 'doing' versus a 'being' frame of mind to your problems; The core tasks negotiated by patients in the 8 week MBCT program; The rationale behind intentionally facing and moving

into difficulties and discomfort with an open and acceptant mode of responding; Practice three forms of mindfulness training utilized in MBCT, the Body Scan, Mindfulness of the Breath, and Three Minute Breathing Space; Learn about outcomes from a multi-centre randomized trial of MBCT for the prevention of depressive relapse.
Contact information: Leading Edge Seminars Inc., 88 Major St., Toronto, ON, M5S 2L1, toll-free at 1-888-291-1133 (in Toronto 416-964-1133), Website: http://www.leadingedgeseminars.org/register.html

Cognitive Therapy Tools

December 3, 2004
Harbourfront, Toronto, Ontario
This practical one-day intensive gives professionals a rare opportunity to gain confidence from practicing CBT tools while under expert supervision. Dr. Greg Dubord explains the key features of each tool and clearly demonstrates step-by-step how each is best implemented. Participants then receive coaching while practicing the tools in dyads. Over twenty tools are taught, including counter-attitudinal advocacy, Chicken Little logging, distortion identification, exposure & response prevention (E/RP), multiplied ratios, reductio ad absurdum, Socratic questioning and systematic desensitization. Applications reviewed include panic disorder, recurrent depression, hypochondriasis, alcoholism, borderline PD and chronic worry. We'll discuss how to integrate CBT tools within natural practice styles and with real-life cases. Experience the benefits of small-group learning!
Contact Information: Visit the website at:www.cbt.ca or phone Sara at 416-410-6699

CMA Leadership Workshop for Medical Women

December 3 – 4, 2004
Westin Harbour Castle, Toronto, ON
The workshop is an opportunity for women physicians with an interest in leadership roles to network and learn more about being an effective leader, including balancing professional and personal demands. This workshop is usually oversubscribed, so look for the registration form that is mailed to all women members of the CMA.
Contact information: Canadian Medical Association, 1867 Alta Vista Drive, Ottawa, Ontario, K1G 3Y6 Tel: Toll free 1 800-457-4205,Fax: (613) 236-8864, email: professional_development@cma.ca, website http://www.cma.ca/index.cfm/ci_id/39349/la_id/1.htm

Brief Therapy Approaches with "Chronic" Long-Term Families & Individuals

December 9 – 10, 2004
Toronto
Areas to be addressed will include: How to proceed when despair appears to preclude goal setting; Naming and addressing constraints to change; Challenging intergenerational family scripts using genograms and time lines; Larger systems issues; dealing with multiple and conflicting goals and mandates; Practices for "shining the light" on small changes and pivotal events; Moving beyond language: active and experiential approaches; Accessing beliefs, spiritual considerations (exploring beliefs, finding faith); Temporal considerations in systems that are "frozen in time"; Using collegial consultations and teams to stay on track.
Contact information: The Hincks-Dellcrest Centre - Gail Appel Institute, 114 Maitland Street, Toronto, Ontario, Canada M4Y 1E1, Telephone: (416) 972-1935, Fax: (416) 924-8208, e-mail: institute@hincksdellcrest.org, website: http://www.hincksdellcrest.org/institute/

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

ATTENTION MEMBERS! CALL FOR NOMINATIONS TO OPA 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 2005 OPA Elections are now being accepted. Five Council Meetings are held in Toronto throughout the year - in January (2 during the OPA Annual Conference), March, June, and October.

We are looking for a President-Elect, three Council Members (Full Members) and one Member-in-Training beginning January 2005. 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. Therefore, the next term of office for President-Elect is January 2005 to 2006; and the term is from January 2005 to January 2008 for Council Members and January 2005 to January 2007 for a Member-in-Training Council Member.

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.

Role Descriptions can be obtained by contacting the OPA office - telephone: (905) 827-4659 or by email: opa@bellnet.ca

Written nominations must include the nominee's signature and must be received by the OPA office by November 29, 2004.

For further information please contact Dr. Bob Buckingham, OPA Past President, by telephone: 416-340-3037 or by email: Robert.Buckingham@uhn.on.ca.

MEET A COUNCIL MEMBER

Richard L. O'Reilly, MB, BA, MRCP(1), MRC Psych, FRCP(C) is currently Professor, Department of Psychiatry at the University of Western Ontario and Director of Research at Regional Mental Health Care London/St. Thomas.

OPA: WHAT IS YOUR CURRENT POSITION ON THE OPA COUNCIL AND ON WHAT COMMITTEES DO YOU SERVE?
Dick: I am a new Council member and I am also a member of the Advocacy Committee.

OPA: TELL US A LITTLE ABOUT YOUR BACKGROUND.
Dick: I was born in Armagh, a small town in Northern Ireland. I received my medical training through Trinity College in Dublin and completed my Membership in Medicine and Psychiatry (equivalent of the Canadian Fellowship), before emigrating to Canada in 1984. I completed further training at The University of Western Ontario before moving to Saskatchewan, where I worked for three years, returning to London in 1989.

OPA: WHAT HAS BEEN YOUR MOST VALUABLE EXPERIENCE AS AN OPA MEMBER?
Dick: Working with colleagues from the Coalition to make the 2000 amendments to the Mental Health Act, which introduced less restrictive committal criteria and community treatment orders to the Province.

OPA: WHAT DO YOU THINK IS IMPORTANT FOR PSYCHIATRISTS TO BE AWARE OF IN THE 21ST CENTURY?
Dick: I believe that as a profession, we will need to know more about genetics and the relevance of genetic markers to the syndromes we are diagnosing and treating.

OPA: IF YOU WEREN'T A PSYCHIATRIST, WHAT OTHER PROFESSIONAL ENDEAVOUR WOULD YOU BE PURSUING?
Dick: If I had another few lives to live, in one of them I would like to work as a detective in a police force.

OPA: IF YOU HAD THREE WISHES, WHAT WOULD THEY BE?
Dick:
1. Financial independence.
2. Have one of the sports teams that I follow win a trophy.
3. Another three wishes.

OPA: IF YOU HAD THREE WISHES FOR THE PROFESSION OF PSYCHIATRY, WHAT WOULD THEY BE?
Dick:
1. That our profession would put a greater distance between itself and the pharmaceutical industry.
2. That we would embrace, and not just pay "lip service" to, a biopsychosocial approach. In my view, we are becoming overly biologically orientated.
3. That we would be politically active in advocating, both for our patients and for ourselves.

Report of the Continuing Education Committee

By: Ann Thomas, Chair, Continuing Education Committee

The 2005 Annual Meeting, "The Times: Are They Changing?" is fast approaching. The meeting will be held January 27, 28 & 29, 2005 at the Toronto Marriott Eaton Centre Hotel. Planning for the meeting continues and we are excited about the speakers we have arranged for your education and enjoyment.

Jeanne Safer, PhD, is a psychoanalyst and psychotherapist who has been in private practice in New York City for 30 years. She has published professional papers on female psychology, nightmares, and gender issues in psychotherapy, and has also written for The New York Times, the Wall Street Journal and The Washington Post. Dr. Safer's presentation to the OPA, entitled "The Normal One: the Secret Life of Siblings of the Mentally and Physically Ill" is based on personal experience, 30 years of psychoanalysis practice and intensive interviews with 60 higher-functioning adult siblings of the mentally and physically dysfunctional and disabled.

Philip Klassen, Deputy Clinical Director of the Law and Mental Health Program at the Centre for Addiction and Mental Health, and Assistant Professor in the Departments of both Psychiatry and Medicine, at the University of Toronto, will present "Pharmacological Sex Drive Reduction: A Review of Available Agents and Their Efficacy/Effectiveness".

Our luncheon symposia will include presentations on novel neuroleptics and attention deficit disorder. Other topics we plan on including in the programme include severe & persistent mental illness, mood disorders, children's issues, psychopharmacology, and addiction issues.

On Wednesday, January 26th, our Pre-conference one-day workshop entitled "Interpersonal Psychotherapy", will be presented by John C. Markowitz, M.D. Dr. Markowitz is a Research Psychiatrist at NYSPI, Adjunct Clinical Associate Professor of Psychiatry at Columbia University, and Clinical Associate Professor at Weill Medical College of Cornell University. He has extensive experience in psychotherapy and pharmacology trials using a variety of psychotherapeutic modalities. Dr. Markowitz has published widely and has lectured on psychotherapy across the United States and in more than twenty other countries.

This year's T.A. Sweet Award recipient is Mr. Phil Upshall, President of the Mood Disorders Society of Canada. This award is presented annually to individuals who have made a major contribution to the understanding of mental illness and its impact on individuals in society. The OPA was greatly heartened by Mr. Upshall's efforts to speak publicly about his own experiences of the impact of mental illness, specifically, bipolar disorder.

The OPA Annual General (Business) Meeting will be held during a buffet breakfast on Friday, January 28, 2005. Attendance at the AGM is free to all OPA members.

The OPA Dinner/Dance will be held Friday, January 28th and will include a sumptuous buffet dinner and live band. This is always an event not to be missed.

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

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

Collaborative Mental Health Care in Ontario

In December 2003, Health Canada announced that the proposal from the Canadian Consortium on Collaborative Mental Health Care would receive $3.8 million to improve collaboration between the primary and mental healthcare systems. The consortium is made up of 12 national organizations representing health care professional, community service, consumer and family organizations – psychiatrists, psychologists, nurses, mental health nurses, occupational therapists, family doctors, social workers, community mental health agencies, dieticians, pharmacists and consumer advocates. The intent of the consortium is to develop a national strategy on interdisciplinary and intersectoral mental health care that will produce better outcomes for Canadians with mental health problems. This strategy will lay the foundation for collaborative mental health care in Canada and extend the shared care work between family physicians and psychiatrists. Work has already been done to encompass the optimal role and contribution of all providers of mental health care, from medicine to social work to self-help groups. In addition, the consortium will be synthesizing and analyzing existing evidence on collaborative care and will be developing guidelines to develop, implement and evaluate effective collaborative projects in different settings. The project will serve as a clearinghouse by disseminating information on current projects and research to health care providers and community-based services. By March 2006, the project will provide specific recommendations on best practices for the integration of collaborative care principles into primary and mental health care systems.

The source of the funding is the national envelope of Health Canada's Primary Health Care Transition Fund that was created to support common approaches to primary health care reform across jurisdictions.

Dr. Nick Kates, the Canadian Psychiatric Association representative to the consortium, as well as its chair, was the lead author of the proposal to Health Canada. An information session on the National Primary Health Care Transition Fund Initiative on collaborative mental health care was presented at the Fifth Annual National Conference on Shared Mental Health Care, held in Vancouver on June 4 – 6. During the presentation, and for the first time at this annual conference, the program included a plenary presentation (by Phil Upshall of CAMIMH) on the consumer perspective and role in shared care. Dr. Kates reviewed the evolution of shared care in Canada and identified some of the challenges faced in the coming years - the need for good outcome data, ways of demonstrating the effectiveness of these approaches to service funders and how to take advantage of opportunities for prevention and early detection that collaboration opens up. Dr. Kates described the conference to OPA as follows:

"Attended by almost 250 people, the conference again featured a balance between plenary sessions, workshops and informal paper sessions, and time for colleagues to get together and exchange information ideas on their programs or activities. As in previous years, participants came from across Canada and from a number of other countries including the US, the United Kingdom and Israel. It was particularly pleasing to see a broadening of the range of professional groups represented at the Conference, with attendees representing providers, service administrators, academic faculty, health planners and funders, as well as a small number of consumer and family members. Approximately one third of attendees were physicians (slightly more psychiatrists than family physicians).

There was also an entertaining plenary session on ways of communicating messages by Mike Evans and a panel discussion that showcased 7 shared mental health care projects in BC. The conference was formally opened by the honorable Susan Bryce, BC's minister of state for mental health and addictions (the only such position in Canada) and the ensuing presentations reflected the ways in which shared care has developed in Canada over the last 10 years. There was a strong focus on evaluation with a presentation by Paul Waraich on another Primary Health Care Transition Fund initiative that aims to achieve consensus on measures to be used for evaluating outcomes in primary mental health care projects. This was followed by a presentation from Stephen Campbell on a similar project in the United Kingdom.

Many of the workshop presentations reflected the broadening variety of collaborative projects such as innovative approaches to teaching, working with children and the elderly, working with rural and isolated communities, shared care and addictions, adapting shared care principles to the workplace and practical issues such as strategies for establishing collaborative projects, working with government and approaches to evaluation.

Once again the conference provided a great opportunity for colleagues from across the country to get together and renew acquaintances, discuss ideas of common interest and plan for future collaborative projects. Thanks are due to the members of the program and local organizing committees who helped to make it such a memorable weekend. Special thanks go to Terry Isomura, who worked tirelessly to make the Conference happen and Daniela Derrick who looked after the local organization superbly. Presentations at the conference as well as preliminary details of next year's conference, which will be held in Ottawa, can be found on the shared care web site http://www.shared-care.ca/ "

Another project which received funding from the Primary Health Care Transition Fund is a mental health demonstration project on shared mental health care from the Ottawa Hospital Department of Psychiatry, the Central Ottawa Family Medicine Associates and the Family Medicine Unit of the Ottawa Hospital to set up a mental health demonstration project on shared mental health care. Dr. Bob Swenson told OPA recently that the Ottawa project will set up a multi-disciplinary mental health care team - a psychiatrist, an advanced-practice psychiatric nurse, a social worker and a psychologist - to provide on site mental health care to patients at each of the two family practices. In addition, the project will facilitate patients, from the mental health services of the Ottawa Hospital, who do not have a family physician, but need comprehensive primary care, to be integrated into the family practices. The project will be evaluated at several levels including access to mental health and primary care services, patient and provider satisfaction with shared care, illness severity and quality of life. For further information, contact Dr. Bob Swenson, Deputy Head (General Campus) and Director of Outpatient and Community Psychiatry, The Ottawa Hospital and Associate Professor of Psychiatry, University of Ottawa at: tel: (613)737-8083 or by email: jrswenson@ottawahospital.on.ca

MEMBERS ON THE *MOVE*

Dr. Krishna Balachandra, past OPA Council Member-in-Training, is doing a one-year fellowship in Addiction Psychiatry and hopes to finish June 30, 2005. Krishna can be reached at krishna.balachandra@yale.edu

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

AGENDA OPA Council

FRIDAY, JUNE 11, 2004

1.0 Remarks from the President
i) Approval of Agenda
2.0 Approval of Council Minutes of April 2, 2004
3.0 Business Arising
3.1 Mental Health Implementation Task Forces/Authorities
3.2 Strategic Planning and Governance
3.2.1 Review of Role Descriptions
3.2.2 Nominations and Election Procedures
3.2.3 OPA Human Resources Task Force
3.3 Implementation of the Personal Information Protection and Electronic Documents Act (PIPEDA)
4.0 Treasurer's Report
5.0 Reports of Task Forces and Committees
5.1 Advocacy Committee
5.2 Communications Committee
5.3 Continuing Education Committee
5.4 Finance/Audit Committee
5.5 Member Services Committee
6.0 Standing Reports
6.1 CPA Reports
6.1.1 Directors
6.1.2 Council of Provinces
- discussion re: length of training time
6.1.3 Standing Committees
6.1.3.1 Education
6.1.3.2 Professional Standards & Practice
6.1.3.3 Scientific & Research
6.2 OMA Section on Psychiatry
6.3 Working Group on Mental Health Services
6.4 Coalition
6.5 Alliance for Mental Health Services
6.6 Section Reports
7.0 New Business
7.1 Guest: Dr. Sonu Gaind, OMA Tariff Chair
7.2 Consent & Capacity Board
7.3 Guest for October 1st Council Meeting

Collaborative Mental Health Care Network continues to expand its research and evaluation component

The Ontario College of Family Physicians' Collaborative Mental Health Care Network (CMHCN) is now in its fourth year and it continues to grow and develop and enhance the delivery of mental health care in Ontario. The Network was launched in order to provide much needed support for family physicians. This unique provincial mentoring program utilizes psychiatrists and GP psychotherapists to help meet the needs of family physicians in the area of mental health care delivery through timely access to specialist support and education in the areas of psychotherapy, pharmacotherapy and community resources.

CMHCN participants are provided with support and guidance in the areas of pharmacotherapy, psychotherapy, and access to community resources. To date, the CMHCN has 37 GP Psychotherapist and Psychiatrist mentors and 265 family physician mentees located throughout the province who serve a mean number of 119 patients per week. 28.4% of these patients are seen for serious and persistent mental health concerns. The CMHCN has also incorporated adjunct mentors within the program to provide clinical support in high need but lower frequency areas of clinical practice (i.e. Adult ADHD, child psychiatry).

Lena Salach and Dr. Patricia Rockman, from the Ontario College of Family Physicians provided OPA with the following details on the Network:

Family physicians are the most frequent primary point of contact for patients with mental disorders. Between 30% and 40% of family practice patients have a diagnosable mental health condition (Kates N, Craven M, Bishop J, Clinton T, Kraftcheck D, LeClair K, et al. Shared Mental Health Care in Canada. Ottawa, ON: Canadian Psychiatric Association and College of Family Physicians of Canada; 1997; Lesage, Alain D., Goering Paula, Lin Elizabeth, Family physicians and the mental health system: Report from the Mental Health Supplement to the Ontario Health Survey. Can Fam Physician 1997; 43:251-256; Government of Alberta. Alberta's Health System, Some Performance Indicators. November 2002. www.health.gov.ab.ca).

The CMHCN continues to expand its research and evaluation component. Research results based on post evaluations demonstrated that mentees consulted with their psychiatrist mentor an average of 3.8 times and an average of 1.7 times with their GP Psychotherapist mentor in the past year. Mentor logs indicate that mentees and mentors interacted using the following modes of communication: email (54%), telephone (22%), face-face (17%), fax (3%), other (4%) (likely on-line webcam sessions). A sample of 277 Mentor logs indicated 86% of contacts were for individual mentees and 14% were for small group sessions. 76% of contacts were for a single clinical issue and 24% were for multiple clinical issues. Clinical issues include addictions, anxiety, eating disorders, mood disorders, personality disorders, couple dysfunction, etc. 59% of contacts were for single reasons while 41% were for multiple causes. Reasons for contact include pharmacotherapy, psychotherapy, diagnostic questions, suicidality,etc. This indicates that mentees are often contacting mentors about more than one patient at a time.

Mentors within the CMHCN have developed a number of CME modules that are being disseminated either within the small mentoring groups or to a larger audience outside of the CMHCN. These modules include: Using Atypical Anti-Psychotics: Current Evidence, Current Practice, Working with the Difficult Patient, Managing Change for Stress Reduction, and Practical Office Management of Comorbid Alcohol and Anxiety Disorders. These modules have been disseminated across the province as either evening or day workshops.

It has been found that those mentees who have participated in the program since its inception are now known in their communities as Opinion Leaders due to their increase in confidence in treating mental health patients and an increase in knowledge. As a result a Mentor Training Program has been developed to assist mentees making the transition to mentor and to assist new mentors to understand the concept of mentoring and how to facilitate the interaction between mentor and mentee. Participants in this program have utilized those involved as a resource and this program allows for an open discussion of the mentoring process. To date, two Mentor Development sessions have taken place with 7 mentors participating.

If you are interested in participating in the Collaborative Mental Health Care Network as a mentor, please contact Lena Salach at 416 867-9646 ext 21.

Community-Based Mental Health Services

The following is an excerpt from the Official Report of Debates (Hansard) on Monday June 14, 2004. Legislative Assembly of Ontario, First Session, 38th Parliament.

Hon. George Smitherman (Minister of Health and Long-Term Care): I'm pleased to rise in the House to tell you today that the McGuinty government is taking action in an area of health care that has been neglected for far too long in this province: community-based mental health services. That means a system that gives people across the province enhanced health services in their communities, because we believe that the best health care is found as close to home as possible.

What we are building in Ontario is a responsive, accountable, accessible health care system that serves the needs of Ontarians. To deliver on this plan, we are restoring and fortifying the essential health services that Ontarians need. We are using our precious health care resources in the best possible way to deliver the best possible results. Our strategy is to drive vital health resources down into communities where they can do the most good, and that embraces all aspects of health care, including mental health services.

For a long time there has been a stigma around the issue of mental illness, and that has created a wall between people and the care that they need. Twenty per cent of Canadians will personally experience mental illness in their lifetime. It touches most families, it has certainly touched mine. The economic cost of mental illness in Canada was estimated to be over $8 billion in 1998.

Our government believes that it is crucial that people who are mentally ill receive care in their communities from people that they know and can trust. Today I'm pleased to inform Ontarians that the McGuinty government is making a record investment in community mental health. It is an investment that is going to have a major impact on the way this care is provided for Ontarians who need it. That's because we have committed an additional $185 million in new annual funding over four years, for a total investment of $583 million in these crucial services by 2007-08.

Our government is reaching out a caring hand to Ontarians with mental illness and expanding services where they are needed. That is because we know that community-based mental health care is more therapeutically effective and more cost-effective. Community-based mental health care keeps people out of hospitals and jails, leaving both institutions to focus on those with more pressing needs.

This investment will help relieve some of the stress that many families face in caring for loved ones with mental illnesses. Our over half-billion-dollar total investment will help relieve some of the stress that many families face in caring for loved ones with mental illnesses. This will come as a helping hand to families and communities.

I want to take a moment to tell you about some of the particulars of our commitment to community-based mental health care in Ontario.

Our investment will result in expanded case management for people living with mental illnesses. Case management provides a vital anchor to people coping with mental illness. This involves a team of mental health professionals who build a trusting and respectful relationship with the patient and help that individuals negotiate through a complicated system to ensure they get the care and support they need.

This funding will also expand crisis response services. These services come to the assistance of individuals who are in acute distress. They include telephone crisis lines and mobile outreach teams that are rapidly deployed to individuals in times of need.

We are also funding more early intervention programs. We know that the earlier a person with mental illness is diagnosed and assisted, the better their chances of recovery.

I am also very pleased to announce that our government will be providing a based funding increase to stabilize the capacity of community mental health agencies in communities all across the province – the first such increase in 12 years.

The public has a significant need for up-to-date and accessible information on mental health resources. The Ontario Drug and Alcohol Registry of Treatment – DART, as it has become known – has come forward with a proposal for a provincial mental health registry. This registry will be a one-stop portal for information about mental health services. Information can be accessed 24/7 through a toll-free line, staffed by professionals, as well as on-line services. Part of this funding will go toward improving coordination and collaboration with other ministries and the police to better service the needs of mentally ill people who have been convicted of crimes or are involved with the criminal justice system.

More than 78,000 Ontarians – our friends, family members and neighbours – are suffering from mental illness. They will benefit directly from the expansion of these services.

We know that investment in community-based mental health services has proved to be a cost-effectiveness of health care dollars. We know that the mental health community is behind us as we make this commitment.

Now Available: A Practical Guide to Help Police Respond to People with Mental Illness

A number of coroners' inquests have recommended that practical guidelines be developed to assist police officers to effectively respond to people with mental illness who are exhibiting behaviours that are contrary to social norms and may be a threat to the community and/or public peace. In 2004, the Ontario Police College, Ontario's Ministry of Community, Safety and Corrections, St. Joseph's Health Care London & Regional Mental Health Care St. Thomas, and the Centre for Addiction and Mental Health have produced a 63-page practical guide entitled, "Not Just Another …Police Response to People with Mental Illnesses in Ontario – A Practical Guide for the Frontline Officer." which explains the nature of various mental illnesses, provides legislative rules and requirements, and response strategies/techniques to enable police to fulfill their legal obligations, diffuse difficult situations and restore calm.

For more information on the guide, contact Reggie Caverson in CAMH's Sudbury office at tel: (705) 675-1195. The document is also available in pdf form from the OPA office.

The Association of General Hospital Psychiatric Services (AGHPS) provided the following update to OPA on its past and future activities:

Earlier this year at our Annual General Meeting, Dr. Brian Hoffman was elected as President (Many thanks to Dr. Ty Turner, for his past leadership as he steps down from his role as President but will remain on the Executive as Past President.) We are thrilled with the work and commitment of all of the Executive members, Mr. Bruce Whitney, Ms. Cathy Seguin, and Dr. Gerry McNestry as we continue to forge ahead in dealing with current issues and keeping our membership informed.

One initiative that was completed this year was our "People at Risk of Suicide Project". This project was conducted over a 2-year period by the AGHPS with one-time funding from the Ministry of Health and Long Term Care (MOHLTC). Through a comprehensive process that involved general hospitals throughout Ontario, the Project has developed practical recommendations for implementing suicide prevention programs in general hospitals. Although these recommendations are practical, they are also evidence based, with clear direction from the literature. This document was completed in April of this year and a presentation was made to the staff of the Mental Health and Addictions Branch, MOHLTC .(Copies of this document were distributed to all designated Schedule 1 General Hospitals in Ontario, and can be accessed via our web site at www.aghps.com.)

The " People at Risk of Suicide Project" found that:

People not identified in the SMI population, but who are at risk of suicide, require supports that are not necessarily built into the current mental health system. The general hospitals are often the first contact for these people and strategies to address the need of this population require development. The Project reflects preliminary work to develop strategies to address the needs of this group including methods of supporting consumers through primary care givers such as family physicians, nurse practitioners and emergency department staff and physicians.

90% or more of suicides have one or more psychiatric disorders at time of death (Roy 2001). Of individuals in the general population that suicide, over 40% had been an inpatient within a year of death (Pirkis and Burgess, 1998). Therefore, based on our findings, the AGHPS is confident in recommending that strategies to reduce suicide must be directed at general hospitals/ schedule 1 facilities. These initiatives must include professionals in all disciplines that provide care to those at risk of suicide, and must transcend many departments within the hospital (e.g. emergency departments). In addition, this collaborative effort must include other stakeholders, such as police and coroners.

The AGHPS recommends the following specific initiatives as initial strategies to reduce the incidence of suicide in Ontario.

1. **Develop provincial guidelines for suicidal presentation for pre-assessment, assessment, treatment and follow up within mental health, emergency departments and on medical units.**
2. **Provide leadership in developing standards and identify best practices**
3. **Investigate and provide guidelines on issues such as false positives, repeat suicide assessments, rapid follow up, documentation, care planning**
4. **Develop provincial liaison initiative with Police**
5. **In collaboration with the Coroner's office, undertake a review of suicide and recommendations from Coroner inquests, and provide this consolidated information to general hospitals**

Our findings were very well received by the Ministry and we are presently awaiting word on continued support. This will allow us to begin taking action on the five recommendations that were derived from our work.

In April of this year the AGHPS communicated with the Honourable George Smitherman regarding the process of Consent and Capacity Boards. There were several recommendations made for improvements for the psychiatrist's time, legal responsibilities and the efficiency of the hearing processes. Further to this, the AGHPS collaborated with the Centre for Addiction and Mental Health and the University of Toronto to present a one-day workshop entitled "Certification and Consents: A Psychiatrists Guide to Surviving the Consent & Capacity Board" on June 12, 2004 in our continuing efforts to improve the practices and efficient usage of time for psychiatrists.

Along with St. Michael's Hospital Mental Health Service, the AGHPS will be co-sponsoring "The 9th Annual Clinical Day in Psychiatry" (For further information please see the Calendar of Events for October 29, 2004 in this issue of *Dialogue* on Page 7 .)

Special issue on Aging and Mental Health in the Canadian Journal of Community Mental Health

In recent years, much public debate has been centered on the "aging of the Canadian population", and alarmist "apocalyptic demography" public discourses emphasizing impacts on pension liabilities and health and social services provision and cost.

What is the current reality of seniors in Canadian society? Is being old now equivalent to being ill and "sad"? What is the place of positive aspects of aging and of mental health promotion in the current research and interventions in mental health? What are the social and health circumstances of elderly people suffering from mental health illnesses and disabilities (including severe conditions, such as schizophrenia)?

The special issue on Aging and Mental Health which will be in the Canadian Journal of Community Mental Health in 2005 will explore these themes, with a special interest for articles that present innovative analytical approaches, reveal emerging social phenomena, or present new trends in research or interventions.

For more information visit: http://www.wlu.ca/cjcmh or contact: Prof. Joseph Tindale, Dept. of Family Relations & Applied Nutrition, University of Guelph, ON, Email: jtindale@uoguelph.ca

Funding to Webequie First Nation to Address Suicide

The McGuinty government is providing funding of $30,000 to Webequie First Nation to help address current suicide issues within the Northern Ontario Aboriginal community. The funding will allow Webequie to develop a community approach to recent suicides in the area. Through the Aboriginal Healing and Wellness Strategy, the Ontario government already provides $1.2 million to Nishnawbe Aski Nation, which includes Webequie, for crisis intervention workers to manage issues such as suicide, accidents and violent death. In May, the province announced an additional $5 million in funding to the strategy as part of its Plan for Change budget. The government and its Aboriginal partners are in the process of determining the allocation of this funding.

Mental Health in the Workplace

There has recently been an increased interest in mental health problems in the workplace and many people and organizations are now paying attention to what is considered to be a serious threat in terms of cost, diminished or lost work productivity, and, to put it even more simply, a terrible waste of human potential.

Last spring, for example, the Institute for Work and Health (www.iwh.on.ca) sponsored a two-day, first of its kind in Canada workshop, on "Mental Health and the Workplace" under the leadership of the Canadian Institutes of Health Research. More than 100 participants, including researchers, clinicians, policy-makers, health economists, labour representatives and occupational health experts attended the workshop to discuss priorities for workplace mental health research for the next decade. It was reported at the workshop that:

- each year about 12 per cent of Canadians aged 15 to 64 are affected by mental health problems such as anxiety, depression and substance abuse (according to a recent Canadian Community Health Survey);
- at any given time in Ontario, about eight per cent of the working population has a diagnosable mental illness;
- compared to disability claims for chronic physical disorders, including musculoskeletal disorders, the average duration of a depression-related, short-term disability claim is longer – between 33 and 95 days;
- the burden of mental health and addiction problems in Canada, in direct productivity costs alone, exceeds $11 billion – including indirect costs would drive this figure up by triple.

A recent article in The Ottawa Citizen provided excerpts from a speech that Bill Wilkerson, CEO, Global Business and Economic Roundtable on Addiction and Mental Health (see www.mentalhealthroundtable.ca) gave to the Royal Ottawa Hospital Business Luncheon on May 6, 2004:

"The Roundtable has identified four management practices which are most likely to aggravate or precipitate mental health problems at work:

- The imposition of unreasonable demands on subordinates.
- Withholding information that is materially important to them to carry out their jobs.
- Refusing to give employees reasonable discretion over the day-to-day means and methods of their own work.
- And failing to credit or acknowledge the contributions and achievements of employees".

"We have also isolated the leading sources of problem stress at work:

- Rejecting "out of hand" employee workload and deadline concerns.
- Creating a treadmill effect in the allocation of work priorities.
- Pushing unnecessarily tight deadlines as a force-feeding performance management technique.
- Promoting an "e-mail only" culture of one-on-one communication.
- Jumping to conclusions that individual performance problems are attitudinal, not health-based.
- Managers changing priorities without notice or reasons.
- And tolerating a culture of ambiguity or confusion which distorts the employment contract."

"Myth and misinformation is the No.1 barrier to treatment and recovery from mental illness."

"We need research on the impact of stress in the workplace on mental illness and addiction. This needs to be linked to a study of how changes in management and other workplace practices can reduce stress."

The following article describes a new program to assist managers, supervisors and co-workers of people with mental illness to understand what mental illness is and how to ensure that a mentally healthy work environment exists for all employees –

DO TOXIC WORKPLACES PRESENT A RISK TO RECOVERY?
By Mary Ann Baynton, Director of Mental Health Works

How often do you send a recovering patient back to their place of employment, only to have them relapse as a result of workplace stress? In many cases, a dysfunctional or toxic work environment is responsible. This exists when workplace relations with the manager, supervisor or co-workers contributes to the pressures brought on by jobs that have high demands or low rewards. There is a way to be proactive in reducing this type of risk to recovery and the requirement to do so is enshrined in human rights law. Human rights legislation requires employers to provide workplace accommodations for those with mental disorders on par with the accommodations for those with physical disabilities. With physical disabilities the accommodation often involves building or equipment changes. With mental disorders, the accommodation is more likely to involve flexibility in hours, number of breaks, or interaction with others. Patients who are unaware of this right may fail to ask for it and may miss out on an opportunity for a successful return-to-work.

Mental Health Works is an initiative of the Canadian Mental Health Association, Ontario. It provides services to businesses for a fee and net profits are directed back to the non-profit endeavours of CMHA, Ontario. To effectively address the issues that arise in the workplace, Mental Health Works offers a variety of services including workshops for managers around the legal duty to accommodate people with mental disorders, workshops for employees to bust stereotypes and reduce stigma in the workplace, and consultation services around complex accommodations or return-to-work situations that involve mental health.

Mental Health Works recognizes that the majority of mental health patients are of working age and that time at work represents a significant portion of their daily life experience. Our consultation services involve working directly with the psychiatrist or other mental health professional around creating a solution that is healthy for the employee and manageable for the organization. We pay a fee (usually $100 per hour) to the psychiatrist for their time and set up a meeting or conference call with the employee/patient present for the conversation. It is always done with the employee/patients' express permission. The intention is to have the mental health professional aware of the workplace issues that their patients are facing and to inform Mental Health Works of any psychiatric or psychological issues that may affect a successful return-to-work. We benefit by creating an accommodation strategy that has the support of the mental health professional and the psychiatrist benefits through an increased awareness of the workplace issues faced by the patient.

In some of our consulting cases, the organization has preceded the return-to-work with mandatory training for managers and/or supervisors. The workshop provides the participants with a level of comfort in discussing issues of mental health or illness, communication strategies to deal with emotional or conflictual issues, and an understanding of the accommodation process for people with mental illness. Our workshop allows the participants (managers and supervisors) to provide resources for the employees who may be experiencing mental health issues. We discourage any attempt by managers to act as counsellors to employees. We stress that their role as supervisor or manager necessarily involves a power differential

and therefore they should leave therapeutic counselling to others and concentrate instead on workplace and performance issues. This serves two purposes: it redistributes responsibility for the employee's mental health and it encourages managers to become aware of when outside help may be warranted.

All of our work involves sensitivity to the fact that the employee/patient has the right not to disclose a diagnosis. In fact, we suggest to managers and supervisors that their level of understanding of mental illness would make the diagnosis virtually irrelevant to the workplace setting. We ask them to focus instead on the workplace limitations or issues and collaborate with the employee on ways to overcome obstacles and get the job done.

Our work is directed at providing the employee/patient with a healthy work environment and ensuring their continued gainful employment. In addition, we strive to improve workplace relations for managers and co-workers and to reduce the stigma and stereotype that continues to follow mental illness. In situations where a toxic work environment is affecting your patients ability to recover, please think of Mental Health Works as a way to affect positive change in the workplace.

If you would like more information about Mental Health Works you can visit: www.mentalhealthworks.ca or contact Mary Ann Baynton, MSW, RSW, Director, Mental Health Works, Canadian Mental Health Association – Ontario, 180 Dundas Street West, Suite 2301, Toronto, ON M5G 1Z8, Phone: 416-977-5580/1-800-875-6213 ext. 4120 Fax: 416-977-2813 Email: mabaynton@ontario.cmha.ca

Ontario Directory for Children and Adults with Obsessive Compulsive Disorder

By Diane Esber, President, Ontario OCD Network

It is estimated that 2.5% of the population may suffer from OCD at some point in their lives but there is only limited information on professionals who treat children and adults with OCD in Ontario. The Ontario Obsessive Compulsive Disorder Network was very pleased to have been awarded an Ontario Trillium Foundation grant to research, produce and distribute a directory of Ontario based hospitals, clinics, physicians, psychiatrists, psychologists, therapists, social workers, nurses and others who treat children and adults with OCD as well as other resources, such as up-to-date information on OCD, self help groups, mental health services, suggested reading materials and other OCD web sites. The directory will be easily accessible on our web site and, on request, can be mailed out as well.

The Ontario OCD Network is an incorporated, volunteer, non-profit charity whose mission is to improve the quality of life of children and adults with OCD and their families through support, education and community awareness. The Network was founded in 1995 by a group of OCD patients, family members and health care professionals.

Our web site is currently being upgraded to permit health care professionals to register on line with the Network and to provide updated information on services they provide. We anticipate access to this interactive database by mid-November 2004.

Although much work is being done to update our web site, we need to begin the research portion of the directory.

If you provide treatment to people with OCD please contact the Network for a questionnaire via email at ocdnetworkdirectory@rogers.com, by fax at 905-472-4473 or leave a message on our information line at 416-410-4772. We would appreciate if you would advise your colleagues about this questionnaire and ask them to contact us. On behalf of the children and adults of Ontario with OCD, we thank you for your assistance.

Ontario's first Centre of Excellence for Child and Youth Mental Health at CHEO

Dr. Marie Bountrogianni, Minister of Children and Youth Services announced the appointment of Senator Michael Kirby as Chair of the Advisory Council of the Centre of Excellence for Child and Youth Mental Health at the Children's Hospital of Eastern Ontario on June 22, 2004. The Centre will have a broad provincial mental health focus and will link institutional, community-based and academic sectors through a common vision for the children and youth of Ontario. The Centre and its partners will undertake research and development to increase the body of knowledge regarding child and youth mental health, mental illness, and how to respond to it. Strategies to educate and train mental health service providers as well as disseminating new and existing knowledge are also key priorities. The Centre will facilitate consultation and advice on evidence-based practices. It will also establish networks and partnerships that will reduce fragmentation and build capacity to better respond to the mental health needs of children and youth.

SIX INTERESTING WEBSITES FOR YOU TO EXPLORE

1. http://www.mhcva.on.ca/
The Simcoe County Mental Health and Addiction Education site is a multi agency partnership with the Simcoe-York District Health Council acting as lead agency. Technical and financial resources are provided by Mental Health Centre Penetanguishene. Local agency pages and the MHC Penetanguishene site are linked to this site.

2. www.pscyhdirect.com
PsychDirect is the public education website of the Department of Psychiatry and Behavioural Neurosciences at McMaster. The emphasis is on evidence-based mental health information and education. The content has been developed for both the professional and the general public.

3. www.shelternet.ca
Shelternet provides a list of shelters and a helpline for women who have been abused.

4. www.mentalhealth.com
Internet Mental Health from Phillip W. Long, M.D. provides a description of 54 common disorders, "Diagnose Yourself", an online assessment of quality of life as well as descriptions of 74 common medications, research and mental health news – topics include alcohol and drug abuse, childhood and adolescence, dementia, general mental health, health care economics, health, fitness & diet, pharmacology, etc.

5. www.motherisk.org
Motherisk provides evidence-based information about the safety or risk of drugs, chemicals and disease during pregnancy and lactation.

6. www.progressplace.org
Progress Place is the first and largest clubhouse in Canada. It is located in downtown Toronto. Their website describes a variety of services that are offered to users.

Children's Mental Health Services in South West Region

By Margaret Steele, MD, FRCPC, Physician Lead, Child & Adolescent Mental Health Care Program, London Health Sciences Center, OPA Past President

Developing a comprehensive system of care for children and youth with mental health needs is a complex task. The Ministry of Community and Social Services (MCSS) and the Ministry of Children's Service (MCS) began the task of developing and implementing a comprehensive system of care in collaboration with the Ministry of Health and Long Term Care and the Ministry of Education in the South Western Ontario region.

During the first phase of the planning, there were three working groups to address the issue of Highly Specialized Services and Supports. The three working groups were the CPRI Working Group, the St. Joseph's Hospital -Regional Mental Health Care- London site Adolescent Unit Working Group and the Special Needs Initiative Working Group. I had the pleasure of being a member of the CPRI Working Group.

The working groups consisted of many different mental health professionals from a variety of children's mental health agencies in addition to Ministry officials.

During the process, our group provided feedback on the definition of highly specialized services and supports, addressed what services were currently being offered at CPRI and whether they would be deemed primary, secondary or tertiary care, generated ideas about what services should be offered at CPRI, and where there were gaps in the mental health system for children and youth. The process was a highly collaborative one and it enabled service providers to reflect on what they are doing currently and what directions they should be taking.

It will be interesting to see the evolving process particularly since there is a new Ministry of Children and Youth. The rest of the province will also be examining the process because other regions of the province would like to enhance the delivery of mental health services to children and youth and their families.

The following is a summary of the Final Report: An Ideal Model for Children's Mental Health Services in South West Region Year 1 Implementation – Highly Specialized Services and Supports which was prepared by Elizabeth Leach, Editor, OPA Dialogue:

This report deals with the creation of highly specialized services and supports for children with mental health needs in the Southwest region of Ontario. Released in February 2004, the report is from the Ministry of Community and Social Services (MCSS) and the Ministry of Children's Services (MCS) South West Region and was done in collaboration with the Ministry of Health and Long Term Care and the Ministry of Education. A review of the children's mental health system including the development of community and service provider profiles was conducted in 2000. (To obtain a copy of the full report please contact the OPA office.)

The review led to a three-phased project. Phase 1 (Review and Mapping) involved creating a vision for children's mental health services ("A high quality system of children's mental health services that is accountable to the child and family, easily accessible and integrated with other supports to children.") and first principles. Phase 2 determined the "ideal" MCSS, MCS Children's Mental Health Services Model for the South West Region in order to ensure that future potential resources would be allocated effectively within the South West Region. Phase 2 also included the development of a working draft definition of children's mental health and definitions for children's mental health services as well as providing the foundation for the future implementation of the "Ideal" Model. Phase 3 will consist of the development of a multi-year implementation plan to operationalize the "ideal" model and will support implementation of activities that can be operationalized immediately and are consistent with the "ideal" model and the overall vision for children's mental health services, within the MCSS, MCS South West Region.

The MCSS, MCS South West Region has developed a three-year implementation plan and although the "ideal" model is not expected to be implemented in three years, it is expected that the best implementation strategies can be worked out in that timeframe.

The first year of the implementation plan deals with highly specialized services and supports that address the most severe and complex mental health needs of children.

The phrase "highly specialized services and supports", was first defined in An Ideal Model for Children's Mental Health Services in the South West Region - Final Report, September 2001, page 9:

"Highly Specialized Services and Supports are those that address the most severe and complex needs of children as well as providing mechanisms for research and training. These more specialized services may be located in the community or, regionally, depending on the size of the population and the critical mass needed to provide the 24-hour psychiatric telephone support and consultation, local acute-care hospitilization where indicated and treatment for high-risk behaviours."

Some of the "highly specialized services and supports" discussed in the September 2001 document, such as 24-hour psychiatric telephone support and consultation and local acute care hospitalization, were re-categorized as Core Services in the more recent document released in February 2004. In addition the definition of the phrase "highly specialized services and supports" was changed to:

"Highly Specialized Services and Supports are those provided to children/youth and their families with the highest needs. These needs are complex and determined to be refractory to first line (primary) and intensive (secondary) care.

Criteria for access:

1. The local Children's Mental Health Service sector supports the need to access Highly Specialized Services and Supports through a defined protocol
   AND EITHER
2. Need for higher levels of intervention and/or safety due to high risk of harm to self or others
   OR
3. Diagnosis or suspicion of a serious emotional disturbance and/or complex mental illness.

Highly Specialized Services and Supports provide a breadth and depth of multidisciplinary expertise and may include:

Assessment (4 Functions: Medical/Psychological Diagnosis, Multi-Disciplined Team, Inpatient Assessment and Outpatient Assessment), and/or treatment (Four Functions: Outpatient Treatment, Inpatient Treatment, Day Treatment and Transition/Discharge Planning) Capacity Building (the development and implementation of ways and means to increase the capacity of the children's mental health system to serve children, youth and their families): Consultation (informal and case specific consultation to designated stakeholders within the local community via a pre-determined access protocol as a means for building the capacity of the local community to respond effectively to children/youth and their families), Training (to designated children's mental health service providers as a means of building the capacity of the local community to respond effectively to children/youth and their families) and Research (on matters related to children's mental health for the purposes of the edification of the children's mental health services system and stakeholders) and Education (education to designated

children's mental health service providers as a means for building the capacity of the local community to respond effectively to children/youth and their families."

The report recommends where and by whom these services and supports should be provided. Years 1,2 and 3 deal also with Front Door Services, Core Services (which includes MCSS, MCS funded services and also Schedule 1 hospitals and/or local hospitals and the Ministry of Health and Long Term Care funded services that serve children and adolescents with mental health problems) and Residential Services. Highly Specialized Services and Supports were dealt with first because of the need to deal with the strategic direction of CPRI and the need to determine whether or not the Adolescent Unit currently situated with the Regional Mental Health Centre in London should be part of the new centre to be erected by St. Joseph's Health Care by 2005.

A preliminary identification of highly specialized service system gaps and enhancements required included services for:

- Sexual Aggressors (including those children and youth with a developmental challenge)
- Fire setters
- Addictions
- Concurrent Disorders
- Programs for Conduct Disorder
- Dual-Diagnosis
- Autism supports for children over 6
- Deaf Children with Mental Health Problems
- Crises Response
- Inpatient Forensic Assessment and/or Treatment
- A Locked Treatment Unit per Section 124 of the CFSA, and,
- the need for investment in best practices and transitional support, research, training and education, and, to build capacity for the diagnosis and treatment by physicians in the community.

Editor's Note: Children's Mental Health Services, the Centre for Excellence in Child and Youth Mental Health, and youth probation and custody are among the programs that have been transferred to the newly expanded Ministry of Children and Youth Services. For a full list of programs offered by this Ministry, see their website at:www.children.gov.on.ca.

Health Canada Advisory Notices:

Health Canada advises Canadians of stronger warnings for SSRIs and other newer anti-depressants

Health Canada is taking Additional Safety Measures to Ensure the Safe Use of Clozapine

The antidepressant trazodone may interact with certain medications

Health Canada is advising Canadians that all newer anti-depressant prescription drugs, known as Selective Serotonin Re-uptake Inhibitors (SSRIs) or Serotonin Noradrenalin Re-uptake Inhibitors (SNRIs), now carry stronger warnings. These new warnings indicate that patients of all ages taking these drugs may experience behavioural and/or emotional changes that may put them at increased risk of self-harm or harm to others. The new warning for each of these drugs, which are listed below, appears in the information package received by patients and in the prescribing information available to health professionals.

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

It is important to note that Health Canada has not authorized these drugs for use in patients under 18 years of age. The prescribing of drugs is a physician's responsibility. Although these drugs are not authorized for use in children, doctors rely on their knowledge of patients and the drugs to determine whether to prescribe them at their discretion in a practice called off-label use. Off-label use of these drugs in children is acknowledged to be an important tool for doctors.

Doctors are advised to carefully monitor patients of all ages for emotional or behavioural changes that may indicate potential for harm, including suicidal thoughts and the onset or worsening of agitation-type adverse events.
This advisory stems from advice given by an independent expert panel and is the result of Health Canada's extensive review of the latest worldwide safety data available for these drugs. It follows the advisory Health Canada issued on February 3 advising Canadians of the need for patients under the age of 18 who are being treated with newer anti-depressants to consult a physician.

Following the meeting with the expert panel, Health Canada conducted an analysis of all adverse reactions experienced by patients taking SSRIs. Although Health Canada did not find a direct link between taking SSRIs and incidents of death, the Department felt it important to let health professionals and consumers know of the possible risks associated with the drugs.

This advisory applies to the following anti-depressants:

- Bupropion (Wellbutrin(R) and Zyban(R)).
  that both of these drugs share the same active ingredient. Zyban, a smoking cessation drug, now carries an appropriately modified version of the above warning.
- Citalopram (Celexa(R))
- Fluoxetine (Prozac(R))
- Fluvoxamine (Luvox(R))
- Mirtazapine (Remeron(R))
- Paroxetine (Paxil(R))
- Sertraline (Zoloft(R))
- Venlaflaxine (Effexor(R))

Health Canada is taking additional steps to ensure the safe use of clozapine, a drug used in the treatment of schizophrenia. Clozapine is used for patients that are unresponsive to, or not tolerant to, conventional drugs. The use of clozapine is known to potentially cause a decrease in white blood cells, known as agranulocytosis, which impairs the body's defence mechanism against infection. As such, patients must have regular blood tests to monitor their white blood cell count. Results are recorded in patient registries, which are accessed by treating physicians and pharmacists to ensure that the drug is not given to a patient at risk for agranulocytosis.

cont'd on next page

In consultation with the Canadian Psychiatric Association (CPA), the Schizophrenia Society of Canada and the National Association of Pharmacy Regulatory Authorities (NAPRA), Health Canada is taking a number of steps to improve safety measures for clozapine use in Canada. These steps involve a) revisions to the Product Monographs of all clozapine products marketed in Canada b) a new proposed statement to be added to the Patient Registration Form and c) a "Questions and Answers" patient information leaflet.

Currently, patients on clozapine, treating physicians and dispensing pharmacists must all be enrolled in registries to track the use of clozapine, and monitor the health of the patients on the drug.

From 1991 to 2003, there was only one company distributing clozapine in Canada. Since 2003, other companies have received approval to market these products, which has led to the establishment of new, independent, registries. As a result, some health care professionals and companies have experienced difficulties in the transfer of patients' information among registries.

In order to address these difficulties, Health Canada is proposing the inclusion of additional information to be added to the Patient Registration Form. This new Patient Registration Form statement will help to improve the way patient information is collected and shared by facilitating the exchange of information between registries.

Health Canada is also providing a "Questions and Answers" patient information leaflet, to help patients better understand the information exchange process between registries. Both of these measures will achieve a more efficient network of independent registries, and therefore improve the continuity of care of patients treated with clozapine.

This advisory applies to the following currently marketed clozapine products:
- Apo-clozapine (Apotex Incorporated)
- Clozaril(R) (Novartis Pharmaceuticals Canada Ltd.)
- Gen-Clozapine (GenPharm)

The new statement for the Patient Registration Form and the patient information leaflet on consent are available at the following address: http://www.hc-sc.gc.ca/hpfb-dgpsa/tpd-dpt/clazopine_hpc_e.html Health Canada has also posted a Dear Healthcare Professional Letter and a Notice to Hospitals discussing the above-mentioned information. These letters can be accessed at Health Canada's website at www.hc-sc.gc.ca/hpfb-dgpsa/tpd-dpt/index_advisories_professionals_e.html.

Any suspected adverse reactions associated with clozapine can be reported directly to the product manufacturer or to:
Canadian Adverse Drug Reaction Monitoring Program (CADRMP, Marketed Health Products Directorate, HEALTH CANADA,Address Locator: 0701C, OTTAWA, Ontario, K1A 0K9, Tel: (613) 957-0337 or Fax: (613) 957-0335.
Health Canada, in association with Bristol Myers Squibb Canada, is advising Canadians to consult with their health care professionals if they are currently being treated with the antidepressant trazodone in combination with any of the following medications: ketoconazole (an antifungal agent), ritonavir and indinavir (protease inhibitors used in the treatment of HIV), or carbamazepine (an anti-epileptic therapy). When trazodone is combined with these drugs, patients may experience the following symptoms: nausea, low blood pressure, temporary loss of consciousness (increased trazodone levels), or decreased effectiveness of the trazodone therapy (decreased trazodone levels). Patients who have questions about their current medications, should, consult with their physician or pharmacist directly. It is important that patients do not stop taking medications without first consulting with a health care professional. This advisory applies to the following antidepressants:
- Apo-Trazodone (Apotex incorporated)
- Desyrel(R) (trazodone) (Bristol-Myers Squibb)
- Dom-Trazodone (Dominion Pharmacal)
- Gen-Trazodone (Genpharm Inc.)
- Trazorel (ICN Canada Ltd.)
- Novo-Trazodone (Novopharm Limited)
- Nu-Trazodone (Nu-Pharm Inc.)
- Penta-Trazodone (Pentapharm Ltd.)
- PMS-Trazodone (Pharmascience Inc.)
- PHL-Trazodone (Pharmel Inc.)
- Trazodone (Pro Doc Limitée)
- Ratio-Trazodone (Ratiopharm Inc.)
- Scheinpharm Trazodone (Schein Pharmaceutical Canada Inc.)

Bristol-Myers Squibb Canada, in collaboration with Health Canada, has sent a letter to health care professionals to inform them of this safety information. A copy of the letter can be found at Health Canada's website at: http://www.hc-sc.gc.ca/hpfb-gpsa/tpddpt/index_advisories_professionals_e.html

Health Canada is also working with manufacturers to revise the prescribing information found in the Product Monograph for trazodone in order to provide physicians and pharmacists with updated safety information regarding drug interactions. Any suspected adverse reactions associated with trazodone can be reported directly to the product manufacturer or to: Canadian Adverse Drug Reaction Monitoring Program (CADRMP), Marketed Health Products Directorate, HEALTH CANADA, Address Locator: 0701C, OTTAWA, Ontario, K1A 0K9, Tel: (613) 957-0337 or Fax: (613) 957-0335.

To report an Adverse Reaction, consumers and health professionals may call toll free: 866 234-2345; Fax: 866 678-6789; http://www.hc-sc.gc.ca/hpfb-dgpsa/tpd-dpt/adr_guideline_e.html
The Adverse Reaction Reporting Form and the Adverse Reaction Guidelines can be found on the Health Canada web site or in The Canadian Compendium of Pharmaceuticals and Specialties.
http://www.hc-sc.gc.ca/hpfb-dgpsa/tpd-dpt/adverse_e.html
http://www.hc-sc.gc.ca/hpfb-dgpsa/tpd-dpt/adr_guideline_e.html

Health Canada news releases are available on the Internet at http://media.health-canada.net/

CMHA National Programs and Research Are Valuable Resources

By: Frances Bartlett

From early psychosis intervention to the role of home care in supporting seniors' mental health, projects carried out by the National Office of the Canadian Mental Health Association (CMHA) provide services, supports and information for mental health consumers of all ages and those who work with them.

The direction of program and research projects has been determined in large measure by a model based on self-help groups, family/friends, mental health services and generic community organizations and groups, all grounded in a foundation that includes housing, income, work, and education.

Rather than dealing with the clinical aspects of mental illness, CMHA focuses more in areas that may not be covered by clinical research -- disseminating information that is beneficial to clients and mobilizing formal and informal community services and supports for clients.

CMHA believes that it is important to communicate with people in any way that they can about the resources that have been developed. Whether it's a mini web site, a manual or a community program, what is most important is that the information gets to the people who need it. For example, CMHA National has published two guides that contain the conclusions and recommendations of the 2000-2002 study of how home care can support seniors' mental health. The more recent Early Childhood Care & Mental Health project, based on interviews at 80 day care centers across Canada, explores how the mental health of young children could be promoted through day care, with a booklet for day care providers planned for publication in late 2004.
Two current projects aim to promote access to mainstream education for students with mental illness. The recent Mental Health & High School project will ensure that education settings have the information they need to accommodate and maximize the inclusion of people with mental illness and mental health problems. A network of students, parents, service providers and organizations of educators have contributed to the development of electronic and print guides for students, parents and high school staff.
In addition, a Higher Education Handbook is being developed for students with psychiatric disabilities who are attending or planning to attend college or university. This resource, planned for publication in mid-October 2004, will be a handy compendium of information about resources, accommodations and supports that can help these students succeed in school and beyond.

In the area of employment, the Routes to Work program has been very successful in assisting consumers to find and keep mainstream employment in eight sites across Canada.

Another project, focused on the community role in early psychosis intervention, has produced information resources and supported sites across the country to raise awareness of this need at the local level. In Newfoundland, one of the project sites, travelling road shows have brought panels of families and psychiatrists to communities across the province to help the public, families and others enhance their understanding of what psychosis is and the necessity for early intervention. This year, CMHA will publish two new guides related to this project – a guide for siblings of young people with early psychosis and a community guide that offers suggestions for local activities that can support an early psychosis intervention approach.

For more information on CMHA National programs and research, please visit: www.cmha.ca. Canadian Mental Health Association, National Office, 810-8 King Street East, Toronto ON M5C 1B5, Telephone: (416) 484-7750 X233, Fax: (416) 484-4617

Lance Krassman Memorial Centre for Community Mental Health, Richmond Hill

The Lance Krasman Memorial Centre for Community Mental Health, located at 10121 Yonge Street in Richmond Hill, is a resource facility that works collaboratively with consumer/survivors and their families who reside in York region. The Centre provides information, networking, self-help, mutual support and partnership and strives to be as welcoming and available as possible to their clients and their friends and families.

One of their programs is the Warm Line, a unique non-crisis telephone line accessible to all residents of York Region who are in need of support. The Warm Line operates four evenings a week (Tuesdays, Thursdays, Saturdays and Sundays) from 6pm until midnight. The Warm Line can be accessed in both North York Region at (905) 954-4110 and South York Region at (416) 685-7480.

Another program is called "Peer Chats". This is a weekly event held at the Centre for those who wish to interact with their peers in the community. Peer Chats provides assistance to those who are supporting someone with a mental health issue. The Self-Help Network was created to unite people who are coping with similar issues in the hope that they will empower themselves and each other. A monthly Bulletin provides the opportunity for those who are unable to reach the Centre to keep up to date with programs, activities and community events. The Bulletin is available on a monthly basis either by mail, fax or email. A peer support program is currently being revamped and friendly visits are also available.

The Centre also allows access to on-site resources; such as the educational library, phones, computers, photocopier and fax machine. For more information about The Krasman Centre and its many services and events, please call (905) 780-0491 or Toll Free at 1-888-780-0724 or visit their Website at www.krasmancentre.com

Editor's Note: Thanks to Camille Semerjian, a graduate of the Social Service Work program at Seneca College who provided the above information above to the OPA.

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

THERAPEUTIC CLASSIFICATION Antipsychotic Agent

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

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

WARNINGS Neuroleptic Malignant Syndrome (NMS) Neuroleptic Malignant Syndrome is a potentially fatal symptom complex that has been reported in association with antipsychotic drugs, including SEROQUEL (quetiapine). The clinical manifestations of NMS are hyperthermia, muscle rigidity, altered mental status, and evidence of autonomic instability (irregular pulse or blood pressure, tachycardia, diaphoresis, and cardiac dysrhythmia). Additional signs may include elevated creatine phosphokinase, myoglobinuria (rhabdomyolysis) and acute renal failure. In arriving at a diagnosis, it is important to identify cases where the clinical presentation includes both serious medical illness (e.g., pneumonia, systemic infection, etc.) and untreated or inadequately treated extrapyramidal signs and symptoms. Other important considerations in the differential diagnosis include central anticholinergic toxicity, heat stroke, drug fever and primary central nervous system pathology. The management of NMS should include immediate discontinuation of antipsychotic drugs, including SEROQUEL, and other drugs not essential to concurrent therapy; intensive symptomatic treatment and medical monitoring; and treatment of any concomitant serious medical problems for which specific treatments are available. There is no general agreement about specific pharmacological treatment regimens for uncomplicated NMS. If a patient requires antipsychotic drug treatment after recovery from NMS, the potential reintroduction of drug therapy should be carefully considered. The patient should be carefully monitored since recurrences of NMS have been reported. **Tardive Dyskinesia (TD)** A syndrome of potentially irreversible, involuntary, dyskinetic movements, may develop in patients treated with antipsychotic drugs. Although the prevalence of the syndrome appears to be highest among the elderly, especially elderly women, it is impossible to rely upon estimates to predict which patients are likely to develop the syndrome. It has been hypothesized that agents with a lower EPS liability may also have a lower liability to produce TD. In controlled clinical trials with SEROQUEL, the incidence of EPS was not statistically significantly different than placebo across the recommended therapeutic dose range. This may predict that SEROQUEL has less potential than standard antipsychotic agents to induce TD. The risk of developing TD and the likelihood that it will become irreversible are believed to increase as the duration of treatment and the total cumulative dose of antipsychotic drugs administered to the patient increase. However, the syndrome can develop, although much less commonly, after relatively brief treatment periods at low doses. There is no known treatment for established cases of TD, although the syndrome may remit, partially or completely, if antipsychotic treatment is withdrawn. Antipsychotic treatment, itself, however, may suppress (or partially suppress) the signs and symptoms of the syndrome and thereby may possibly mask the underlying process. The effect that symptomatic suppression has upon the long-term course of the syndrome is unknown. Given these considerations, SEROQUEL should be prescribed in a manner that is most likely to minimize the occurrence of TD. Chronic antipsychotic treatment should generally be reserved for patients who appear to suffer from a chronic illness that is known to respond to antipsychotic drugs, and for whom alternative, equally effective, but potentially less harmful treatments are not available or appropriate. In patients who do require chronic treatment, the smallest dose and the shortest duration of treatment producing a satisfactory clinical response should be sought. The need for continued treatment should be reassessed periodically. If signs and symptoms of TD appear in a patient on SEROQUEL, drug discontinuation should be considered. However, some patients may require treatment with SEROQUEL despite the presence of the syndrome. **INTERACTIONS** Concomitant use of SEROQUEL with hepatic enzyme inducers (such as carbamazepine) may substantially decrease systemic exposure to quetiapine. Depending on clinical response, higher doses of SEROQUEL may need to be considered. If SEROQUEL is used concomitantly with a hepatic enzyme inducer. During concomitant administration of drugs which are potent CYP3A4 inhibitors (such as azole antifungals and macrolide antibiotics), plasma concentrations of quetiapine can be significantly higher than observed in patients in clinical trials. As a consequence of this, lower doses of SEROQUEL should be used. Special consideration should be given in elderly and debilitated patients. The risk-benefit ratio needs to be considered on an individual basis in all patients. **PRECAUTIONS Hyperglycaemia** As with some other antipsychotics, exacerbation of pre-existing diabetes, hyperglycaemia, diabetic ketoacidosis, and diabetic coma including some fatal cases have been reported very rarely (<0.01%) during the use of SEROQUEL, sometimes in patients with no reported history of hyperglycaemia. (see ADVERSE REACTIONS, Post-Marketing Experience). Appropriate clinical monitoring is advisable in diabetic patients and in patients with risk factors for the development of diabetes mellitus. **Hypotension and Syncope:** As with other drugs that have high alpha-1 adrenergic receptor blocking activity, SEROQUEL (quetiapine) may induce orthostatic hypotension, dizziness, and sometimes syncope, especially during the initial dose titration period. Syncope was reported in 1% (20/1162) of patients treated with SEROQUEL, compared with 0% (0/306) on placebo and 0.5% (2/478) on active control drugs. The risk of hypotension and syncope may be reduced by more gradual titration to the target dose (see DOSAGE and ADMINISTRATION). SEROQUEL should be used with caution in patients with known cardiovascular disease (e.g., history of myocardial infarction or ischemic heart disease, heart failure or conduction abnormalities), cerebrovascular disease, or other conditions predisposing to hypotension (e.g., dehydration, hypovolemia and treatment with antihypertensive medications). **Cataracts: The development of cataracts was observed in association with quetiapine treatment in chronic dog studies at 4 times the recommended human dose. Lens changes have also been observed in patients during long-term SEROQUEL treatment, but a causal relationship to SEROQUEL use has not been established. The possibility of lenticular changes during long-term use of SEROQUEL in man, thus can not be excluded at this time. Eye examinations (e.g., slit lamp exam) prior to or shortly after initiation of treatment with SEROQUEL and at 6 month intervals thereafter, are recommended. If clinically significant lens changes associated with SEROQUEL use are observed, discontinuation of SEROQUEL should be considered. Seizure:** In controlled clinical trials, there was no difference in the incidence of seizures in patients treated with SEROQUEL or placebo (incidence of 0.4 % or 3 events per 100 patient-years in patients given SEROQUEL, compared with 0.3% or 0.9 events per 100 patient years for placebo). Nevertheless, as with other antipsychotics, caution is recommended when treating patients with a history of seizures or with conditions associated with a lowered seizure threshold. **Hypothyroidism:** Clinical trials demonstrated that SEROQUEL is associated with a dose-related decrease in total and free thyroxine (T_4). On average SEROQUEL was associated with about a 20% mean reduction in thyroxine levels (both total and free). Forty-two percent of SEROQUEL-treated patients showed at least a 30% reduction in total T_4 and 7% showed at least a 50% reduction. Maximum reduction of thyroxine levels generally occurred during the first two to four weeks of treatment with SEROQUEL. These reductions were maintained without adaptation or progression during longer-term treatment. Decreases in T4 were not associated with systematic changes in TSH or clinical signs or symptoms of hypothyroidism. About 0.4% (5/1296) of patients treated with SEROQUEL experienced persistent increases in TSH, and 0.25% of patients were treated with thyroid replacement. **Cholesterol and Triglyceride Elevations:** In short-term placebo-controlled trials, SEROQUEL-treated patients showed mean increases from baseline in cholesterol and triglycerides of 11% and 17%, respectively, compared to mean decreases in the placebo-treated patients. There was little relation between these changes and weight changes observed during the trial. **Hepatic Impairment:** Decreased clearance of SEROQUEL was observed in patients with mild hepatic impairment. Patients with mild hepatic impairment should be started at 25 mg/day. The dose should be increased daily in increments of 25 to 50 mg/day to an effective dose, depending on the clinical response and tolerability in the individual patient. No pharmacokinetic data are available for any dose of SEROQUEL in patients with moderate or severe hepatic impairment. However, should clinical judgment deem treatment with SEROQUEL necessary, the drug should be used with great caution in patients with moderate or severe hepatic impairment (see DOSAGE AND ADMINISTRATION). **Transaminase Elevations:** During premarketing clinical trials, therapy with SEROQUEL was associated with elevations of hepatic transaminases, principally ALT (SGPT). Within a clinical trial database of 1892 SEROQUEL-treated patients, with baseline ALT (SGPT) levels: <50 IU/L, 5.3% (101/1892) had treatment-emergent ALT (SGPT) elevations to >120 IU/L, 1.5% (29/1892) had elevations to >200 IU/L, and 0.2% (3/1892) had elevations to >400 IU/L. No patients had values in excess of 1000 IU/L. Many of the SEROQUEL-treated patients who had elevated transaminase values manifested clinical symptomatology associated with liver impairment. The majority of transaminase elevations were seen during the first two months of treatment. Most elevations were transient (80%) while patients continued on SEROQUEL therapy. Of the 101 SEROQUEL-treated patients whose enzyme levels increased to >120 IU/L, 48 discontinued treatment while their ALT (SGPT) values were still raised. In 114 SEROQUEL-treated patients whose baseline ALT (SGPT) was >80 IU/L, only 1 experienced an elevation to >400 IU/L. Precautions should be exercised when using SEROQUEL in patients with pre-existing hepatic disorders, in patients who are being treated with potentially hepatotoxic drugs, or if treatment-emergent signs or symptoms of hepatic impairment appear. For patients who have known or suspected abnormal hepatic function, prior to starting SEROQUEL, standard clinical assessment, including measurement of transaminase levels is recommended. Periodic clinical reassessment with transaminase levels is recommended for such patients, as well as for patients who develop any signs and symptoms suggestive of a new onset liver disorder during SEROQUEL therapy. **Hyperprolactinemia:** Elevation of prolactin levels was not seen in clinical trials with SEROQUEL. Increased prolactin levels were observed in rat studies with this compound. As is common with compounds which stimulate prolactin release, the administration of SEROQUEL resulted in an increase in the incidence of mammary neoplasms in rats. The physiological differences between rats and humans with regard to prolactin make the clinical significance of these findings unclear. To date, neither clinical nor epidemiological studies have shown an association between chronic administration of drugs that stimulate prolactin release, and mammary tumorigenesis. Tissue culture experiments, however, indicate that approximately one third of human breast cancers are prolactin dependent in vitro; a factor of potential importance if prescription of these drugs is contemplated in a patient with previously detected breast cancer. Possible manifestations associated with elevated prolactin levels are amenorrhea, galactorrhea, and hirsutism. **Weight Gain:** In controlled clinical trials (up to 6 weeks), mean weight gain was approximately 2.3 kg compared to a mean weight gain of 0.1 kilograms in patients taking placebo (n=427). In open-label extension trials, after 9 to 13 weeks of quetiapine monotherapy, the mean weight increase was 1.58 kg (n=1113). After 53 to 78 weeks of treatment, the mean weight increase was 1.98 kg (n=137). These data are obtained from uncontrolled, open-label trials; the relevance of these findings to clinical practice is unknown. *Weight change* over time appeared to be independent of quetiapine dose (see ADVERSE REACTIONS). **Potential Effect on Cognitive and Motor Performance:** Somnolence was a commonly reported adverse event in patients treated with SEROQUEL, especially during the initial dose titration period. Since SEROQUEL may cause sedation and impair motor skills, patients should be cautioned about performing activities requiring mental alertness, such as operating a motor vehicle or hazardous machinery, until they are reasonably certain that SEROQUEL therapy does not affect them adversely. **Antiemetic Effect:** Consistent with its dopamine antagonist effects, SEROQUEL may have an antiemetic effect. Such an effect may mask signs of toxicity due to overdosage of other drugs, or may mask symptoms of disease such as brain tumor or intestinal obstruction. **Body Temperature Regulation:** Although not reported with SEROQUEL, disruption of the body's ability to reduce core body temperature has been attributed to antipsychotic agents. Appropriate care is advised when prescribing SEROQUEL for patients who will be experiencing conditions which may contribute to an elevation of core temperature, e.g., exercising strenuously, exposure to extreme heat, receiving concomitant medication with anticholinergic activity, or being subject to dehydration. **Suicide:** The possibility of suicide or attempted suicide is inherent in psychosis, and thus close supervision and appropriate clinical management of high-risk patients should accompany drug therapy. **Drug Interactions:** Given the primary central nervous system effects of quetiapine, SEROQUEL should be used with caution in combination with other centrally acting drugs. SEROQUEL potentiated the cognitive and motor effects of alcohol in a clinical trial in subjects with psychotic disorders. Alcoholic beverages should be avoided while taking SEROQUEL. Because of its potential for inducing hypotension, SEROQUEL may enhance the effects of certain antihypertensive agents. As it exhibits in vitro dopamine antagonism, SEROQUEL may antagonize the effects of levodopa and dopamine agonists. CYP3A4 is the primary enzyme responsible for cytochrome P450-mediated metabolism of quetiapine. Thus, coadministration of compounds (such as ketoconazole, erythromycin, clarithromycin, diltiazem, verapamil, or nefazodone) which inhibit CYP3A4, may increase the concentration of SEROQUEL. In a clinical study examining the pharmacokinetics of quetiapine following coadministration with cimetidine, (a non-specific P-450 enzyme inhibitor), no clinically significant interaction was observed. Clinical study data on SEROQUEL co-administration with specific CYP3A4 inhibitors, however is not available. In a multiple-dose trial in healthy volunteers to assess the pharmacokinetics of quetiapine given before and during treatment with ketoconazole, co-administration of ketoconazole resulted in an increase in mean Cmax and AUC of quetiapine of 235% and 522%, respectively, with a corresponding decrease in mean oral clearance of 84%. The mean half-life of quetiapine increased from 2.8 to 6.8 hours, but the mean Tmax was unchanged. Due to the potential for an interaction of a similar magnitude in a clinical setting, the dosage of SEROQUEL should be reduced during concomitant use of quetiapine and potent CYP3A4 inhibitors (such as azole antifungals and macrolide antibiotics). The pharmacokinetics of quetiapine were not significantly altered following co-administration with the antidepressants imipramine (a known CYP2D6 inhibitor) or fluoxetine (a known CYP3A4 and CYP2D6 inhibitor). Coadministration of SEROQUEL and phenytoin (microsomal enzyme inducer) caused five-fold increases in clearance of quetiapine. Increased doses of SEROQUEL may be required to maintain control of psychotic symptoms in patients coadministered SEROQUEL and phenytoin, or other hepatic enzyme inducers (e.g., carbamazepine, barbiturates, rifampicin). The dose of SEROQUEL may need to be reduced if phenytoin is withdrawn and replaced with a non-inducer (e.g., sodium valproate). Coadministration of thioridazine (200 mg bid) with SEROQUEL (200 mg bid), increased the clearance of SEROQUEL by 65%. However, fluoxetine (60 mg daily), imipramine (75 mg bid), haloperidol (7.5 mg bid), and risperidone (3 mg bid) did not significantly alter the steady state pharmacokinetics of SEROQUEL. The pharmacokinetics of lithium were not altered when coadministered with SEROQUEL. However, in a multiple dose trial in patients to assess the pharmacokinetics of quetiapine given before and during treatment with carbamazepine (a known hepatic enzyme inducer), co-administration of carbamazepine significantly increased the clearance of quetiapine. This increase in clearance reduced systemic quetiapine exposure as measured by AUC to an average of 13% of the exposure during administration of quetiapine alone; although a greater effect was seen in some patients. As a consequence of this interaction, lower plasma concentrations can occur, and hence, in each patient, consideration for a higher dose of SEROQUEL, depending on clinical response, should be considered. It should be noted that the recommended maximum daily dose of SEROQUEL is 750 mg/day and continued treatment at higher doses should only be considered as a result of careful consideration of the benefit risk assessment for an individual patient. Co-administration of SEROQUEL and with another microsomal enzyme inducer, phenytoin, also caused increases in the clearance of quetiapine. Increased doses of SEROQUEL may be required to maintain control of psychotic symptoms in patients co-administered SEROQUEL and phenytoin and other hepatic enzyme inducers (e.g. carbamazepine, rifampicin etc.). The dose of SEROQUEL may need to be reduced if phenytoin or carbamazepine or other hepatic enzyme inducers are withdrawn and replaced with a non-inducer (e.g., sodium valproate). Divalproate did not induce the hepatic enzyme systems involved in the metabolism of quetiapine. **Use in the Elderly:** The number of patients 65 years of age or over, with schizophrenia or related disorders, exposed to SEROQUEL during clinical trials was limited (n=38). When compared to younger patients the mean plasma clearance of quetiapine was reduced by 30% to 50% in elderly subjects. In addition, as this population has more frequent hepatic, renal, cerebral nervous system, and cardiovascular dysfunctions, and more frequent use of concomitant medication, caution should be exercised with the use of SEROQUEL in the elderly patient, (see DOSAGE AND ADMINISTRATION). **Use in Children and Adolescents:** The safety and efficacy of SEROQUEL in children under the age of 18 years have not been established. **Use in Patients with Renal Impairment:** There is little experience with SEROQUEL in patients with renal impairment, except in a few pharmacological single dose trials. SEROQUEL should thus be used with caution in patients with known renal impairment, especially during the initial dosing period (see DOSAGE AND ADMINISTRATION). **Use in Pregnancy:** Patients should be advised to notify their physician if they become pregnant or intend to become pregnant during treatment with SEROQUEL. The safety and efficacy of SEROQUEL during human pregnancy have not been established. Therefore, SEROQUEL should only be used during pregnancy if the expected benefits justify the potential risks. **Use in Nursing Mothers:** The degree to which quetiapine is excreted into human milk is unknown. Women who are breast feeding should therefore be advised to avoid breast feeding while taking SEROQUEL.

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

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

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

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

*Subjects may have had more than one adverse event.

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

Resident's Review

Part 2: The Efficacy of Transcranial Magnetic Stimulation in Treating Depression

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Enthusiasm for Transcranial magnetic stimulation (TMS) as a treatment of depression and other neuropsychiatric disorders began when it was noted that TMS produced neuroendocrine, neurotransmitter, and sleep phase shifts in animals that was similar to the physiological changes that generally occur in depressed patients who remit to euthymia with antidepressant medications. The literature on TMS and depression is comprised of several small controlled trials. Efficacy comparisons are difficult since most studies have a limited follow-up, focus on treatment resistant depression, vary the TMS treatment protocols, and perform TMS concurrent with antidepressant medications.

George et al. (1997) reported the results of a placebo-crossover trial in 12 medication resistant depressed patients who sequentially underwent TMS of the left prefrontal cortex or sham treatment[1]. Each treatment course consisted of 10 sessions over a 2-week period followed by crossover to the other study arm. There was a modest decline in Hamilton Depression Rating Scale (HDRS) scores when the subjects received active treatment.

Pascual-Leone et al. (1996) conducted a sham controlled study that included a crossover design. Seventeen patients with treatment resistant depression with psychotic features were studied[2]. The sham was created by placing the TMS magnetic coil obliquely to the skull. This orientation does not produce intracerebral currents sufficient for neuronal depolarization. An attempt was made to discontinue antidepressant medication before the TMS therapy but that was not possible in all patients. Moreover, some patients required reintroduction of medications during the TMS study. Each course of TMS consisted of 5 sessions over 5 consecutive days. The patients received 5 different courses of TMS. The authors concluded that stimulation of the left dorsolateral prefrontal cortex (L-DLPFC) had marked antidepressant effect, with 11 of 17 patients showing a decline in HDRS scores of 50% or greater. These results are in-line with neuroimaging studies which demonstrate hypoperfusion of the L-DLPFC in depressed patients. Confusing these results is a study by Loo et al. (1999) [3] which employed identical stimulation parameters as Pascual-Leone (1996)[2]. In the Loo et al. study both the active TMS and sham treatment depressed groups showed significant improvement based on HDRS scores. It has been debated, however, that the sham in this latter study was actually active treatment thereby negating this spurious finding.

Klein et al. conducted a randomized TMS sham controlled trial in seventy depressed patients[4]. The stimulation parameters used in this study, described as "slow" (<1 Hz) were different than the above studies, which used "fast" (>1 Hz) stimulation. In addition, sham TMS consisted of stimulation over the right (as opposed to left) prefrontal cortex. Treatment consisted of 10 daily sessions over a 2-week period. At the end of the study, forty percent of those in the treatment group reported at least a fifty percent decrease in HDRS scores compared to only a seventeen percent decline for those in the sham-treated group.

In a meta analysis of 16 published trials, a Cochrane Review concluded that there is no strong evidence of benefit from TMS when used in the treatment of depression[5]. Moreover, the Cochrane Review found ECT was more effective than TMS.

Transcranial magnetic stimulation of the brain is considered investigational as a treatment of mental disorders. It is a relatively new and presumptively benign technology. It will likely be another decade before the debate over efficacy and standardized treatment protocols emerges. This technology may flourish or flounder over the years ahead. The lure of office-based physiological/procedural treatment of mental illness is unheralded in the history of psychiatry. As residents, we should at least have an appreciation of the rationale, methods, pitfalls, and controversy. Hopefully these articles have sparked your interest.

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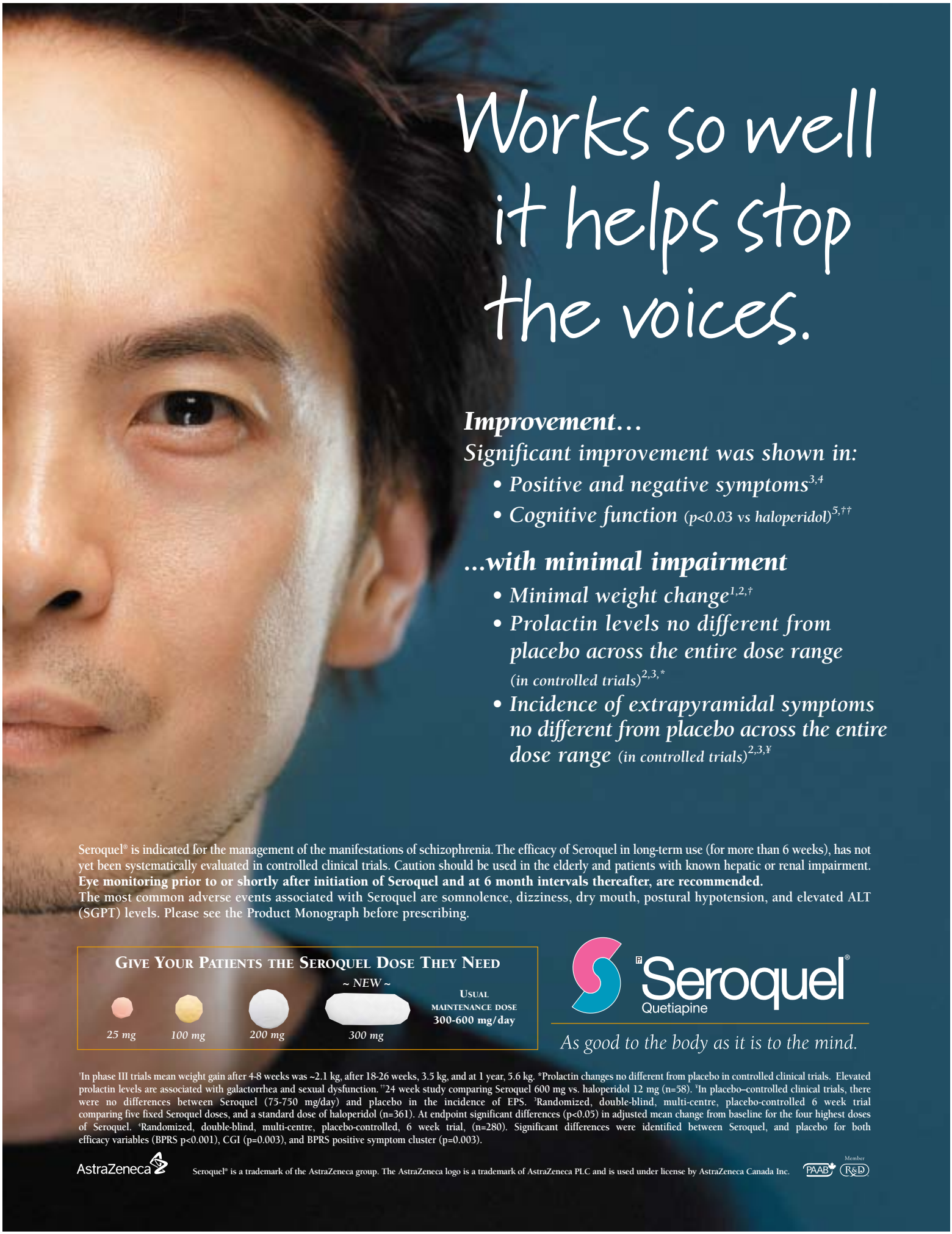

Works so well it helps stop the voices.

Improvement…

Significant improvement was shown in:

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

…with minimal impairment

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

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

GIVE YOUR PATIENTS THE SEROQUEL DOSE THEY NEED

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

USUAL MAINTENANCE DOSE
300-600 mg/day

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Quetiapine

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

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

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