Ontario Psychiatric Association
DIALOGUE
THE NEWSLETTER OF THE ONTARIO PSYCHIATRIC ASSOCIATION / UNE PUBLICATION DE L'ASSOCIATION DES PSYCHIATRES DE L'ONTARIO
SEPTEMBER
2005

MESSAGE FROM THE PRESIDENT

As summer draws to a close and the students return back to school, there is an almost audible, collective sigh of relief - from parents and children alike. It has been a good summer, and it is time to get back to other more academic activities.

The OPA Council has continued to work over the summer, to be ready for the academic year. We are pleased to offer some excellent programs to enhance your learning needs. The Fall Psychotherapy Conference will be held in Toronto, on Saturday October 1st, 2005, featuring Dr. Glen Gabbard. Dr. Gabbard is a well-known highly regarded speaker. After reading the short article included in this issue of the Dialogue, I know many of you will want to attend the conference to hear more.

Take the time now to register for the OPA Annual Meeting, held in January at the Toronto Eaton Centre Marriott Hotel. This promises to be exciting, stimulating, and educational. We are pleased to announce the theme as “Healthy Practices “, and the theme speaker is the internationally renowned Dr. Michael Myers. Dr. Myers is one of the pioneers in the field of Physician Health, and speaks engagingly with vast amounts of skill, humor, and experience. I encourage you to participate in the Annual Meeting by submitting a paper and / or registering. Be sure to “bring a buddy”.

The OPA Committee on Member Affairs has given much time and thought to a concerning issue of dwindling membership in your organization. Currently, there are 737 members in the OPA. 25% of these are Life Members, and therefore exempt from paying membership fees. The OPA is happy to recognize the achievement of our senior colleagues and afford them due respect. Unfortunately, this has led to serious financial consequences. We have decided to review the membership categories and fees, to assist in making the OPA healthier. We need your input. Tell us what you think may be viable solutions - to increasing membership, as well as increasing our financial security. We are all ears! Many of you played a key role in the creation of the OPA. We are now asking for you to play an equally key role in sustaining it.

Finally, we are requesting nominations for OPA Council. This is an excellent opportunity for enthusiastic leaders to work with colleagues and contribute to the profession.

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

Mamta Gautam, MD, FRCPC
2005 OPA President

Ontario Psychiatric Association Executive and Council

President
Dr. Mamta Gautam

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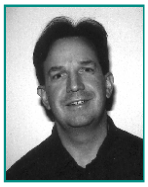
Dr. Susan Abbey



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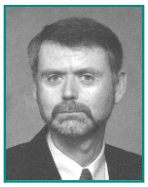

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FROM THE EDITOR

This issue of Dialogue is interactive and invites your participation. The OPA is your professional association. We are fortunate to have a strong Council who have been actively working on education and advocacy initiatives for psychiatry in Ontario. However, to really represent your interests we need to hear from you.

If you are a Life Member we want your advice! The OPA is struggling to balance costs while providing excellent service to members. As someone with a longstanding interest in the profession, your thoughts and ideas will help to guide the future of the OPA.

As a Program Director or psychiatrist in an academic setting, we ask you to participate by encouraging Residents to submit a paper or poster at the Annual Meeting. The first annual Dr. Ann Thomas Award for the Best Resident Presentation is a wonderful opportunity to recognize Residents and involve them, perhaps for the first time, in the OPA. The article by Dr. Andrea Waddell gives a Resident's perspective on the value of supporting the professional association.

As an expert in your field, we encourage you to respond to the Call for Papers. Make this the year that you commit to participate.

As an OPA member, support your association. Plan to attend the Fall Conference and the Annual Meeting. Send us your thoughts and suggestions.

As a Resident, become involved early in supporting the OPA, so that we can represent you now and in the future.

As you read through the *Dialogue* I hope you will take time to consider some of the ways that you can participate in the work of the OPA. With over 700 members, a small contribution on the part of many will ensure our success.

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

June Hylands
Editor

INSIDE

IN EVERY ISSUE

IN THIS ISSUE

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.

September 10, 2005**:** ***World Suicide Prevention Day***
Prevention of Suicide is Everyone's Business
3rd Annual World Suicide Prevention Day
International Association for Suicide Prevention
http://www.med.uio.no/iasp/wspd/menu2005.html

September 11-14, 2005: ***The 2005 International Conference - The International Institute on Special Needs Offenders and Policy Research (Canada).***
'Beyond the Next Horizon - Partnership in Action'
Fairmont Château-Laurier Hotel - Ottawa, Ontario, Canada
For programme information visit:
www.specialneedsoffenders.org

September 26-27, 2005: ***The Best Practices Conference on Seniors' Mental Health***
Canadian Coalition for Seniors Mental Health
The CCSMH is pleased to host a Best Practices in Seniors' Mental Health Conference, to be held at the Crowne Plaza Hotel in Ottawa. **The Purpose of the conference is:**

To showcase/highlight evidence based strategies
To create an awareness of best practices
To educate and provide strategies for best practices
To facilitate activities and partnerships
To foster a multidisciplinary, integrated, comprehensive approach to seniors mental health

For more information please contact Faith Malach at fmalach@baycrest.org or at 416-785-2500 ext 6331 for further information. Or visit: www.ccsmh.ca.

September 29 and 30, 2005: ***The Anatomy of Personality, Intuition, and Illness***
Led by Dr. Mona Lisa Schulz
This workshop provides an overview of how to combine and apply the insights of neuropsychiatry and Medical Intuition. Neuropsychiatrist, Dr. Mona Lisa Schulz, will discuss how the last two decades of brain research have revolutionized our scientific understanding of how mood, anxiety, perception, attention, memory, intuition, and decision-making are wired in specific networks in our brains.
Location: Metro-Central YMCA, 20 Grosvenor Street, Toronto
For more info and to register visit:
www.leadingedgeseminars.org

September 30, 2005: ***The Toronto Psychoanalytic Society Scientific Program presents: Psychoanalysis as Seen Through Cinema - What is Truth and What is Fiction in Terms of Present Day Psychoanalysis***
Dr. Glen Gabbard will be addressing this subject through presenting film clips from selected movies.
Location: Hart House, Debates Room 7 Hart House Circle, University of Toronto
Entrance Fee: $25.00
For more information contact Jean Bowlby at 416-922-7770.

October 1, 2005: ***OPA Psychotherapy Section Fall Conference***
Dr. Glen Gabbard will be speaking on the topic of Borderline Personality Disorders.
Register early, as space is limited!
Location: University of Toronto Faculty Club
For more information and to register visit: www.eopa.ca.

October 3-10 2005: ***Mental Health Awareness Week***
Mental Illness Awareness Week (MIAW) is an annual national public education campaign designed to help open the eyes of Canadians to the reality of mental illness. The week was established in 1992 by the Canadian Psychiatric Association, and is now coordinated by the Canadian Alliance on Mental Illness and Mental Health (CAMIMH) in cooperation with all its member organizations and many other supporters across Canada.
Campaign elements include: a grassroots public education initiative; a nationally-distributed poster and bookmark series; the 3rd Annual Champions of Mental Health Awards luncheon in Ottawa and an education initiative with federal Members of Parliament, both in their home ridings and on Parliament Hill.
Why Mental Illness Awareness Week?
For too long, Canadians with mental illnesses have been in the shadows. Too few Canadians know about the burden of mental illness on our society, and too few sufferers seek help when they need it. Mental Illness Awareness Week seeks to raise awareness of the level of mental illness in Canada; to reduce negative stigma about mental illness amongst the general population and health care professionals; and to promote the positive effects of best practice in prevention, diagnosis and medical treatment.
For more information go to:
www.miaw-ssmm.ca/home.php

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.

October 17-18, 2005: ***Constructing a New Self: Cognitive Therapy for Personality Disorders***
2 day / 12 hour Workshop featuring Dr. Christine A.Padesky
An intensive two-day workshop that will help you treat a range of personality disorders using cognitive therapy techniques. This workshop targets construction of new belief systems, rather than focusing on dysfunctional beliefs and behaviours. Using clinical demonstrations, structured exercises, didactic presentations, thorough handouts and engaging videos, Dr. Padesky will show you how to guide clients to construct a "new" system of personality that offers possibilities and hope.
For more information visit: www.CognitiveWorkshops.com

October 5th, 2005: ***3rd Annual Champions of Mental Health Awards Luncheon***
Fairmont Château Laurier, Ottawa
To purchase tickets and for more information:
miaw@gpc.ca or 613-238-2091 x 243.

October 23-26, 2005: ***Making Gains in Mental Health and Addictions: Transformation Challenges and Opportunities***
Canada's most important mental health and addictions conference is taking place again! Ontario's leading organizations in mental health, addictions and substance abuse will be hosting this major conference, to be held at the London Convention Centre, London, Ontario.
For more information contact:
Rachel Gillooly, Conference Planner
Voice: 1-905-384-1817 or 1-705-454-8107
E-mail: rachel@haliburtonhighlands.com

January 26-28, 2006: ***Ontario Psychiatric Association 86th Annual Meeting "Healthy Practices"***
Toronto Marriott Eaton Centre Hotel, Toronto
For more information visit: www.eopa.ca
(see article on page 10 for more information)

January 25, 2006: ***OPA Pre-Conference one-day workshop***
Toronto Marriott Eaton Centre Hotel, Toronto

Ontario Psychiatric Association - Council Meeting AGENDA

Date: Friday June 3rd, 2005
Time: 10:30 - 12:30

1.0 Remarks from the President and Approval of Agenda

2.0 Approval of Minutes of April 15th 2005

3.0 Business Arising
- 3.1 President Theme Update
  - 3.1.1 Insurance
  - 3.1.2 Doctors facing mental illness
  - 3.1.3 Physician Appreciation Week

4.0 Treasurer's Report
- 4.1 Report on finances

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
- 5.6 Task Force on Governance

6.0 Standing Reports
- 6.1 CPA Reports
  - 6.1.1 Directors
  - 6.1.2 Council of Provinces
  - 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 Committee meeting schedule for summer
- 7.2 Inquest - Funding for Long Term Care

Why join the OPA?

Dedicated to excellence in psychiatric education, advocacy, representation and the advancement of public policy.

The Ontario Psychiatric Association was incorporated in 1956. Dr. Edward Ryan, Superintendent of Rockwood Hospital, established the Ontario Neuro-Psychiatric Association in 1920.

Objectives of the Ontario Psychiatric Association:

EXCHANGE of scientific information
PROMOTE an optimal level of professional development and practice
ADVOCATE for persons with mental illness and their families
REPRESENT the members in their relationships with governments at all levels, universities, other medical associations and other associations
PROMOTE the prevention of mental disorders in Ontario

Member Benefits:

Access to specialty Sections, workshops and courses
Opportunities for networking
Peer Mentorship Programme
Registration discounts for the Annual Conference
Complimentary membership for Residents and longstanding members
Voting privileges at the Annual General Meeting and general meetings (Full Member, Life Member and Member in Training only)
Opportunities for maintenance of competence and continuing education credits
Effective representation to the Canadian Psychiatric Association, the Alliance of Mental Health Services
Joint partnership, with the Ontario Medical Association Section on Psychiatry, by means of the Coalition of Ontario Psychiatrists
Dialogue - the quarterly Association Newsletter provides up-to-date information on issues affecting psychiatry and psychiatric practice

Other Information:

Standing Committees;
Advocacy, Communications, Continuing Education, Finance/Audit, and Member Services
Membership Categories:

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.

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.

Associate Member - is any person who is a legally qualified medical practitioner or who occupies a position in nursing, psychology, social work, occupational therapy, or any other profession or occupation, closely related to psychiatry.

Life Member - is any Member who has reached the age of 65 and whose years of age and years of Full Membership totals 80 in the Association.

For more information about the OPA please visit our website at www.eopa.ca.

The Role of Psychotherapy: Mentalization and Theory of Minds

Glen O. Gabbard, MD

(The following is an excerpt from AMJ Psychiatry 162:4, April 2005)

The capacity to mentalize, or have a "theory of mind," involves being able to recognize that someone else has a different mind from one's own (33,34). These terms also imply the ability to infer what is going on inside someone else's mind by their facial expression, tone of voice, and other nonverbal communications. In essence, it is the ability to understand one's own and others' behaviors in terms of mental states such as beliefs, feelings, and motivations (35). Inherent in mentalization are an appreciation and recognition that the perceived states of one's self and others are fallible and subjective and are representations of reality that reflect only one of a range of possible perspectives. Mentalization is created in the context of secure attachment with a caregiver who ascribes mental states to the child, treats the child as a mental agent, and helps the child to create internal working models (35). In other words, one automatically reads the expression on another's face and knows what that person is feeling without extensive conscious effort to figure out the meaning of the facial expression. Hence it is not the same as conscious introspection. Neither is it identical with empathy. Mentalization refers specifically to the capacity to represent mental states of self and other. Empathy implies emotional resonance with another person. One can conceive of the mental state that may drive a person to murder without feeling empathy for that person.

In the absence of secure attachment, children have difficulty discerning their own mental states or those of others. A securely attached caregiver passes on this secure attachment and capacity to mentalize to the infant. Research has linked borderline personality disorder patients with categories of insecure attachment - either preoccupied or unresolved/disorganized attachment (36-39). The failure to resolve trauma appears to distinguish the borderline personality disorder group from others. Early childhood trauma leads to a defensive withdrawal from the mental world on the part of the victim. Hence some patients with borderline personality disorder who have had severe trauma cope with the abuse by avoiding reflection on the content of the caregiver's mind, which prohibits resolution of abusive experiences (39,40). One patient whose mother threatened to cut her hands off when she made a mess said that she stopped thinking about why her mother yelled at her because she was afraid her mother hated her and regarded her as a monster.

Fonagy et al. (41) studied an inpatient group that consisted predominantly of female patients with severe personality disorders. Using a reflective functioning scale that was developed to measure the capacity for mentalization (42), Fonagy et al. were able to quantify this dimension. Ninety-seven percent of the subjects with abuse and low reflective functioning met the criteria for borderline personality disorder. However, only 17% of the subjects reporting abuse in the group who had high reflective functioning met the criteria for borderline personality disorder. Hence patients with mentalizing capacity could understand the caregiver's mind and process what happened so as to resolve the trauma. On the other hand, those who coped with abuse by refusing to think about what was going on in the caregiver's mind failed to mentalize and therefore could not resolve the abuse experience.

In normal development, mentalization is a psychological achievement. A child younger than age 3 operates primarily in a psychic equivalence mode (33). In this mode, the child assumes that perceptions of reality are identical to the reality itself. Around age 4 or 5 years, the child begins to integrate the pretend mode with the psychic equivalence mode of thinking. The 5- or 6-year-old child understands that one's perception is influenced by subjective factors. This understanding allows for the phenomenon of play, where a child and a playmate can pretend to be others and perceive each other in those roles even though they are aware that the perception is different from the reality. Patients with borderline personality disorder often have great difficulty shifting from the psychic equivalence mode to the pretend mode, and this difficulty interferes with their capacity to recognize transference in psychotherapy. They often hold on to their perception as an absolute fact rather than viewing it as one of several possible alternatives, as the following case vignette illustrates:

Ms. A was a 28-year-old patient with borderline personality disorder in dynamic psychotherapy. About 6 months into the process, an apparently minor event in the therapy session triggered a major reaction in Ms. A. With about 5 minutes left in the therapy session, Ms. A was talking about having visited her family during the Thanksgiving holidays. She felt unimportant to her father because he seemed much more interested in her brother's activities than hers. In the course of this discussion, I looked at the clock on my wall because I knew the time was running out and I wanted to see if I had time to make an observation about her assumption regarding her father's feeling about her. Ms. A stopped talking and looked at the floor. I asked her what was wrong. After a few seconds of silence, she burst into tears and said, "You can't wait for me to get out of your office! I'm sorry if I'm boring you! I've known for a long time that you can't stand me, and you just do this for the money. I'll leave now if you want me to." I was taken aback and replied, somewhat defensively, that I was simply monitoring the time because I wanted to be sure I had time to say something before our session was over. Ms. A replied by saying, "Nice try to get out of it. You think I'm going to believe that?" Escalating in my defensiveness, I stated emphatically, "Whether you believe it or not, that's the truth." Ms. A was adamant: "I saw what

I saw." Placing her hand firmly on the wooden table next to her chair, she raised her voice: "It's like you're telling me that this table is not made out of wood!" Feeling as misunderstood as she was, I continued: "All I'm saying is this: it's possible that I looked at the clock for reasons other than the ones you attribute to me - just like you may make assumptions about your Dad." Ms. A became even more insistent in response to my efforts fo offer other possibilities: "Now you're trying to say I didn't see what I saw! At least you could admit it!"

One of the greatest challenges for a psychotherapist is managing this almost delusional conviction of some patients with borderline personality disorder that their perception is a direct reflection of reality rather than a representation of reality based on their internal beliefs, feelings, and past experiences. This failure to mentalize may make it extremely difficult for them to work on transference issues because they are convinced that their view of the therapist is "correct" rather than one of a number of possible interpretations of the therapist's behavior, facial expression, or comments. Fortunately, mentalization occurs on a continuum, and at times patients with borderline personality disorder may be capable of entering the pretend mode and reflecting on their own internal world and that of others. Whereas states such as autism are characterized by complete absence of mentalization on a neurological basis, a patient with borderline personality disorder often retains partial ability to mentalize under some circumstances, particularly when there is not an affectively intense involvement in an attachment relationship.

This vignette reflects how the misreading of the therapist's mind led to an activation of a trauma-based internal object relationship associated with a hyperreactive HPA axis. I became a potentially malevolent persecuting object; she became a victimized self; and a hypervigilant, anxious, humiliated affect state linked self and object. In this state of feeling terrorized, one cannot think or reflect. The intensity of Ms. A's accusation also eroded my capacity to think, and I escalated my defensiveness to the point where I actually became a version of the persecuting object that she feared. This projective identification process, where the therapist is coerced under pressure from the patient into playing a role in the patient's internal drama, can cause therapists to temporarily lose their capacity for thoughts in a psychotherapeutic role (43). In other words, I was insisting that only my version of reality was valid. Patients with borderline personality disorder colonize the minds of others as a way of extruding and controlling perceived danger from within. They unconsciously coerce the therapist into taking on the characteristics of an abusive internal object. I had become "bad" in two senses of the word - a bad object and a bad therapist. Although my interpretation that Ms. A's misreading of me was similar to her misreading of her father may have been accurate, my timing was poor. Neither the patient nor I was in a reflective state of mind where meanings could be entertained. Our research in the Menninger Clinic Treatment Interventions Project (44) found that transference interpretation may need to be postponed under such circumstances until the patient's ability to reflect returns.

Neural imaging studies suggest that mentalization entails several different brain structures working in concert (45-49). Most of these studies involved asking the subject to perform mental activities that require an understanding of someone else's inner world. Recently Calarge et al. (48) asked 13 healthy volunteers to place themselves in another person's place and attribute mental states to that person by having them describe the experience of a crying stranger met during a chance encounter on a park bench. The authors noted that these capacities are necessary in psycho-dynamic practice. As in other studies, the medial frontal region was activated when the subjects attributed mental states to others. One of the most significant findings was that the largest activation during the task occurred in the right cerebellum. Like Frith and Frith (45), these investigators suggested that it is best to think of a "theory of mind" system or network that is widely distributed and made up of interactive nodes, probably in the medial prefrontal regions, the superior temporal sulcus, the inferior frontal region, and the cerebellum.

Mirror neurons may also play a role in a neurobiological basis understanding of mentalization. These neurons in the premotor cortex, first identified in monkey studies, respond when a primate observes certain hand movements performed by another primate or by a human or when the animal performs the same movements itself. In other words, these neurons are encoding object-oriented actions, whether they are performed or observed. This group of neurons in the ventral premotor cortex is activated during observation of an agent acting in a purposeful way upon objects (50). Fogassi and Gallese (50) suggested that mirror neurons may have a crucial role in goal detection and therefore in action understanding. They point out that the "mind reading" associated with theory of mind studies involves a series of explicit behavioral signals. They proposed that the capacity to understand another person's internal world is related to the activation of this shared representation through mirror neurons. In other words, these neurons recognize intrinsically meaningful behavioral signals.

The fact that certain brain areas are activated during theory of mind experiments does not help the psychotherapist much when a patient with borderline personality disorder is sitting in the consulting room. However, the theory of mind construct helps bridge the domains of brain and mind. Within this conceptual model,

mind becomes a sense of a subjective internal world accompanied by the recognition that others have internal worlds different from our own. There is no resort to Cartesian dualism in this model, but there is a recognition that subjectivity is extraordinarily complex and involves a language of meanings, perceptions, feelings, intentions, beliefs, and motivations that are not readily reducible to neuroscience constructs. Although the brain is an objective, observable entity, the mind of another is known through empathic connection. The vocabulary of the psychotherapist draws on the lexicon of the mind. To create a "mind" in the patient with borderline personality disorder requires the language of the mind.

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To hear Dr. Gabbard, register for the OPA Psychotherapy Section 2005 Fall Conference.

Saturday, October 1st, 2005
Registration is Limited!

Join us on October 1st at the University of Toronto Faculty Club to hear Dr. Gabbard speak on the topic of Borderline Personality Disorders. In addition to a full day of informative lecture, you will enjoy a gourmet lunch with wine, in the private Dining Room located within the Toronto Faculty Club.

The morning lecture entitled "The Mind-Brain Interface in Borderline Personality Disorder", will look at recent neurobiological data regarding borderline personality disorder. These findings will be used to inform a psychological perspective on understanding borderline patients that integrates neurobiology and psychodynamics.

The afternoon lecture will be "Combining Medication and Psychotherapy in the Treatment of Borderline Personality Disorder." This talk will outline a practical psychodynamic approach to the treatment of borderline personality disorder. It will also summarize recent data on the psychopharmacology of borderline patients and suggest how to integrate the psychotherapy with the medication treatment.

Registration begins at 8:45 AM with the program commencing at 9:30 and completing at 4:30 PM. For full program details and to register, please visit us at www.eopa.ca or complete the enclosed registration form.

We look forward to seeing you there!

OPA Fall Conference Registration

Fill in the form below and fax (905) 849-8606 or mail to "The OPA Fall Conference".

Name: _____

Address: _____

Phone: _____

Email: _____

Are you a member of the OPA? Yes ____ No ____

Degree/Title: _____

Institutional Affiliation: _____

	Fees
OPA Members	$235.00
Non Members	$255.00
Residents	$150.00

Fee Payment
Cheques:
Please make payable to the Ontario Psychiatric Association and mail this form with your cheque to:
The Ontario Psychiatric Association
344 Lakeshore Rd. E. Suite B
Oakville, ON
L6J 1J6

Credit Cards: (please print clearly)
Card Type: VISA _____ MasterCard _____

Card Holder Name: _____

Card Holder Signature: _____

Card Number: _____

Expiry Date: _____

Refund Policy: Please provide your request for refund in writing to the OPA.
Notification received between September 2nd and October 1st refunded 50%.

Privacy Policy: Personal information collected on this form will only be used for purposes of conference administration.
I consent to have my information used to provide me with brochures for other OPA events and conferences:

Yes _____ No _____

Unrestricted educational grants provided by:

GENPHARM
People Matter

Report of the Continuing Education Committee

By: Roumen Milev, Chair, Continuing Education Committee

The Continuing Education Committee has been working over the summer months to plan an outstanding Annual Meeting. The following will provide you with information about our theme speaker, Dr. Michael Myers. We are also excited to announce a new program - Bring a Buddy - to encourage new registrants. Information on submitting abstracts is included in this issue of Dialogue and we look forward to receiving submissions from our members. In addition, we hope that you will encourage Residents to submit a paper or poster. Posters and oral presentations submitted by Residents will be judged for the 1st Annual Dr. Ann Thomas Award for the Best Resident Presentation. With the end of summer, time will move quickly and our schedules will fill up. Mark your calendar today and register early. We look forward to seeing you in January.

The Ontario Psychiatric Association Annual Meeting

January 26th - 28th, 2006

The OPA Annual Meeting will be held at The Marriott Eaton Centre Toronto Hotel.

The Conference will bring together an audience of over 200 community and academic psychiatrists, as well as psychologists, residents, and other stakeholders with an interest in mental health.

The format of this three-day Conference will combine plenary sessions, thematic sessions and smaller group workshops, all designed to promote dialogue, debate and healthy controversy. These sessions will be interspersed with opportunities for social interaction and networking.

Theme Speaker

In keeping with the OPA President's Theme of Healthy Practices, the Continuing Education Committee is delighted that Dr. Michael Myers has agreed to be the Theme Speaker for the Annual Conference. In addition to his extensive credentials, Dr. Myers is an outstanding speaker. Do not miss this opportunity to attend his lecture!

Michael Myers, MD, FRCPC, FAPA

Dr. Myers is the Director of the Marital Therapy Clinic at St. Paul's Hospital in Vancouver, BC and Clinical Professor in the Department of Psychiatry at the University of British Columbia Faculty of Medicine. He graduated in medicine from the University of Western Ontario in 1966 and did residencies at Los Angeles County-USC Medical Center, Wayne State University (Detroit General Hospital), and the University of British Columbia. Since completing his residency training in 1973, he has taught half-time and been in private practice half-time. He is board certified in Psychiatry by both the Royal College of Physicians & Surgeons of Canada and the American Board of Psychiatry & Neurology.

Dr. Myers is the author of six books: *Men and Divorce* (Guilford, New York, 1989); *Doctors' Marriages: A Look at the Problems and Their Solutions* (Second Edition, Plenum, New York, 1994); *How's Your Marriage? A Book for Men and Women* (American Psychiatric Press Inc., Washington, DC, 1998); *Intimate Relationships in Medical School: How to Make Them Work* (Sage Publications, Thousand Oaks CA, 2000); (with Larry Goldman, MD and Leah Dickstein, MD) *The Handbook of Physician Health* (American Medical Association, Chicago, 2000); and (with Carla Fine) *Touched By Suicide* (Gotham/Penguin Books, New York, 2006). His publications also include over 100 articles, book chapters, and book reviews and 8 videotapes covering a range of topics: marital therapy, men and reproductive technology, divorce, health concerns of medical students, psychiatric illness in physicians and their loved ones, boundary crossing in the doctor-patient relationship, suicide, sexual assault of women and men, AIDS, the stigma of illness, and gender issues in training and medical practice.

At this time, Dr. Myers serves on the Board of Directors of the Robert E. Jones Foundation (a benevolent society for families of ill physicians) of the American Psychiatric Association and the Editorial Board of American Psychiatric Publishing Inc. In 2003 he joined the Editorial Board of the Canadian Journal of Psychiatry. In 1990, he was named to Canadian Who's Who.

Dr. Myers has received awards for excellence in teaching from the University of British Columbia, the Dr. Nancy Roeske Award from the American Psychiatric Association, the Distinguished Member Lecture Award from the Canadian Psychiatric Association, the Douglas Utting Award from McGill University, the Distinguished Leader in Medicine Award from Dalhousie University and a number of other named lectureships in Canada and the United States. From 1997 - 2000, he served on the Board of Trustees of the American Psychiatric Association and from 2000 - 2001 he was President of the Canadian Psychiatric Association.

Dr. Myers is a specialist in physician health. With the support of the Committee on Physician Health, Illness, and Impairment of the American Psychiatric Association, he has produced an educational videotape for medical students, physicians, and their families called "Physicians Living With Depression" (American Psychiatric Press Inc., Washington, DC, 1996). His videotape "When Physicians Die By Suicide: Reflections of Those They Leave Behind" won the 1999 APA Psychiatric Services Award. For his advocacy efforts, Dr. Myers received the 2002 CAIR (Canadian Association of Interns and Residents) Resident Well-Being Award.

Bring A Buddy!

We are excited to announce a new program aimed at increasing attendance at the Annual Conference and saving registrants some money! Any member that recruits a new registrant to the Annual Meeting will receive recognition through the "Bring a Buddy" campaign.

Here is how it works….

The referring OPA member will receive a $50 discount on their registration fee for the Annual Conference.
The new registrant will also receive a $50 discount on their registration fee for the Annual Conference.
A "New registrant" is defined as a person who has not attended the Annual Conference for the last 3 years.
The recruiter's registration form must indicate the name of the "Buddy" recruited.
The new registrant registration form must indicate who referred them.

There will be a poster at the Annual Conference acknowledging those who have participated in "Bring a Buddy", and an acknowledgement will also appear in the issue of *Dialogue* following the Conference.

Call for Papers for the Annual Conference

Deadline for Submission is October 15th 2005

The 2006 Scientific Program at the OPA Annual Conference will provide you with an excellent continuing education program, which has been designed to enhance your psychiatric knowledge.

There is an award to the OPA Full Member who presents the best Paper

OPPORTUNITIES FOR RESIDENTS

The OPA conference is a perfect opportunity for Residents to gain exposure to a scientific conference in a friendly atmosphere. Please circulate this to Residents and encourage them to make a submission. Posters and oral presentations submitted by Residents will be judged for the 1st Annual Dr. Ann Thomas Award for the Best Resident Presentation

Please note the following guidelines:
Oral presentations - 20 minutes
Workshops - 1.5 hours
Symposia - 3-5 presenters on a topic - 2-3 hours

Members will be given preference but submissions from non-members are welcome.

All presenters will be required to register for the Annual Conference. A Registration form will be sent to you with your confirmation of acceptance to present.

To obtain forms for submission of abstracts contact the OPA office at 905-827-4659 or go to www.eopa.ca to download forms from the web site.

Registration: Complete the enclosed registration form and fax it to us at 905-849-8606 or Register online at www.eopa.ca

Ontario Psychiatric Association Annual Meeting - Healthy Practices
January 26th - 28th, 2005 Toronto Marriott Eaton Centre Hotel
Registration Form

Please ***print clearly*** and submit via mail or fax to the OPA Head Office:
344 Lakeshore Rd. East, Suite B, Oakville, Ontario L6J 1J6
Fax (905) 849-8606

Title:_____ First Name:_____ Last Name:_____

Address:_____ City:_____ Postal Code:_____

Telephone:_____ Email:_____ Profession:_____

Registration Fee Information:

Included in your Member/Member Resident registration: Complimentary continental breakfast, luncheon symposia, morning and afternoon coffee breaks each day. One complimentary ticket to the OPA Dinner/Dance. (Please ensure to register below.)
Included in your Non Member/Resident registration: Complimentary continental breakfast, luncheon symposia, morning and afternoon coffee breaks each day. Tickets to the OPA Dinner/Dance are available at an additional cost. (See below.)

EARLY BIRD SPECIAL - Register by January 6, 2006 and SAVE $100.00!!

Registration Fee	Before January 6th		After January 6th	Dinner/Dance Fri. Jan. 27th
	Daily Rate	***Full Conference***	***Full Conference Only***	
OPA Member - Full	$250.00	$395.00	$495.00	1 complimentary ticket per registrant. Additional tickets $60.00 each
OPA Member - Associate/Life/Inactive/Honorary	$210.00	$320.00	$420.00	
OPA Member - Resident	$25.00	$50.00	$75.00	
Non Members	$295.00	$495.00	$595.00	$60.00 each

Refund Policy:
A $50 cancellation fee will apply to all refunds issued before January 20, 2006. After this date, no refunds will be issued.
7% GST is included in all registration rates.

Registration Fee Calculation:

Total of all registration fees: $ _____
Total of all Dinner/Dance fees: # of tickets: _____ $ _____

TOTAL Payable: **$** _____

Form of Payment:

Visa MasterCard Cheque (made payable to The Ontario Psychiatric Association)
Card Holder Name (Please print)_____ Signature_____
Card Holder #_____ Expiry Date_____

Privacy Policy for conferences:
Personal information collected on this form will only be used for purposes of conference administration.
I consent to have my information used to provide me with brochures for other OPA events and conferences.
YES *NO*

OPA GST Registration Number: R120428529

Award Nominations

The Ontario Psychiatric Association has taken great pleasure in submitted the following nominations for awards to recognize the outstanding contributions of our colleagues.

Submitted to the Canadian Psychiatric Association

C.A. Roberts Award

This award is dedicated to the memory of Dr. C.A. Roberts and is presented annually to a psychiatrist-clinician who has made a significant contribution to the improvement of patient care.

Nominee:
Dr. Simon I. Davidson, M.B., B.Ch., F.R.C.P. (C)

Dr. Davidson is currently Chief of Psychiatry at the Children's Hospital of Eastern Ontario (CHEO), Medical Director of the Mental Health Patient Service Unit at CHEO and Executive Director of Planning and Development of the Provincial Centre of Excellence for Child and Youth Mental Health at CHEO. He is the Chairman of the Division of Child and Adolescent Psychiatry in the Department of Psychiatry at the University of Ottawa. He is also a Past President of the Canadian Academy of Child & Adolescent Psychiatry (CACAP).

Submitted to the Canadian Psychiatric Association

Paul Patterson Education Leadership Award

This award is dedicated to the memory of Dr. Paul Patterson, and is presented annually to a psychiatric educator who, in responding to change or leading in new directions, makes a significant contribution to undergraduate, postgraduate, continuing professional or public education.

Nominee:
Katharine Gillis MD, FRCPC

Dr. Katharine Gillis has been an active member of the Department of Psychiatry at the University of Ottawa for almost a decade. In that time, she has been a remarkable champion of psychiatric education and training, and has led massive and successful education initiatives both locally and nationally.

Submitted to the Canadian Psychiatric Association

Alex Leighton Award

The *Alex Leighton Award* is a joint initiative of the Canadian Psychiatric Association (CPA) and the Canadian Academy of Psychiatric Epidemiology (CAPE). Its purpose is to recognize an individual or a group of individuals that have made a significant contribution to the advancement and diffusion of Canadian psychiatric epidemiology through innovative studies, methods, teaching, or transfer of knowledge.

Nominee:
Harriet L. MacMillan, M.D., MSc., FRCP (C)

Dr. MacMillan, a member of the Offord Centre for Child Studies, is a psychiatrist and pediatrician conducting research on the psychiatric epidemiology of violence against children and women, including a special focus on approaches to prevention. She is a Professor in the Departments of Psychiatry and Behavioural Neurosciences, and Pediatrics at McMaster University with associate memberships in the Departments of Clinical Epidemiology and Biostatistics, and Psychology. Dr. MacMillan is principal investigator on a Canadian Institutes of Health Research (CIHR) New Emerging Team (NET) grant that investigates the health impacts of violence across the life span, including violence against women, child maltreatment, dating violence and abuse of older persons. In addition, she is currently principal investigator of a grant funded by the Ontario Women's Health Council to evaluate the effectiveness of screening for violence against women in reducing subsequent violence.

The Association of General Hospital Psychiatric Services (AGHPS)

Provided the following update to the OPA on its past and future activities:

In the last issue of the Dialogue, the AGHPS reported on issues related to implementation of the ***Resident Assessment Instrument Mental Health (RAI-MH).*** After surveying general hospital mental health services throughout the province, the AGHPS sent a letter to the Minister of Health and Long Term Care (see below). The survey results are available on our web site at www.aghps.com.

It is our intention to follow up with hospitals in September to ascertain what progress has been made, and to determine (1) the status of implementation plans, (2) whether the issues identified continue to challenge hospitals, and (3) potentially identify new issues that may emerge as the implementation date approaches.

Dear Minister Smitherman,

The Association of General Hospital Psychiatric Services is a provincial association that represents over 50 of the Ontario General Hospitals, which have Psychiatric Services. Additionally, we represent a smaller number of specialty hospitals. Our members are the hospitals themselves. Almost all of our member hospitals are designated Schedule 1 under the Mental Health Act (MHA).

We recently undertook a survey of General Hospitals regarding the RAI-MH assessment tool, scheduled for implementation in October 2005. Given the responses submitted we are writing to encourage the Ministry to:

1. *Extend the deadline for implementation*
2. *Provide one time funding for the purchase of capital equipment necessary for implementation*
3. *Provide ongoing funding for the staffing and licensing costs associated with implementation*

Enclosed are the results of the survey, that articulate in detail the challenges faced by mental health services within hospitals. In summary the issues include:

The Need for Additional Technology (hardware and software)
Education
Operational issues
Vendor Issues

The hospitals that responded to our survey were clear in their commitment to work with the Ministry on this important initiative and there is a conviction that the data will be helpful in providing improved mental health services. However, there is also a concern that failure to effectively implement the RAI-MH as a result of the stated constraints will lead to long-term negative outcomes.

Thank you for your consideration of these recommendations. We look forward to working with the Ministry of Health and Long Term Care to resolve these issues and successfully implement the RAI-MH.

Sincerely,
Dr. Brian Hoffman, President,
AGHPS

MEMBERS ON THE *MOVE*

To get your new appointment in “Members on the Move”, send us the following information - your name, position, date of appointment, the organization you were with and the new organization (if applicable), your email, phone number and address.

We will run these announcements as we receive them, and as space in the *Dialogue* allows. Please forward your items in writing to the OPA Office, 344 Lakeshore Road East, Suite B, Oakville, Ontario, L6J 1J6 or by email to: opa@bellnet.ca. Please ensure these are clearly marked “*Dialogue* Members on the Move”.

SPECIAL ADVANCED NOTICE

Mark your calendars for the 2006 Child and Adolescent Conference
Presenting
Dr. James Garbarino, Ph.D.
as the keynote speaker
Conduct Disorder in Children and Adolescents

Friday, April 7th, 2006
London, Ontario

Dr. Garbarino is Elizabeth Lee Vincent Professor of Human Development at Cornell University, and from 1985-1993 he was President of the Erikson Institute for Advanced Study in Child Development. Dr. Garbarino holds the Maude C. Clarke Chair in Humanistic Psychology at Loyola University, Chicago. He serves as a consultant to television, magazine, and newspaper reports on children and families. Recognized as a leading authority on child development and youth violence, Dr. Garbarino has appeared frequently on nationally broadcast news and information programs including ABC-TV's "Nightline", PBS-TV's "News Hour", CNN's "Larry King Live", NBC's-TV's "Meet the Press", and "The Today Show", National Public Radio's "All Things Considered", and many more. He also serves as a scientific expert witness in criminal and civil cases involving issues of violence.

Some of the books he has authored: Parents Under Siege: Why You Are the Solution, Not the Problem in Your Child's Life (2001;) Lost Boys: Why Our Sons Turn Violent and How We Can Save Them (1999); Raising Children in a Socially Toxic Environment (1995).
His presentation examines the special challenges we face as we go about the business of educating children and youth in today's socially toxic environment. It will focus on the concept of "child protection" as the antidote for social toxicity. Contributors to the toxicity of the social environment include instability of relationships, economic polarization, desensitization to violence, and the nastiness of popular culture. Of special concern is that the effects of this social toxicity are felt and expressed most by the most vulnerable children and youth -- e.g. those from destabilized families, those subject to racism, and those with disabilities.
Efforts to deal with the issues of social toxicity involve both strengthening children and youth to decrease their vulnerability and simultaneously detoxifying the social environment.

Presented by
University of Western Ontario
Department of Psychiatry, Division of Child Psychiatry
CHILD AND ADOLESCENT MENTAL HEALTH CARE PROGRAM
London Health Sciences Centre, Schulich School of Medicine, Children's Hospital of Western Ontario
Adolescent Program, St. Joseph's Health Centre, Regional Mental Health Care
Registrations will be mailed out in early 2006.
If you would like to receive a registration form please contact Linda Yeoman 667-6640 or Lorrie Vandersluis (519) 685-8500 ext. 52534

OMA Section on Psychiatry Executive Election 2006

The OMA Section on Psychiatry and the OPA are the partners in the Coalition of Ontario Psychiatrists. Together they represent the 1700 psychiatrists in Ontario. The Coalition allows these two organizations to coordinate their efforts.

The OMA Section on Psychiatry Executive focuses on representing Ontario psychiatrists in negotiations regarding remuneration. The Section, as part of the OMA, represents psychiatrists in a number of other issues that affect all physicians. The Executive of the Section networks with other medical colleagues at the OMA.

There are thirteen psychiatrists from across Ontario on the Section Executive. There are representatives of the OPA, Academy of Child Psychiatry, Association of General Hospital Psychiatric Services, Ontario Psychoanalytic Societies and the Association of Ontario Physicians and Dentists in Public Hospitals and others who represent the membership at large.

The OMA Section on Psychiatry Executive holds elections every two years. The next election will be in May 2006. If you would be interested in being part of Section Executive please contact Dr. Doug Weir, Past Chair, OMA Section on Psychiatry by email at dcweir@on.aibn.com or mail a letter care of the Ontario Medical Association, 525 University Avenue, Toronto, Ontario, M5G 2K7.

Call for Nominations to OPA Council

The OPA needs your ideas, enthusiasm and expertise to continue to provide 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 2006 OPA Elections are now being accepted.

We are looking for a President Elect, Council Members (Full Members) and one Member-in-Training beginning January 2006. 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 2006 to 2007; and the term is from January 2006 to January 2009 for Council Members and January 2006 to January 2008 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 4th, 2005.

For further information please contact Dr. Doug Wilkins, OPA Past President, by telephone: 613-798-5555 ext 19240 or by email: dwilkins@ottawahospital.on.ca

Lifetime Members - We Need Your Advice

The OPA Council would like advice from Lifetime Members. Like many professional associations, the OPA is struggling with financial pressures. In addition to the usual cost increases, many of our members are becoming eligible for Life Membership, and therefore no longer pay membership dues.

In 2004, the OPA had 182 Life Members. By 2010 the OPA expects to have 287 Life Members. Despite our efforts to recruit new members, we cannot improve our position under these circumstances. Using an analogy, the OPA's current financial position is much akin to a swimmer tied to the dock. He is moving his legs and arms, but just isn't getting anywhere. Similarly, the OPA is taking measures to increase membership, but can't make sufficient gains to improve its financial position.

The success of the OPA is due, in large part, to the enduring efforts and contributions of those who are now Life Members. We are committed to recognizing your contributions through initiatives such as Life Member status. However, we also believe that this group, more than any other, would want the OPA to be strong and successful.

Please take a few minutes to complete the survey below. You can fax your response to the OPA office at 905-849-8606, or send it by mail to:

The Ontario Psychiatric Association
344 Lakeshore Road East, Suite B
Oakville, Ontario
L6J 1J6

We will collate the information and bring forward a recommendation to our members at the Annual General Meeting in January 2006. Thank you for your time, consideration and lifelong support of the OPA.

A Life Member is any Member who has reached the age of 65 and whose years of age and years of Full membership total 80 in the Association. A Life Member no longer pays an annual fee for membership to the Ontario Psychiatric Association (OPA) but does pay registration for the Annual Meeting. The current membership fee for members of the OPA is $257.00.

Survey

(Please detach and fax or mail response)

I advise the OPA Council to:

Leave the Life Membership unchanged.

Charge a membership fee of $100 but provide Life Members with a complimentary registration to the Annual Meeting. (Value of $395.00 - $495.00.)

Charge a reduced rate for Life Members in the amount of:

$50 $75 $100 $125 $150

Other suggestions: _____

_____

_____

_____

_____

Psychiatrists Will See Fee Increases and Two New Funding Initiatives October 2005

By Douglas C. Weir M.D. F.R.C.P.(C), OMA Co-Chair Mental Health Funding Working Group, OMA Medical Assembly Board Director, Member 2004-2005 OMA Negotiation Team, Past-Chair, OMA Section on Psychiatry

In July, Ontario psychiatrists billing fee-for-service should have received a 2% across-the-board fee increase to all psychiatric fees retroactive to April 1, 2004.

Effective October 1, 2005 in keeping with the 2004 OMA/MOHLTC Agreement, a number of fees for psychiatric services will increase again. These are part of a multitude of fee increases which will include fees used by all physicians including psychiatrists.

At the same time, two new funding initiatives to improve remuneration for physicians providing hospital mental health services, including emergency and in-patient services will be implemented.

The new fees for services most frequently billed by psychiatrists are below.

In September you will receive an OHIP Bulletin that describes the two new funding initiatives.

1. Mental Health Sessional Fee Supplements

The Mental Health sessional fee supplements will be available to each hospital or community mental health group currently receiving mental health sessional funding. Sessional funding is a mechanism to pay for a variety of "indirect" psychiatric services provided by psychiatrists/physicians in the general hospital system and through community mental health programs. 80% goes to hospital-based psychiatrists and 20% goes to psychiatrists working in community mental health services and addiction services. The sessional fee supplement will be applicable to sessional hours, beginning October 1, 2005, provided by physicians in the Mental Health Sessional group. The sessional fee supplement is in addition to the sessional fees those physicians are currently receiving. Hospitals who are eligible for the psychiatric stipend and currently receive sessional funding will receive the supplement and the stipend. This is a significant improvement which addresses a need the Coalition of Ontario Psychiatrists has been working to achieve for several years.

2. Psychiatric Stipend

As per the 2004 Physician Services Agreement, the psychiatric stipend was negotiated to enhance the remuneration of physicians providing psychiatric services in hospitals and to attract psychiatrists to work in hospitals. This funding is intended to be implemented in two installments. The first installment of $5 million will be invested on October 1, 2005.

Additional funding of $9.4 million has been allocated for investment as of July 1, 2006. The Mental Health Funding Working Group will be developing options on allocation of this additional money per the criteria outlined in the Agreement (Appendix "J").

The shortage of psychiatrists is common in most Schedule 1 Hospitals, where recruitment of psychiatrists is a top priority. The Psychiatric Stipend program is intended to help attract psychiatrists to work in General Hospitals and compensate them for work that currently they are either not being paid for, or which is remunerated at an amount that makes working in a General Hospital unattractive.

All Ontario physicians will receive an OHIP Bulletin that will describe these two funding initiatives. Chiefs of Psychiatry of all Schedule 1 Hospitals and all Directors of Community Mental Health Agencies and Addiction Services who currently receive Sessional Funding will receive more details on these initiatives.

Members of Mental Health Funding Working Group

OMA: Members of Pro Temp MHFWG May & June 2005
Dr. Douglas Weir, Psychiatrist, Toronto, OMA Board
Dr. Gerry McNestry, Psychiatrist, Peterborough
Dr. Ty Turner, Psychiatrist, Toronto

Members of MHFWG as of July 1, 2005
Dr. Douglas Weir, Psychiatrist, Toronto, OMA Board
Dr. Gerry McNestry, Psychiatrist, Peterborough
Dr. Brian Hoffman, Psychiatrist, Toronto

MOHLTC Members:
Ms. Suzanne McGurn, Director (Acting) - Director's Office
Ms. Carrie Hayward, Director - Mental Health and Addiction Branch
Ms. Sandy Nuttall, Manager, Hospital Operations Policy (Acting) - Hospital Operations Policy Unit

The MHFWG consists of three members appointed by the OMA and three members appointed by the MOHLTC with a member of each group being appointed as co-chairs. The mandate for the MHFWG is:

i. to obtain information on the various psychiatrist payment programs and service requirements;
ii. to identify areas of inconsistencies (e.g. funding level, geographic availability of Mental Health Sessional payments, community and acute care programs);
iii. to develop options and make recommendations to the Parties on mental health issues including integrating payment and administration of the Mental Health Sessional Payments, the Psychiatric Stipend and payment to psychiatrists on ACT teams.

The first task of the MHFWG was to allocate $5 million for the new Psychiatric Stipend program. The MHFWG will next be developing and recommending a plan for the allocation of $9.4 million, scheduled to be implemented July 2006.

The Coalition of Ontario Psychiatrists wanted the 2004 negotiations to address relativity, sessional fee rates, payment for indirect services in hospitals, and an increase to psychiatric fees that would keep us competitive with other provinces. The October fee increases and these two new programs are major gains in all these areas. The Mental Health Funding Working Group, will give Ontario psychiatrists the opportunity to realize additional, ongoing improvements in remuneration.

October 2005 OHIP Fee Increases

Code	Description	2003 fee	April 2004 fee	October 1, 2005 fee
K197	Individual out-patient psychotherapy	$58.40	$59.55	$62.20
K198	Psychiatric Care, out-patient	$58.40	$59.55	$62.20
K199	Psychiatric Care, in-patient	$62.60	$63.85	$65.25
K195	Family psychotherapy out-patient	$63.95	$65.25	$65.25
A195	Outpatient Consultation	$125.00	$127.50	$153.00
A197	Consultation interview with a child	$125.00	$127.50	$163.20
A198	Consultation interview with parents	$125.00	$127.50	$163.20
A895	Consultation in association with special visit in hospital or LTC (i.e. emergency visits)	$134.25	$136.95	$178.50
C895	Consultation non-emergency hospital services	$140.00	$142.80	$178.50
W895	Consultation non-emergency long-term care in-patient services	$134.25	$136.95	$178.50
A/C/W795	Geriatric Consultation	$168.40	$171.75	$183.60
A/C/W695	Neurodevelopmental consultation	$224.65	$229.15	$255.00

Please note that fee increases taking place after October 2005 have not been included. For fee increases to services that are not unique to psychiatry and psychiatric fee codes used less frequently by psychiatrists please see OHIP Bulletins and the updated version of the Schedule of Benefits available on the Ministry of Health and Long-Term Care website http://www.health.gov.on.ca/.

Resident's Review

Submitted by: Dr. Andrea Waddell, 3rd year Resident at the University of Toronto

As a resident, you receive offers of membership in an endless array of local, national and international organizations often at little or no cost. So, when you already belong to the CPA, APA, OMA and an alphabet soup of letters and acronyms why join the OPA?

Most residents don't know what the OPA is or what it has to offer. As a relatively new member myself, I thought I would run through some of the common questions residents might have about the OPA and becoming a member.

First things first…membership is free for residents, but there may be other questions:

What is the OPA?

The Ontario Psychiatric Association (OPA) is the provincial voice of Ontario's psychiatrists. The OPA promotes professional development, advocates for the mentally ill and their families and represents members to governments, universities and other medical associations.

What can the OPA offer residents?

The OPA provides a number of educational events that are open to residents at a significant discount. For example, this fall Dr. Glen Gabbard will be presenting at a full day conference in Toronto (http://www.eopa.ca/events-oct2005.doc).

In January, the OPA hosts its annual meeting in Toronto. Beginning in 2006, the meeting will include sessions targeted at Members-In-Training (MITs) covering topics such as formulation, emergency management and tackling PDMs. These meetings and the related social events provide MITs with a chance to learn from some leaders in the field as well as the opportunity to meet psychiatrists and trainees from around the province.

Membership with the OPA provides residents with opportunities for education, mentorship and networking and it's free!

But before this starts to sound too much like an infomercial…

Think about joining the OPA and check out the website at: www.eopa.ca . Membership forms are available on the website.

If you have any ideas for OPA Annual Meeting MIT workshops - topics, speakers etc. - please e-mail them to: residents@eopa.ca

Interesting Websites for You to Explore

www.eopa.ca **- Ontario Psychiatric Association**
Online registration for the OPA Fall Conference is now available. Keep checking our website for updates on this and the upcoming Annual Meeting taking place in January 2006. Please visit our website and give us your feedback.

www.emergingintolight.ca - Emerging Into Light focuses on the inclusion of people who have mental illness as part of the community. Rather than focus on the implied negative message, of "anti-stigma", people who have been affected by mental disorders are encouraged to share and celebrate their stories and struggles. The Emerging into Light symbol speaks to the public about recovery and resilience. We are united behind a symbol that says our struggle is important, far from over and needs to be publicly recognized.

www.specialneedsoffenders.org - The institute works to ensure both short and long-term personal and public safety and security by promotion of a variety of improved systems and services for adult and adolescent offenders who are mentally ill and/or developmentally disabled and have other special needs, utilizing the least restrictive and most cost effective and efficient methods possible.

www.caremh.ca - *CAREMH*, the Consortium for Applied Research and Evaluation in Mental Health, is a network of people focused on improving the well-being of persons with serious mental illness (SMI) by promoting applied research, evaluation and knowledge transfer in mental heath services.

www.who.int/mediacentre/news/notes/2005/np14/en/index - The World Health Organization's effort to outline glaring inequalities for people with mental disorders is addressed in this collaborative publication by global experts and stakeholders in mental health, law and human rights.

www.conferencealerts.com - This website lists worldwide conferences by topic or by country. A free email update is available that matches your interest, available dates and preferred locations.

www.camh.net/education/cpe online - Centre for Addiction and Mental Health: Continuing Professional Education (CPE) Online Courses for September - November.

Meet a Council Member

Deborah Elliott, M.D., FRCPC

OPA: What is your current position on the OPA Council and on what committee do you serve?
Deborah: I am a council member and serve on the Advocacy Committee.

OPA: Tell us a bit about your background.
Deborah: My father was a surgeon in the army so my family moved often and I attended schools in Ontario, Nova Scotia and Germany. I finished High School in Kingston, Ontario and did my undergraduate degree, Medical School and internship at Queen's University. I did my residency in psychiatry at the University of Ottawa and worked at the Royal Ottawa Hospital and in Guelph before moving to Yarmouth, Nova Scotia in 1995. We moved back to Kingston Ontario in 2003 when I accepted a position at Queen's University as Chair, Division of Developmental Disabilities in the Department of Psychiatry. I am married to a retired social worker and have two daughters.

OPA: When did you join the OPA and why?
Deborah: I joined the OPA as a resident in the early eighties and attended meetings regularly during the eighties and early nineties. I have presented several times on such topics as Psychiatric Rehabilitation and Mentoring. When I was a resident and early career psychiatrist, John Rassell, Keith Anderson and Edgardo Perez were instrumental in encouraging many young Ottawa psychiatrists to become involved with the OPA over the years and annual meetings were always an enjoyable way to reconnect and network with colleagues. The current council consists of several members of that cohort from Ottawa.

OPA: What has been your most valuable experience as an OPA member?
Deborah: The opportunity to meet colleagues from around the province and share experiences. I have particularly appreciated being able to network with female colleagues. There is a low-key friendly quality to the Annual Meetings and the academic offerings are practical and understandable even to those of us who emphasize clinical service over academic advancement. I also enjoy meeting the senior members of our profession, remembering our history and recognizing the achievements of many intelligent caring psychiatrists who have fascinating stories to share.

OPA: In what ways have you seen the OPA change over the last 10 years?
Deborah: I was out of the province from 1995 to 2003 (the Harris years) and when I returned to Ontario was shocked at the deterioration of our social safety net. The cutbacks in benefits and supports to our most vulnerable citizens are disturbing. I am very pleased that the Advocacy Committee of the OPA has decided to emphasize advocacy for our patients in its mandate. With other groups of Psychiatrists taking the lead for our own financial negotiations there is a real opportunity for the OPA to champion the social concerns of our patients and to highlight the inequities that confront those persons who have psychiatric disabilities.

OPA: What do you think is important for psychiatrists to be aware of in the 21st century?
Deborah: Psychiatrists need to be aware of our history and should read critical accounts of the uses and abuse of the power of psychiatry. We should consider alternate points of views, such as feminism, community development principles and different paradigms of research, including participatory research.

I think psychiatry should continue to emphasize the value of the therapeutic relationship and we should not allow ourselves to become too enamored with the biological models that reduce most conditions to neurotransmitters and receptor sites. Although fascinating, these models are not sufficient to provide the full scope of what is therapeutic in a patient's road to recovery.

OPA: If you weren't a psychiatrist, what other professional endeavour would you be pursuing?
Deborah: During my undergraduate years I was studying mathematics and computing in order to become a systems analyst. I think I would have enjoyed being a forensic accountant or even the Auditor General. I am now taking a Masters in Public Administration so I may yet become a policy analyst or bureaucrat.

OPA: If you had 3 wishes for the profession of psychiatry, what would they be?
Deborah: I wish that we could give up the fee for service method of billing entirely. I wish that we had more resources so that we could better serve those patients who are most vulnerable. And I wish that we had a very large cohort of enthusiastic, idealistic, dedicated young psychiatrists who wanted to work in all parts of the country, including rural areas and general hospital inpatient settings.

Seroquel

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

PHARMACEUTICAL CLASSIFICATION Antipsychotic Agent

INDICATIONS AND CLINICAL USE **Schizophrenia** SEROQUEL (quetiapine) is indicated for the management of the manifestations of schizophrenia. The antipsychotic efficacy of SEROQUEL was established in short-term (5-week) 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 of patients with manifestations of schizophrenia. **Bipolar Disorder – Mania** SEROQUEL is indicated as monotherapy for the acute management of manic episodes associated with bipolar disorder. The efficacy of SEROQUEL in bipolar disorder – mania was established in two 12-week clinical trials of bipolar patients. The safety and effectiveness of SEROQUEL for long-term use, and/or prophylactic use in bipolar disorder has not been evaluated.

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 suppose 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.

PRECAUTIONS **Hyperglycaemia** As with some other antipsychotics, exacerbation of pre-existing diabetes, hyperglycaemia, diabetic ketoacidosis, and diabetic coma including comatal 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-Market Experience). Appropriate clinical monitoring is advisable in diabetic patients and in patients with risk factors for the development of diabetic mellitus. **Hypotension and Syncope** As with other drugs that have high α1-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% (23/2217) of patients treated with SEROQUEL, compared with 0% (0/406) on placebo, and 0.4% (9/2527) 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. Seizures** In controlled schizophrenia 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 1 000 patient years in patients given SEROQUEL, compared with 0.5% or 0.8 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 in schizophrenia 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 T_4 were not associated with systematic changes in TSH or clinical signs or symptoms of hypothyroidism. Approximately 0.4% (12/2595) of patients treated with SEROQUEL (schizophrenia and bipolar studies combined) experienced persistent increases in TSH, and 0.25% of patients were treated with thyroid replacement. **Cholesterol and Triglyceride Elevations** In short-term placebo-controlled schizophrenia trials, SEROQUEL-treated patients showed mean increases from baseline in cholesterol and triglyceride 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 on 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 (see DOSAGE AND ADMINISTRATION). **Transaminase Elevations** During premarketing clinical trials, therapy with SEROQUEL was associated with elevation of hepatic transaminases, primarily ALT (SGPT). Within a clinical trial database of 1892 SEROQUEL-treated schizophrenia patients, with baseline ALT (SGPT) levels <40 IU/L, 5.3% (101/1892) had treatment-emergent ALT (SGPT) elevations to >= 3 (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 500 IU/L. None 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 three months of treatment. Most elevations were transient (50%) while patients continued on SEROQUEL therapy. Of the 101 SEROQUEL-treated patients whose enzyme levels increased to >120 IU/L, 40 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. In the bipolar disorder – mania trials, the proportions of patients with transaminase elevations of > 3 times the upper limits of the normal reference range, was approximately 1% for both SEROQUEL-treated and placebo-treated patients. 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 respect 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 mammary hypertrophy. In the multiple fixed-dose schizophrenia clinical trial there were no differences in prolactin levels at study completion for SEROQUEL across the recommended dose range, and placebo. **Weight Gain** In controlled schizophrenia clinical trials (up to 6 weeks), mean weight gain was approximately 2.5 kg compared to a mean weight gain of 0.1 kilograms in patients taking placebo (n=427). In open-label extension trials, after 6 to 13 weeks of quetiapine monotherapy, the mean weight increase was 1.56 kg (n=170). After 53 to 78 weeks of treatment, the mean weight increase was 1.36 kg (n=137). These data are obtained from uncontrolled, open-label trials; the relevance of these findings to clinical practice is unknown. Weight change was dose appeared to be independent of quetiapine dose (see ADVERSE REACTIONS). In the acute placebo-controlled bipolar mania clinical trials (up to 12 weeks) mean weight gain in patients taking SEROQUEL was 1.8 kg compared to a mean weight loss of 0.1 kg in patients taking placebo. In patients completing the entire 12 weeks of treatment, mean weight gain in patients taking SEROQUEL was 2.8 kg.

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 confident that SEROQUEL therapy does not affect them adversely. **Antiemetic Effect** Consistent with its dopamine antagonistic 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 diseases 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 bipolar disorder and schizophrenia, 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. **The Effect of SEROQUEL on Other Drugs** Alcohol: 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. Antihypertensive Agents: Because of its potential for inducing hypotension, SEROQUEL may enhance the effects of certain antihypertensive agents. Levodopa and Dopamine Agonists: As it exhibits in vitro dopamine antagonism, SEROQUEL may antagonize the effects of levodopa and dopamine agonists. Lithium: The single dose pharmacokinetics of lithium were not altered when coadministered with SEROQUEL. Antipsychotic SEROQUEL did not induce the hepatic enzyme systems involved in the metabolism of amphetamine.

Lorazepam: SEROQUEL did not affect the single dose pharmacokinetics of lorazepam. Divalproex: Co-administration of SEROQUEL (750 mg bid) and divalproex (500 mg bid) increased the mean oral clearance and the mean maximum plasma concentration of total valproic acid (administered as divalproex) by 11%. These changes were not clinically relevant. **The Effect of Other Drugs on SEROQUEL** Hepatic Enzyme Inducers: Concomitant use of SEROQUEL with hepatic enzyme inducers such as carbamazepine may substantially decrease systemic exposure to quetiapine. 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 800 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 another microsomal enzyme inducer, phenytoin, caused five-fold increases in the clearance of quetiapine. Increased doses of SEROQUEL may be required to maintain control of psychotic symptoms in patients co-administered SEROQUEL and phenytoin and other hepatic enzyme inducers (e.g., barbiturates, rifampicin, etc.). The dose of SEROQUEL may need to be reduced if phenytoin or carbamazepine or other hepatic enzyme inducers are withdrawn and replaced with a non-inducer (e.g., sodium valproate). CYP 3A4 Inhibitors: CYP 3A4 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 CYP 3A4, may increase the concentration of SEROQUEL. In one 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 T_{max} 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 2.9 to 6.9 hours, but the mean C_{max} 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 CYP 3A4 inhibitors (such as azole antifungals and macrolide antibiotics). Special consideration should be given if sedation and debilitated patients. The risk-benefit ratio needs to be considered on an individual basis in all patients. Divalproex: Co-administration of SEROQUEL (750 mg bid) and divalproex (500 mg bid) increased the mean maximum plasma concentration of quetiapine by 17% without changing the mean oral clearance. Cimetidine: In a clinical study examining the pharmacokinetics of SEROQUEL following coadministration with cimetidine, (a non-specific P450 enzyme inhibitor), no clinically significant interaction was observed. Divalproex: Coadministration of thioridazine (200 mg b.i.d.) with SEROQUEL (200 mg b.i.d.), increased the clearance of SEROQUEL by 65%. Fluoxetine, Imipramine, Haloperidol, and Risperidone: Fluoxetine (60 mg daily), imipramine (75 mg b.i.d.), haloperidol (7.5 mg b.i.d.), and risperidone (3 mg b.i.d.)

dicted significantly after the steady-state pharmacokinetics of SEROQUEL. **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=39). 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 a more frequent hepatic, renal, ventricular nervous system, and cardiovascular dysfunctions, and more frequent use of concomitant medications, 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 (subclinical) single dose study. 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 benefit 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 The stated frequencies of adverse events represent the proportion of individuals who experienced, at least once, a treatment-emergent adverse event of the type listed. An event was considered treatment-emergent if it occurred for the first time or worsened while receiving therapy following baseline evaluation. The prescriber should be aware that the figures in the tables and tabulations cannot be used to predict the incidence of side effects in the course of usual medical practice where patient characteristics and other factors differ from those that prevailed in the clinical trials. Similarly, the cited frequencies cannot be compared with figures obtained from other clinical investigations involving different treatments, uses, and investigators. The figures cited, however, do provide the prescribing physician with some basis for estimating the relative contribution of drug and nondrug factors to the side effect incidence in the population studied. **Commonly Observed Adverse Events in Short-Term Placebo-Controlled Clinical Trials** Schizophrenia: 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. *Bipolar Disorder - Mania:* In the bipolar mania studies, the following treatment-emergent adverse events, commonly encountered during acute therapy with SEROQUEL, the incidence of at least 5%, and an incidence at least 5% higher than that observed with placebo: somnolence, dry mouth, and weight gain. **Adverse Events Associated with Discontinuation** Short-Term Placebo-Controlled Clinical Trials:

Schizophrenia: Overall, 5.0% of SEROQUEL-treated patients (n=516) discontinued treatment due to adverse events compared with 2.8% of placebo-treated patients (n=208). 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 1.8% of quetiapine-treated subjects, compared to 0.5% of placebo-treated subjects. *Bipolar Disorder - Mania:* Discontinuations due to adverse events were similar for SEROQUEL (5.7%) and placebo (5.1%). Combined Short- and Long-term Controlled Trial Database in Schizophrenia: 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 2.8% 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 leucopenia. 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** Certain portions of the discussion below relating to dose/titration or numeric safety parameters are derived from studies in patients with schizophrenia and have not been duplicated for bipolar mania trials. However, this information is also generally applicable to bipolar mania. 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.

Weight Gain: During acute therapy (up to 6 weeks) in placebo-controlled schizophrenia 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 1.55 kg, after 14 to 26 weeks, 0.26 kg, after 27 to 39 weeks, 1.66 kg, after 40 to 52 weeks, -1.53 kg and after 53 to 78 weeks, 1.36 kg (see PRECAUTIONS). In the acute placebo-controlled bipolar mania clinical trials (up to 12 weeks) mean weight gain in patients taking SEROQUEL was 1.8 kg compared to a mean weight loss of 0.1 kg in patients taking placebo. In patients completing the entire 12 weeks of treatment mean weight gain in patients taking SEROQUEL was 2.8 kg. **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 -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 in schizophrenia, postural hypotension was reported with an incidence of 6% in SEROQUEL-treated patients compared to 2% in placebo-treated patients. SEROQUEL was associated with a mean baseline to endpoint increase in heart rate of 5.8 beats per minute, compared to 1.6 beats per minute among placebo-treated patients. **Laboratory Changes:** As with other anti-psychotics, leucopenia and/or neutropenia have been observed in patients administered SEROQUEL. Occasionally eosinophilia has been observed. There were no cases of persistent severe neutropenia or agranulocytosis reported in controlled clinical trials with SEROQUEL. Asymptomatic elevations in serum transaminases (SGOT [AST], SGPT [ALT]) or -GT levels have been observed in some patients administered SEROQUEL. These elevations were usually reversible on continued SEROQUEL treatment (see PRECAUTIONS). Small elevations in non-fasting serum triglyceride levels and total cholesterol have been observed during treatment with SEROQUEL (see PRECAUTIONS). SEROQUEL treatment was associated with small dose-related decreases in thyroid hormone levels, particularly total T_4 and free T_4. The reduction in total and free T_4 was maximal within the first 2 to 4 weeks of quetiapine treatment, with no further reduction during long-term treatment. There was no evidence of clinically significant changes in TSH concentration over time. In nearly all cases, cessation of quetiapine treatment was associated with a reversal of the effects on total and free T_4, irrespective of the duration of treatment (see PRECAUTIONS). Smaller decreases in total T_3 and reverse T_3 were seen only at higher doses. Levels of TBG were unchanged and in general reciprocal increases in T3H were not observed, with no indication that SEROQUEL causes clinically relevant hypothyroidism. **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 3- to 6-week placebo-controlled clinical trials for the treatment of schizophrenia revealing a 7% (93/999) incidence for SEROQUEL compared to 0.8% (1/119) incidence for placebo. SEROQUEL use was also 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). In bipolar disorder - mania trials, the proportion of patients meeting the criteria for tachycardia was 8.9% (74/832) for SEROQUEL compared to 8% (24/76) for placebo. **Extrapyramidal Symptoms (EPS):** Table 2 enumerates the percentage of patients with treatment-emergent extrapyramidal symptoms (i.e. short-term acute phase clinical trial in patients with schizophrenia comparing five fixed doses of SEROQUEL with placebo (= ~ 50 patients per group), as assessed by: 1) spontaneous complaints of parkinsonism (extrapyramidal syndrome, hypertonia, tremor and cogwheel rigidity), or akathisia; 2) Simpson-Angus scores (mean change from baseline); and 3) use of anticholinergic medication to treat emergent EPS.

Table 2 Treatment-Emergent Extrapyramidal Symptoms, Assessed By Spontaneous Reports, Simpson Scale, and Incidence of Anticholinergic Use

		SEROQUEL				
	placebo	75 mg	150 mg	300 mg	600 mg	750 mg
Spontaneous Reports of Parkinsonism Symptoms*	10%	6%	4%	4%	8%	4%
Spontaneous Reports of Akathisia	8%	2%	2%	8%	8%	2%
Simpson Scale	- 0.6	- 1.8	- 1.2	- 1.6	- 1.8	- 1.8
Incidence of Anticholinergic Use	14%	11%	13%	8%	12%	11%

*Patients may have had more than one parkinsonism adverse event

There were no differences between the SEROQUEL and placebo-treatment groups in the incidence of EPS or concomitant use of anticholinergics and no evidence of dose-related increase in EPS or in the use of concomitant anticholinergics across the dose range of 75 – 750 mg/day. In 2 bipolar disorder - mania placebo-controlled clinical trials using variable-doses of SEROQUEL, there were no differences between the SEROQUEL and placebo treatment groups in the incidence of EPS, as assessed by Simpson-Angus total scores and Barnes Akathisia rating scale, spontaneous complaints of EPS and the use of concomitant anticholinergic medications to treat EPS.

Post-Market Experience During post-marketing experience, leucopenia and/or neutropenia have been reported during SEROQUEL treatment. Precipitous drop in leucocyte and/or neutrophil counts including pre-existing low white cell count and history of drug induced leucopenia and/or neutropenia. 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. A causal relationship to SEROQUEL has not been established.

SYMPTOMS AND TREATMENT OF OVERDOSAGE **Clinical Trials** In clinical trials, experience with SEROQUEL (quetiapine) in overdosage is limited. Estimated doses of up to 28 g of SEROQUEL have been taken, no fatalities were reported and patients recovered without sequelae. **Postmarketing** In postmarketing experience, there have been cases of coma and death in patients taking a SEROQUEL overdose. The lowest reported dose associated with coma has been in a patient who took 5 g and had a full recovery within 3 days. The lowest reported dose associated with a death was in a patient who took 6.8 g. In general, reported signs and symptoms were those resulting from an exaggeration of the drug's known pharmacological effects (e.g., drowsiness and sedation, tachycardia and hypotension. **Treatment** There is no specific antidote to quetiapine. In cases of severe intoxication, the possibility of multiple drug involvement should be considered, and intensive care procedures are recommended including establishing and maintaining a patent airway, ensuring adequate oxygenation and ventilation, and monitoring and support of the cardiovascular system. Close medical supervision and monitoring should be continued until the patient recovers.

DOSAGE AND ADMINISTRATION **Schizophrenia** The usual starting dose of SEROQUEL (quetiapine) is 25 mg b.i.d., titrated with increments of 25-50 mg b.i.d. per day, as tolerated, to a target dose of 300 mg/day given b.i.d. within four to seven days. Further dosage adjustments may be indicated depending on the clinical response and tolerability in the individual patient. Dosage adjustments should generally occur at intervals of not less than 2 days, as steady state for SEROQUEL would not be achieved for approximately 1 -2 days in the typical patient. When adjustments are necessary dose increments/decrements of 25-50 mg b.i.d. are recommended. SEROQUEL can be administered with or without food. Clinical trials suggest that the usual effective treatment dose will be in the range of 300-600 mg/day. However, some patients may require as little as 150 mg/day. The safety of doses above 800 mg/day has not been evaluated. The need for continuing existing EPS medications should be re-evaluated periodically as SEROQUEL has not been associated with treatment-emergent EPS across the clinical dose range.

Bipolar Disorder - Mania Oral Dose: The titration rate, based on the clinical trials is shown in the table below:

Day	1	2	3	4	5	6
BID	100 mg/day	200 mg/day	300 mg/day	400 mg/day	Up to 600 mg/day	Up to 800 mg/day

Dosage adjustments should be made depending on the clinical response and tolerability in the individual patient. Approximately 69% of patients responded between 400 and 800 mg/day, while over 58% of patients responded between 600 and 800 mg/day (the average median dose for responders during the last week of treatment was approximately 600 mg/day). The safety of doses above 800 mg/day has not been evaluated. **Elderly** In clinical trials, 39 patients with schizophrenia or related disorders, 65 years of age or over, were treated with SEROQUEL (see PRECAUTIONS). Given the limited experience with SEROQUEL in the elderly, and the higher incidence of concomitant illness and concomitant medication in this population, SEROQUEL should be used with caution. The mean plasma clearance of SEROQUEL was reduced by 30% to 50% in elderly subjects when compared to younger patients. The rate of dose titration may thus need to be slower, and the daily therapeutic target dose lower, than that used in younger patients. **Hepatic Impairment** Quetiapine is extensively metabolized by the liver. Therefore, SEROQUEL should be used with caution in patients with mild hepatic impairment, especially during the initial dosing period. Patients with mild hepatic impairment should be started on 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 to severe hepatic impairment. However, should clinical judgement dictate treatment with SEROQUEL necessary, the drug should be used with great caution in patients with moderate or severe hepatic impairment (see PRECAUTIONS). **Renal Impairment** No clinical experience in lacking, caution is advised (see PRECAUTIONS).

PHARMACEUTICAL INFORMATION **Composition** SEROQUEL is available in 5 strengths containing 25, 100, 150, 200 or 300 mg quetiapine per tablet (as quetiapine fumarate). The core of the tablet contains the excipients povidone, calcium hydrogen phosphate, microcrystalline cellulose, sodium starch glycolate type A, lactose monohydrate and magnesium stearate. The coating of the tablet contains hydroxypropyl methylcellulose 2910, polyethylene glycol 400, titanium dioxide, yellow ferric oxide (25 mg, 100 mg and 150 mg tablets) and red ferric oxide (25 mg tablets).

AVAILABILITY OF DOSAGE FORMS SEROQUEL (quetiapine) is available as film-coated tablets containing quetiapine fumarate equivalent to 25 mg, 100 mg, 150 mg, 200 or 300 mg of quetiapine free base as follows: 25 mg quetiapine tablets are peach coloured, round, biconvex, intaglioed with "SEROQUEL" and "25" on one side and plain on the other, available in blister packages of 60 tablets and high-density polyethylene (HDPE) bottles of 100 tablets. 100 mg quetiapine tablets are yellow coloured, round, biconvex, intaglioed with "SEROQUEL" and "100" on one side and plain on the other, available in blister packages of 56 tablets and HDPE bottles of 100 tablets. 150 mg quetiapine tablets are pale yellow coloured, round, biconvex, intaglioed with "SEROQUEL" and "150" on one side and plain on the other, available in HDPE bottles of 100 tablets. 200 mg quetiapine tablets are white, round, biconvex, intaglioed with "SEROQUEL" and "200" on one side and plain on the other, available in blister packages of 56 tablets and HDPE bottles of 100 tablets. 300 mg quetiapine tablets are white, capsule-shaped, biconvex, intaglioed with "SEROQUEL" on one side and "300" on the other, available in HDPE bottles of 100 tablets.

Full Product Monograph available upon request.

REFERENCES: 1. Seroquel® Product Monograph. AstraZeneca Canada Inc., November 2004 **2.** Arvanitis LA, Miller BG. Seroquel Trial 13 Study Group. Multiple fixed doses of "Seroquel" (quetiapine) in patients with acute exacerbation of schizophrenia: a comparison with haloperidol and placebo. Biol Psychiatry 1997;42(4):233-46. **3.** Small JG, Hirsch SR, Arvanitis LA et al. Quetiapine in patients with schizophrenia. A high- and low-dose double-blind comparison with placebo. Arch Gen Psychiatry 1997;54:549-57. **4.** Velligan DI, Newcomer J, Pultz J, et al. Does cognitive function improve with quetiapine in comparison to haloperidol? Schizophrenia Research 2002;53:239-48.

Seroquel® Quetiapine

AstraZeneca

AstraZeneca Canada Inc., 1004 Middlegate Road, Mississauga, Ontario L4Y 1M4

2004-413E

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

Body system and COSTART Term	Percentage of subjects with adverse events*	
	Quetiapine (n = 449)	Placebo (n = 202)
Whole body		
Headache	20	17
Abdominal pain	4	1
Back pain	3	1
Fever	2	1
Nervous system		
Somnolence	18	11
Dizziness	10	4
Digestive system		
Constipation	9	5
Dry mouth	7	2
Dyspepsia	6	2
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		
Ear pain	1	0

*Subjects may have had more than one adverse event.

schizophrenia

Up to 800 mg[1]*

...and who knows how many calls to mom?

Significant improvement in:

- Positive and negative symptoms[2,3]
- Cognitive function (p< 0.03 vs. haloperidol)[4]**
- Total BPRS† score[2,3]††

Titrate with confidence[1]:

- EPS side effects and prolactin levels comparable to placebo through its dose range (in controlled clinical trials)
- Weight change minimal and dose independent (in controlled clinical trials)

℗ Seroquel®
Quetiapine

Aim High

Seroquel® is indicated for the management of the manifestations of schizophrenia. The efficacy of Seroquel® in long-term use has not been evaluated in controlled clinical trials.

Eye examinations are recommended prior to, or shortly after initiation of treatment, and at 6 month intervals thereafter. Caution should be used in the elderly and those with known hepatic or renal impairment. The most common adverse events associated with Seroquel® were somnolence, dizziness, dry mouth, postural hypotension and elevated ALT (SGPT) levels. Please see the Product Monograph before prescribing.

* Dose increments of 25 mg to 50 mg BID to a target dose of 300 mg/day given BID within 4-7 days. Further dosage adjustments may be indicated depending on the clinical response and tolerability in the individual patient. Clinical trials suggest that the usual effective treatment dose is 300 – 600 mg/day. Further dose adjustments should generally occur at intervals of not less than 2 days. Safety and efficacy have not been evaluated beyond 800 mg/day.

** In a 24 week study comparing Seroquel® 600 mg versus haloperidol 12 mg (n=58).

† Brief Psychiatric Rating Scale.

†† Randomized, double-blind, multicentre, placebo-controlled 6 week trial, (n=280). Significant differences between Seroquel and placebo for both efficacy variables (BPRS p<0.001), CGI (p=0.003), and BPRS positive symptom cluster (p=0.003). Symptoms examined as clusters in composite endpoints of positive and negative symptoms.