MESSAGE FROM
THE PRESIDENT

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

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

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

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

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

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

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

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

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

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

Dr. Margaret Steele, HSc; MD, FRCP(C)
President, Ontario Psychiatric Association
Ontario Psychiatric Association
Executive and Council

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

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

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

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

The Editor

Contributors to this issue of Dialogue are:

Tanya Baglole  Nick Kates  Clare Pain
A.S. David  Francine Knoops  M. L. Phillips
Katie Hardy  M.V. Lambert  C. Senio
Ann Howarth-Wiles  Bernard C. Leblanc  M. Sierra
Elaine Hunter  N. Medford  Douglas C. Weir

Otario Psychiatric Association
Executive and Council

President
Dr. Margaret Steele

President Elect
Dr. Bob Buckingham

Past President
Dr. Keith Anderson

Secretary
Dr. Federico Allodi

Treasurer
Dr. Jane Howard

Dr. Krishna Balachandra
Dr. Khrista Boylan
Dr. Rajith Chandraena
Dr. Mamta Gautam
Dr. Adrian Hynes
Dr. Rosemary Meier
Dr. Roumen Milev
Dr. Clare Pain
Dr. Derek Puddester
Dr. Ann Thomas
Dr. Doug Wilkins

From THE EDITOR

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

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

Dialogue will be featuring telepsychiatry in the future. We would be pleased to receive your submissions on this topic.
Please forward any submissions to the Editor by email at opa@bellnet.ca or by fax: 905-469-8697
HOW THE DIALOGUE HAS EVOLVED OVER THE PAST TEN YEARS
Participants will participate in a two-hour consultation/supervision session during sessions with clients before proceeding to the next level of training. In addition, the participants will be required to have used EMDR for at least 25 hours of treatment; applications of EMDR including personal use; seven hours of practice for the EMDR procedure; eight phases of research findings; how to use EMDR as a form of psychotherapy; client selection criteria and cautions; and how to do the EMDR procedure. Participants must possess a Master’s Degree in a counselling discipline and be licensed or registered with a profession organization. The cost is $550.00 per person.

Contact information: Sue Fraser, MSW, RSW, Certified Trauma Specialist, Fraser Counselling Services, 1-877-392-7954 email: sue@frasercounselling.com website: www.frasercounselling.com.

First International Conference on Symptom, Diagnostic and Disability Validity: Improving Patient Outcomes
September 26 - 29, 2002
Markham -Toronto
Canada Symposium Website: www.icpro.org
Associated Post Conference Workshop: Clinical Assessment of Malingering and Deception September 30, 2002, Markham-Toronto, Ontario, Canada
Contact information: Physical Medicine Research Foundation, Suite 204, 856 Homer Street, Vancouver, BC V6B 2W5, Toll Free (800) 872-3105, Fax (604) 681-6247 E-mail: pmrf@icpro.org; www.icpro.org

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

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

October 2 - 5, 2002
Toronto
Chair: Dr. Deborah Klaman, Keynote Speaker, Richard Tiberius.
Contact information: http://www.hsc.wvu.edu/aap/2002_annual_meeting.htm
Shifting Abuse-Related Internalizations: Treating Childhood Trauma
October 4 - 5, 2002
R.A. Centre, Ottawa, Ontario
The Centre for Treatment of Sexual Abuse & Childhood Trauma presents their 10th Anniversary Conference for psychologists, psychological associates, psychiatrists, social workers, youth workers, child protection workers and other mental health professionals. Featuring Dr. Sandra Wieland, this workshop will provide both the novice and advanced clinician with a clear conceptual framework, her Internalization Model, to improve clinical effectiveness.
Contact information: Centre for Treatment of Sexual Abuse & Childhood Trauma phone: 613-233-4929

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

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

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

Post-Traumatic Stress Disorder (PTSD and New Canadians: Exploring the Implications)
October 9 – 10, 2002
CAMH – Toronto Participants will: identify challenges experienced by this unique population; recognize diagnostic criteria for and symptoms of PTSD; understand assessment methods used for PTSD; identify and understand a variety of treatment options for PTSD; understand the relationship between PTSD and addiction.
Contact information: CAMH, Education & Training Services, 53 Russell Street, Toronto, M5S 2S1, phone: 1-800-661-1111 or 416-595-6059, email: marketing@camh.net, website: www.camh.net

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

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

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

49th Annual Meeting of the American Academy of Child and Adolescent Psychiatry
October 22 – 27, 2002
Hilton San Francisco Towers, San Francisco, CA.
Contact information: http://www.aacap.org/meeting/index.htm

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

Second Canadian Inter-Professional Conference on Spirituality & Health Care
October 25 – 27, 2002
Mt. Sinai Hospital & University of Toronto
Health professionals of diverse specialty and training and spiritual leaders of all affiliations are working to bridge spirituality and health care in their professional work; introduce participants to different therapeutic modalities for integrating spirituality into health care; showcase cutting edge models of clinical programs, research and interdisciplinary work in spirituality and health care; make participants aware of resources relating to spirituality in health; encourage the development of further research in this field; foster dialogue in a non-aligned multi-faith atmosphere, honouring all faiths and spiritual traditions; provide a forum for inter-professional bridging, collaboration and learning, to foster mutual understanding and respect.
Contact information: Conference Secretariat at: Office of Continuing Education, Faculty of Medicine, University of Toronto, 500 University Avenue, Suite 650, Toronto, Ontario M5G 1V7 PH: 416.978.2719 Fax: 416.971.2200 Toll-Free: 1.888.512.8173
Certificate in Trauma Counselling for Front-Line Workers
October 29-30; November 12-13; November 26-27; December 10-11, 2002
Hincks-Dellcrest Institute, Toronto, Ontario
This 8-day course is designed for front-line workers who provide short-term counselling contact with vulnerable populations in community-based settings such as hospitals, community health centres, rape crisis centres, battered women’s shelters, homeless shelters, addiction services, crisis phone lines and short-term counselling centres.
The program is designed for persons with a minimum of 2 years full-time employment working with vulnerable and/or traumatized populations.
Contact information: Hincks-Dellcrest Institute, 114 Maitland Street, Toronto, ON, M4Y 1E1, phone: 416-972-1935, fax: 416-924-9808, email: training@hincksdellcrest.org

Canadian Psychiatric Association 52nd Annual Meeting
October 31 – November 3, 2002
Fairmont Banff Springs Hotel
Contact information: www.cpa-apc.org

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

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

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

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

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

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

Ontario Hospital Association Convention & Exhibition
November 18, 19, 20, 2002
Metro Toronto Convention Centre
OHAs Annual Convention & Exhibition will afford participants opportunities to explore the identified topics in detail. They represent the “umbrella” phrases for the development of OHA Feature Theme, General and Allied Group sessions for convention delegates. The Convention Preview which features educational sessions, speakers, registration details and confirmed exhibitors to date is now available on the OHA website at www.oha.com/convention
Contact Information: Educational Services at 416-205-1561

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

Ontario Psychiatric Association 83rd Annual Meeting, “Psychiatry Across the Life Span”
January 30, 31, February 1, 2003
Toronto Marriott Eaton Centre Hotel, 525 Bay St., Toronto
Contact information: Lorraine Taylor, OPA Office, 905-827-4659, email: opa@bellnet.ca

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

By Tanya Baglole & Francine Knoops, Canadian Psychiatric Association

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

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

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

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

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

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

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

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


AGENDA OPA Council J u n e 1 4 , 2 0 0 2

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

MEMBERS ON THE MOVE

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

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

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

To get your new appointment in “Members on the Move”, send us the following information – your name, position, date of appointment, the organization you were with and the new organization (if applicable), your email, phone number and address. We will run these announcements as we receive them, and as space in the Dialogue allows. Please forward your items in writing to the OPA Office, 1141 South Service Rd. W., Oakville, ON, L6L 6X4 or by email to: opa@bellnet.ca or fax to: 905-469-8697.

OPA Dialogue September 2002
ATTENTION MEMBERS!

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

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

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

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

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

Meet A Council Member:

An Interview with Khrista Boylan, M.D.

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

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

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

OPA: Tell us a bit about your background.

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

OPA: When did you join the OPA and why?

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

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

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

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

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

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

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

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

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

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

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

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

ATTENTION MEMBERS!

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

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

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

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

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

Meet A Council Member:

An Interview with Khrista Boylan, M.D.

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

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

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

OPA: Tell us a bit about your background.

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

OPA: When did you join the OPA and why?

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

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

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

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

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

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

Khrista: I wish there were more funding for children’s education. I wish housing was more affordable. I wish we all would work 4 days a week.
Your Continuing Education Committee is looking forward to presenting an outstanding lineup of presentations at the OPA Annual Meeting in Toronto at the Toronto Marriott Eaton Centre Hotel on January 30, 31 and February 1, 2003.

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

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

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

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

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

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

We look forward to seeing you in January!

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INNOVATIVE LEARNING, family focus at CPA Annual Meeting

By Katie Hardy, Canadian Psychiatric Association

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

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

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

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

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

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

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OPA CONFERENCE AND ANNUAL MEETING:

By: Dr. Ann Thomas, Continuing Education Committee Chair

Psychiatry
ACROSS THE LIFE SPAN

OPA Dialogue September 2002
Federal agency overhauls disability tax credit form

By Katie Hardy & Francine Knoops, Canadian Psychiatric Association

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

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

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

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

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

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

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

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

SET MINIMUM STANDARDS FOR MENTAL HEALTH CARE SERVICES, COMMISSION TOLD

By Tanya Baglole & Francine Knoops, Canadian Psychiatric Association

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

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

- minimum standards for mental health care services so Canadians know what to expect
- strategies that address the unique range of needs for children, elderly, incarcerated, Aboriginal peoples, visible minorities, people living with chronic and serious mental illnesses and people living with moderate mental illnesses
- a surveillance program to monitor achievement of national goals

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

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

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

Wanted: Book Reviewers

Do you know of book that should be reviewed for the Dialogue? Would you like to be a book reviewer? Are you aware of a website that would be of interest to our Members? If so, please contact the Editor.
OPA DIALOGUE 2002 SURVEY RESULTS

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

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

1. Do you read Dialogue on a regular basis?
   - all the time 23
   - most of the time 18
   - sometimes 12
   - not too often 4
   - not at all 1

2. Do you pass on Dialogue to others?
   - all the time 2
   - most of the time 9
   - sometimes 12
   - not too often 4
   - not at all 35

3. Do you think Dialogue tells you about what is happening in psychiatry?
   - all the time 5
   - most of the time 27
   - sometimes 22
   - not too often 3
   - not at all 1

   Membership Category
   - Full 48
   - Associate 1
   - Member in Training 3
   - Life 6

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

6. Other comments or suggestions
   None.
In almost every Canadian community the family physician plays a key role in delivering mental health care. Almost forty percent of people who receive mental health care receive it only from their family physician. In addition, while seventy two percent of individuals with mental health problems receive no care over the course of the year, the majority of these individuals will visit their family physician. And many individuals with serious medical problems also have co-morbid psychiatric problems, predominately depression and anxiety. Few of these individuals are referred to mental health services, but the majority receive regular treatment from their family physician. For these reasons, primary care may be the optimal setting to detect problems at an early stage. Quite simply, the family physician is uniquely placed to initiate treatment and monitor progress.

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

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

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

The term “shared care” describes patterns of collaboration between providers from different services or disciplines who share the responsibility for the care an individual receives. Working together, these providers are able to pool their resources, according to the needs of an individual client, service availability and their respective skills. In doing so they will attempt to ensure an individual reaches the services they need when they need it.

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

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

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

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

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

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

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

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

One Year After September 11th: A PERSPECTIVE

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

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

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

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

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

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

For me, the specific emotional connection with that time is not the visual images so much as the poignant snippets of cell phone conversation we heard or read about. They were from workers trapped in the WTC offices to the spouses they had left at home weak with repeated telling. But learning again, that the need for continued authentic personal connectedness continues to link us to others, and to ourselves, and persists, despite all and to the end, is somehow heartening.

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

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

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

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

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

5. Feed your nervous system with quality foods. Reduce junk food; coffee, pizza, muffins, cakes, pastries, and other white flour products. Increase water, fruits, vegetables, whole grain products and low fat protein sources such as chicken, fish and lean cuts of meats. Use raw almonds, raw sunflower and/or pumpkin seeds as snacks and most importantly, replace supermarket oil with cold pressed olive oil. Since stress can deplete vitamins (especially the B’s) and minerals as well as depress our immune system, investigate supplementation such as a good quality vitamin and mineral formula. Vitamin C can lower stress hormone levels. In a study at the University of Alabama, in 1999, vitamin C fed rats showed lower stress hormone levels as well as fewer incidences of typical stress indicators, such as weight loss and enlarged adrenal glands.
Responding to Complaints: Don’t Make Matters Worse

By: Bernard C. LeBlanc

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

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

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

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

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

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

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

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

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RBRVS

Commission Finds Psychiatric Fees Are Undervalued Relative to Other Services

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

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

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

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

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

OPA Dialogue September 2002
All Ontario physicians will have received a newsletter from the RBRVS Commission with a summary of the final report, along with an explanation of the approach and methodology of the Commission. In that newsletter, Dr. John Wade, Chair of the RBRVS Commission reminds the profession that the reason the RBRVS Commission was established was due to a widespread perception, within the profession, that the existing fee schedule has significant inequities requiring redress and that a more equitable and rational approach for evaluating and compensating medical services was required.

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

Background

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

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

Much as we are today hearing criticisms of the RBRVS process, previous efforts to address fee inequities also were subject to a similar response. In the past, reports that identified under-valued services or Sections have been shelved and no remedial actions taken. Generally the outcome was further stalled and was eventually given up when the present Commission grew out of the OMA/MOHLTC Agreement in 1997.

RBRVS Final Report and Psychiatric Services

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

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

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

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

<table>
<thead>
<tr>
<th>SPECIALTY</th>
<th># MDs</th>
<th>Total OHP Professional Fee Payments</th>
<th>Final RBRVS Change</th>
<th>Reallocation of $$$</th>
<th>Reallocation of $$$ per MD</th>
<th>Pre RBRVS Average Gross OHP Fee Payments per MD</th>
<th>Average Gross OHP Fee Payments per MD after Reallocation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Biochem</td>
<td>6</td>
<td>$197,769</td>
<td>62.31%</td>
<td>$123,224</td>
<td>$20,537</td>
<td>$329,615.77</td>
<td>$53,498.95</td>
</tr>
<tr>
<td>Lab Medicine</td>
<td>251</td>
<td>$9,484,871</td>
<td>1.72%</td>
<td>$162,929</td>
<td>$649</td>
<td>$37,788.33</td>
<td>$38,457.45</td>
</tr>
<tr>
<td>Genetics</td>
<td>8</td>
<td>$315,669</td>
<td>12.50%</td>
<td>$39,453</td>
<td>$4,932</td>
<td>$39,458.33</td>
<td>$4,390.27</td>
</tr>
<tr>
<td>Geriatrics</td>
<td>44</td>
<td>$3,920,105</td>
<td>48.07%</td>
<td>$1,884,572</td>
<td>$42,831</td>
<td>$80,933.30</td>
<td>$131,924.48</td>
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<tr>
<td>Therapeutic Rad</td>
<td>126</td>
<td>$11,602,890</td>
<td>-2.25%</td>
<td>-$265,504</td>
<td>-$2,091</td>
<td>$92,800.71</td>
<td>$90,709.41</td>
</tr>
<tr>
<td>Emergency Med</td>
<td>93</td>
<td>$9,556,749</td>
<td>33.81%</td>
<td>$1,884,572</td>
<td>$42,831</td>
<td>$102,760.74</td>
<td>$137,504.59</td>
</tr>
<tr>
<td>Haematology</td>
<td>62</td>
<td>$8,540,138</td>
<td>2.49%</td>
<td>$212,455</td>
<td>$3,427</td>
<td>$164,959.99</td>
<td>$170,132.48</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>1,745</td>
<td>$250,877,067</td>
<td>11.95%</td>
<td>$29,983,700</td>
<td>$17,183</td>
<td>$143,769.09</td>
<td>$160,951.73</td>
</tr>
<tr>
<td>Phys Med &amp; Rehab</td>
<td>134</td>
<td>$20,377,816</td>
<td>4.10%</td>
<td>$836,073</td>
<td>$6,239</td>
<td>$152,073.26</td>
<td>$158,312.60</td>
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<tr>
<td>Rheumatology</td>
<td>41</td>
<td>$6,610,094</td>
<td>5.36%</td>
<td>$354,426</td>
<td>$8,645</td>
<td>$161,221.81</td>
<td>$169,866.35</td>
</tr>
<tr>
<td>General Practice</td>
<td>10,283</td>
<td>$1,692,540</td>
<td>3.36%</td>
<td>$56,931,747</td>
<td>$5,536</td>
<td>$164,595.99</td>
<td>$170,132.48</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>762</td>
<td>$128,193,734</td>
<td>11.57%</td>
<td>$14,832,161</td>
<td>$19,465</td>
<td>$168,233.25</td>
<td>$187,698.02</td>
</tr>
<tr>
<td>Neurology</td>
<td>225</td>
<td>$43,200,767</td>
<td>3.60%</td>
<td>$1,553,076</td>
<td>$6,903</td>
<td>$192,003.41</td>
<td>$198,905.97</td>
</tr>
<tr>
<td>Clinical Immunology</td>
<td>6</td>
<td>$1,198,606</td>
<td>7.58%</td>
<td>$90,879</td>
<td>$15,146</td>
<td>$214,914.04</td>
<td>$214,914.04</td>
</tr>
<tr>
<td>Anaesthesiology</td>
<td>844</td>
<td>$178,897,837</td>
<td>-10.28%</td>
<td>-$21,387,819</td>
<td>-$21,787</td>
<td>$211,964.26</td>
<td>$190,177.75</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>1,663</td>
<td>$300,159,137</td>
<td>-2.71%</td>
<td>-$9,743,592</td>
<td>-$5,859</td>
<td>$210,712.90</td>
<td>$210,712.90</td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>167</td>
<td>$37,538,731</td>
<td>-6.68%</td>
<td>-$2,509,369</td>
<td>-$15,026</td>
<td>$224,782.82</td>
<td>$209,756.66</td>
</tr>
<tr>
<td>Resp Diseases</td>
<td>92</td>
<td>$21,681,328</td>
<td>5.56%</td>
<td>$1,205,082</td>
<td>$13,099</td>
<td>$235,666.61</td>
<td>$248,765.32</td>
</tr>
<tr>
<td>General Surgery</td>
<td>652</td>
<td>$165,806,876</td>
<td>-8.01%</td>
<td>-$13,289,420</td>
<td>-$20,383</td>
<td>$254,305.02</td>
<td>$233,922.48</td>
</tr>
<tr>
<td>Gen Thoracic Surg</td>
<td>24</td>
<td>$6,281,383</td>
<td>-5.00%</td>
<td>-$314,155</td>
<td>-$13,090</td>
<td>$261,724.28</td>
<td>$248,634.50</td>
</tr>
<tr>
<td>Orthopaedic Surgery</td>
<td>414</td>
<td>$108,707,147</td>
<td>0.70%</td>
<td>$756,812</td>
<td>$1,828</td>
<td>$262,577.65</td>
<td>$264,405.70</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>71</td>
<td>$18,764,657</td>
<td>11.66%</td>
<td>$2,187,495</td>
<td>$30,810</td>
<td>$264,290.95</td>
<td>$295,100.73</td>
</tr>
<tr>
<td>Dermatology</td>
<td>190</td>
<td>$50,594,352</td>
<td>-4.27%</td>
<td>-$2,162,422</td>
<td>-$11,381</td>
<td>$266,286.06</td>
<td>$254,904.89</td>
</tr>
<tr>
<td>Obstetrics &amp; Gyn</td>
<td>663</td>
<td>$178,264,869</td>
<td>-2.89%</td>
<td>-$5,145,283</td>
<td>-$7,761</td>
<td>$268,876.12</td>
<td>$261,115.52</td>
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<tr>
<td>Otolaryngology</td>
<td>224</td>
<td>$6,424,986</td>
<td>-6.56%</td>
<td>-$4,028,664</td>
<td>-$19,985</td>
<td>$274,218.69</td>
<td>$256,233.50</td>
</tr>
<tr>
<td>Nuclear Medicine</td>
<td>42</td>
<td>$12,010,266</td>
<td>-41.03%</td>
<td>-$4,928,268</td>
<td>-$117,340</td>
<td>$285,958.71</td>
<td>$268,619.01</td>
</tr>
<tr>
<td>Urology</td>
<td>224</td>
<td>$6,167,936</td>
<td>-6.82%</td>
<td>-$4,442,786</td>
<td>-$19,834</td>
<td>$290,928.29</td>
<td>$271,094.42</td>
</tr>
<tr>
<td>Diagnostic Rad</td>
<td>775</td>
<td>$251,597,989</td>
<td>-23.20%</td>
<td>-$58,379,210</td>
<td>-$75,328</td>
<td>$324,642.57</td>
<td>$249,314.46</td>
</tr>
<tr>
<td>Cardiology</td>
<td>277</td>
<td>$92,675,406</td>
<td>-14.39%</td>
<td>-$334,389,990</td>
<td>-$48,140</td>
<td>$334,568.58</td>
<td>$286,428.15</td>
</tr>
<tr>
<td>Ophthamology</td>
<td>413</td>
<td>$139,633,528</td>
<td>-22.14%</td>
<td>-$30,919,801</td>
<td>-$74,866</td>
<td>$338,095.71</td>
<td>$263,229.36</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>99</td>
<td>$35,190,222</td>
<td>-6.97%</td>
<td>-$2,451,847</td>
<td>-$17,985</td>
<td>$355,456.79</td>
<td>$330,090.96</td>
</tr>
<tr>
<td>Thoracic &amp; Card Surg</td>
<td>74</td>
<td>$30,978,324</td>
<td>10.63%</td>
<td>$3,292,541</td>
<td>$44,494</td>
<td>$418,626.00</td>
<td>$463,119.79</td>
</tr>
<tr>
<td>Grand Total</td>
<td>20,694</td>
<td>$4,002,081,913</td>
<td>0.00%</td>
<td>$0</td>
<td>$0</td>
<td>$193,393.35</td>
<td>$193,393.35</td>
</tr>
</tbody>
</table>
The Section Executive met February 15, 2002 with the Commission. At that time we argued that the RVUs for K202, Group psychotherapy, in-patients 6-12 people and K205, Group psychotherapy, out-patients created fees for groups of 6-12 did not reflect clinical reality. The reason for this was that the Commission assumed the typical number in these groups was 9, whereas it was the experience of psychiatrists doing group psychotherapy that most of the time the average of such groups is more commonly 7. The Commission did not accept that argument and as a result the fees for K202 and K205 would be $7.73 in a cost-neutral implementation of RBRVS, a 19.1% decrease from the 2002 OHIP fee of $9.55.

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

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

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

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

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>RBRVS Fee</th>
<th>2002 OHIP Fee</th>
<th>% Difference from OHIP 2002</th>
</tr>
</thead>
<tbody>
<tr>
<td>A193</td>
<td>Specific assessment</td>
<td>$89.86</td>
<td>$57.10</td>
<td>57.4 %</td>
</tr>
<tr>
<td>A194</td>
<td>Partial assessment</td>
<td>$32.55</td>
<td>$24.65</td>
<td>32.0 %</td>
</tr>
<tr>
<td>A195</td>
<td>Consultation</td>
<td>$180.85</td>
<td>$122.00</td>
<td>48.2 %</td>
</tr>
<tr>
<td>A196</td>
<td>Repeat consultation</td>
<td>$109.79</td>
<td>$73.85</td>
<td>48.7 %</td>
</tr>
<tr>
<td>A197</td>
<td>Consultation on behalf of disturbed child - consultative interview with parents</td>
<td>$187.90</td>
<td>$107.20</td>
<td>75.3 %</td>
</tr>
<tr>
<td>A198</td>
<td>Consultation on behalf of disturbed child - consultative interview with child</td>
<td>$172.00</td>
<td>$107.20</td>
<td>60.4 %</td>
</tr>
<tr>
<td>C192</td>
<td>In-Patient Services - Subsequent visits - up to five weeks - per visit</td>
<td>$16.38</td>
<td>$18.25</td>
<td>-10.2 %</td>
</tr>
<tr>
<td>C193</td>
<td>Hospital In-Patient Services - Specific assessment</td>
<td>$99.20</td>
<td>$57.10</td>
<td>73.7 %</td>
</tr>
<tr>
<td>C194</td>
<td>Hospital In-Patient Services - Specific re-assessment</td>
<td>$67.35</td>
<td>$41.15</td>
<td>63.7 %</td>
</tr>
<tr>
<td>C196</td>
<td>Hospital In-Patient Services - Repeat consultation</td>
<td>$109.79</td>
<td>$73.85</td>
<td>48.7 %</td>
</tr>
<tr>
<td>C197</td>
<td>Hospital In-Patient Services - Subsequent visits - 6th-13th wks inclusive (max. of 5/wk) - per visit</td>
<td>$16.38</td>
<td>$18.25</td>
<td>-10.2 %</td>
</tr>
<tr>
<td>C198</td>
<td>Hospital In-Patient Services - Concurrent care</td>
<td>$18.09</td>
<td>$18.25</td>
<td>-0.9 %</td>
</tr>
<tr>
<td>C199</td>
<td>Hospital In-Patient Services - Subsequent visits - after 13th wk (max. of 6/mth) - per visit</td>
<td>$16.38</td>
<td>$18.25</td>
<td>-10.2 %</td>
</tr>
<tr>
<td>C895</td>
<td>Hospital In-Patient Services - Consultation</td>
<td>$219.64</td>
<td>$134.25</td>
<td>63.6 %</td>
</tr>
<tr>
<td>K190</td>
<td>Individual in-patient psychotherapy</td>
<td>$57.71</td>
<td>$54.15</td>
<td>6.6 %</td>
</tr>
<tr>
<td>K191</td>
<td>Family psychiatric care, in-patient</td>
<td>$66.02</td>
<td>$61.40</td>
<td>7.5 %</td>
</tr>
<tr>
<td>K192</td>
<td>Individual Hypnotherapy</td>
<td>$64.66</td>
<td>$54.15</td>
<td>19.4 %</td>
</tr>
</tbody>
</table>

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

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

<table>
<thead>
<tr>
<th>SOB CODE</th>
<th>SCHEDULE OF BENEFITS CODE</th>
<th>LABEL</th>
<th>KJ</th>
<th>CI</th>
<th>TS</th>
<th>RS</th>
<th>Intensity Rating</th>
<th>Intensity Units</th>
<th>TIME</th>
<th>PW RVU</th>
<th>PC%</th>
<th>PRACTICE COST UNITS</th>
<th>TOTAL UNITS</th>
<th>2002 RBRVS FEE</th>
<th>APRIL 2002 OHIP SOB FEE (%)</th>
<th>% DIFFERENCE FROM OHIP 2002</th>
</tr>
</thead>
<tbody>
<tr>
<td>K007</td>
<td>GP - Ind Psychotherapy</td>
<td></td>
<td>4.1</td>
<td>5.3</td>
<td>1.0</td>
<td>2.9</td>
<td>13.3</td>
<td>14.10</td>
<td>30.0</td>
<td>425.00</td>
<td>45.3%</td>
<td>339.70</td>
<td>762.70</td>
<td>59.44</td>
<td>50.45</td>
<td>17.82%</td>
</tr>
<tr>
<td>K197</td>
<td>Psych - Individual out-patient psychotherapy</td>
<td>4.7</td>
<td>6.1</td>
<td>1.0</td>
<td>3.4</td>
<td>15.2</td>
<td>17.20</td>
<td>30.0</td>
<td>516.00</td>
<td>33.3%</td>
<td>224.50</td>
<td></td>
<td>740.50</td>
<td>57.71</td>
<td>54.15</td>
<td>6.57%</td>
</tr>
<tr>
<td>K004</td>
<td>GP - Family Psychotherapy</td>
<td></td>
<td>4.2</td>
<td>5.3</td>
<td>1.0</td>
<td>3.1</td>
<td>13.6</td>
<td>14.60</td>
<td>30.0</td>
<td>438.00</td>
<td>45.3%</td>
<td>303.70</td>
<td>741.70</td>
<td>57.80</td>
<td>54.75</td>
<td>5.57%</td>
</tr>
<tr>
<td>K195</td>
<td>Psych - Family out-patient therapy</td>
<td></td>
<td>4.8</td>
<td>6.2</td>
<td>1.0</td>
<td>3.4</td>
<td>15.4</td>
<td>17.60</td>
<td>30.0</td>
<td>528.00</td>
<td>33.3%</td>
<td>229.80</td>
<td>757.80</td>
<td>59.05</td>
<td>61.40</td>
<td>-3.83%</td>
</tr>
</tbody>
</table>

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

TABLE 4:


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

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

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

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

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

In this sample other psychiatric illnesses were present, in particular depression (47%) and generalised anxiety (30%). The results are in line with data from a specialised clinic at the Mount Sinai Hospital, New York (Simeon et al, 1997). Rating and quantifying the phenomenology and severity of the disorder has been improved by refinements in various scales such as items from the Dissociative Experiences Scale (see Simeon et al, 1998a; Sierra & Berrios, 2000). We have found that it is probably not possible to distinguish primary and secondary depersonalization on these grounds alone and that some level of depression and anxiety is frequently observed even in primary cases (Lambert et al, 2001a). Investigation of the neuropsychological features of the disorder is underway. A main focus of the research of the unit has been the investigation of the neurobiological basis of DPD. We have been able to employ functional magnetic resonance imaging (fMRI) to demonstrate abnormal neural responses to the neurobiological basis of DPD. We have been able to employ functional magnetic resonance imaging (fMRI) to demonstrate abnormal neural responses to

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

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

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

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

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

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

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

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

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

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

References


Editor’s Note: Thanks to Dr. Ann Thomas for suggesting this article for Dialogue. This article was reprinted from ISSD News (60 Revere Dr., Suite 500, Northbrook IL, http://www.issd.org), with permission.

BEST PRACTICES PERTAINING TO CONCURRENT DISORDERS

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

“National Program Inventory: Concurrent Mental Health and Substance Use Disorders” is a national inventory of specialized concurrent disorders programs and services as a companion to the first document. It contains information from 37 agencies that provide services to individuals with concurrent disorders, including geographic area served, services provided, types of interventions, fee for service and inclusion/exclusion criteria and can be found at http://www.hc-sc.gc.ca/hppb/cds-sca/cds/pdf/e522_lc_proginventory-e.pdf
Five years ago, at the age of fifteen, our son tried to take his life. So began a four-year journey into the world of mental illness: meetings with psychiatrists and psychologists, weeks and months spent on the adolescent psychiatric ward, encounters with the confusing world of medications; and a journey into our own self awareness and identities.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

continued on page 24
See an anxiety disorder. Look for depression. And vice versa. You’ll find up to 70% of patients could have a comorbid condition. Which can make treatment more difficult. Relapse more likely. And an appropriate choice of therapy, very important. PAXIL®. No other antidepressant has more indications.

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

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

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

*PAXIL® (paroxetine HCl) is a registered trademark, used under license by GlaxoSmithKline Inc.*
the incidence of ejaculatory disturbance in males with 20 mg per day of paroxetine was 6.5% (3/46) versus 0% (0/23) in the placebo group.

1. Events reported by at least 1% of patients treated with PAXIL

2. The efficacy and safety of the concurrent use of PAXIL and ECT have not been established.

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been established. PAXIL® should not be used during pregnancy unless the potential benefit to the patient outweighs the risk to the fetus.

Concurrent Administration of PAXIL® with Smoking, Caffeine, Tobacco, Barbitone, Oxazepam, Theophylline, Drugs Highly Bound to Plasma Protein: Paroxetine's extent of inhibition of CYP3A4 activity would not be significant in PAXIL® patients who are smoking, caffeine users, or who are consuming drugs that are highly bound to plasma protein. Paroxetine's extent of inhibition of CYP3A4 activity would not be significant in PAXIL® patients who are smoking, caffeine users, or who are consuming drugs that are highly bound to plasma protein.

In clinical trials and post marketing. Patients should be monitored for these and other symptoms when discontinuing treatment. See CONTRAINDICATIONS.

The most commonly observed adverse experiences associated with the use of PAXIL® (paroxetine hydrochloride) have been nausea, discomfort, dizziness, headache, dyspepsia, somnolence, insomnia, rigidity, myoclonic jerks, dream disturbances, asthenia, fatigue, tremor, paresthesia, increased sweating, ptyalism, and anemia.

Twenty-one percent of over 4000 patients who received PAXIL® in worldwide clinical trials in depression, OCD, social anxiety disorder, panic disorder, GAD, primary dysmenorrhea, postmenopausal symptoms, and SAD demonstrated an increase in a single or multiple adverse experiences. Agitation/restlessness, sleep disturbance, anxiety, nausea, vomiting, diarrhea, tremor, myalgia, paresthesia, rash, increased sweating, dysphoria and increase in heart rate (2% or more) have also occurred in 1% to 2% of patients treated with PAXIL®. Paroxetine's extent of inhibition of CYP3A4 activity would not be significant in PAXIL® patients who are smoking, caffeine users, or who are consuming drugs that are highly bound to plasma protein.

The common adverse experiences associated with the use of PAXIL® (paroxetine hydrochloride) have been nausea, discomfort, dizziness, headache, dyspepsia, somnolence, insomnia, rigidity, myoclonic jerks, dream disturbances, asthenia, fatigue, tremor, paresthesia, increased sweating, ptyalism, and anemia.

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

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

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

The CMHEI Newsletter is delivered in Adobe Acrobat format. If you do not have the Acrobat Reader, it can be downloaded free at [http://www.adobe.com/products/acrobat/readstep2.html](http://www.adobe.com/products/acrobat/readstep2.html).

If you would like to subscribe to the CMHEI Newsletter distribution list, simply send an email to smacartney@ontario.cmha.ca with the word “subscribe” in the subject field.

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

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**Housing Guide Available from the Centre for Addiction and Mental Health**

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

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

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

Editor’s Note: The Toronto District Health Council estimated that in the year 2001 between 8,430 to 16,861 adults in Toronto have a serious mental illness. Using benchmarks from the Ministry of Health and Long-Term Care, which establishes that housing supports should be made available to approximately one-third of people with severe mental illness, the Toronto District Health Council concluded that there should be between 2,782 and 5,564 housing units, with supports, for this population. The Toronto District Health Council published the “Toronto Mental Health Housing Study” in September 2001; this survey states that there is a lack of affordable and supportive housing units, an insufficient supply and range of housing supports and insufficient financial assistance for people with serious mental illness. To access this document go to [www.tdhc.org-public-pdf-TorontoMentalHousingStudy-Sept2001.pdf](http://www.tdhc.org-public-pdf-TorontoMentalHousingStudy-Sept2001.pdf).