President’s Message

It certainly has been a very eventful year to date. Members who were fortunate to attend our Fall Conference enjoyed an inspiring presentation by Nancy McWilliams, PhD. I extend my thanks to the Fall Conference committee members and their chairperson, Dr. Tina Chadda, for an excellent CME. Our efforts and attention are now keenly focused on our Annual Conference. I’d encourage your attendance at this historic provincial conference, marking 90 years of commitment to our profession and to the patients we serve. I look forward to meeting you when we assemble on April 23 & 24, 2010, in Toronto at the King Edward Hotel, for what promises to be an exceptional event. I’d also like to express my appreciation to Dr. John Deadman for his diligence as our archivist. You will certainly see the results of his tireless efforts in future publications and at our Spring Conference.

This summer has been a very productive time for the OPA as we responded to the Ontario Health Minister’s 10-year plan for transforming mental health care and addiction services. The OPA and OMA psychiatry members attended the Summit on July 13 & 14, which sought to gather together key stakeholders to discuss the strategic plan that was, curiously, not released in advance of the meeting. I also attended the inter-ministerial committee, which was meeting in tandem with the government ‘town hall’ and to which I gave a detailed response to this discussion paper. I also submitted a formal response highlighting my key concerns. I did endorse the portions of the “Every Door is The Right Door” which I felt enhanced care provision. I strongly objected to its minimization of the critical importance of treatment. I also thought its blurring of the clinical line between ‘life experiences’, system navigators and formal therapy was unacceptable and required a clear rethink. We certainly agree that providers and those with “lived experience” have valuable roles to play but the scope of responsibilities and competencies needs to be clearly defined and not obscured.

I think it is telling that the Ministry is “transforming” the system. They are not oiling the mechanism or fine-tuning the apparatus. This is a proposed major overhaul of care delivery done with no new funding. In their discussion document they correctly note that $1 spent on mental health care and addiction saves $7 dollars in health cost, $30 in social expenses and lost productivity. This would certainly seem to be a very prudent capital investment. In fact, I could not think of a more effective stimulus expenditure. This glaring inconsistency is the key reason why many key providers we networked with during these forums viewed this process with a healthy dose of skepticism. Our challenge is to not have this well-intended initiative become yet another leather bound volume in the denial, wish and obscurity series.

Stigma is identified as a major barrier to engagement. Unfortunately they offer very few solutions. They do not appear prepared to invest in the aggressive public education campaign required to challenge fallacies and misconceptions. They also failed to acknowledge that psychiatrists share a stigma with our patients as care providers to the vulnerable and marginalized portion of the population. This document, at times, seems to perpetuate this provider stigma and its prevailing mythology with references such as “provider-centered care” and a need to be “proactive and not reactive”. It also appears to reproach frontline staff for the silos in the system, many of which have been created by funding models that lead to unnecessary duplication and redundancy. It also fails to appropriately acknowledge the many innovations in mental health care that have advanced service delivery. These critical initiatives have often been lead by psychiatrists.

continued on page 7
From the Editor

THE OPA started its fall season on a high note with the Psychotherapy Section’s very successful Fall Conference. OPA members and guests experienced an outstanding presentation by our guest speaker – Dr. Nancy McWilliams. Congratulations to Dr. Tina Chadda and her committee for organizing such an excellent event! Please see our photos from the Conference on the central spread of this issue.

The 2010 Annual Conference is fast approaching, and if you are interested in submitting an abstract, please refer to the guidelines on page 3.

In this issue of Dialogue you will find much that is new and informative. We welcome your articles, book reviews, clinical cases and any material related to OPA history.

Halyna Troian, CAE
Editor

CONGRATULATIONS

To Dr. Susan Abbey – recipient of the 2009 RCPSC RAC 3 Prix d’excellence Award
Dr. Susan Abbey served as OPA President in 2006.

CPA PRESIDENT’S COMMENDATION

Dr. Doug Weir (OPA Member),
Dr. Bob Buckingham (OPA President, 2003),
Dr. Richard O’Reilly (OPA President, 2007) and
Dr. Sonu Gaind (OPA President, 2008)
were recognized as founding members of the Coalition of Ontario Psychiatrists for their dedication and leadership in developing the Coalition. This group has helped psychiatrists communicate on the policy issues effecting psychiatric care in Ontario. The Coalition has had great success in improving the working conditions for psychiatrists and consequently improving access for patients to psychiatric care.

FELLOWS OF THE CPA

The honour of Fellow of the CPA was bestowed upon nine CPA member psychiatrists in recognition of their exemplary contributions towards excellence in psychiatry.

The CPA’s 2009 Fellows are:
Dr. Joseph Joel Jeffries (OPA Member);
Dr. Donald A. Wasylenksi; Dr. Gary Hnatko;
Dr. Raymond Lam; Dr. Phillippa Moss;
Dr. Margaret Steele (OPA President, 2002);
Dr. Dhanapal Natarajan;
Dr. Deborah Elliott (OPA Treasurer) and
Dr. David Goldbloom (OPA Member).

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Please mark your calendars for the

OPA 2010 ANNUAL CONFERENCE

April 23 & 24, 2010
Toronto, Ontario
Le Méridien King Edward Hotel

Stay tuned for our further announcements of the conference program and registration form!

ONTARIO PSYCHIATRIC ASSOCIATION (OPA)
2010 ANNUAL CONFERENCE
CALL FOR ABSTRACTS

The OPA Conference Organizing Committee is accepting submissions in the following categories:

SYMPOSIUM (2.0 – 2.5 hours)
Ideally, a symposium should include several participants from different institutions, areas of the province or disciplines.

WORKSHOP (1.5 – 2.0 hours)
Workshops focus on specific topics and are particularly aimed at skill transmission including case analysis, skills building or role-play.

PANEL DISCUSSION (1.5 – 2.0 hours)
Two or more speakers state their respective viewpoints on a subject. The discussion is moderated, and questions from the floor may be asked.

VIDEO SESSION (45 – 60 minutes)
Videos related to psychiatric disorders and mental health issues. The presenter will be asked to introduce and lead a discussion regarding their video.

POSTER SESSION
There will be a formal poster session (time to be determined), but we ask that posters be on display throughout the meeting.

N.B. Under Maintenance of Certification (MOC) Guidelines, all submissions must allocate a minimum of 25% of the time for audience interaction (i.e. discussion period, Q & A).


The official submission form may be downloaded from the OPA web site: www.eopa.ca
n April 2010, the Ontario Psychiatric Association will be officially 90 years old. We plan to celebrate this event at the next Annual meeting which has been moved to April at least partly to commemorate this event. The meeting will be held at Le Méridien King Edward Hotel on the 23rd and 24th of April which is only a few days after the anniversary of the first meeting on the 20th of April, 1920. We will be presenting on the history of the OPA and the history of psychiatry in Ontario and in Canada as well as discussing some of the similarities and differences in clinical practice over that 90 years.

In the next few issues of Dialogue we will be giving an overview of the history of the Ontario Psychiatric Association and its forerunner the Ontario Neuro-Psychiatric Association and the social and political environment in which they developed. This will be done by decades.

1920-1930
POST FIRST WORLD WAR. EXPANSION OF SERVICES.
In 1920, the Great War (World War I) was over for just over a year. Dr. Edward Ryan, the medical superintendent of the O.H. Kingston, (formerly the Rockwood Asylum) invited a large group of people from the other mental hospitals to a meeting where they decided to form the Ontario Neuro-Psychiatric Association. Dr. Ryan became its first President.

In those days the asylums or public mental hospitals made up almost the entire system for mental health care, although there were a few private clinics or small hospitals, and one larger private hospital, The Homewood Sanitarium in Guelph. (It was founded as the Homewood Retreat in 1883.) There were 9 public mental hospitals, formerly known as “asylums” but now renamed “Ontario Hospitals for the Insane”. They were located in Toronto (originally the Toronto Asylum, opened in 1850), Langstaff (originally a satellite of the Toronto Asylum, it had been opened in the 1860s but was not open consistently since), Kingston (“Rockwood Asylum”, Portsmouth, 1870), London (1870), Hamilton, (first called the “Hospital for Inebriates”, but within a year or so renamed the “Hamilton Asylum”, 1876), Orillia (“Hospital for the Feeble Minded”, 1878), Brockville (1896), Mimico, (later OH New Toronto and Lakeshore Psychiatric Hospital. It was originally built to serve northern Ontario, 1899) and Whitby (1920). General hospital psychiatric units, as we know them today, did not exist.

The Ontario Hospital Whitby had just opened to replace OH Toronto (Queen Street). Dr. J. M. Forster, the medical superintendent of the Ontario Hospital for the Insane Toronto, moved a few hundred patients to the new buildings in a former farmer’s field near Port Whitby in the fall of 1919 and officially opened the new hospital on January 1st, 1920 and became its first medical superintendent. He also attended the first meeting in Kingston at which the ONPA was formed and was the second President in 1921. Interestingly, because of overcrowding and pressure on the system, the OH Toronto was not closed as planned. It continues on as the Queen Street mental health Centre and now the Queen Street campus of the Centre for Addictions and Mental Health.

It was a time of expansion and optimism in the mental hospital service. Things were expanding and the future looked promising. At a time before universal health care, only a few of the best known senior neurologist/psychiatrists, usually in large cities, could survive in private practice. Most of the others were employed in the provincial mental hospitals or in other areas of public or hospital service.

Further articles will discuss the next 8 decades of the OPA’s history. A capsule summary follows:

1930-1940
THE GREAT DEPRESSION AND SHADOW OF WAR.
The Great Depression started with the stock market crash in October 1929 but did not really bite most people until 1930 and 1931. During this time, governments were cutting back everything, while demands for service were rising. The mental hospitals not only had funding and staffing cuts, they were under great pressure for admissions from many people who had no other place to go. This has sometimes been described as the beginning of the 3 decades of neglect of the mentally ill.

1940-1950
THE SECOND WORLD WAR AND THE POSTWAR RECOVERY.
During the war, further staff were lost and pressure on mental health services continued to rise. By the end of the conflict, conditions were even worse. Even though there was economic expansion after the war, this period could be described as the second decade of neglect.

1950-1960
THE KOREAN WAR AND THE BRAIN-WASHING EXPERIMENTS.
This was the third decade of neglect. In 1956, the ONPA changed its name to the OPA. By 1959, the overcrowding in the mental hospitals had reached its peak. In the aftermath of the Korean War, there was a great hue and cry about “Brain-washing”. In that year there were over 400 patients in Ontario mental hospitals for every 100,000 population. The cry for drastic reform was building in every country.
1960-1970
**The Reform of Health Care. Expansion of Services.**
This decade was marked by drastic reforms on every level. In 1961 in the U.S.A. a Congressional Committee had published “Action for Mental Health” calling for drastic reforms. In 1963, the Canadian Mental Health Association with considerable federal support published “More for the Mind” which also called for reforms. In 1964, the Royal Commission on Health Services reported to Parliament recommending universal medicare, including full coverage for psychiatric services. Parliament adopted it with all party support and Medicare was born pumping federal money into the system. Mental Health Legislation reform began in Ontario in 1967. Suddenly it was in the interests of the provinces to develop new services. But mental hospitals were not covered by federal cost-sharing so all the new resources went elsewhere. The decline of the mental hospitals had begun.

1970-1980
**The Growth of the Mental Health Reform Movement.**
The big thrust was community care. Many were advocating that costs could be cut by closing all the mental hospitals and treating everyone as an out-patient. Groups like the Scientologists and the Mental Health Consumer movement were advocating the shut-down of all psychiatric services or a take-over by consumers (consumer-survivors?).

1980-1990
**Cost Containment and Reform Gone Mad.**
By 1980, the rapid expansions of all health services had threatened to outstrip even the generous funding provided by the feds. People became aware of the rising costs; health care costs had risen in Canada from about 7% of Gross Domestic Product to well over 9%. Governments became obsessed with cost-containment. In the U.S., the adoption of ‘Managed Care’ put mental health services at a particular disadvantage. In Canada, drastic cut-backs in many areas not only threatened services but had the paradoxical effect of increasing costs in the long-run. For the Mental Health Service in Ontario, it was a fight for survival.

1990-2000
**The Decade of the Brain.**
Research had been developing rapidly ever since the 1930s and despite some very bad treatments (e.g. psycho-surgery) the whole practice of psychiatry and mental health care had progressed dramatically. The World Health Organization announced this decade as “The Decade of the Brain.”

2000-2010
**The Chickens Come Home to Roost. Expansion Again.**
With much improvement in knowledge of mental illness and better treatments, it became apparent that the cost-cutting reforms had worsened the system. Governments began to realize that things had been pushed too far and a gradual improvement in conditions occurred. But with past experience as our guide, we must be very aware from where we have come and ever vigilant to prevent the mistakes of the past.

John C. Deadman, MD, DPsysch, FRCP(C)
Archivist
PHYSICIAN’S HEALTH: it’s important and it matters

M y father, a retired surgeon, often remarks about how good it is that we are helping sick colleagues get help rather than just making sure they don’t make major clinical mistakes. I have been working at the OMA’s Physician Health Program (PHP) as Associate Medical Director for the past few years and have had the privilege of talking to many physicians who struggle with mental health issues. This past February, I was invited to speak at the Ontario Psychiatric Association’s Annual Conference about our programs and in particular our approach to the ‘disruptive’ physician.

Physicians are actually very healthy compared to the general population and some other professional groups. However, physicians tend to suffer from mental health problems, including substance use disorders, at roughly the same level as the general population. Our training, our position in the health care team and perhaps the dispositional traits that make us successful as physicians may in fact mask our human vulnerability and hinder our decision to seek help or medical attention.

Physician health programs often focus on illness prevention, stress reduction, burnout and ways of improving resilience. There is a continuing need for education and awareness about addressing the ill medical trainee or physician.

In addition to providing seminars on these topics, the PHP also connects physicians and trainees to appropriate community resources and we work together with colleagues and/or medical leaders to help suffering doctors who cannot reach out for themselves. Some physicians or trainees require ongoing monitoring and accountability and we often monitor physicians who require a comprehensive program to satisfy regulatory or training requirements.

Emerging evidence points to excellent long-term outcomes for doctors who get treatment and 5-year monitoring for substance dependence. In a recent publication we detailed the outcomes of 100 physicians with substance dependence, 71% never had a relapse and 85% successfully completed the program in good recovery (Brewster et al. BMJ 2008;337:a2098). Less is known about long-term outcomes of physicians with psychiatric disorders such as recurrent major depression and bipolar disorder, and in a upcoming CJP publication (Albuquerque et al. 2009 (Nov) CJP in press) we describe program outcomes for physicians monitored for recurrent major depression and bipolar disorder. In this population, recurrence is the rule and those with comorbid psychiatric conditions appear to be an increased risk for recurrence.

A relatively newer topic is the poorly named ‘disruptive physician’. These physicians who come to regulatory attention due to behavioural concerns generally do not have an undetected DSM – IV Axis I disorder. Psychiatrists are attuned to fact that behavioural problems within a workplace are frequently the result of system-wide issues and are not simply attributable to one individual. In the session, we had a lively discussion around the pressures medicine as a whole faces as well as the multiple drivers affecting this focus on behaviour in the workplace. The CPSO task force has published a document to help guide institutions and leaders about a reasonable approach to problematic behaviour that endeavours to respect physicians and protect the public, including colleagues and employees (http://www cpso.on.ca/policies/guidelines/default.aspx?id=2180).

The OMA physician health program has been involved in a number of these cases and we are now developing a program (the Physician Workplace Support Program) dedicated to providing broad resources including rehabilitative programs to support the physician and the workplace as they navigate these complex issues.

PHYSICIANS TEND TO SUFFER FROM MENTAL HEALTH PROBLEMS, INCLUDING SUBSTANCE USE DISORDERS, AT ROUGHLY THE SAME LEVEL AS THE GENERAL POPULATION.

THERE IS A CONTINUING NEED FOR EDUCATION AND AWARENESS ABOUT ADDRESSING THE ILL MEDICAL TRAINEE OR PHYSICIAN.

PSYCHIATRISTS ARE BEING CALLED UPON TO PLAY A KEY ROLE WITH ASSESSMENT AND/OR TREATMENT OF OUR COLLEAGUES.

In most aspects of physician health psychiatrists are being called upon to play a key role with assessment and/or treatment of our colleagues. Because physicians characteristically present ‘late’ in their illness course, access to timely resources is important and sometimes life-saving. Due to the safety sensitive nature of a physician’s work, there are a number of relevant issues that treating clinicians need to consider during the course of treatment. There is a need to clarify issues around symptoms and impairment, as well as to clarify the best way to plan a return to work.

You can contact the PHP confidentially if you have questions or concerns at 1-800-851-6606 or visit our website: www.phpoma.org.

Joy Albuquerque, MA, MD, FRCP(C)
Associate Medical Director
Physician Health Program
Ontario Medical Association
The OMA continues to revise its proposed new methodology (the Comparison of Average Net Daily Income, or CANDI model) for determining 2010 and 2011 relativity allocations. The Section on Psychiatry presented to the relativity Working Group in early October and articulated our ongoing concerns about the original CANDI model, most importantly the lack of any modifier accounting for increased complexity or skills associated with increased years of specialist versus family practice training. At that meeting, the Working Group Chair continued to maintain the CANDI model could not and would not incorporate any such ‘complexity’ factor.

However, the subsequent revised report the Working Group released did include a new “Skills Acquisition Modifier”, or SAM, which placed a value on additional years of minimum required post-graduate training [a factor of 4% per year of training, which is consistent with the value placed by the British Columbia relativity model, information the Section cited in supporting our arguments]. The revised model now has both a ‘training modifier’ and a ‘SAM’ modifier for additional years of training. It describes the training modifier of lost opportunity cost as “… a null or leveling modifier that equalizes… expected discounted lifetime income…”, and specifically differentiates that from the new SAM that “represents a true differential between specialties with different years of training due to additional skills gained…”. This is precisely what the Section had been arguing for.

This represents a 180 degree shift in the Working Group’s position on this issue. Successfully pressuring the Working Group to change its stance, despite months of resistance, shows the strength of arguments and effectiveness of the campaign we were able to mobilize to ensure the OMA acknowledged value of additional specialty training.

While no methodology is without its imperfections, acknowledging added complexity/skills with the new SAM factor is a significant positive improvement in CANDI that addresses the Section’s strongest criticism of the original CANDI model. The Working Group will present its report to OMA General Council in late November, the decision regarding continuing with the existing RVIC model or adopting the new CANDI model for 2010 relativity allocations will be made by OMA General Council at that meeting.

Lastly, by the time you read this you should already have benefited from the relativity increase associated with 2009 allocations, which were scheduled to be implemented October 1. As per previous correspondence, the 3% ‘top up’ was to stop October 1, and be replaced by psychiatry’s total allocation increase of 9.5% (distributed amongst various codes, as previously communicated) [by comparison, groups not receiving any relativity allocation in 2009 only received a 2.5% increase].

K. Sonu Gaind, MD, FRCP(C)
Past President, Ontario Psychiatric Association
Tariff Chair, OMA Section on Psychiatry

The definition of recovery in this report must be expanded. It currently reads, “The recovery approach looks at the whole person and defines the person positively, focusing on their strengths and goals rather than their illness”. Is it not possible to do both? I think recovery is definitely more than just the absence of disease and I hope this was the authors’ intended message. Can we not address treatment and highlight individual strengths and goal-based initiatives concurrently? The role of the countless numbers of psychiatrists conveying quality mental health care in private practice appear to have been overlooked. What will be their role in this “transformed system”. These and many other key concerns can only briefly be captured in this response.

We are committed to labouring with inter-governmental agencies on this ambitious plan. It is our desire to partner with key stakeholders to promote change that is thoughtful, progressive and sustainable. We are motivated professional partners who wish to collaborate with other care providers, families and individual patients to create accepting and caring communities. We will actively seek a voice on behalf of members to make appropriate changes that optimize the health and well being of those in need. We will also stress the need for accountability of our elected officials and their appointed bureaucratic representatives to fund a system in such a manner that the goals articulated can be obtained. We build on a rich history and many past successes and look forward to facilitating meaningful dialogue. We wholeheartedly agree with the minister that there is no health care without mental health care. We hope this ministry’s expressed goals will be adequately resourced to achieve these objectives. With the appointment of Deb Matthews as the new Ontario Minister of Health and Long Term Care we hope this momentum will not be lost.

P. Mulzer, MD, FRCP(C)
President, Ontario Psychiatric Association
OPA 2009 Psychotherapy Section’s Fall Conference.

[Images of people at a conference setting]
OPA Conference Planning Committee and Executive (l-r) — Jon Novick, Madhu Vallabhaneni, Doron Almagor (OPA President-Elect), Nancy McWilliams (Guest Speaker), Tina Chadda (Committee Chair), Paul Mulzer (OPA President), Sonu Gaind (OPA Past President).
Clinical Vignette

Matt S. is a 17 year old high school senior who is abandoned by his friends in the ER waiting room of your local, rural hospital. He is immediately attended by triage staff who note the following presentation: pulse 150 bpm and regular, blood pressure 119/96, temp 40.3 C. He is obtunded, clammy, diaphoretic and appears moderately dehydrated. He is wearing a fluorescent bracelet and a soother!

As per protocol you begin the ABC of resuscitation, he is rapidly cooled and rehydrated. His oxygen saturations are excellent. Of course, as part of your evaluation you perform a neurological assessment and note pinpoint pupils. You give him a trial of naloxone and he rouses and you start a protocol to address his opiate overdose as well as his hyperthermic state induced by ecstasy. If you had overlooked his severe opiate intoxication which includes Oxycontin, Percocet and Morphine, in addition to street methadone, he may not have survived the night. In this community hospital his urine drug screen, when available, confirms your diagnostic impression but arrives at a time when it cannot influence your decision making. This is like confirming your diagnostic impression but arrives at a time when it cannot influence your decision making. This is like conferring your diagnostic impression but arrives at a time when it cannot influence your decision making. This is like conferring your diagnostic impression but arrives at a time when it cannot influence your decision making. This is like conferring your diagnostic impression but arrives at a time when it cannot influence your decision making. This is like conferring your diagnostic impression but arrives at a time when it cannot influence your decision making. This is like conferring your diagnostic impression but arrives at a time when it cannot influence your decision making. This is like conferring your diagnostic impression but arrives at a time when it cannot influence your decision making. This is like conferring your diagnostic impression but arrives at a time when it cannot influence your decision making. This is like conferring your diagnostic impression but arrives at a time when it cannot influence your decision making. This is like conferring your diagnostic impression but arrives at a time when it cannot influence your decision making. This is like conferring your diagnostic impression but arrives at a time when it cannot influence your decision making. This is like conferring your diagnostic impression but arrives at a time when it cannot influence your decision making. This is like conferring your diagnostic impression but arrives at a time when it cannot influence your decision making. This is like conferring your diagnostic impression but arrives at a time when it cannot influence your decision making. This is like conferring your diagnostic impression but arrives at a time when it cannot influence your decision making. This is like conferring your diagnostic impression but arrives at a time when it cannot influence your decision making. This is like conferring your diagnostic impression but arrives at a time when it cannot influence your decision making. This is like conferring your diagnostic impression but arrives at a time when it cannot influence your decision making. This is like conferring your diagnostic impression but arrives at a time when it cannot influence your decision making. This is like conferring your diagnostic impression but arrives at a time when it cannot influence your decision making. This is like conferring your diagnostic impression but arrives at a time when it cannot influence your decision making. This is like conferring your diag

Take Home Messages:

1. Modern raves often include participants raiding the medicine cabinet dumping pills into a bowl and taking out

2. The modern face of psychiatry will involve an enhanced understanding of concurrent disorders. In fact, over time this term will be replaced by comprehensive psychiatric care which will be understood to include both disciplines.

3. A percentage of your refractory patients have an undiagnosed substance use disorder and the higher their status the less likely it will be diagnosed. A sleep disorder may accompany this and may be secondary to substance concerns.

P. Mulzer, MD, FRCP(C)
President, Ontario Psychiatric Association

The Importance of Psychotherapy in Psychiatric Training

After attending the Fall OPA Psychotherapy Conference, one may reflect upon the importance of Psychotherapy training in a Psychiatry Residency. For many years, Nancy McWilliams’ writing has been used to teach Psychodynamic Concepts to Psychiatry Residents. Her lectures, infused with personal clinical examples, demonstrate how a psychodynamic understanding of a patient can simply and effectively be incorporated into clinical practice. Throughout her talk, McWilliams provided examples of the application of these psychodynamic concepts in settings outside of the Psychotherapy office. This is of particular importance for Residents in the early stages of their careers.

In the course of a Psychiatry Residency, one is often forced to learn in the pressured clinical environments of busy outpatient clinics, Emergency Departments and Inpatient Units. Residents are constantly balancing the needs of patients with his or her own learning needs. Under the weight of this pressure, the psychodynamic complexity of our clinical interactions may be overlooked. Transference and Countertransference dynamics seem particularly potent to the novice trainee and, while the psychodynamics of an interaction may not have been overtly addressed, the emotional residue may linger with us long after the clinical encounter is over. Residents who have a poor understanding of Psychodynamic Psychiatry may run the risk of feeling overwhelmed by these interactions and possibly suffering from emotional burnout early in their careers.

Recent trends in training programs have seen Residents dividing themselves into “those who will” and “those who will not” do psychotherapy as part of their future careers. This may reflect a naivety on behalf of early-stage trainees who do not recognize that even the most “biological” psychiatrists intuitively use psychodynamic concepts guide interactions with their patients. This dichotomy becomes incorporated into our understanding of psychiatry early in our training, thereby potentially undermining the protection that comes with achieving the balance of both approaches in practice. While teaching Psychodynamic concepts in the context of Psychotherapy Supervision is important, Residents may not intuitively know the importance of applying these concepts to work outside of Psychotherapy. It is therefore important to continue to find ways to teach Psychodynamic concepts in a variety of settings so that all Residents have the opportunity to see how Psychodynamic concepts can enrich their clinical work.

Nadia Aleem, PGY 5, University of Western Ontario
Prescribing Summary

INDICATIONS AND CLINICAL USE

Adults: SEROQUEL XR® (quetiapine fumarate extended-release) is indicated for the symptomatic relief of major depressive disorder (MDD) when currently available antidepressant drugs have failed either due to lack of efficacy and/or lack of tolerability. While there is no evidence that the efficacy of SEROQUEL XR is superior to other antidepressants, it provides a treatment option for patients who have failed on previous antidepressant treatments. Clinicians must take into account the safety concerns associated with antidepressant drugs, a class of drugs to which SEROQUEL XR belongs.

SEROQUEL XR should only be prescribed in patients with MDD by clinicians who are aware of the importance and are experienced in the early detection and management of the aforementioned safety issues associated with this class. Long-term safety of SEROQUEL XR in MDD has not been systematically evaluated. Thus, the physician who elects to use SERQUEL XR in the treatment of MDD should use SERQUEL XR for the shortest time that is clinically indicated. When long-term treatment is indicated, the physician must periodically reevaluate the long-term use of the drug for the individual patient keeping in mind the long-term risks (see SUPPLEMENTAL PRODUCT INFORMATION). Quetiapine fumarate is contraindicated in patients with known cardiovascular disease (e.g., history of myocardial infarction or ischemic heart disease, heart failure or conduction abnormalities), cardiomyopathy, or conditions predisposing to hypotension (e.g., dehydration, hypovolemia and treatment with antihypertensive medications) (see OVERDOSAGE).

CONTRAINDICATIONS

SEROQUEL XR is contraindicated in patients with known hypersensitivity to this medication or any of its ingredients.

Special Populations

Pregnant Women: Patients should be advised to notify their physician if they become pregnant or intend to become pregnant during treatment with SERQUEL XR. The safety and efficacy of SERQUEL XR during human pregnancy have not been established. Therefore, SERQUEL XR should only be used during pregnancy if the potential benefits justify the potential risks. Quetiapine fumarate is known to cross the placental barrier and enter human milk. Women who are breastfeeding should be advised to discontinue breastfeeding while taking SERQUEL XR. Pediatric Use (<18 years of age): The safety and efficacy of SERQUEL XR in children and adolescents under the age of 18 years have not been established. Quetiapine fumarate is contraindicated in patients with known hypersensitivity to this medication or any of its ingredients.

SERQUEL XR is contraindicated in patients with a known hypersensitivity to this medication or any of its ingredients.

Patient Selection Criteria

Therapeutic class: Antipsychotic/Antidepressant agent.

Safety Information

WARNINGS AND PRECAUTIONS

Increased Mortality in Elderly Patients with Depression

Elderly patients with depression treated with atypical antidepressant drugs are at an increased risk of death compared to placebo. Analysis of thirteen placebo-controlled trials with various atypical antidepressant drugs (median duration of 10 weeks) in these patients showed a mean 1.6-fold increase in death rate in the drug-treated patients. Although the causes of deaths were varied, most of the deaths appeared to be either cardiovascular (e.g., heart failure, sudden death) or infections (e.g., pneumonia) in nature.

General: Body Temperature Regulation

Disruption of the body's ability to induce core body temperature has been attributed to antipsychotic agents. Appropriate care is advised when prescribing SERQUEL XR (quetiapine fumarate extended-release) for patients who will be undergoing conditions which may contribute to an intolerance of core temperature, e.g., exercising strenuously, exposure to extreme heat, receiving concomitant treatment with anticholinergic activity or being subject to diaphoresis. Acute Withdrawal (Discontinuation) Symptoms: Acute discontinuation symptoms such as insomnia, nausea, headache, dizziness, vomiting, dizziness and irritability have been described after abrupt cessation of antidepressant drugs including SERQUEL XR. Stupor was observed over a period of 3 to 6 months following discontinuation. The abrupt discontinuation of these drugs usually occurred after 1 week post-discontinuation.

Cardiovascular: Hypotension and Syncope: As with other drugs that have high serotonin receptor blocking activity, SERQUEL XR may induce orthostatic hypotension, dizziness, and somnolence syncope, especially during the initial dose titration period. These events may lead to falls. In placebo-controlled SERQUEL XR trials, there was little difference in the adverse event reporting rates of syncope in patients treated with SERQUEL XR (0.3%, 11/3536) compared to patients on placebo (0.3%, 4/1276). Syncope was reported in 1.0% (5/490) of patients treated with SERQUEL XR (quetiapine fumarate initiation formulation), compared with 0.3% (2/710) on placebo and 0.4% (2/527) on active control drugs. SERQUEL XR 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), cardiomyopathy, or conditions predisposing to hypotension (e.g., dehydration, hypovolemia and treatment with antihypertensive medications) (see OVERDOSAGE).

Chloride and Potassium Elevations: Very common (>10%) cases of hyperkalemia (serum potassium levels >5.7 mmol/L or at least once every 24 hours) and elevations in total chloride (predominantly LK chloride) (>120 mmol/L or at least once every 24 hours) have been observed during treatment with quetiapine in clinical trials (see ADVERSE REACTIONS). Use should be managed as clinically appropriate. In a 4-week MDD monotherapy clinical trials, SERQUEL XR treated patients had increases from baseline in mean potassium levels of 0.6% compared to a mean decrease of 1.5% for placebo-treated patients. In the same trials, both SERQUEL XR- and placebo-treated patients had decreases from baseline in mean chloride of 1.5% and 3%, respectively. In a long-term randomized withdrawn MDD trial, patients who completed at least 158 days of SERQUEL XR treatment (n=196) showed mean increases from baseline in triglycerides of approximately 5% and mean decreases from baseline in cholesterol of approximately 4%.

Endocrine and Metabolic/Contraception: Hypoglycemia: As with other antipsychotics, hyperglycemia and diabetes mellitus (including an association of pre-existing diabetes, diabetic ketoacidosis and diabetic coma including some fatal cases) in the aggregate have been reported rarely (0.01% to 0.1%) during the use of quetiapine in postmarketing experience, sometimes in patients with no reported history of hyperglycemia (see ADVERSE REACTIONS, Post-Marketing Adverse Drug Reactions). Blood glucose increases to hypoglycemic levels (fasting glucose ≤7.0 mmol/L, or a nonfasting blood glucose ≥11.1 mmol/L and at least one episode) have been observed commonly (>1% to <10%) with quetiapine in clinical trials. Occasional reports of diabetes mellitus have been observed in clinical trials with quetiapine (see ADVERSE REACTIONS, Abnormal Hematologic and Clinical Chemistry Findings). Assessment of the relationship between antipsychotic use and glucose abnormalities is complicated by the possibility of an increased background risk of diabetes mellitus in patients with schizophrenia and the increasing incidence of diabetes mellitus in the general population. Given these confounders, the relationship between antipsychotic use and hyperglycemia-related adverse events is not completely understood. However, epidemiological studies suggest an increased risk of treatment-emergent hyperglycemia-related adverse events in patients treated with the atypical antipsychotics. Precise risk estimates for hyperglycemia-related adverse events in patients treated with atypical antipsychotics are not available. Any patient treated with atypical antipsychotics should be monitored for symptoms of hyperglycemia including polydipsia, polyuria, polyphagia and weakness.

Patients who develop symptoms of hyperglycemia during treatment with atypical antipsychotics should undergo fasting blood glucose testing. In some cases, hyperglycemia has resolved when the atypical antipsychotic was discontinued; however, some patients required continuation of anti-diabetic treatment despite discontinuation of the suspect drug. Patients with risk factors for diabetes mellitus (e.g., obesity, family history of diabetes) who are starting treatment with atypical antipsychotics should undergo fasting blood glucose testing at the beginning of treatment and periodically during treatment. Patients with an established diagnosis of diabetes mellitus who are started on atypical antipsychotics should be monitored regularly for worsening of glycemic control. Hyperprolactinemia: During Clinical
trials with quetiapine, aripiprazole, and placebo. The differences in prolactin levels were not statistically significant between the groups. The use of antipsychotic medications, including quetiapine, aripiprazole, and placebo, was well tolerated by the patients, with no significant differences in adverse events or changes in prolactin levels observed. However, the study was limited by the small sample size and the use of a single-center design, which may have affected the generalizability of the results.

In conclusion, the results of this study suggest that antipsychotic medications may have a role in the management of prolactin levels in patients with schizophrenia. Further research is needed to confirm these findings and to explore the potential mechanisms by which antipsychotics may influence prolactin levels.
PRECAUTIONS

50 mg quinapril tablets are pinkish-coloured, capsule-shaped, biconvex, intagilated with "XR 50" on one side and plain on the other, available in high-density polyethylene (HDP) bottles of 60 tablets. 150 mg quinapril tablets are white, capsule-shaped, biconvex, intagilated with "XR 150" on one side and plain on the other, available in HDP bottles of 60 tablets. 200 mg quinapril tablets are yellow, capsule-shaped, biconvex, intagilated with "XR 200" on one side and plain on the other, available in HDP bottles of 60 tablets. 300 mg quinapril tablets are pale yellow, capsule-shaped, biconvex, intagilated with "XR 300" on one side and plain on the other, available in HDP bottles of 60 tablets. 400 mg quinapril tablets are white, capsule-shaped, biconvex, intagilated with "XR 400" on one side and plain on the other, available in HDP bottles of 60 tablets. SERQUEL XR is available in 5 strengths containing 50, 150, 200, 300 or 400 mg quinapril per tablet (see Quinapril Tartrate).

The core of this tablet contains the excipients hydroxypropyl methylcellulose, lactose monohydrate, magnesium stearate, microcrystalline cellulose and sodium citrate. The coating of this tablet contains hydroxypropyl methylcellulose, polyvinylpyrrolidone (PVP), red ferric oxide (50 mg tablets), titanium dioxide and yellow ferric oxide (50, 200 and 300 mg tablets).

SUPPLEMENTAL PRODUCT INFORMATION

Adverse Reactions

The stated frequency of adverse events represents the proportion of individuals who experienced at least one event during the trial. Certain events were considered serious adverse events (SAEs) defined as \( \geq 500 \text{ mg/day} \) adult, doses in the clinical trial. Patients were assessed for the possibility of serious adverse events during the trial. The frequency of serious adverse events was not determined by any clinical events during the trial. The frequency of serious adverse events was not determined by any clinical events during the trial.

To report adverse events:

Astrazeneca Canada Inc.
1104 Haddington Place
Mississauga, Ontario
L4Y 1M4

www.astrazeneca.ca
T 1-800-433-0733
F 1-800-267-5743

DRUG DRUG INTERACTIONS

Drug-Drug Interactions: When the primary central nervous system effects of quinapril, SERQUEL XR (quinapril fumarate extended-release) should be used with caution in combination with other centrally acting drugs (see SUPPLEMENTAL PRODUCT INFORMATION).

Administration

SERQUEL XR (quinapril fumarate extended-release) tablets should be swallowed whole and not split, chewed or crushed. SERQUEL XR can be administered with or without food. SERQUEL XR should be administered once daily, generally in the evening (see INDICATIONS AND CLINICAL USE). Usual Dose: The titration rate, based on the clinical trial, is shown in the table below.

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dosage (mg)</th>
<th>Day 1</th>
<th>Day 2</th>
<th>Day 3</th>
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<td>Quinapril</td>
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The usual starting dose is 150 mg. Some patients may respond to doses as low as 50 mg/day and, when clinically indicated, doses may be increased to 300 mg/day after Day 4. In clinical trials, doses between 50-300 mg/day were shown to be effective, however, the incidence of central adverse events increased with dose. In MDD, the safety of doses above 300 mg/day has not been evaluated. Some of the safety concerns associated with SERQUEL XR and the class of agents (i.e., antipsychotics) may be dose-related. The SERQUEL XR dose should therefore be partially increased to achieve a therapeutic level. For the individual patient, a dose of up to 400 mg/day may be considered for a maximum of 14 days in the initial treatment phase. Patients with SERQUEL XR Tablets for SERQUEL XR Tablets: For more convenient dosing, patients who are currently being treated with divided doses of SERQUEL XR (quinapril, immediate-release formulation) may be switched to SERQUEL XR or the equivalent daily total dose taken at a time. Individual dosage adjustments may be necessary.

Switching Patients From Other Antipsychotics: For many antipsychotics a gradual taper is recommended prior to discontinuation of the drug. (prescriptions should refer to the approved Product Monograph of the specific antipsychotic). There are no systematically collected data to address switching patients from other antipsychotics to SERQUEL XR. Generally, there should be no need for a wash-out period between stopping an antipsychotic and starting SERQUEL XR. The physician may elect to initiate SERQUEL XR treatment while tapering the antipsychotic; however, patients may experience adverse side-effects during the tapering period. Doing Considerations in Special Populations: Elderly: As with other antipsychotics, SERQUEL XR should be used with caution in elderly patients, especially during the initial dosing period. The dose of SERQUEL XR is usually started at a lower dose for elderly patients. In elderly patients, age 65 or over, were treated with SERQUEL XR. Given the limited experience with SERQUEL XR in the elderly, the incidence of anticholinergic and central nervous system side effects in the population, SERQUEL XR should be used with caution. The mean plasma clearance of SERQUEL XR was reduced by 38% to 52% in elderly subjects as compared to younger patients. Elderly patients should be started on the lowest possible dose (i.e., 50 mg/day) of SERQUEL XR. The dose can be increased in increments of 50 mg/day to an effective dose, depending on the clinical response and tolerance of the individual patient. In elderly patients with MDD, initial dosing should begin at 50 mg/day for 5-7 days, the dose can be increased to 100 mg/day on Day 4, and 150 mg/day on Day 8. Hypertensive Impairment: Quinapril is extensively metabolized by the liver. Therefore, SERQUEL XR 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 the lowest available dose (i.e., 50 mg/day) of SERQUEL XR. The dose should be increased daily in increments of 50 mg/day to an effective dose, depending on the clinical response and tolerance of the individual patient. The blood pressure tolerance of patients is monitored and no necessary hepatic impairment. However, should clinical judgement deem treatment with SERQUEL XR necessary, the drug should be used with caution in patients with moderate to severe hepatic impairment (see WARNINGS AND PRECAUTIONS, Hepatitis). Baseline Dosage: SERQUEL XR should not be taken at the same time each day. If a previous day's dose has been missed, administration should be resumed the next day at the normal administration. Dosage Forms and Packaging: SERQUEL XR (quinapril fumarate extended-release) is available as film-coated tablets containing quinapril fumarate equivalent to 50, 150, 200, 300 or 400 mg of quinapril fumarate as follows:

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dosage (mg)</th>
<th>Day 1</th>
<th>Day 2</th>
<th>Day 3</th>
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<tbody>
<tr>
<td>Quinapril</td>
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SEROQUEL XR (quetiapine fumarate extended-release) is indicated for the symptomatic relief of major depressive disorder (MDD) when currently available approved antidepressant drugs have failed either due to lack of efficacy and/or lack of tolerability.

While there is no evidence that the efficacy of SEROQUEL XR is superior to other antidepressants, it provides a treatment option for patients who have failed on previous antidepressant treatments. Clinicians must take into account the safety concerns associated with antipsychotic drugs, a class of drugs to which SEROQUEL XR belongs. Safety concerns of this class include weight gain, hyperlipidemia, hyperglycemia, tardive dyskinesia, and neuroleptic malignant syndrome (see WARNINGS AND PRECAUTIONS). SEROQUEL XR should only be prescribed to patients with MDD by clinicians who are aware of the importance and are experienced in the early detection and management of the above-mentioned safety issues associated with this class.

Long-term safety of SEROQUEL XR in MDD has not been systematically evaluated. Thus, the physician who elects to use SEROQUEL XR in the treatment of MDD should use SEROQUEL XR for the shortest time that is clinically indicated. When long-term treatment is indicated, the physician must periodically re-evaluate the long-term usefulness of the drug for the individual patient keeping in mind the long-term risks.

SEROQUEL XR is also indicated for the management of the manifestations of schizophrenia, as monotherapy for the acute management of manic episodes associated with bipolar disorder and as monotherapy for the acute management of depressive episodes associated with bipolar I and bipolar II disorder. Please consult the Product Monograph for complete prescribing information.

SEROQUEL XR (quetiapine fumarate extended-release) is contraindicated in patients with a known hypersensitivity to this medication or any of its ingredients.

During acute MDD therapy with SEROQUEL XR, the most commonly observed adverse events associated with the use of SEROQUEL XR include insomnia, somnolence, tremor, dizziness, headache, and nausea.

Infection and hyperglycemia, and occasional reports of diabetes have been observed in 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 and renal impairment.

Serious Warnings and Precautions

Increased Mortality in Etiologic Patients With Dementia

Elderly patients with dementia treated with antipsychotic drugs are at an increased risk of death compared to placebo. Analyses of 1181 placebo-controlled trials with various antipsychotics (mean duration of 10 weeks) in these patients showed a mean 1.5-fold increase in death rate in the drug-related patients. Although the causes of death were varied, most of the deaths appeared to be either cardiovascular (e.g., heart failure, sudden death) or infectious (e.g., pneumonia) in nature.

Please consult the Product Monograph for warnings, precautions and adverse events.


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THIS WAY

See prescribing summary on page