



Message from THE PRESIDENT



The first quarter of this year has been extremely busy for Council. OPA has always been asked to respond to documents from a variety of agencies and organizations and we are pleased that our opinion continues to be wanted and respected.

Lately, a number of draft documents have found their way to our Council table. The OPA was asked to respond to the Association of General Hospital Psychiatric Services document entitled "General Hospital Psychiatric Services in Ontario's Mental Health System: The AGHPS Perspective". We provided a reply to the AGHPS document and to the College of Physicians and Surgeons of Ontario draft document entitled "Guidelines for Clinical Practice and Facility Standards for Psychotherapy".

The OPA also provided comment on the Draft Rules of Practice sent to us by the Consent and Capacity Board. In addition, The Schizophrenia Society of Ontario approached the OPA for input during their organizational review.

As Chair of the Section Task Force, I am pleased to report that we have been very busy looking at the roles and goals of Sections. A draft discussion paper will be presented to OPA Council at our meeting in June. We want to focus on six Sections to begin with - Child and Adolescent, Community, Consultation-Liaison, Geriatric, Psychotherapy and Residents - before we tackle others. Two of these sections - Community and Residents - will be new and we are excited about how this will unfold. Many thanks to Elizabeth Leach, Krista Boylan, Jane Howard, Rosemary Meier, Don Pearsall and Lorraine Taylor who have worked diligently on this project with me. We are hoping to move quickly to ask OPA members to choose which Sections they would like to belong. We are also planning to provide a lunch meeting for members of each Section at the 2003 OPA Annual Meeting, to serve as a launch for our revitalized Sections.

The OPA continues to actively contribute to the activities of the Coalition of Ontario Psychiatrists. Some of the Mental Health Implementation Task Forces will be submitting their final recommendations to the Minister by the end of this month. The OPA will be reviewing these recommendations in a timely manner in order that the best interests of individuals with mental illness will be considered.

As you know, the OMA Section on Psychiatry held their Annual General Meeting on May 3, 2002. I am pleased to report that OPA President-Elect, Dr. Bob Buckingham, is now the OPA representative to the OMA Section on Psychiatry and Dr. Derek Puddester, OPA Council Member, will be representing the Canadian Academy of Child Psychiatry on the OMA Section on Psychiatry.

I would like to emphasize the educational mandate of the OPA. I am deeply committed to education and I believe it is important for professionals to engage in life long learning. The OPA allows psychiatrists and other health professionals to

learn about important aspects of psychiatric practice. Dr. Ann Thomas, Chair of the Continuing Education Committee, has planned another outstanding program for the next Annual Meeting based on the theme "Psychiatry Across the Life Span". Please mark the dates on your calendar for the OPA Annual Meeting and AGM - January 30, and 31 and February 1, 2003.

I would like to continue to thank my colleagues on the OPA Council and Elizabeth Leach, Director, Policy and Planning and Lorraine Taylor, Executive Assistant, 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.

*President, Ontario Psychiatric Association
Margaret Steele, HBSc, MD, FRCP(C)*

INSIDE

IN EVERY ISSUE	PAGE
• Message From The President	1
• From The Editor	2
• Calendar Of Events	3
• OPA Council Meeting Agenda	7
• Meet A Council Member	12
• Resident Column	23
IN THIS ISSUE	
• Update Of Items Previously Reported In The <i>Dialogue</i>	6
• The Ministry Of Health Response To OPA	8
• OPA's Letter To Workplace Safety and Insurance Board	8
• OPA'S Letter To Ministry of Education	9
• Ministry Of Education Response To OPA	9
• OPDPS/PH AGM	10
• Physical Medicine Research Foundation	11
• AGHPS AGM	11
• Update: OMA Section On Psychiatry	12
• Central Tariff Committee (CTC) Update	13
• RBRVS	13
• Dialogue Readership Survey	14
• The Ontario Medical Association Department Of Legal Services	15
• Report Of The Continuing Education Committee	15
• Feature Article - Meeting Of The Minds: The Interface Between Naturopathy and Psychiatry	16
• Mental Health Care In Canada	20
• Canadian Mental Health Association	21
• New Books For Children	22
• The 2001 OSDUS Mental Health Report: CAMH	24
IN NEXT ISSUE	
• "Responding to Complaints: Don't Make Matters Worse" Information on: Children's Mental Health Ontario Results of the June 2002 <i>Dialogue</i> Readership Survey	

Ontario Psychiatric Association — Executive and Council —



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*The OPA reserves the right to refuse requests for advertising.
The views expressed in this newsletter do not necessarily reflect the views of the OPA Council.*

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From THE EDITOR

This issue of *Dialogue* is packed with information about what's new from OPA and what is new in mental health in general. The feature article is entitled "Meeting of the Minds: the Interface between Naturopathy and Psychiatry". If you enjoyed reading about this topic, let me know and additional information can be included in future issues.

Dr. Ann Thomas provides an update on the 2003 OPA Annual Meeting to be held in Toronto on January 30, 31 and February 1st.

There are also updates on topics that have been covered previously in *Dialogue*, such as CTC, RBRVS, the Bloor Viaduct luminous veil project and the disability tax credit. Many thanks to Dr. Sonu Gaind and Dr. Doug Weir for continuing to provide updates on CTC and RBRVS. Dr. Weir provides a summary of the OMA Section on Psychiatry Annual General Meeting in this issue as well, complementing two AGM reports from the OPDPS and the AGHPS, written by Dr. Federico Allodi and June Hylands, respectively.

In this issue we "Meet a Council Member" – Dr. Roumen Milev from Kingston. Please let me know if you would like to see other questions and answers in this column as we work our way through introducing you to all of the OPA Council Members.

"Resident's Review" continues to focus on topics of interest to psychiatry residents. Our thanks to Dr. Khrista Boylan for putting together this informative and important column.

Legal topics continue to be of interest to OPA members; this issue includes a description of the legal services available through the OMA.

Our Annual Readership survey is included in this issue. Please take a few minutes to fill this out and return. The survey is also being sent by email to those members who have given us email addresses and we hope that this will increase the number of responses. We will share the results of the survey with you in the September 2002 issue. And you may win \$100 off your registration fee to the 2003 OPA Annual Conference in Toronto.

Is anything new happening in your neck of the woods? Would you like to provide an editorial on an issue that is important to you? I would be pleased to hear from you so that we can share this information with all our readers.

Elizabeth Leach
Editor

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 to
opa@bellnet.ca or by fax: 905-469-8697

CALENDAR OF EVENTS



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

Ontario Psychiatric Association 2002 Council Meetings

Toronto – Friday, September 20; Friday, November 15

Space is limited, please contact Lorraine Taylor, OPA Executive Assistant, for locations or further details; (905) 827-4659, email: opa@bellnet.ca

19th Annual Cape Cod Summer Symposia

June 17 – August 23, 2002

Sheraton Four Points Hotel, Eastham, MA

The Nineteenth Annual Cape Cod Summer Symposia provides mental health professionals with an outstanding opportunity to combine a stimulating symposium with a relaxing summer vacation. Distinguished faculty, many of whom are leaders in their fields, will present 30 different week-long symposia during the ten weeks of summer from June 17 through August 23. Each symposium will convene at the Sheraton, Four Points Hotel, Eastham, 9:00 am until 12:15 pm, Monday through Friday. Topics include; Clinical Psychopharmacology, Overview and Recent Advances; Trauma Therapy: Challenges in Treatment; Substance Abuse and Dual Diagnosis: New Treatment Approaches; Mindfulness, Willingness and Radical Acceptance in Psychotherapy.

Contact Information: New England Educational Institute, 92 Elm Street, Pittsfield, MA, 02101, Tel: 413-499-1489, FAX: 413-499-6584, website: www.neei.org, email: educate@neei.org

Interpersonal Psychotherapy Summer Training Institute

June 20, 2002

CAMH - Toronto

Interpersonal Psychotherapy (IPT) is a brief psychotherapy for treatment of depression, understood as a medical illness in an interpersonal context. IPT is an empirically proven primary treatment for acute major depression and can be readily combined with antidepressant medications to decrease relapse. The IPA Training Institute's 3-day curriculum provides an evidence-based elaboration of central theoretical constructs upon which the work is based. It includes both didactic and interactive components to impart both knowledge and therapeutic skills in a small group format. Participants will gain a theoretical framework in the basic principles of IPT and learn which patients are most likely to benefit from IPT, which patients will require combined IPT and pharmacotherapy, how to formulate an appropriate focus for the therapeutic work and to apply the strategies and techniques in conducting IPT for treatment of Major Depression.

Contact information: Melissa Least, phone: 416-535-8501 ext. 6638, email: melissa_least@camh.net

Annual General Meeting, Centre for Addiction & Mental Health

Thursday, June 27, 2002 at 4:00 pm

Queen Street Site, 1001 Queen St. W., Toronto, M6J 1H4, ph: 416-535-8501

Details available on the website: www.camh.net

Molson Indy Bike Challenge

June 27, 2002

Exhibition Place, Toronto

The Canadian Mental Health Association is proud to be participating for its 7th consecutive year in the Molson Indy Bike Challenge. Sponsored by the Molson Indy

Festival Foundation, teams obtain pledges and sponsorships to race and raise money to support the Canadian Mental Health Association.

This is a fun, friendly and competitive event. Participants are encouraged to get \$100 in pledges and will receive two general admission passes to July 5th Molson Indy, a Molson Indy Bike Challenge T-shirt, a team photo and a voucher for food and drinks at the event.

Contact information: Lucas Southern, 416-977-5580 ext. 4131 Fax: 416-977-2264 email: lsouthern@ontario.cmha.ca

Harvard Medical School 13th Annual Summer Seminars

July 1 - 5, 2002

Brewster MA, Cape Cod.

A) Mind/Body Medicine: Past, Present and Future. B) Enhancement of Peak Performance in Sports, the Performing Arts and the Worksite. C) New Strategies in the Assessment and Treatment of Depression and Anxiety - 2002 Update.

Contact information: Jean-Marie Flynn 617-629-9427, e-mail: jean-marie_flynn@hms.harvard.edu

Harvard Medical School 13th Annual Summer Seminars

July 8 - 12, 2002

Brewster, MA, Cape Cod.

A) The Psychiatrist as Expert Witness: Beginning and Developing Your Forensic Practice. B) Psychotherapy for Difficult Patients: Treating Multiple Interacting Disorders. C) Psychodynamic Psychotherapy: Contemporary Applications.

Contact information: Jean-Marie Flynn 617-629-9427, e-mail: jean-marie_flynn@hms.harvard.edu

Healing the Future: Therapeutic Contributions to the Welfare, Education and Development of Young People

July 10 - 12, 2002

Sheffield Hallam University, England.

This international conference will have 30 workshops as well as papers and keynote speakers. Themes include bullying, conduct disorder, emotional literacy, multiple intelligences, bereavement, brief counselling, working through trauma, using reality therapy, enhancing classroom behaviour, and setting up a school counselling service.

Contact information: Dr. Colin Feltham, e-mail: C.D. Feltham@shu.ac.uk

The Tenth Ottawa Conference

July 13 - 16, 2002

The 10th Ottawa Conference on Medical Education will be held in the city of Ottawa, where it all began. Pre-Conference activities will be held on Thursday and Friday, July 11th and 12th. Information available at <http://www.ottawa10th-at-home.org/> or e-mail: ottawa10th@home.com

The 8th International Conference on Alzheimer's Disease and Related Disorders

July 20 - 25, 2002

Stockholm, Sweden.

At daily plenary sessions and 20 symposia over five days, 135 invited speakers will explore research advances in Alzheimer's disease *continued on following page*

and other neurodegenerative disorders that cause dementia. More than 1,300 researchers are expected to submit abstracts for oral presentations and poster presentations spanning the entire spectrum of dementia research. There will be a half-day program targeted to social and behavioural issues. Contact information: www.alz.org/internationalconference

Cognitive-Behaviour Therapy (CBT) with Children

July 25 –27, 2002

Centre for Addiction and Mental Health, Toronto

Principles of CBT and their application to children will be reviewed briefly, with most of the course devoted to interactive workshops on specific, practical applications of CBT in children of various ages with various disorders. Both group and individual applications will be discussed. Participants will be encouraged to bring case vignettes that will be discussed regarding suitability for CBT and (for those already using this modality) regarding specific treatment challenges. The course facilitators will provide participants with periodic, case-focused follow-up workshops via Telepsychiatry during the 2002-2003 academic year, to consolidate course learning. The 3-day course will be limited to 30 participants.

Contact Information: Karine Laroche, 416 535-8501 ext. 6017; fax, 416 595-6644; website www.camh.net/ets/ e-mail, karine_laroche@camh.net

Harvard Medical School 13th Annual Summer Seminars

July 29 - August 2, 2002

North Falmouth, MA, Cape Cod

A) The Practice of Grief Counselling: From Uncomplicated Grief to the Aftermath of September 11, 2001. B) Phase-oriented Treatment for Psychological Trauma. C) Cognitive-Behavioral Therapy and Dialectical Behavior Therapy.

Contact information: Jean-Marie Flynn 617 629-9427, e-mail: jean-marie_flynn@hms.harvard.edu

The 2002 Kingston Summer Play Therapy Institute

August 5 - 9 2002

Kingston, Ontario.

This is a series of workshops with the objective of increasing the professional skills of participants in the area of child and play therapy techniques: allowing participants an intensive participation in practical child and play therapy methods that can be used in practice upon completion of the program; increasing the comfort level working with children in creative arts realms. Limited enrolment.

Contact information: 613-63403125; fax, 613 634-0866; e-mail, pti@playtherapy.org

Harvard Medical School 13th Annual Summer Seminars

August 5 - 9, 2002

North Falmouth, MA, Cape Cod

A) Knowledge, Experience and Relationships: Agents of Therapeutic Change. B) Essential Psychopharmacology, 2002: Practice and Update. C) The Psychology of Investing.

Contact information: Jean-Marie Flynn 617 629-9427, e-mail: jean-marie_flynn@hms.harvard.edu

Cognitive Therapy Summer Training Institute

August 15 - 17, 2002

CAMH, Toronto

In cognitive therapy people explore and become aware of how attitudes, beliefs, expectations and automatic thoughts can produce and maintain their unpleasant moods. This awareness creates the possibility of seeing themselves and others in new ways. Thus, the first step towards change involves becoming aware of self-defeating thinking styles and behavioural patterns, many of which take place outside of awareness. The next step involves experimenting with new ways of looking at things and/or trying out new patterns of behaviour. The focus in this short-term treatment is on the here and now, with an emphasis placed upon present feelings, behaviours, thoughts and interactions.

Contact information: Karine Laroche, Education and Publishing Services, 416 535-8501 x 6017; karine_laroche@camh.net.

Harvard Medical School 13th Annual Summer Seminars

August 19 - 23, 2002

Stockbridge, MA, Berkshire.

Intensive Dynamic Treatment of the Severely Disturbed Patient.

Contact information: Jean-Marie Flynn 617 629-9427, e-mail: jean-marie_flynn@hms.harvard.edu

12th World Congress of Psychiatry

August 24 - August 29, 2002

Yokohama, Japan.

Contact information wpa_sec@c-linkage.co.jp website, www.wpa2002yokohama.org

Mindfulness Based Cognitive Therapy: A Seven-Day Workshop/Retreat (MBCT)

August 26 - September 1st, 2002

CAMH, Toronto

Mindfulness Based Cognitive Therapy is an innovative eight-session group program designed to prevent relapse in people who have recovered from unipolar depression. Drs. Segal, Teasdale and Williams, long time researchers, clinicians and authors in the field of cognitive therapy have integrated the tools of cognitive therapy with the practice and clinical application of mindfulness meditation, as originally developed in Mindfulness-Based Stress Reduction. The workshop/retreat will stress the importance of one's own mindfulness meditation practice in doing clinical work in the emerging field of mindfulness based clinical care for emotional disorders. This will be supported by formal mindfulness practice throughout the seven days. Practical information on how to implement the program, including description of session themes, curricula, samples of participant handouts and case examples will be provided.

Contact information: Karine Laroche, Education and Publishing Services, 416 535-8501 x 6017; karine_laroche@camh.net.

Institute for the Advancement of Self Psychology

September 2002

The Institute offers a four-year training program in the psychoanalytic theory and clinical techniques of self-psychology.

Contact information: IASP, 416 690-3722; e-mail rosemary.adams@sympatico.ca

Royal College of Physicians and Surgeons. Reaching Higher, Growing Stronger

September 26 - 28, 2002

Ottawa

Annual Conference on Achieving Quality Health Care through Education, Professional Development and Research. Dedicated as we are to ensuring the highest standards and quality of healthcare, the Royal College makes important contributions and collaborates with other organizations in the areas of medical education, continuing professional development, research and the development of health policy that supports quality in Canadian health care. And so it is that our Annual Conference is once again focused on these key areas for 2002. The Conference will also continue to offer quality programming in generic aspects of specialty medicine that are important to the practicing physician such as biomedical ethics, the history of medicine and medico legal topics.

Contact information <http://rcpsc.medical.org/english/meetings/>

Eye Movement Desensitization and Reprocessing (EMDR) – Level I

September 26 – 28, 2002

Toronto

An initial 18-hour programme consisting of: history and theory of EMDR; efficacy of EMDR: research findings; how to use EMDR as a form of psychotherapy; client selection criteria and cautions; how to do the EMDR procedure: eight phases of treatment; applications of EMDR including personal use; seven hours of practice using EMDR. This initial 18-hour program will cover the material presented in Shapiro's text, Chapters 1-9. The participants will be required to have used EMDR for at least 25 sessions with clients before proceeding to the next level of training. In addition, the participants will participate in a two-hour consultation/supervision session during this interval to ensure that they are applying the EMDR procedure

correctly. A certificate of attendance will be given to participants who complete this part of the program. 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

Call for Papers/Posters - Deadline June 30, 2002 Cash Prize Competition

Scientific Chair: Dan Costa MD, PhD, FRCPC Scientific Co-Chair: Jack Richman MD, CCFP, CCBOM, FACOEM, DOHS, CIME

Associated Post Conference Workshop: Clinical Assessment of Malingering and Deception September 30, 2002, Markham-Toronto, Ontario, Canada

Workshop Faculty: Phillip J. Resnick, MD & Richard Rogers PhD, ABPP

Contact information: Physical Medicine Research Foundation, Suite 204, 856 Homer Street, Vancouver, BC V6B 2W5, Toll Free (800) 872-3105, Fax (604) 684-6247 E-mail: pmrf@icpro.org; www.icpro.org

Association of Academic Psychiatry 2002 Annual Meeting: Advances in Psychiatric Education, "The Exemplary Educator: Getting There and Getting the Recognition You Deserve"

October 2 - 5, 2002

Toronto

Chair: Dr. Deborah Klamon, Keynote Speaker, Richard Tiberius.

Contact information: http://www.hsc.wvu.edu/aap/2002_annual_meeting.htm

Mental Illness Awareness Week

October 6 - 12, 2002

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. Included in the "special populations" under consideration for this conference are those within the following categories: * Those with health conditions (e.g. MICA/dual diagnosis, physically challenged, HIV/AIDS, mentally/developmentally disabled, on substance-maintenance). *Those impacted by life situations and circumstances (e.g. poverty, homeless, in residential settings, incarcerated). *Those within specific demographic groups (e.g. elderly, people of color, college students, gay/lesbian/bisexual/transgender, rural, families, adolescents, women. Contact Information: Jane Angelone - angelone@binghamton.edu - tel:607-777-4447 - fax:607-777-6041

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, Pitsfield, MA 01201, Tel: 413-499-1489, Fax: 413-499-6584, email: educate@neei.org; web: www.neei.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>

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 becoming increasingly interested in ways of integrating spirituality with health-care. The health benefits of specific spiritual therapeutic modalities and spiritual practices are now beginning to be documented by research studies. The purposes of this conference are to: enable participants to network with others who 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 an 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

Canadian Psychiatric Association 52nd Annual Meeting

October 31 - November 3, 2002

Fairmont Banff Springs Hotel

Contact information: www.cpa-apc.org

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 abreactions; 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. 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

CMHA National Conference 2002- People Policy & Passion - New conversations about mental health

November 16 - 19, 2002

Ottawa, Ontario

Crowne Plaza Hotel

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

OHA's Annual Convention & Exhibition will afford *continued on following page*

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. More information will be available on the OHA website in August: www.oha.com

OPA 83rd Annual Meeting, "Psychiatry Across the Life Span"

January 30, 31, February 1, 2003

Toronto Marriott Eaton Centre Hotel, 525 Bay St., Toronto

Call For Papers deadline is August 9, 2002

Contact information: OPA Head Office, (905) 827-4659; opa@bellnet.ca

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

THE ONTARIO PSYCHIATRIC ASSOCIATION IS PLEASED TO WELCOME THE FOLLOWING NEW MEMBERS UP TO APRIL 5TH, 2002

Archana Bapat
Gail Maureen Beck
Marcia Benjamin
Catherine Boucher
Corine Carlisle
Katherine Cochrane-Brink
Julio Fernando Diaz-Bobadilla
Kent Dunn
Carla Edwards

Alicja Fishell
Paul Garfinkel
Cynthia Gertsman
Ewa Godlewski
Meyer Isenberg
Jeffrey Jackson
Ronald Kimberley
Katalin Kovacs
David Lam

Robert Levitan
Gunter Lorberg
Ana Lulic-Hrvojc
Moiria MacLean
Valerie Anne MacLeod
John Maher
Marilyn Marshall
Deanna Mercer
Roumen Milev

David Ng
Ebenezer Okyere
Hoa Pham
Beth Reade
Nur Shaw
Victoria Stergiopoulos
Janice Van Kampen

Congratulations to the following Members-in-training who have completed their residencies, and have become OPA Full members

Elizabeth Cvejic
C. Gerin-Lajoie

Berverly Goodwin
Susan Johnston

Derek Pallandi
Tanya Petter

Paula Ravitz
Johanne Roberge

UPDATE of items previously reported in the *Dialogue*

Barrier to prevent Suicides on Toronto Bridge

In the June 2001 issue of *Dialogue* we reported on OPA's support of the wide-spread efforts to erect a barrier on the Bloor Viaduct in Toronto in order to reduce the number of suicides at this site. More than 400 people have committed suicide from the bridge since it was built in 1919. For a number of reasons, the installation of the barrier was delayed for some time. The OPA is pleased to report that work has begun on the "luminous veil" and a tragic chapter of Toronto's history will soon be closed. The design of the barrier will make it impossible for anyone who is intent on committing suicide to jump from the bridge.

The Disability Tax Credit

In the last issue of *Dialogue*, Lembi Buchanan reported on the fight to change the Disability Tax Credit Certificate so that individuals with severe and prolonged mental illnesses such as schizophrenia and bipolar disorder can qualify for this tax credit. Ms. Buchanan updates her story for us:

After three months of investigations into the way the Canada Customs and Revenue Agency (CCRA) administers the Disability Tax Credit (DTC), a report prepared by the Sub-committee on the Status of Persons with Disabilities was tabled in the

House of Commons on March 21, 2002. The report, *Getting it Right for Canadians: The Disability Tax Credit*, criticizes CCRA for practices that are "grossly inadequate" for people with disabilities and recommends immediate action to reform the DTC. The members of the Sub-committee held several public hearings with representatives of numerous organizations and medical associations including Dr. Blake Woodside, President-elect of the Canadian Psychiatric Association, into the abuse of CCRA's mandate toward individuals with disabilities. During its study, members also recognized the need to make the DTC work more fairly for people with mental illnesses. The current DTC form demonstrates a fundamental misunderstanding of the overall impact and burden of a severe mental illness on the lives of Canadians and their families. The report calls for amendments to the Income Tax Act and a complete overhaul of the way the tax credit is administered. The report also emphasizes the need for consultations between the government departments and the stakeholders of the disability community as well as the medical professionals to ensure that the eligibility criteria for the tax credit reflects the reality of living with a disability. The report, *Getting it Right for Canadians: The Disability Tax Credit* can be accessed from the Home Page of www.disabilitytaxcredit.com.

For more information contact Lembi Buchanan at (416) 922-0202 or drc@the-wire.com or visit www.disabilitytaxcredit.com ■

MEMBERS ON THE MOVE MOVE MOVE

To get your new appointment in "Members on the Move", send us the following information – your name, position, date of appointment, the organization you were with and the new organization (if applicable), your email, phone number and address. We will run these announcements as we receive them, and as space in

the *Dialogue* allows. Please forward your items in writing to the OPA Head Office, 1141 South Service Rd. W., Oakville, ON, L6L 6K4 or by email to: opa@bellnet.ca or fax to: 905-469-8697.

LETTER TO THE OPA PRESIDENT

Dear Dr. Steele,

As a past President, 1976 (twenty four years ago), I was pleased, indeed thrilled to receive the gold pin you so kindly sent to me following the Annual General Meeting in January. Thank you. Thank you. Thank you. Since my retirement 15 years ago, I've been fortunate enough to winter in Florida. Thus it is many years since I've attended the Dinner/Dance. But I've watched our Association grow and change. I read the newsletters avidly. I cannot believe the progress, remembering as I do the lesser breadth of involvement and activity in 1976. Congratulations too, on your chairmanship of a task force "considering new Sections as well". You asked for thoughts on this topic. Sadly I've none. I wish I did. I can only say: "Best wishes and thank you for your leadership, for the time and energy you are giving to our professional Association and profession".

Yours truly,
John Clayton

Dear Dr. Clayton,

It is great to be thanked, but the time and energy is really given by many and we are all grateful for the work done by Council, Sections and many others.

Sincerely,
Margaret Steele, OPA 2002 President

AGENDA OPA Council April 5th, 2002

1.0 Remarks from the President

Approval of Agenda

2.0 Approval of Minutes of January 16, January 18 and January 19, 2002 OPA Council

3.0 Old Business

- 3.1 Coroner's Reports
- 3.2 Letter to Dr. T. Richard, MOHLTC
- 3.3 Workplace Safety & Insurance Board
- 3.4 Report of the Sections Task Force
- 3.5 OPA/Telepsychiatry
- 3.6 ISA

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 Ontario College of Family Physicians – Mental Healthcare
- 7.2 Consent & Capacity Board – Rules of Practice
- 7.3 AGHPS Document/OPA Response
- 7.4 Draft Privacy of Personal Information Act
- 7.5 SSO Interview

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March 5, 2002

PRIVATE AND CONFIDENTIAL

K. Anderson, MD
Ontario Psychiatric Association
1161 South Service Road West
Oakville ON L6L 6K4

Dear Dr. Anderson:

Thank you for your letter, addressed to Dr. T. Richard, dated January 31, 2002.

The letter discussed was sent to a large group of physicians in December 2001 as part of a new Provider Education Program. The goal of this project was to educate and remind physicians of the Schedule of Benefits' requirements regarding documentation of time-based fee schedule codes. In response to concerns by physicians who received this letter, an amended version was sent to the rest of the physicians selected for the project. Please see the attached copy of the amended letter.

As stated in Bulletin #4311, the Schedule of Benefits requires that, for all time-based services billed in units, the time the service commenced and terminated must be documented on the patient's medical record. When it appeared that these requirements were not always being followed, the Ministry contacted physicians who had a significant number of these claims to remind them of the requirements.

While mass mailings such as Bulletins and inserts in newsletters are certainly efficient, the letters were sent by courier in this case to emphasize the importance of this information.

You discussed phrases that were felt to be alarming such as "Please be aware that the Ministry continues to monitor claim submissions and that this letter does not preclude the Ministry from taking additional action on previous or future claims submitted to OHP". This is to clarify that the Ministry is making no comment on the validity of any specific claims, reserving the right to take action if it is suspected that some claims were improper.

K. Anderson, MD
March 5, 2002

Your suggestion of the OPA newsletter is appreciated and will be considered in future endeavors.

I hope this clarifies this initiative. Please contact me should you have any further concerns.

Sincerely,

J. Smealman, MD
Medical Consultant
Monitoring and Control

JS:sh

c. Hon. Tony Clement, Minister of Health & Long-Term Care

Encl.

Editor's Note: It appears that the letter from OPA resulted in a new letter to physicians from the Ministry on this issue.



March 18, 2002

Ms Slavica Teodoric
Director, Benefits Policy Branch
Workplace Safety and Insurance Board
200 Front Street West, 18th Floor
Toronto, ON
M5V 3J1

Dear Ms Teodoric:

I am writing on behalf of the Ontario Psychiatric Association (OPA) regarding WSIB's Mental Stress Policy.

We would be interested in receiving information on the developments further to the mental stress policy consultation and to the current status with respect to that policy.

The OPA fully endorses the Response to WSIB "Mental Stress" Guidelines Issues of Concern to Physicians, signed by Dr. Michael S. Ross, Member of the Committee on Work and Health, Ontario Medical Association, submitted last year.

We are interested in your response to their recommendation that:

"Outside consultation with physicians and others whose relevant knowledge and expertise enables them to provide useful input is desirable at every stage of such process."

Should you wish to proceed with the above recommendation, the OPA will be pleased to respond to your invitation to participate in such process.

Yours sincerely,

Federico Allodi, MD, FRCPC
Secretary (Acting), OPA Council

c.c. Mr. James Mendel, Health Policy Department, Ontario Medical Association, 525 University Ave., Toronto, ON, M5G 2K7
Dr. Alice Dong, Workplace Safety Board, Corporate Health Centre, 15th Floor, 200 Front St. W., Toronto, ON, M5V 3J1
Dr. Michael Ross, 2401 Yonge St., Suite 215, Toronto, ON, M4P 3H1

Editor's Note: No response has been received from WSIB as yet.

Streamlining Access to Mental Health Services and Supports

The Ministry of Health and Long-Term Care has released a document entitled "A Guide to Developing Recommendations on Streamlining Access to Mental Health Services and Supports". The guide is intended to assist Mental Health Implementation Task Forces in developing recommendations regarding streamlining access to mental health services across Ontario. The guide describes the four key features of a system with streamlined access, details of the goals and the outcomes to be achieved, and poses questions for consideration as options are assessed. The guide is intended to assist Mental Health Implementation Task Forces, Regional Offices, and other stakeholders in developing and assessing options and recommendations for improving access to mental health services and supports according to the particular needs and characteristics of their local communities.

To obtain a copy of this 10 page report, please contact the OPA Head Office by phone: (905) 827-4659 or by email: opa@bellnet.ca.

Statistics Canada & Mental Health

For the first time ever, Statistics Canada will do a population health survey on mental health. Starting in May 2002, Statistics Canada will survey 30,000 Canadians about their mental health and establish baseline data. The questions will be based on a survey developed by the World Health Organization. The results will be released in the fall of 2003. More information will be available in *Dialogue*.

REMINDER

submissions for the next issue of *Dialogue* are to be in to the Editor by August 15, 2002

Have you found any interesting/informative websites that you would like to share with others? Please forward the information to the Editor by email: opa@bellnet.ca or by fax: 905-469-8697.



November 22, 2001

Honorable Janet Ecker
Minister of Education
Queens Park
Toronto, Ontario
Canada

Dear Minister Ecker:

RE: CRITERIA FOR ISA CLAIMS SUBMITTED FOR PROFILES 1.2/1.3 - BEHAVIOR

The Ontario Psychiatric Association (OPA) would like to express its concerns with respect to the new criteria for ISA claims submitted for profiles 1.2/1.3 - Behavior.

The OPA is aware that in 1998 the Ministry of Education introduced a new funding approach for students with special needs. Boards of Education were funded through Foundation Grants and a Special Education Per Pupil Amount. Boards could further apply for funds to provide programs and services for students requiring an intensive support amount (ISA). In August, 2001 the Ministry of Education released a modified approach to funding students requiring intensive supports. Rather than ISA funds being attached to individual students, this funding flows to Boards to be placed in the overall Special Education 'Envelope' to be used to support all students with special needs. The change that is most concerning to the OPA relates to the requirement that ISA claims first and foremost must be supported by a diagnostic statement (based on the Diagnostic Statistical Manual - Fourth Edition (DSM-IV)) by a member of the College of Physicians and Surgeons of Ontario or Ontario College of Psychologists.

It is important to know the serious barriers that this change creates. There are approximately 90 full time child psychiatrists in Ontario with the majority being located in London, Hamilton, Toronto, Kingston, and Ottawa. As a result, in most small cities and rural communities, school boards have minimal or no contact with a child psychiatrist. Child psychiatrists and general psychiatrists are the only physicians who are trained extensively in the DSMIV criteria. To request that family physicians and pediatricians make these diagnoses is inappropriate.

A recent survey of family physicians in South Western Ontario demonstrated that 84% of family physicians had no training in children's mental health; and that 16% only had minimal training. In addition, when asked what their areas of diagnostic limitations were they identified attention deficit with hyperactivity disorder and behavior disorders, which are the predominant problems experienced by school-age children in schools (Steele, M., Dickie, G., Fisman, S., Rourke, J., Stretch, N., Gingrod, A., 2001). This suggests that family physicians need extensive training before they can competently provide the required diagnoses. The OPA would like to know if it is the intention of the Ministry of Education to be offering the necessary training for the family physicians.

Dr. Mervyn Fox, a developmental pediatrician and Associate Professor in the Department of Pediatrics, Psychiatry and Occupational Therapy at the University of Western Ontario, has said there is "a growing tendency to transfer from the schools to the health system the responsibility for assessing the educational needs of handicapped children." He goes on to say that "To expect family physicians and pediatricians, few of whom have any relevant experience or training, to undertake this work seems designed only to reduce funding for special children while quietly increasing the costs of an already overburdened and under-funded health service" (Fox, M. Educators must assess special needs. VOX POP, London Free Press, September 6, 2001).

Developing a policy that is based on asking physicians to write letters to schools limits access for patients and increases the workload of physicians, who are already extremely overworked. Most important, it does not necessarily meet the best interests of children and families.

Therefore, the OPA is expressing serious concerns about the inappropriateness of this policy; to expect that ISA funding should be based on family physicians, pediatricians and child psychiatrists providing a diagnostic label is neither fair nor feasible. We strongly recommend that the Ministry of Education change the criteria for ISA funding such that physicians are not responsible for ensuring that the children receive this resource. The OPA looks forward to your response on this urgent matter, and will be happy to discuss the matter with the Ministry of Education.

Sincerely,

Keith Anderson, M.D., FRCPC
OPA 2001 President

cc: Mr. Gerrard Kennedy, Liberal Critic Ministry of Education
Mr. Rosario Marchese, NDP Critic Ministry of Education
Peter Gooch, Ministry of Education
Lynn Ziraldo, Chair, Minister's Advisory Council on Special Education
The Ontario Medical Association
Dr. Gregory Gillis
Dr. EG McNeary, Chair, OMA Section on Psychiatry
Dr. Kenneth Hook, President, Ontario College of Family Physicians
Dr. Calvin L. Gutkin, President, College of Family Physicians of Canada
Raymond LeBlanc
Dr. Janice L. Currie, Coordinator of Psychology, Toronto District School Board

Ministry of Education

Minister's Office
Queens Park
Toronto, ON M5S 1A2

Ministère de l'Éducation

Bureau du Ministre
Parc des Édifices
Toronto, ON M5S 1A2



Education Finance Branch
2177 Place Royal/Banc
Tel. No. (416) 326-2424 Fax: 326-2423

March 8, 2002

Dr. Keith Anderson
President
Ontario Psychiatric Association
1141 South Service Road West
Oakville, ON L6L 6K4

Dear Dr. Anderson,

Thank you for your letter to the Minister of Education about the Intensive Support Amount (ISA). I regret the delay in responding, however, I am pleased to reply on behalf of Minister Kelso.

Let me start off by saying that the government recognizes the important role that psychologists and psychoeducators play in providing support to ISA claims.

Regarding your concerns about ISA claims, boards are given flexibility in allocating ISA funding to allow them to provide the necessary supports for all high-needs students. Funding that is generated through the review of ISA files is not tied to individual students, nor does the funding determine programming or support levels. Supports for individual students may cost more or less than the funding level assigned to their file, and boards are given flexibility to meet these costs.

As announced in May 2001, the Ministry has committed to a comprehensive review of ISA funding. The ISA eligibility criteria have been clarified by the ISA Eligibility Group with consultation on issues from the ISA Working Group, the Minister's Advisory Council on Special Education, the Second Expert Panel that proposed refinements to the ISA profiles in 1999, former ISA validators, and clinical professionals. The intent and purpose of the ISA process is to determine, in the most fair and equitable manner possible, the funding necessary to serve the students with the highest needs in our educational system.

In order to achieve such a goal, it is necessary to have consistent, credible, and professionally recognized criteria. The DSM IV, the most widely used standard in North America, is familiar to psychologists, psychoeducators, and related professionals. Using the DSM-IV as a reference manual helps to maximize consistency of profile interpretation across the province.

It is up to individual physicians, within the professional standards to which they are accountable, to determine whether they are qualified to make the diagnosis required by the various ISA eligibility criteria profiles.

With regard to your concerns about the role of physicians and pediatricians in providing supporting documentation for ISA claims, physicians and other physicians are among those regulated professionals who can provide relevant assessments. Boards have flexibility, within the requirements of the eligibility criteria, to use a variety of professional experts to support the ISA process.

I have enclosed a copy of an article titled *The Physician's Role in the New ISA Funding Criteria*, by Carolyn Hare and Jay Rosenfeld. The article, originally published in the Learning Disabilities Association of Ontario newsletter, does an excellent job in outlining the support physician and pediatrician play in the ISA comprehensive review. The article is also available on the Ministry's ISA comprehensive review Web site, located at: http://www.edu.gov.on.ca/eng/ISA_Comp_revision.

Thank you again for presenting an opportunity to respond to your concerns.

Sincerely,

Peter Gooch
Director
Education Finance Branch

Enclosure

Editor's Note: This information is being provided in Dialogue in order to ensure that more child psychiatrists are made aware of this issue.

OPDPS/PH Section of OMA

ANNUAL GENERAL MEETING

A Brief Report

By: Federico Allodi, MD, Chair, OPDPS/PH Section of OMA

The Annual General Meeting of the Association of Ontario Physicians and Dentists in Public Service was held on May 3 2002, conjointly with the Section of Ontario Hospitals Hospital Schools ("Psychiatric Hospitals") of the Ontario Medical Association since both organizations have an identical and co-terminous Board of Directors.

In the business part of the agenda, the Chairperson reported on the demonstrated success of the re-structuring of the OPDPS/PH Section, which has been part of the service corporate body of OMA for one year. As a consequence, and for the first time in the last few years, the budget showed a positive balance. The slate presented by the Nominations Committee was elected unanimously, as follows: Chair, Dr. Federico Allodi; Past- Chair, Dr. Michael Chan; Vice-Chairs, Drs. Ian Jacques and Ruth Kajander; Treasurer, Dr. Rita Rabheru; Secretary, Dr. Bill Komer. The same Board as last year was also elected. It included Drs. Leon Genosove,

Edan Corcoran, John Deadman, Steven Ingle, Mary Naidu, Ed Rostein, Badrash Surti, Barnaby Tamacloe, Pat Achiume, John Thompson and Omar Aguilar.

A panel discussion on "How We Failed the Severely Mentally Ill" formed the educational part of the meeting. The panel members were Dr. John Deadman, OPDPS Board member, Dr. Stephen Connell, Past Chair of the OMA Section on Psychiatry and past Co-Chair of the Coalition of Ontario Psychiatrists, and Mr. Leonard Wall, President of the Schizophrenia Society of Ontario. An historical perspective, ending with the present difficulties, an experiential description of the difficulties encountered by the families of the consumers of services and an outline of a blended consumer and professional organizations approach all served to provide the audience with an attempt to recover, successfully, from the current situation. In the discussion that followed, the OPDPS/ PH Section decided to formulate a plan to make a presentation on system issues to the Board of the OMA, which in turn may choose to involve the Physicians Services Committee and the Government of Ontario. ■

DRUG ALERTS

Physicians are reminded of a recent letter they received from Health Canada - Therapeutic Products Directorate, alerting them to important emerging safety information suggesting that the use of Clozapine (sold under the tradename Clozaril®) is associated with an increased risk of Myocarditis especially during, but not limited to, the first month of therapy. Please visit the Novartis website at <http://www.novartis.ca> for further information.

Health Canada also provides warnings concerning nefazodone. Nefazodone (sold in Canada under the following tradenames; SERZONE®, LIN-NEFAZODONE® and APO-NEFAZODONE®) has been associated with jaundice, hepatitis and liver failure.

Health Canada also provides warnings on several herbal products. Visit the Health Canada website at http://www.hc-sc.gc.ca/hpb-dgps/therapeut/htmleng/advisss_tpd_bgtid_e.html for further information.

Mental Illness Awareness Information

The Canadian Psychiatric Association has made available on its website information on:

- Anxiety, Depression & Manic Depression
- Schizophrenia
- Youth and Mental Illness
- Mental Illness and the Family
- Mental Illness and Work
- Mental Illness: Teamwork in Service Delivery
- Alzheimer Disease

You can print on-line copies or use the wording in your own material but you must acknowledge that the material originates from the Canadian Psychiatric Association. The website address is: www.cpa-apc.org/Publications/brochures.asp

Shared Mental Health Care

The April 2002 Shared Mental Health Care: A Bibliography and Overview supplement is now available from the Canadian Psychiatric Association.

For more information and to order a copy contact: Canadian Psychiatric Association, 260-441, MacLaren Street, Ottawa, ON, K2P-2H3; Tel: 613-234-2815; Fax: 613-234-9857; Email: orders@cpa-apc.org

Yukon Telehealth Network

The Yukon's Telehealth Network project was launched in March. The initial project focuses on four applications – telemental health, telelearning and family visitation, and emergency medical x-ray support in Mayo and Whitehorse. Other locations will be added in time. Scheduled educational sessions are also planned and will be given by B.C. and Yukon health providers on a range of topics identified as priorities by health care professionals. Funding for the project is provided by Health Canada. For more information contact: Pat Living, Communications Specialist, Health and Social Services at (867) 667-3673 or email: patricia.living@gov.yk.ca

The OPA has a
NEW
email Address

Contact us at opa@bellnet.ca

CALL FOR PAPERS AND FIRST ANNOUNCEMENT

The Physical Medicine Research Foundation (PMRF) is pleased to invite you to participate at the First International Conference on Symptom, Diagnosis, and Disability Validity: Improving Patient Outcomes, September 26 - 29, 2002, Toronto-Markham.

The validation of health care practices is a vital priority today. Patient care and disability determination and management is being shaped by economic forces and the demand that current practices must be based upon sound scientific research. At this conference, Canadian and international experts from a broad range of health disciplines will present current research and systematic evidence-based knowledge on this important and under explored area. The conference will be the first in a series on this topic and will spawn a new journal and research awards.

Cash Prizes for Best Posters and Papers

We are pleased to announce the Physical Medicine Research Foundations' Best Poster Program. Up to \$1,000 (Canadian Funds) will be paid to the principal author of selected poster(s) demonstrating innovation and excellence in research activities. Your poster should address one of the themes of the conference (see below). Complete abstracts must be received by June 30, 2002. (Abstracts for late breaking posters must be received by July 15, 2002 and are not eligible for the cash prize program.)

Student/New Investigator, Best Paper/Poster Award Program

Up to \$500 (Canadian Funds) will be awarded to selected students/new investigators for best paper or poster. New investigator refers to graduate students engaged in research projects or new investigators within one year of graduation.

The winners will be selected by a blinded peer-review process. Competition is limited to those authors who have submitted their abstract(s) and registration fee(s) by June 30, 2002. Deadline for submission is June 30, 2002.

Abstract Themes

Medical, Ethical and Legal Aspects of Symptom, Diagnostic and Disability Validity
Diagnostic Validity
Validity of Disability
Symptom Validity
Validity in Treatment Efficacy Research
Physician Patient Communication

Submit an abstract (maximum 500 words). Italics should be used where appropriate, no underlining. Please include the author(s) name, affiliation, address, telephone number, fax number and e-mail address of the presenting author for future correspondence. You can forward your abstract via mail, fax, e-mail, or on disk. If you are sending it on disk please identify the software used. We

will acknowledge receipt of your abstract by e-mail, fax, or mail. It is preferred that you submit your abstract electronically via e-mail as an attachment using MS Word 2000 or less.

More than 600 medical specialists and allied health practitioners including Psychiatrists, Physiatrists, Orthopaedic Surgeons, Occupational Medicine Physicians, Rheumatologists, Family Physicians, Psychologists, Physiotherapists, Occupational Therapists, Chiropractors, Workers Compensation Board - directors and staff, insurers, Ministry of Health personnel, and disability adjudicators will be attending this conference.

This conference has been planned and implemented in accordance with the Essential Areas and Policies of the Accreditation Council for Continuing Medical Education through the Joint Sponsorship of the American College of Occupational and Environmental Medicine and the Physical Medicine Research Foundation. (See website for accreditation details)

The following professional organizations have joined PMRF as co-sponsors or partners in launching this international program: American Board of Independent Medical Evaluators, American College of Occupational and Environmental Medicine, American Physical Therapy Association, British Neuropsychiatry Association, Canadian Association of Occupational Therapists, Canadian Association of Rehabilitation Professionals, Canadian Chiropractic Association, Canadian Memorial Chiropractic College, Canadian Neurological Society, Canadian Physiotherapy Association, Canadian Psychological Association, Canadian Society of Medical Evaluators, Center for International Rehabilitation Research Information and Exchange, Institute for Work and Health, International Society of Physical and Rehabilitation Medicine, National Spine Network, Occupational Injury Prevention and Rehabilitation Society, Ontario Physiotherapy Association, Ontario Psychiatric Association, Ontario Psychological Association, International Organization for Clinical and Disability Validity, The Bone and Joint Decade.

For more information visit our website: www.icpro.org. Early-bird registration available. Marc White, Executive Director, Physical Medicine Research Foundation, 856 Homer St, Suite 204 Vancouver, B.C. V6B 2W5, Canada, Tel: In North America +800 872-3105, Elsewhere +1 604 684-4148 Fax: +1 604 684-6247 ■

AGHPS AGM

by June Hylands, Executive Director, AGHPS

The Annual General Meeting of the Association of General Hospital Psychiatric Services was held Thursday, January 17th, 2002 at the Marriott Hotel in Toronto.

Dr. Ty Turner, President, reviewed the activities of the last year. The results of the survey conducted in 2000 have formed the basis for the development of an AGHPS Perspective. The draft document was circulated for comment. The Perspective will be finalized and distributed in May 2002.

Many of our members have been actively participating on Mental Health Implementation Task Forces throughout the province.

The Board has established an Executive Committee to expedite issues between Board meetings. This structure is proving to be quite effective.

The AGHPS has traditionally enjoyed strong working relationships with the Ministry of Health and Long-term Care as well as several professional associations. The

AGHPS will focus attention on broadening our relationship to include other stakeholder groups and the private sector.

The Treasurer reviewed the financial report.

Election of Officers for January 2002 through January 2004 were held.

The officers are:

Dr Ty Turner, President
Dr. Brian Hoffman, Vice President
Mr. Bruce Whitney, Vice President
Ms. Cathy Seguin, Treasurer

For information about the AGHPS please contact our office: 344 Lakeshore Road East, Suite B, Oakville, Ontario, L6J 1J6, Telephone: 905-849-8299, Fax: 905-849-8606, Email: jhylands@idirect.com ■



MEET A COUNCIL MEMBER:

An Interview with Roumen Milev, M.D, PhD, MRCPsych, FRCPC

Dr. Roumen Milev is currently the Program Clinical Director of Adult Treatment and Rehabilitation Program and the Acting Deputy Head, Department of Psychiatry at PCCC

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

Roumen: I am a Council member, and also I sit on the Continuing Education Committee

OPA: Tell us a bit about your background.

Roumen: I finished Medical School in my native Bulgaria, specialized in Psychiatry and completed a PhD in Forensic Psychiatry. After spending a few years in the UK, where I obtained MRCPsych, I moved to Saskatchewan. For the last two years I was the President of the Saskatchewan Psychiatric Association. I moved recently to Kingston to become Clinical Director of Mood Disorder Service, PCCC – Mental Health Services. Recently I was appointed as the Program Clinical Director of Adult Treatment and Rehabilitation Program, and also as Acting Deputy Head, Department of Psychiatry at PCCC. I have been involved in research, most recently in Mood Disorders and Schizophrenia and have several publications. I am actively involved in teaching of medical students, residents and also have done numerous presentations to Family physicians, Psychiatrists and Other Health Professionals.

OPA: When did you join the OPA and why?

Roumen: I joined OPA after I transferred from Saskatchewan, because I am a strong believer in the role Provincial Psychiatric Associations could play in both the Provincial and Federal (through CPA) level.

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

Roumen: Learning more about the particular details and differences in the work of psychiatrists in Ontario and also the specific concerns which separate groups may have had.

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

Roumen: It is difficult for me to comment about a period of 10 years, as I have been in Ontario for less than one. It seems though that there is some real progress in terms of members' recruitment and educational opportunities through the Annual Meeting.

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

Roumen: I feel that recent advances and major breakthroughs in genetics, imaging techniques and neuropsychopharmacology will continue to change and shape our field. It still continues to be extremely important, I would say even more important than ever before, to pay attention to the psychological dimensions of development and presentation of mental disorders. I also believe that there will be further advances in classification and nomenclature of mental disorders, as the conceptual schema we currently use dates back more than a hundred years and seems to be hampering further research.

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

Roumen: If you asked me this question some years ago, the answer might have been a computer programmer, but now it will be simpler: racing or rally driver.

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

Roumen: To have more free time to devote to my family and friends, and to spend some time experimenting with sailing.

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

Roumen: To become more united, e.g. by becoming members of OPA, to make every effort to improve its image in society and amongst the other members of the medical profession, and to increase significantly medical student enrollment into the field. ■

UPDATE: OMA Section on Psychiatry

By Douglas C. Weir, M.D., F.R.C.P.(C)

Chair & RBRVS Representative, OMA Section on Psychiatry

New Section Executive Elected May 3, 2002.

The Annual General Meeting of the OMA Section on Psychiatry was held May 3, 2002 in conjunction with the OMA Annual General Meeting. At that time a new executive was elected, the new executive members are:

Chair	Dr. Doug Weir
Vice Chair	Dr. Michael O'Mahony
Past Chair	Dr. Gerry McNestry
Secretary	Dr. Rayudu Koka
CTC	Dr. Sonu Gaind
Chair of the Scientific Program Committee	Dr. Adrian Hynes
Members at Large	
Dr. Robert Buckingham	Ontario Psychiatric Association

Dr. Derek Puddester
Dr. Tyrone Turner

Academy of Child Psychiatry
Association of General Hospital
Psychiatric Services
Ontario Psychoanalytic Society
OPDPS

Dr. Barry Gilbert
Dr. Federico Allodi
Dr. Desi Brownstone
Dr. Bill Komer

The new executive has a number of issues to deal with. Our first priorities will be MRC and the Monitoring Branch of OHIP, RBRVS, Regional Mental Health Authorities and representing psychiatrists in setting our fees. If you have comments about any of these issues or you wish to bring other issues to our attention I invite you to contact any of the Executive Members or you can reach me by email at: dcweir@interlog.com ■

Central Tariff Committee (CTC) Update

by K. Sonu Gaiind, Tariff Chair, OMA Section on Psychiatry

The Section on Psychiatry presented its submission to the OMA Central Tariff Committee on Thursday, May 9, 2002. The following items were requested in this year's submission:

1. Increase to Consultative Interview with Parents, A197, and Increase to Consultative Interview with Child, A198.

Given the high intensity and significant time requirements of each of these codes, the Section is seeking an increase in A197 and A198. The Section requested that A197 be increased by 38.1%, and A198 be increased by 26.4%. These increases would place A197 and A198 above the A195 consultation code by 21.3% and 11%, respectively (which is consistent with the recommendations contained in the RBRVS Draft Report).

2. Telepsychiatry Consultation, Telepsychiatry Repeat Consultation, and Telepsychiatry Assessment

The Section is requesting the introduction of several codes which would allow for telepsychiatry consultations/assessments to be provided utilizing remote video applications, with feedback and recommendations being provided to health care providers directly involved in care of the patient.

Information on telepsychiatry applications, including guidelines and regulations developed in other jurisdictions, was also submitted to the CTC.

3. EPS (Extrapyramidal System) Assessment

The Section is seeking introduction of a non-time-based code to allow billing for use and interpretation of a standardized assessment of extrapyramidal system symptoms (the AIMS was suggested).

4. Team Psychiatric Management of Disturbed Patient

The Section is seeking introduction of a new code to allow for billing of time spent providing assessment and recommendations regarding management of behaviourally disturbed hospital patients. This code would remunerate psychiatrists both for time spent with the patient, and for time discussing management of the patient with the team. The CTC has been very reluctant to allow codes for "indirect" services or "non-face-to-face" time, however the Section argued that psychiatry is in a unique position in sometimes being asked to manage the behavioural disturbance of patients, and not simply provide clinical care to patients.

The CTC will provide preliminary feedback and responses to the Section's recommendations over the summer. ■

R B R V S

Commission Final Report to be Released Summer 2002

by Douglas C. Weir, M.D., F.R.C.P.(C), 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 (now the Ministry of Health and Long-Term Care or MOHLTC) in May 1997 with a mandate to recommend a Resource-Based Relative Value Schedule (RBRVS) to replace the current Ontario Health Insurance Plan (OHIP) Schedule of Benefits. In the more recent 2000 OMA/MOHLTC Agreement, the parties re-committed to this process.

The Resource-Based Relative Value Schedule (RBRVS) Commission of Ontario released its Draft Report September 7, 2001. Once more the Report confirms that psychiatric services are under-valued. The OMA Economics Department estimated, based on the new fees for the codes evaluated to date in the Draft report, the typical psychiatrist providing services to typical patients, is estimated to have a net fee increase by about 12.79 percent (an increase in gross billings of approximately \$18,701 for the average psychiatrist).

The Executive of the OMA Section on Psychiatry has made numerous submissions to the Commission. With the support of the Coalition of Ontario Psychiatrists we have engaged appropriate experts to help us understand the various documents the Commission has produced in the last 4 years and to prepare our presentations. February 15, 2002 Dr. Gerry McNestry, Dr. Sonu Gaiind and Dr. Douglas C. Weir met with the Commission and had a full discussion of codes that we had concerns about.

It is expected that in late June or July 2002 the RBRVS Commission will complete its work and release its final report.

Since 1997 when the RBRVS Commission started its work there has been discontent by some Sections and efforts being made to derail the relativity process. The Section Executive has stated that the OMA must unite and take action to address the inequities identified by the RBRVS Commission. Failure to do so will further entrench the current inequities and lead to further demoralisation and fragmentation of the profession and the OMA. The Commission's Final Report cannot go the way of previous studies. The profession must work together to find a way to implement the findings of the Commission in a way that is fair to all.

As the Commission says, implementation is yet to come. We expect that there will be a variety of implementation models discussed within the OMA, involving the Committee on Economics and the Central Tariff Committee, and that funding for implementation will become an important part of future negotiations. The Section on Psychiatry will be an active participant in ensuring the development of fair remedial models that rectify the established fact that the services of many Sections have been undervalued and under-compensated for more than 20 years. ■

DIALOGUE READERSHIP SURVEY

Dear OPA Member,

Please take a few minutes to complete this *Dialogue* Readership Survey. Your answers will help us to ensure *Dialogue* is providing information that is important to you. If you complete and return this survey by July 31, 2002, we will enter your name in a draw for a chance to win \$100.00 off your Registration Fee for the 2003 OPA Annual Meeting in Toronto, January 30, 31 and February 1st. Thank you for your time.

You can complete this survey online @ www.daemarinc.com/opa_survey.html



- 1) Do you read *Dialogue* on a regular basis ? (please check one)
all the time _____ most of the time _____ sometimes _____ not too often _____ not at all _____
- 2) Do you pass on *Dialogue* to others? (please check one)
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- 4) Should *Dialogue* continue to offer ? (please circle Yes(Y) or No (N))
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Message from the President	Y N A B C D E	Central Tariff Committee (CTC) information	Y N A B C D E
From the Editor	Y N A B C D E	Book Reviews	Y N A B C D E
Calendar of Events	Y N A B C D E	Resident Assessment Instrument -	Y N A B C D E
OPA Council Meeting Agenda	Y N A B C D E	Mental Health (RAI-MH) information	
Council Highlights	Y N A B C D E	Government news	Y N A B C D E
Meet A Council Member	Y N A B C D E	General Mental Health Information	Y N A B C D E
Members on the Move	Y N A B C D E	Mental Health Resources	Y N A B C D E
Resident's Review	Y N A B C D E	(e.g. books, reports and websites)	
Coalition of Ontario Psychiatrists news	Y N A B C D E	Legal issues/topics	Y N A B C D E
AGHPS news	Y N A B C D E	Pharmaceutical Advertisements	Y N A B C D E
OPDPS news	Y N A B C D E	Other advertisements	Y N A B C D E
OMA Section on Psychiatry newst	Y N A B C D E	Classified ads from members	Y N A B C D E
Resource Based Relative Value Schedule (RBRVS) Commission information	Y N A B C D E	Classified ads from non-members	Y N A B C D E

- 5) What other topics would you like to see covered in *Dialogue* ?
- 6) Other comments or suggestions ?

Membership category: Full Associate Member-in-Training Life

Please print your name and phone number below to be entered in the draw:

Name _____ Phone number _____

Thank you for completing our survey. The results will be available in the September 2002 issue of *Dialogue*.

Surveys can be returned by fax to the OPA Head Office at (905) 469-8697 or mailed to: 1141 South Service Rd. W., Oakville, ON, L6L 6K4

THE ONTARIO MEDICAL ASSOCIATION DEPARTMENT OF LEGAL SERVICES

by Robert Lee B.A., M.A., B.Ed., LLB.
OMA Legal Counsel

The OMA offers legal assistance to its members on matters that impact daily practice. There are two lawyers in the Department, Jim Simpson and Robert Lee. The Department provides written and verbal advice on many topics and serves about 200 OMA members monthly.

The Department also assists physicians with legal representation at meetings when required. The Department is currently assisting the negotiating team for OPDPS in discussions with Management Board for a new contract. In the past, both Jim and Robert have been invited to meet with the medical staff associations of various psychiatric hospitals in the province to discuss matters of collective concern.

The Department provides advice, support and representation with the following issues:

1. Alternate funding and payment plans.
2. Representation in disputes or contract negotiations with hospitals.
3. Assistance with internal governance arrangements such as practice plans, association agreements or partnerships.

4. Opinions on practice issues involving OHIP, hospital privileges, divestment and contracts.
5. Negotiating template contracts with the Ministry.
6. Employment issues for office staff.

The increasing complexity of the healthcare sector has made legal advice mandatory in many instances. The Department does not deal with issues of a strictly private nature, such as lease agreements for office space or problems within the purview of CMPA coverage.

We invite the readers to contact the Department of Legal Services for assistance should the need arise.

For more information please contact Robert Lee at 416-340-2934, 1-800-268-7215, extension 2934, or email to robert_lee@oma.org. ■

Editor's Note : Are there legal issues that you would like have more information on? Let us know and we can cover those topics in future issues of Dialogue.

WANTED: BOOK REVIEWERS

Do you know of a book that should be reviewed for the *Dialogue*?
Would you like to be a book reviewer? If so, please contact the Editor.

REPORT OF THE CONTINUING EDUCATION COMMITTEE

by Ann Thomas, Chair, Continuing Education Committee



Plans are well underway for the 2003 Annual Meeting. The theme for the meeting, as chosen by Dr. Margaret Steele, will be "Psychiatry Across the Life Span". We have also chosen a logo for the Annual Meeting:



A survey of our membership was conducted to give us a better idea of why some people do not attend. Thank you to all those who provided comments and suggestions - your input is needed and appreciated. Congratulations to Dr. Richard Swinson of Hamilton, who won \$100.00 off his 2003 Annual Meeting Registration Fee in our random draw of returned surveys.

We have incorporated your suggestions as best we could. One common suggestion was to move the Annual Conference further away from the Christmas break, so the dates for next year have been moved to January 30, 31 and February 1. Once again, the meeting will be held at the Toronto Marriott Eaton Centre Hotel. Because the Friday night buffet dinner and dance was such a great success, we will repeat this event and once again include food from different ethnic communities.

It is clear that the membership want Maintenance of Certification credits, so once again we will endeavour to have as many accredited talks as possible. Please keep in mind that getting accreditation for the luncheons is a challenge, but we think we will be able to manage this.

Based on responses to our survey, we will be trying to have some talks that one usually does not find at a conference to attract those avid meeting goers who are well versed in meeting presentations.

Confirmed speakers are Dr. Philip Sarrell from Yale speaking on the "Role of Estrogen in Psychiatric Illness". Dr. Paul Sandor will present "Tourette's Syndrome Across the Life Span" and Dr. Raj Velamoor will discuss "Neuroleptic Malignant Syndrome Across the Life Span".

We are working on confirming speakers on topics such as, the Role of Androgen in Psychiatric Illness and Andropause, Bipolar Illness across the Life Span, Attention Deficit Disorder Across the Life Span and Anorexia Nervosa Across the Life Span. Posttraumatic Stress Disorder will be included, focusing on combat stress in the Canadian Military, since more of our membership is having to deal with this condition.

OPA Section luncheons, with speakers, are being planned for Saturday, February 1st.

Many thanks to the Continuing Education Committee Members, Krishna Balachandra, Mamta Gautam, Jane Howard, Roumen Milev, Margaret Steele and Elizabeth Leach.

So mark your calendar now - January 30, 31 and February 1, 2002 - Plan to attend, see your colleagues, and have a great time! ■

MEETING OF THE MINDS: the Interface between Naturopathy and Psychiatry

By: *Monica Vermani BSc, MA, Fraser Smith ND, and Martin A. Katzman BSc, MD, FRCPC*

The first line treatment option for various physical, mental and cognitive health concerns is, for the majority of people, a medical, science based, professional opinion. However, the research literature suggests that in many parts of the world, herbs, naturopathic mixtures and alternative/complimentary therapies (such as acupuncture) are an intrinsic part of various established cultures. Within many communities, these alternative forms of treatment are commonly relied on, readily practiced and have been found to be successful for the treatment of physical and mental symptoms of various disorders (D'Arcy, 1993).

The growing use of alternative/complementary health services has created a need for physicians to be more informed about the current literature regarding these treatments. An increasing number of patients use natural health products for the alleviation of psychological symptoms of disorders and for a spectrum of mental/mood health concerns. Patients often believe that natural health products are safe and miraculously effective.

Herbal remedies may be encountered in psychiatric practice when they are used to treat psychiatric symptoms, producing changes in mood, thinking, or behaviour, as side effects, or when they interact with psychiatric medications (Wong, Smith & Boon, 1998). While actual incidence rates of herbal remedies being used for self-medication are not known with any certainty, and the various types of reactions and adverse effects have not yet been sufficiently researched, we do know that "it is not unusual for patients in some communities to seek advice and treatment with traditional ethnic practitioners before resorting to more conventional medical

The premise is that the body can heal itself with the proper support and interventions.

advice" (D'Arcy, 1993). Instead of keeping the worlds of naturopathy and psychiatry separate, it is beneficial for us to merge them and openly communicate to better enhance patient care.

Naturopathic Medicine

Naturopathic medicine is a distinct system of healing that is currently practiced as a profession in Ontario and other jurisdictions across North America. Naturopathic medicine began as an association of practitioners in the early 20th century. They incorporated a wide range of natural therapies into one profession. The premise is that the body can heal itself with the proper support and interventions. Today's naturopathic doctor has received a ND diploma or degree from one of 5 recognized colleges/universities in North

America. The four-year, post university program covers as many hours in the biomedical sciences as any medical school. Therapeutic modalities include clinical nutrition, botanical medicine, acupuncture and Traditional Oriental medicine, homeopathy, physical medicine, and lifestyle counseling. Graduates write a series of 15 licensing exams on various subjects in order to practice in regulated areas.

In Canada, the Naturopathic Health Products Directorate is responsible for ensuring the accuracy of labeling. This is done in consultation with experts in the field of natural medicine and pharmacology.

Naturopathic doctors have been regulated in Ontario since 1925, under the Drugless Practitioners Act, and it is anticipated that they will be governed by the Regulated Health Professions Act, 1991 in the near future. Naturopathic doctors are trained as first contact health professionals and have some training in recognizing the potential for clinical psychiatric disorders, and the need for referral for professional assessment. Their training may require expert consultation for the management of more complicated patients with major psychiatric disorders, in a manner that is akin to the consultative role often undertaken by the general practitioner.

Growing Popularity of Alternative/Complementary Medicine

Current literature suggests that alternative/complementary medicine is used by approximately 20% to 30% of the general North American population (Wong et al., 1998) and that its use appears to be most common in patients with chronic conditions (Pies, 2000). Research indicates that North Americans spend more than \$11 billion dollars for chiropractic, naturopathic, and herbal therapies not covered by health plans each year (Wong et. al. 1998). Because alternative options are readily available and widely advertised, the current growth rate of the alternative/naturopathic medicine industry is estimated to be 20%. In Canada, the Naturopathic Health Products Directorate is responsible for ensuring the accuracy of labeling. This is done in consultation with experts in the field of natural medicine and pharmacology. The Executive Director of this Agency is, in fact, a naturopathic doctor. In the U.S., The Dietary Supplement Health and Education Act allows so-called dietary supplements to be sold without U.S. Food and Drug Administration (FDA)

approval, although labels must contain disclaimers. Products sold in a “health food store” are not FDA regulated and thus can be purchased without a prescription or the provision of any clinical advice or professional review. In Canada, supplements and botanicals can also be purchased over the counter, but Health Canada has banned some products due to concerns about user safety.

It is clear that the general public is heavily influenced by nonprofessional advertising claims. For this reason, it is necessary to explore and examine how individuals may be self-medicating and influencing themselves positively or negatively through herb-drug use and interactions. Pies (2000) notes that with the increasing use of alternative medicines, more research has been directed towards studying the positive results and adverse reactions to herbal and natural remedies. Naturopaths and psychiatrists must be aware of each other's professions, in order to treat patients effectively, and must understand herb-drug interactions that may benefit or worsen a patient's overall health condition.

Efficacy of Alternative Treatments

Many consumers believe that naturalness is a guarantee of harmlessness. People often have no qualms about taking alternative medicines either alone or in combination with over-the counter and/or prescribed conventional medicines (D'Arcy, 1993). However, many naturopathic alternative treatments have not been adequately studied, even though some of the agents have been used for centuries, and in some cases, millennia. Psychiatrists should become familiar with most common herbal products used in North America because they will be encountered in psychiatric practice. A working knowledge of the pharmacological data and clinical literature is necessary to properly counsel, diagnose, and treat patients who may be using herbal products. However, a survey showed that only “5% of British doctors claimed more than a poor knowledge of herbal medicine” (Wharton & Lewith, 1986). Most medical practitioners believe that herbal preparations are medical residues from the remote past, harmless and largely ineffective. Unfortunately, both patients and doctors are misinformed since many herbal products can be exceedingly toxic and may indeed present a peculiar hazard if taken in combination with orthodox medicines. With the exception of St. John's wort for depression and ginkgo for dementia, minimal evidence is currently available to recommend the use of herbal medicines as the primary treatment of psychiatric illness. However, due to increasing use of these agents by the general public, it is critical that we ensure that more intensive clinical research is done to establish safety and efficacy. In addition, more research on the biochemical and pharmacological effects of these herbs may uncover novel treatments for psychiatric illness or yield fresh insights regarding basic disease mechanisms (Wong et al., 1998).

Common Herbal Products

Ginkgo (*Ginkgo biloba* L.) is one herbal product that is believed to be helpful in the treatment of memory impairment caused by dementia. It is also used to treat stress, fatigue, chronic cerebro-vascular insufficiency and cerebral trauma and has been used to improve endurance. However, research on this product is limited. Kleijnen and Knipschild (1992) reviewed 40 controlled trials on the use of ginkgo in the treatment of “chronic cerebral insufficiency.” Although only 8 of the studies were deemed to be of good quality, all but 1 found clinically significant improvement in symptoms, such as memory loss, concentration difficulties, fatigue, anxiety, and depressed mood (Pies, 2000).

There is also some evidence, derived from randomized, controlled trials, that ginkgo extracts are effective in the treatment of psychopathological conditions and memory impairment caused by Alzheimer and vascular dementia (Pies, 2000). Ginkgo has also been used by patients in an attempt to treat

impotence, including anti-depressant-induced sexual dysfunction. In one trial sixty patients with proven arterial erectile dysfunction who had not previously responded to papaverine, did show improvement with a daily dose of 60mg of Ginkgo over 12 to 18 months. Still, further research must be undertaken with Ginkgo in erectile dysfunction, in part because both the doctors and patients knew who was on Ginkgo.

Another popular herbal treatment readily used in various forms (tablets, teas etc.) by the public is St. John's wort (*Hypericum perforatum* L.).

Side effects from Ginkgo appear to be relatively uncommon, however they do include symptoms of headache, gastrointestinal tract upset, and skin allergy to the Ginkgo fruit. Many researchers have suggested that Ginkgo theoretically may potentiate other anticoagulants or increase bleeding over time; however these effects rarely have clinically significant implications. Still, caution should still be exercised when Ginkgo is taken in conjunction with anticoagulant treatment (including aspirin) or where there is a risk of bleeding (eg. Peptic ulcer disease and subdural hematoma). As well, the Ginkgo's safety in pregnancy and lactation has not been established. Another popular herbal treatment readily used in various forms (tablets, teas etc.) by the public is St. John's wort (*Hypericum perforatum* L.). Efficacy of hypericum (one of the hypothesized active ingredient in St. John's wort) in the treatment of depression, has been reported in the texts of the ancient Greek physicians Hippocrates, Pliny, and Galen and continued through the Classical, Renaissance, and Victorian eras. Its contemporary usage as an antidepressant has been supported by more rigorous evidence than any other herbal remedy. For example, evidence of efficacy in mild to moderate depression, has been reported by Linde, Ramirez & Mulrow (1996). This meta-analysis of 23 randomized trials with a total of 1757 outpatients, in which extracts of St John's wort alone (20 of 23 trials) or in combination with other herbs (3 of 23) were tested against placebo (15 trials) or antidepressant drugs (8 trials). St. John's wort was reported to be clearly superior to placebo and comparable with conventional drug treatment, with lower side effect and dropout rates.

In general, fewer adverse effects are seen with hypericum than with conventional antidepressants but they may include photodermatitis, delayed hypersensitivity, gastrointestinal tract upset, dizziness, dry mouth, sedation, restlessness, and constipation. The use of St. John's wort is contraindicated in pregnancy, lactation, in patients who experience intense exposure to strong sunlight, and in patients suffering with a pheochromocytoma (Pies, 2000). As well, the pharmacokinetics or ingredients and drug interactions of St. John's wort is poor (John, Brockmoller, & Bauer, 1999). Several anecdotal reports of mania or hypermania have been reported in association with St. John's wort. O'Breasail and Argouarch (1998) reported two cases of individuals with no pre-existing history of bipolar disorder who developed hypomanic episodes after taking St. John's Wort. Similarly, Moses and Mallinger (2000) reported 3 cases of possible mania induction associated with St. John's wort. The potential of St. John's wort to interact with standard prescribed antidepressants, possibly to produce a “serotonin syndrome” is also a concern. Gordon (1998) reported a case in which a female patient taking St.

continued on following page

Johns wort became groggy, weak, and lethargic shortly after taking a single 20mg dose of paroxetine. This patient had tolerated St. John's wort and paroxetine separately, suggesting a herb-drug interaction. (Pies, 2000). Piper methysticum (KAVA KAVA) has been shown to alleviate anxiety symptoms (Volz & Kieser, 1997). This plant, derived from a spicy pepper plant from the Polynesian Islands, has euphoric, anxiolytic and muscle relaxant properties, although its effect on arousal and alertness appears to be minimal (Wong et al., 1998). Reported cases of liver dysfunction have also been reported in patients on Kava Kava (Kraft et al., 2001; Strahl et al., 1998; Escher et al., 2001).

Ginseng is another herbal treatment used in mood and anxiety disorders. Common side effects reported for Ginseng includes insomnia, hypertension, diarrhea, restlessness, anxiety and euphoria. As well, Ginseng may potentiate the effect of MAO inhibitors, stimulants (including caffeine) and haloperidol. Wong et al., (1998) mentions that Ginseng should be used with caution in patients with hypertension and diabetes and in conjunction with other centrally acting medications.

Adverse effects have been reported with Ma Huang. This agent (containing ephedrine) was in a preparation with chromium picolinate, and caffeine, that was reported by Emmanuel et al., (1998) to have induced manic symptoms in a 40 year old woman with a history of bulimia. This patient had been covertly using this herbal product to facilitate weight loss. As well, irritability, motor restlessness, and sleeplessness are reported side effects of Ma Huang.

Oenothera biennis (evening primrose) – sometimes used to treat hyperactivity as well as symptoms of premenstrual syndrome, may have the potential for worsening mania (Pies, 2000).

Yohimbine derived from the herb, Yohimbe (pausinystalia yohimbe (K Schum) has been shown to be an effective agent in erectile dysfunction. When administered to humans, yohimbine causes a variety of symptoms, including anxiety, nervousness, palpitations and restlessness. In fact, yohimbine has been used to provoke panic attacks and anxiety in studies of the pathophysiology, psychopharmacology, and treatment of anxiety disorders (Charney DS, Woods SW, Goodman WK, & Heninger GR, 1987). Yohimbine has been reported to contribute to psychotic symptoms, mania, and seizures. Clearly, yohimbine-containing products have the potential to produce psychiatric symptoms, particularly anxiety or panic, especially in patients with preexisting anxiety disorders.

Although many of the herbal agents believed to be beneficial for the treatment of depression appear to be safe, serious neuropsychiatric side effects and interactions have been reported for several over-the-counter anti-depressants.

Dilemma of Drug-Herb Interaction

One of the most frequent scenarios encountered by the naturopath is the patient who is already taking psychotropic medications and wants to explore

natural solutions. One example is the patient who is taking medication (antidepressant + another medication) for an anxiety disorder, who presents with ongoing depression and anxiety or with panic attacks. In this case, one might find that the psychotropic medication has contributed to making the client functional again but the patient decides to either (a) withdraw from their medication and replace it with an alternative treatment, or (b) supplement their medication with a natural health product. These choices are often undertaken to increase well-being or reduce some unpleasant side effects caused by the antidepressant.

However, there is little research on the adverse effects of herbs interacting with drugs, and vice versa, or herb-drug interactions with over-the-counter agents. Although many of the herbal agents believed to be beneficial for the treatment of depression appear to be safe, serious neuropsychiatric side effects and interactions have been reported for several over-the-counter anti-depressants. Even herbs taken for a quick energy fix can cause one difficulties if combined with certain drugs. For example, with the herb ginseng, which is used often to increase energy, there is at least one report of ginseng induced mania within 4 to 10 days of a patient interrupting treatment with lithium and amitriptyline (Pies, 2000). While herbal and other over the counter depression remedies may generally be safe, and perhaps in some cases helpful, clinicians must be alert to covert use of these agents and their possible adverse psychiatric side effects. Clinicians should always consider the possibility, as yet unexplored in systematic studies, that herbal remedies may interact with prescribed psychotropic medications. Unfortunately, most interactions of this type will not be recognized as such by the self medicated patient, will not be reported to an orthodox medical practitioner and, therefore, will not appear in medical or pharmaceutical literature. In spite of this fact, it would be a critical oversight should physicians, when treating depressed and anxious patients, for example, ignore the potential for these patients to be covertly self-medicating with herbal or alternative treatments that might produce fatal results.

The potential risk of underestimating the possible chemical interactions between medications must be noted by both physicians and alternative and naturopathic clinicians. Patients must be asked if they are using any over the counter drugs or herbs/remedies and they must be educated on the potential risks of drug/herb interactions (Pies, 2000). Unfortunately, we know from surveys on large populations that many patients do not tell their physician about their use of natural therapies. A study by Eisenberg et al. examined trends in alternative medicine use in the U.S. from 1990-1997 and found that less than 40% of the alternative therapies used were disclosed to a physician (Coonerty-Femiano et al., 2000).

Growing Need for the Two Worlds to Emerge

The drug-herb interaction and possible negative consequences for patients forces the medical psychiatry world to be more aware of naturopathy and alternative/complimentary treatments that are offered to their patients. As an illustration, let us return to our previous example of the patient on the traditional pharmacotherapy of an antidepressant + another medication who presents to the naturopathic clinic for treatment. In this case, the naturopath is faced with the following dilemma: (a) should the naturopath advise the patient to discontinue the drug(s) and take a natural health product or other alternative? or (b) should they add such a therapy to an ongoing drug regime? Psychiatrists experience a similar dilemma when they ask their patients to either stop taking alternative options or assume they are safe enough to use concurrently, along side a psychotropic treatment. Professionally, one must wonder before asking a patient to discontinue one option or the other, whether there is a possibility that the alternative option might be improving their patient's condition or reducing certain unpleasant side effects caused by

Alternatively, to supplement by adding a herbal preparation on top of an antidepressant, benzodiazepine, or antipsychotic could lead to unpredicted interactions and unpleasant or frankly dangerous symptoms.

the psychotropic medication use? Either option has its difficulties. On the one hand, withdrawal of the drug can lead to destabilization of the patient's condition, which may not be rapidly amenable to a botanical or nutritional treatment. Alternatively, to supplement by adding a herbal preparation on top of an antidepressant, benzodiazepine, or antipsychotic could lead to unpredicted interactions and unpleasant or frankly dangerous symptoms.

It is critical for the naturopathic doctor and the patient to cooperate with the psychiatrist. This begins with simple information sharing. Of the utmost importance is that the patient informs both parties as to their health care decisions and the treatments that they are receiving. This means that the patient needs to communicate with their psychiatrist their intention to explore alternative options, either by substitution or in addition to their therapy and ongoing drug regimen.

The naturopath must encourage the patient to be candid with their psychiatrist about their proposed treatments. In some cases, a medical letter outlining the proposed plan and intention is beneficial. The psychiatrist can also be helpful in that she/he can communicate to the naturopath the extent of the patient's disorder. In these cases, the naturopathic doctor needs this information to know what she/he is dealing with. For many cases of mild depression or mild anxiety disorder, natural therapies can be sufficient for treatment. For more complicated cases, with little known about the consequences of using alternative treatments, involvement by a clinician with more specialized training is recommended.

We suggest that the psychiatrist can and should:

- Ask each patient if they are using natural health products or seeing a natural health practitioner.
- Recognize that the patient may be covertly self-medicating with herbal or alternative treatments.
- Better studied medications should be substituted.
- Create an environment where the patient is not reluctant to disclose the use of natural health care.
- Obtain contact information so that the specifics of the therapy and therapeutic plan can be requested (if the patient is seeing a naturopathic doctor).
- Communicate directly with naturopathic or alternative clinician changes in treatment choices that are taking place in the ongoing care of the patient. This may often include sending consultation letters and other information to all individuals involved in the treatment of the patient.
- Acquire good reference materials on natural health products. These include: *Natural Alternatives to Prozac* by Michael T. Murray, ND, and *The Textbook of Natural Medicine* by Joseph Pizzorno ND and Michael T. Murray, ND.
- Never underestimate the potential risk of possible chemical interactions between medications.

- Make contact with a community naturopathic doctor who can answer questions about specific natural health products. The Ontario Association of Naturopathic Doctors or The Canadian College of Naturopathic Medicine are good resources for finding qualified NDs. ■

For more information please contact:

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ONTARIO INVESTS \$2.4 MILLION IN NEW FUNDING FOR SUBSTANCE ABUSE TREATMENT PROGRAMS

On April 30, 2002, Health and Long-Term Care Minister Tony Clement announced that the Ontario government is providing \$2.4 million in funding for substance abuse programs across the province. The funding includes more than \$1.8 million in additional annual funding for substance treatment programs. Listed below is a breakdown of funding by region.

The government's total contribution to substance abuse programs for this year is \$118 million. The minister also announced more than \$577,441 in one-time funding to substance abuse agencies across the province for the new Drug and Alcohol Treatment Information System (DATIS) software. DATIS collects information used for planning, monitoring and assessing the cost and health outcomes of addiction treatment services.

REGION	FUNDING
Southwest	\$190,667
Central West	\$155,169
Central South	\$180,206
Toronto	\$377,186
Central East	\$105,999
East	\$316,757
Northeast	\$317,994
Northwest	\$166,728
Provincial Initiatives	\$15,664
TOTAL	\$1,826,370

Psychiatry Referral Service



Dr. Keith Anderson

Keith Anderson, OPA Past President wrote in to describe a crisis faced by primary care physicians in Ottawa regarding the lack of availability of consultations with psychiatrists. In response, the Academy of Medicine Ottawa (AMO) launched a psychiatric referral service on April 1, 2002. 56 community-based psychiatrists have agreed to see at least one new referral from family physicians per month through this service. Ottawa family physicians contact the AMO and receive names and phone numbers of psychiatrists who are appropriate and who are available.

"We are hopeful that this service will make available more than 600 psychiatric consultations a year to family physicians and their patients." says Dr. Anderson.

"Family doctors were quick to utilize the service; the number of requests for referrals received in the first 6 weeks was 115. Positive feedback and keen interest from the physician community has been received."

A GUIDE TO ADVANCE CARE PLANNING

The Ministry of Citizenship has released a guide that helps seniors ensure that their medical and care choices are respected, should they become incapable of making those decisions. A Guide to Advance Care Planning reflects Ontario's commitment to ensuring that seniors live with dignity and independence, now and in the future. Advance care planning helps seniors ensure that their wishes, not someone else's, will guide decisions about their future care and is one part of Ontario's \$68.4 million Strategy for Alzheimer Disease and Related Dementias, which was announced in 1999. Through Advance Care Planning, a substitute decision-maker is given the direction they need to later speak on behalf of a person who is incapable, and accurately reflect that person's wishes about medical, accommodation, and other personal care choices. The Guide to Advance Care Planning is available online on the Ontario Seniors' Secretariat Web Site www.gov.on.ca/citizenship/seniors or through the Alzheimer Society of Ontario. The Secretariat website is also a source of excellent information on resources and issues related to seniors that you may want to bookmark and visit often.

MENTAL HEALTH CARE IN CANADA

The Canadian Institute for Health Information recently published a report entitled "Health Care in Canada 2001". Chapter 4 deals with Mental Health Care in Canada. This chapter states that many Canadians report being in good to excellent mental health although others experience depression, schizophrenia, or other mental health and addiction problems. For example, about 4% of Canadians aged 12 and over reported symptoms that suggest that they had experienced at least one major depressive episode during the past year (on the 1998/99 National Population Health Survey). These symptoms were more common for women (6%) than for men (3%).

Most people with depression do not receive treatment - only 43% of those who reported symptoms suggesting a major depressive episode in the 1994/95 National Population Health Survey said that they had talked to a health professional about their emotional or mental health in the past year.

People who seek help for mental health and addiction problems tend to get help from family physicians, case managers, social workers or other care providers.

Some people require additional interventions because of a severe or persistent mental disorder. As a result of de-institutionalization, long-stay psychiatric patients now require care in their community. In one study conducted in Toronto, over 75% of shelter users were found to have at least one lifetime diagnosis - 51% were mood disorders.

For more information refer to:

Diverty, B., and Beaudet, M.P. (1977) Depression: An Untreated Disorder? Health Reports, 8(4), 9-18.

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Lin, E., and Goering, P. (2000), Fee-for-service core mental health services: changes in provider source and visit frequency. Institute for Clinical Evaluative Sciences Atlas Report 3, 2000.

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Canadian Mental Health Association

This year, the Canadian Mental Health Association, Ontario Division celebrates its 50th anniversary. CMHA was among the first community organizations dedicated to advocacy for the mentally ill. Today, consumers and family members speak for themselves and CMHA's advocacy work has shifted from speaking "for" others to speaking "with" those affected by mental illness. In addition to its advocacy work, the provincial office of CMHA has a knowledge transfer mandate expressed as a role in disseminating accurate, timely and credible information about mental health and mental illness through the magic of the world wide web, as well as through more "old-fashioned" methods such as library materials, educational pamphlets and mental wellness toolkits. CMHA, Ontario Division also hosts health fairs, sponsors a yearly conference with its various partners, responds to legislation and creates policy documents on topical mental health issues.

CMHA, Ontario Division is also composed of thirty-three CMHA branches located throughout the province. CMHA serves thousands of seriously mentally ill clients each year through community mental health programs such as intensive case management, Assertive Community Treatment teams (ACT), housing, clubhouses and peer support, to name only a few initiatives. Building upon a reputation for innovation in the provision of community mental health services, the following are just a few examples of the creativity and effectiveness of CMHA branch programs:

CMHA, Windsor-Essex County branch responds to the medical needs of consumers.

In February, 2000, CMHA, Windsor-Essex County branch recruited a primary care nurse practitioner to establish, in collaboration with a local physician, a first-of-its-kind medical clinic within a community mental health agency. Since its inception, over 400 clients have been rostered and 4,000 visits recorded. The clinic's success has resulted in a reduction in inappropriate psychiatric hospitalization. For example, a community support worker noticed an increase in a client's delusional behaviour. Medical examination revealed a painful urinary tract infection. Treatment of the infection resolved the delusional behaviour. The clinic has also saved lives. A woman who had received no regular medical care for years was found to have a large malignant lump in her breast. The lump was removed and, after follow-up radiation therapy, she is now cancer free. CMHA, Windsor-Essex County Branch - Pam Hines, M.S.W., Chief Executive Officer 519-255-7440, ext. 223

CMHA, Victoria County branch develops community partnerships and increases their services ten-fold - on virtually the same budget.

This branch, located in Lindsay, specializes in housing for the seriously mentally ill and other low-income groups. In 1996, it housed just 18 residents. Through creative community partnerships and outreach to local landlords, the branch increased its service to 54 clients in 1998, 83 in 1999, 146 in 2000 and to 184 in 2001, all with no additional funds. In 2002, they received a small budgetary increase and now serve 244 clients and their families. CMHA Victoria County Branch - Naresh James, Executive Director 705-328-2704

CMHA, Grey-Bruce branch - still there for Walkerton.

In just one hour after the crisis in Walkerton became known, CMHA Grey/Bruce set up a team of trained counselors, available twenty-four hours a day, seven days a week, to serve anyone who needed help and support. Special sessions were convened for hospital staff who were traumatized by seeing so many people they knew fall seriously ill. As the extent of the crisis became fully known, CMHA staff went from door to door, helping residents tape shut their water taps and ensuring that everyone was drinking only bottled water. CMHA staff members remain in Walkerton to this day, as life has not returned to normal. Many children are facing kidney failure and rounds of dialysis. Other residents remain traumatized,

overwhelmed with memories of the odour of bleach because it was used as a sterilizing agent during the crisis, and cringing at any sound that reminds them of the helicopters that air-lifted the very ill and dying to the London Health Sciences Centre.

CMHA, Grey Bruce Branch, Marion Wright, Executive Director 519-371-3642

CMHA, Elgin County branch reduces psychiatric hospitalizations through their Safe Bed program.

Located in St. Thomas, the Safe Bed program was established in September 1999. The purpose of the program is to provide secure accommodation for people with serious mental illness who are experiencing crises. Evaluation of high resource users, defined as clients who spent 145 days in inpatient services in the two years prior to the program opening, showed that usage dropped remarkably to only 14 days for the same length of time through the use of the Safe Bed program. CMHA, Elgin County Branch, Heather DeBruyn, Executive Director 519-633-1781

CMHA, Metro Toronto branch successfully houses the homeless.

Located in Toronto, this branch received funding for 137 units under the Ministry of Health and Long-Term Care's Homelessness Initiative. In a review of 90 case files, 70% of those housed in this new program were homeless or living in the shelter system. The remainder was at extreme risk of becoming homeless. In recent months, more than 60% of referrals have come from shelters. The key to housing retention appears to be the support provided by housing workers, community support staff and the cooperation from building management and neighbours. Only 13% of this very difficult-to-house client group has ended their tenancies.

CMHA, Metro Toronto Branch, Steve Lurie, Executive Director 416-789-7957 (ext. 271) or Mohammed Badsha, Manager of Employment and Housing Services (ext. 266)

CMHA, Hastings and Prince Edward Counties branch achieves employment success for clients.

This CMHA branch runs a Return to Work Action Program for people who have been diagnosed with mental illness. Currently, 73% of participants have achieved either full, part-time or casual competitive employment upon completion of the program's requirements. Assisted by a Job Developer, participants outline their goals accompanied by an action plan. A large part of the Job Developer's work is to meet with local employers to discuss the myths and facts regarding mental illness. Employers are helped to focus on the applicant's strengths and to address workplace accommodation needs. This program's success is noteworthy in light of literature that has shown that 85% of those who are seriously mentally ill are unemployed.

CMHA, Hastings and Prince Edward Counties Branch, Diane Poirier, Executive Director or Ann Trudeau, Job Developer 613-969-8874.

The above examples describe only a fraction of the work done by Canadian Mental Health Association throughout Ontario. We are looking forward to fifty more years of innovation in the provision of community mental health services.

For more information please contact: Barbara Everett, Ph. D., Chief Executive Officer, Canadian Mental Health Association, Ontario Division, 180 Dundas Street West, Suite 2301, Toronto, ON M5G 1Z8, Website: www.ontario.cmha.ca, Phone: 416-977-5580 ext. 4126 Fax: 416-977-2264 Email: beverett@ontario.cmha.ca, Toll-Free: 1-800-875-6213 ■

Preventing Substance Abuse

A new resource entitled "Preventing Substance Abuse Problems Among Young People" is now distributed through the Centre for Addiction and Mental Health's Marketing Department.

For more information contact: Marketing and Sales Services at the Centre, Tel: 1-800-661-1111 or (416) 595-6095 in Toronto or by email: marketing@camh.net

New Resource on Concurrent Disorders

Health Canada has published a report entitled, "Best Practices – Concurrent Mental health and Substance Abuse Disorders". The report synthesizes research information for screening, assessment, treatment and support. To obtain a copy, contact Health Canada by accessing their website: www.cds-sa.com (under Publications, Treatment and Rehabilitation).

New Certificate Program in Community Mental Health

Seneca College has introduced a new part-time post-diploma certificate program in the field of community mental health. Seneca's Community Mental Health Post-Diploma Program has been designed to provide specialized training to individuals who are currently, or would like to be, employed within the mental health field. The program prepares graduates to work with people experiencing severe mental health problems in an effective, supportive and knowledgeable manner. It focuses on knowledge and understanding of mental health/illness and the behaviors, attitudes and skills necessary to provide effective advocacy, counselling and support services with both individuals and groups.

For more information on this program, visit www.senecac.on.ca/part-time

New Books for Children

Edward the "Crazy Man"

A new children's book that destigmatizes mental illness is now available. Edward the "Crazy Man" by Marie Day (Annick Press) is the story of Charlie, a young man whose life is saved by Edward, who has schizophrenia, and how he eventually shows his gratitude. The story follows Charlie from his childhood encounter with Edward to their reunion years later. Edward has become homeless, but Charlie gets him medical treatment, shelter and helps him to reintegrate into society.

Suitable for 7 to 10 year olds, this book demonstrates appropriate reactions to mental illness and shows that people with mental illness can become contributing members of society.

The Toronto Chapter of the Schizophrenia Society of Ontario has copies available for purchase (\$15.95 for hardcover, \$7.95 for paperback). To order, call 416-975-1630.

VON PEEL LAUNCHES VOLUNTEER VISITING PROGRAM

The Victorian Order of Nurses (VON) of Peel has launched a new volunteer visiting program for seniors with chronic mental health issues. The effects of aging, illness and related disabilities make those with chronic mental illnesses particularly vulnerable to isolation and the loss of supportive human relationships. The interaction of a caring person can help to alleviate the loneliness. The VON hopes to have a model volunteer program to share with other VON branches throughout Canada.

For more information call VON Peel Executive Director Kathy Bamford at 905-821-4474.

The LESBIGAY Service

Often, lesbian, gay, bisexual, transgender and transsexual (LGBT) people are not comfortable coming out about their gender and sexual identities when they access services for drug and alcohol concerns. Health care professionals may be uncomfortable asking questions that would help clients disclose such information. The result is that LGBT people are poorly served by addiction agencies. The LesBiGay Service at the Centre for Addiction and Mental Health has developed a two-part assessment tool to help clinicians ask sensitive and relevant questions so they can effectively assess clients' needs.

For more information on the assessment tool or the LesBiGay Service contact: Farzana Doctor, CAMH, phone: 416-535-8501 X 6781, toll free: 1-800-463-2338 X 6781, email: farzana_doctor@camh.net

The OPA launched a Peer Mentoring Program at the Annual Meeting in January 2002. Take advantage of this great opportunity. Become a mentor; find a mentor. For more information, please contact the OPA Head Office by phone: 905-827-4659, email: opa@bellnet.ca or fax: 905-469-8697.

Understanding a Parent's Depression

The Centre for Addiction and Mental Health has a new book available that helps children of depressed parents understand their parent's disorder. "Can I Catch it Like a Cold" addresses key questions that children have through the story of Alex, an 8 year old boy who doesn't understand why his father won't attend his soccer games and cries alone in his bedroom.

The Centre also has a public information brochure entitled "When a parent is depressed: What kids want to know" that briefly outlines the key questions that children ask about their parents' depression. For more information or to order a copy, please contact:

Marketing and Sales Services at (416) 595-6059 in Toronto, or, 1-800-661-1111 or email: marketing@camh.net ■



RESIDENT'S REVIEW



By: *Kbrista Boylan, OPA Council Member and Resident, Department of Psychiatry, McMaster University*

CONGRATULATIONS TO THE OLD, AND WELCOME TO THE NEW!

This is the time of year when residency programs across Ontario lose PGY-5s and gain PGY-1s. At the same time, PGY-2s become seniors, PGY-3s start fretting about what electives to choose and PGY-4s ponder the reality that they are entering one of the busiest and challenging years of their professional lives. The cycle will continue to repeat from July to July, except for those of us who must take parental or medical leaves. If it weren't for our PAIRO vacation contract, there'd be no stopping it.

There is at least one development that will change the process however: the increase in numbers entering PGY-1. Fortunately, more new residents than ever before are realizing how wonderful psychiatry is, and are applying to our programs. Most Ontario programs filled their PGY-1 spots; thanks, in many cases, to the valiant efforts of each program's faculty and residents at improving recruitment. Ensuring enough clerks will apply is not an easy task, as we must not only effectively teach the many content areas of our specialty, but also expose clerks to the many career options in psychiatry through mentoring, during clerkship. These efforts require much planning and teaching on behalf of able residents and faculty. The increased size of medical school classes will, in many ways, put extra strain on our residency programs to increase numbers of supervising psychiatrists and place a greater emphasis on teaching and mentoring. If we do not do this, the outgoing residents and practicing psychiatrists continue to feel the scarcity of new members entering the profession.

Teaching clerks and residents well is perhaps more difficult in psychiatry because of the way many psychiatrists practice. Many psychiatrists are working at maximum capacity with their own patient rosters and do not have adequate time to devote to the supervision of residents' and clerks' interviews and interventions. While ward-based rotations and many specialty clinics are often composed of a team of clinicians and psychiatrists/residents who can supervise clerks effectively, other clinical settings, which are currently considered suitable for training, include a consultant or a treating psychiatrist in solo practice. Often, these supervisors may not be equipped to supervise a clerk or resident, or to supply them with the variety of patients to satisfy the teaching of psychiatry. This is mostly a concern for clerks who have only one exposure to psychiatry provided by one supervisor - and has been a particular challenge for geriatric or child psychiatrists who supervise clerks.

With the greater number of clerks requiring supervision, more non-team (and possibly, non-faculty?) psychiatrists will need to be recruited for teaching, and also more residents. This becomes particularly interesting when the (often junior) resident expresses feeling relatively incompetent in the subject area and as one of my colleagues always retorts "... I don't even like teaching". Given that many of us will choose not to practice in an academic center, we must remember that we are training in one, and teaching is considered an "academic responsibility" - whether we like it or not. Despite the fact that we residents are a generous lot, there is the concern, recently raised by many of my colleagues, that the likelihood that either we, or our teaching time, will be consumed by the increased demands required of our teaching faculty for clerks.

What to do? I welcome your comments as to how your respective programs are addressing the balance of training of new clerks and residents.

To end, I would like to extend best wishes to Ontario's PGY-5s on behalf of the OPA. Many of you will be staying to share your skills within the province's mental health systems. All of us at the OPA will do our best to represent your concerns and to inform you as to changes that will affect your practice in Ontario. Further, we welcome and encourage new psychiatrists to benefit from the support provided by the OPA Mentoring Program for early career psychiatrists and to attend the Annual Meeting to meet colleagues from across the province. Residents receive 3 full days at the Annual Meeting, including luncheon symposia, buffet breakfast on Friday and the President's Dinner/Dance on Friday night, for the deeply discounted rate of \$100.00. Most importantly, however, I wish you a successful and satisfying start to your career. Congratulations!

Please forward your comments and ideas to Kbrista at the Department of Psychiatry, McMaster University, 4th Floor, Fontbonne Building, St. Joseph's Hospital, 301 James St. South, Hamilton, ON, L3P 3B6, email: kbrista_boylan@hotmail.com

The 2001 OSDUS Mental Health Report: CAMH

The recently released Centre for Addiction and Mental Health's Ontario Student Drug Use Survey (OSDUS), is the longest ongoing school survey of adolescents in Canada. The study, which spans over two decades, is based on 13 surveys conducted every two years since 1977. In the spring of 2001, 4,211 students (grades 7 through OAC) from 41 school boards, 106 schools and 272 classes participated in the survey administered by the Institute for Social Research, York University.

The report describes physical health and mental health indicators in 2001 and changes since 1991, and is a companion document to the report *Drug Use Among Ontario Students, 1977-2001: Findings from the OSDUS*. All data are based on self-reports derived from anonymous questionnaires administered in classrooms.

Some highlights of the report –

A majority (87.8%) of students feel close to people at their school, and feel like they are part of their school (85.0%). Almost all (91.9%) students feel safe in school, but 12.5% are worried about being harmed or threatened at school.

Just over half of students (54.2%) report getting along very well with their parents. About 5% do not get along with their parents. One-third (31.7%) seldom or never discuss problems with their mother, while 54.1% seldom or never discuss problems with their father. A small percentage (1.3%) of students report having no friends, and 4.1% report having no one to talk to about their problems.

About one-in-ten (9.2%) students report low self-esteem. There is no significant sex difference. Between 1999 and 2001, low self-esteem decreased among females, from 12.7% to 9.8%. Similarly, 11th-graders and 13th graders showed declines. All three of these subgroups (females, 11th- and 13th-graders) also showed declines in low self-esteem compared to 1995 estimates.

About one-in-twenty (4.6%) students are at high risk for depression, with females more likely to be so than males (7.1% vs 2.1%, respectively). No significant changes between 1999 and 2001 were evident regarding high risk for depression among the total sample, or among subgroups. Elevated psychological distress is reported by 27.7% of students, and is more prevalent among females than males (30.6% vs 24.7%). One-in-twenty students (4%) report both psychological distress and hazardous drinking; about 5% report hazardous drinking only; 23.7% report only psychological distress; and 67.1% report neither problem. Females are more likely than males to report psychological distress only (27.7% vs 19.6%). Males and females are equally likely to report hazardous drinking only, as well as both problems concurrently.

The most common symptoms experienced were feeling constantly under stress (34.3%), followed by losing sleep because of worrying (27.3%). Compared to 1999 estimates, there was a significant decrease in elevated psychological distress in 2001 among females (from 36.0% down to 30.6%), and 10th-graders (from 31.4% down to 23.9%).

About one-in-ten (11.1%) students had seriously considered attempting suicide in the past 12 months, with significantly more females than males reporting so (13.3% vs 8.9%). In 2001, one-in-ten (10.9%) students reported visiting a mental health professional during the past year. This estimate has not significantly changed since 1999.

Just under 2% of students report being prescribed medication for depression in the past 12 months. Less than 1% are prescribed medication for anxiety, and medication for both depression and anxiety.

Over two-thirds (70.5%) of students are satisfied with their weight; 19.2% think they are too fat; and 10.3% think they are too thin. Compared to males, females are more likely to indicate they are too fat, whereas males are more likely to indicate they are too thin. Among males, those trying to lose weight significantly increased in 2001 (21.8%) compared to 1997 (15.9%), as did the percentage of males who want to keep from gaining weight (from 12.2% to 17.8%). Among females, the percentage who think they are too fat declined in 2001 (23.2%) compared to 1997 (30.7%). The percentage of females trying to keep from gaining weight was significantly lower in 2001 (20.3%) compared to 1997 (25.4%).

About one-in-seven students (14.5%) report involvement in three or more delinquent acts during the past year. Such involvement is more common among males than females, and tends to peak in 10th- or 11th-grade. Compared to 1999 estimates, the percentage of all students engaging in at least three delinquent activities significantly declined, from 18.1% down to 14.5% in 2001. Long-term trends among 11th-graders between 1983 and 2001 show that involvement in three or more activities peaked during the mid- to late-1990s, and then significantly declined in 2001.

Just over one-in-ten (12.3%) students (16.9% of males, 8.0% of females) report assaulting someone during the past 12 months. One-in-ten (10.4%) report carrying a weapon, with more males (16.5%) doing so than females (4.6%). About 5% of students (8.3% of males, 2.2% of females) report gang fighting. Short-term trends show that assault has been declining since 1997 among all students (from 20.4% down to 11.5%). Short-term trends show declines in weapon carrying between 1993 and 2001 among all students (from 15.4% down to 9.0%). Gang fighting has remained stable since 1991. Long-term trends among 11th-graders between 1983 and 2001 show very recent declines for assault and weapon carrying. Gang fighting did not significantly change.

Among all students, 15.8% were in a physical fight at school at least once during the past 12 months, with males more likely than females. One-quarter of students (24.6%) were bullied at school since September, and about one-third (31.8%) report bullying others at school. Males are more likely than females to be bullied, and also to bully others.

The most prevalent gambling activity during the past 12 months is card playing (25.7%), followed by lottery tickets (24.5%), and sports pools (22.3%). The least prevalent is casino gambling (2.8%). Males are more likely to gamble at cards, sports pools, sports lotteries, and casinos. Generally, gambling activity increased with grade, with 13th-graders most likely to gamble. Among all students, 6.2% participated in at least four of seven gambling activities, with more males than females doing so (9.8% vs 2.9%). Just under one-in-ten students (8.3%) report any gambling problem during the past 12 months (13.1% of males, 3.6% of females). A smaller percentage (2.7%) report indicators of pathological gambling (4.6% of males, 0.9% of females). Among all students, pathological gambling declined between 1999 (5.8%) and 2001 (2.7%). Declines were also found for males, 8th-graders, 11th-graders, and 12th-graders. Pathological gambling increased among 13th-graders between 1999 (1.8%) and 2001 (5.7%).

The report and the executive summary are available from the OPA Office and can be emailed to you, contact OPA Head Office by phone: (905) 827-4659 or by email: opa@bellnet.ca