

## MESSAGE FROM THE PRESIDENT

I have just returned from the first CPA Ski-CPD conference at Mount Tremblant. It was a well-organized conference that provided an intimate intensive learning experience. The OPA also had another very successful Annual Meeting at the end of January. Registration was at an all time high. It was an excellent opportunity to get Maintenance of Certification credits from a very well organized program. The attendance at the Friday evening President's Dinner/Dance has increased and it appears that the change in format was enjoyed by members, judging by their feedback. The credit for our successful Annual Meeting goes to Dr. Ann Thomas, Chair of the Continuing Education Committee, who is in charge of the planning for the Annual Meeting. Ann has done an incredible job of delivering a high quality program for a number of years and we are fortunate that she has agreed to continue in this position. The paucity of young psychiatrists at the Annual Meeting was noticeable and I would be interested in hearing from members on this issue. Do you have any comments or suggestions as to how we should deal with this?

I want to welcome our President-elect, Dr. Doug Wilkins, who is Chief of Psychiatry at Queensway Carleton Hospital in Ottawa. Doug has been a member of Council for a number of years and it is a pleasure to be able to work with him on the Executive. I also want to thank Dr. Margaret Steele, Past President, for the leadership that she provided the Association over the past year. Margaret took on the challenge of revitalizing the Sections within the organization and will continue to provide liaison between the Sections and Council over the coming year. Margaret has also been an extremely effective advocate for Child Psychiatry.

New members coming onto Council are Dr. Elizabeth Esmond and Dr. Bob Swenson, both from Ottawa, and Dr. Leo Murphy from Toronto. Dr. Andrew Moulden from Toronto also joins Council as a Member-in-Training. I encourage you to keep informed of Council activities through the reports that appear in *Dialogue*.

The OPA continues as a formal partner in the Coalition of Ontario Psychiatrists. This is a very effective forum for advancing the economic and political interests of psychiatrists and psychiatry. The Coalition partnership of the OPA and the OMA Section on Psychiatry has been successful in the past year in supporting the need for services in the community while opposing the establishment of Regional Mental Health Authorities, which are seen as another layer of bureaucracy that would divert money away from direct service. The Coalition has also been able to

represent psychiatry at the fee negotiations within the OMA structure and the Ministry, resulting in an increase in the individual sessional rate, soon to be implemented.

I have chosen as my Presidential theme the battle against stigma. In spite of the advances in treatment of mental illness, stigma still presents a significant barrier to many individuals who need treatment, decent jobs and housing.

I would like to end by thanking all of the members of OPA Council for the dedication they contribute to the Association and especially to our support staff - Elizabeth Leach, Director of Policy and Planning, and Lorraine Taylor, the Association's Executive Assistant.

I encourage you to send me your feedback and comments over the year and I thank you for the privilege of serving as President of your Association.

*Robert Buckingham, MD, FRCPC*  
2003 OPA President

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Executive and Council**



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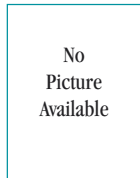
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**Council Members can be contacted through the OPA Head Office.**

**OPA Mailing Address:** 1141 South Service Road West, Oakville, Ontario L6L 6K4  
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**From THE EDITOR**

The health care system remains the top priority of Canadians. Health care is complex, convoluted and changing. My sources tell me that the future cost drivers for the health care system are:

- changes in diagnostic technology
- changes in practice patterns
- new pharmaceuticals
- emerging diseases, and,
- chronic disease conditions

24% of the Canadian population is under 18 years of age – and they have different values from everyone else. The cultural background of Canadians is becoming increasingly diverse and people continue to move away from the rural areas to the urban centres.

As a nation, we are concerned about the affordability and sustainability of health care. There are many problems:

- shortages and maldistribution of health human resources
- aging infrastructure (and aging people !)
- rising costs
- inconsistency in regulatory and policy frameworks
- restricted coverage and comprehensiveness of publicly funded services
- lack of co-ordination and integration among health care services, supports and among providers.

There are many issues too. Governments appear to be interested in creating more private/public partnerships and in professional accountability. Information from the analysis of health records and data on the health system is at an all time high. And, the concept of waiting for appointments with a professional may be supplanted by the acquisition of evidence-based information and advice, from respected experts and by use of walk-in and on-demand services.

Information is needed and necessary to make sense of our health care system and plan for the future. The OPA provides information to you and hopefully this information is useful to you. If it isn't and you want information that is more useful to you, just let us know what you want to know about – write, email or call, it's that simple.

The first issue of *Dialogue* for 2003 provides you with key information about OPA activities of 2002 that were presented during the Annual General Meeting in January.

We continue to provide you with information on a variety of topics, such as children's mental health and news about what is happening in mental health in Ontario. In the next issue, there will be a new book review and articles on a variety of legal topics.

Do you have other topics that you would like covered in *Dialogue*? Are there other resources or websites that you have heard about that you could share with colleagues? Are there legal issues that you think should be explored? What else do you want to know about?

In the next issue, there will be information about what some mental health programs are up to – are there any programs you have heard about that you want others to know about?

Your comments, suggestions and contributions are always welcome.

*Elizabeth Leach*  
Editor

# CALENDAR OF EVENTS



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

## Ontario Psychiatric Association 2003 Council Meetings

Toronto – Friday, April 4; Friday, June 20, Friday, September 5; Friday, November 14, 2003; Space is limited, please contact Lorraine Taylor, OPA Executive Assistant, for locations or further details; (905) 827- 4659, email: opa@bellnet.ca

## Infant Observation Seminar

October 2002 - May 2003

Presented by the Toronto Child Psychoanalytic Program for adult psychoanalytic trainees and graduates, and other mental health practitioners.

There will be 22 sessions (October through May) on Thursday evenings, 6:30 to 8:00 pm. The seminars are being held at the Hincks-Dellcrest Institute.

Leader: Elizabeth Tutters, MSW, Child and Adult Psychoanalyst.

Contact information: Donna or Janice, at woodhouse@golden.net, or Tel: 416-288-8689.

## Clinical Assessment, Formulation and Treatment of Infants, Young Children and Their Families: Observation, Reflection and Understanding - The Importance of Play

October 16, 2002 - April 9, 2003

Hincks-Dellcrest Treatment Centre, Toronto. 22 sessions of 3 hours each on Wednesday afternoons presented by; Leaders, Elizabeth Tutters, MSW, RSW and Sally Doulis, MSW, both of whom are graduate-faculty and supervisor members at the Toronto Child Psychoanalytic Program.

Contact information: Janice 416-288-8689, x 2 or e-mail woodhouse@golden.net.

## 13TH Annual Rotman Research Institute Conference

### Neuroimaging of Cognitive Functions

March 17-18, 2003

Fairmont Royal York Hotel, Toronto

Co-sponsored by the Departments of Medicine and Psychiatry, University of Toronto

At the end of the conference, participants will be able to:

- \* Gain awareness of the various neuroimaging approaches to study cognition;
- \* Understand the biological base of sensation, perception, memory and attention;
- \* Understand application of neuroimaging to study human development and clinical conditions.

Contact information: Rotman Research Institute of Baycrest Centre, 3560 Bathurst Street, Toronto, Ontario, M6A 2E1, Phone (416) 785-2500 ext.2363

Fax (416) 785-4215, E-Mail:conference@rotman-baycrest.on.ca

Web Site: <http://www.rotman-baycrest.on.ca/conference>

## Self-Help Network Conference 2003: Working Together – Professionals and Self-Helpers Supporting Each Other

March 21, 2003, Toronto, ON

This conference welcomes people already involved with self-help/mutual aid and those who wish to learn more about it. It is an excellent opportunity to share, network and learn. Contact information: [www.selfhelp.on.ca](http://www.selfhelp.on.ca)

## Madness and the Arts 2003 World Festival – Celebrating Artistic Inspiration

March 21 – 30, 2003, Toronto, ON

The world's first arts festival devoted to celebrating creativity and mental health.

Contact information: [www.madnessandarts.com](http://www.madnessandarts.com)

## Cognitive Behaviour Therapy with Difficult and Complex Patients: Conceptualization and Treatment Considerations

March 27 – 28, 2003, Toronto, ON

This workshop will focus on the conceptualization and applications of Cognitive Behaviour Therapy with the difficult patient and complex patient.

## American Society for Adolescent Psychiatry 2003 Annual Meeting "Adolescents and Their Environment"

March 27 - 30, 2003 - New York City.

Contact information: <http://www.adolpsych.org/>

## 2003 Anxiety Disorders Association of America Conference – Effective Care: Getting Help to Those Who Need It

March 27 – 30, 2003, Westin Harbour Castle, Toronto, ON

Getting Help to Those Who Need It: Planning for the Big Picture – organized by the Anxiety Association of Canada – March 30 – 31, 2003

Contact information: [www.adaa.org](http://www.adaa.org) or [www.anxietycanada.ca](http://www.anxietycanada.ca)

## International Psychogeriatric Association European Regional Meeting

April 1 - 4, 2003

Cognition, Behavior & Social Performance in the Elderly. Geneva.

Contact information and call for papers: [www.ipa-online.org](http://www.ipa-online.org)

## The Courage to Love: From Trauma to Transformation – Working with Negative Experiences in Self-Relations Therapy

April 3 & 4, 2003

Stephen Gilligan, Ph.D. – Metro-Central YMCA, 20 Grosvenor St., Toronto

This special two-day workshop focuses on specific principles and practices for transforming these core experiences from problems to solutions.

Contact information: The Hincks-Dellcrest Centre, 114 Maitland St., Toronto, phone: 416-972-1935, fax: 416-924-9808, email: [training@hincksdellcrest.org](mailto:training@hincksdellcrest.org)

## World Health Day 2003

### Shape the Future of Life: Healthy Environments for Children

April 7, 2003

Each year, the world celebrates World Health Day. On this day around the globe, thousands of events mark the importance of health for productive and happy lives. This year, the theme for World Health Day is "Healthy Environments for Children". The millions of children that die annually from environmentally related illnesses could be saved through the creation of healthy settings, whether it be the home, the school, or the community at large. Join us in promoting healthy environments for children on World Health Day, and make a difference for the future!

Contact information: Dr. L. A. Cassanha Galvão, Program Coordinator,

Environmental Quality Program-HEQ; Health and Environment Division-HEP; Pan American Health Organization-PAHO, WHO Regional Office for the Americas; 525, 23rd Street, NW., Room 524; Washington, DC-20037-2895-USA; Tel: +1-202-974-3156; Fax: +1-202-974-3645; Email: [galvaolu@paho.org](mailto:galvaolu@paho.org)

## Eating Disorders: Prevention, Assessment and Treatment

April 8 – 10, 2003

This course examines the psychological, social and biological factors related to eating disorders. David Goldbloom, MD, FRCPC. Contact information: Education and Training Services, CAMH, 33 Russell Street, Toronto, Tel: 416-595-6020, FAX: 416-595-6644, email: [ets@camh.net](mailto:ets@camh.net), web: [www.camh.net](http://www.camh.net)

## 3rd Annual International Association of Forensic Mental Health Services (IAFMHS) Conference : From Institutions to the Community

April 9 - 12, 2003

Roney Palace Beach Resort, Miami Beach, Florida Organized by: International Association of Forensic Mental Health Services (IAFMHS)

Contact Information: Tracey Moropito, Conference Coordinator

Phone: 604-669-7055 Fax: 604-669-7054 Email: [info@iafmhs.org](mailto:info@iafmhs.org)

### Second Annual Pharmacogenetics in Psychiatry Meeting

April 11 & 12, 2003

New York Marriott Marquis, New York, New York

A Category 1 CME Conference sponsored by the Zucker Hillside Hospital, the Second Annual Pharmacogenetics in Psychiatry Meeting will include sessions presenting the latest pharmacogenetics data from around the world. Topics to be discussed include: prediction of clinical response to the new antipsychotic drugs, genes associated with the development of adverse side effects, candidate gene studies of antidepressant response, developments in the identification of candidate alleles for the action of the anti-anxiety agents, and novel statistical approaches to dissect the heterogeneity of drug response.

Contact information: Department of Professional and Public Health Education at  
Phone: (516) 465-2500 Fax: (516) 465-8204 Contact: Alfie Truchan, e-mail:  
atruchan@nshs.edu Website: www.northshorelij.edu/education/pharm

### Ethical & Quality Practice in Adventure Therapy

April 20 - 24, 2003 - Victoria, BC.

Sponsored by International Adventure Therapy.

Contact information, e-mail, info@3iatc.com; website, www.3iatc.com

### From Violence to Cooperation: Helping Families Stay Together When Things Fall Apart

April 21 & 22, 2003

Chris Lobsinger, M.S.W.

The psychological, social and financial cost of addressing violence is enormous, and despite our best efforts, it remains one of the most frequent and daunting problems facing helping professionals.

Contact information: The Hincks-Dellcrest Centre, 114 Maitland St., Toronto,  
phone: 416-972-1935, fax: 416-924-9808, email: training@hincksdellcrest.org

### Counselling with Choice Theory: The New Reality Therapy

April 23, 2003

Metro-Central YMCA, Toronto

William Glasser, M.D., is a renowned psychiatrist, lecturer, and author of twenty books. He has worked extensively in adult rehabilitation, juvenile corrections, and public schools, and is founder and president of The William Glasser Institute, an international organization that provides training in Choice Theory-Reality Therapy, quality performance in schools, and lead-management in the workplace. Dr. Glasser demonstrates how these ideas can be used professionally in the many diverse situations in which the participants work. He will focus on a range of problems pertaining to the fields of mental health, substance abuse, corrections, schools rehabilitation, and couple relationships.

Contact information: Leading Edge Seminars Inc., 88 Major Street, Toronto, ON,  
M5S 2L1, toll-free at 1-888-291-1133 (in Toronto 416-964-1133) Fax: (416) 964-7172, website: www.leadingedgeseminars.org

### 6th World Congress in Psycho-Oncology

April 23 - 27, 2003

Banff. The Art and Science of Psychosocial Oncology Advancing Research, strengthening Advocacy, Refining Clinical Care, Forming Alliances.

Contact information: www.capo.ca

### Emotionally Focused Therapy for Individuals and Families

April 25, 2003

Metro-Central YMCA, Toronto

Sue Johnson returns with another workshop on Emotionally Focused Therapy (EFT). Sue is a dynamic presenter and workshop leader whose previous Leading Edge workshops on EFT with Couples have received extremely positive evaluations from participants. This workshop will present the theory and practice of Emotionally Focused Therapy for individuals and for families. EFT is a humanistic experiential approach that actively uses the power of emotional attachments to promote change in individual functioning and family systems.

Contact information: Leading Edge Seminars Inc., 88 Major Street, Toronto, ON,  
M5S 2L1, toll-free at 1-888-291-1133 (in Toronto 416-964-1133) Fax: (416) 964-7172, website: www.leadingedgeseminars.org

For more information on Sue Johnson visit: <http://www.eft.ca>

### Certificate in Trauma Counselling for Front-Line Workers – an eight-day course

Series B – April 25, 26, May 8, 9, 23, 24, June 6, 7, 2003

Series C – June 17, 18, 24, 25, July 8, 9, 15, 16, 2003

This course is designed for front-line workers who provide short-term (non-psychotherapy) counselling contact with vulnerable populations in community based settings such as hospitals, community health centres, rape crisis centres, battered women's shelters, homeless shelters, addiction services, crisis phone lines and short-term counselling centres.

Contact information: The Hincks-Dellcrest Centre, 114 Maitland St., Toronto,  
phone: 416-972-1935, fax: 416-924-9808, email: training@hincksdellcrest.org

### Motivational Interviewing: How to Change Addictive Behaviour

April 30 - June 11, 2003

CAMH offers this course in four Wednesday evening sessions from April to June.

Contact information: Karine Laroche, 416 535-8501 x 6017; e-mail  
Karine\_Laroche@camh.net

### Pain and Addiction: Common Threads IV

May 1, 2003

Sheraton Centre, Toronto

This course will explore a number of clinical issues and concerns related to pain management, addiction and the analgesic use of opioids. Participants will:  
-review current scientific and clinical thinking related to opioid induced hyperalgesia, tolerance and addiction -learn clinical approaches to safe and effective use of opioid analgesics in patients with addictive diseases including recovering patients, individuals on opioid maintenance therapy, and persons with active addiction -explore methods of withdrawing opioids and transitioning patients to non-opioid pain treatments when indicated -develop strategies to minimize the risk of diversion, abuse and trafficking by individuals seeking drugs for illicit purposes.

Contact information: Call the ASAM Office at 301-656-3920. Website:  
www.asam.org

### 34th Annual Meeting & Medical-Scientific Conference

May 1 – 4, 2003

Sheraton Centre, Toronto

The goal of ASAM's 34th Annual Medical-Scientific Conference is to present the most up-to-date information in the addictions field. To attain this goal, program sessions will focus on the latest developments in research and treatment issues and will translate them into clinically useful knowledge. Through a mix of symposia, courses, workshops, didactic lectures, and paper and poster presentations based on submitted abstracts, participants will have an opportunity to interact with experts in their fields.

At the conclusion of the conference, participants should be able to:  
-understand the current clinical approaches to treatment in various settings  
-explore the issues to be addressed in treating individuals in special populations or with special physical and mental illnesses -discuss the development and use of new drugs in treating addictions.

Contact information: Call the ASAM Office at 301-656-3920. Website:  
www.asam.org

### Interpersonal Therapy of Depression: A New and Effective Approach

May 2, 2003

Metro-Central YMCA, Toronto

Interpersonal Therapy (IPT) is a brief individual psychotherapy initially developed to treat depression. More recently, it has been used to treat individuals with a broad range of diagnoses including depression in the medically ill, Borderline Personality Disorder, and Dysthymic Disorder. Dr. Laurie Gillies has an international reputation for teaching IPT in a dynamic, enjoyable workshop. The course will provide an overview of IPT techniques, and will be of interest to therapists and counsellors from both cognitive-behavioural and psycho-dynamic backgrounds. The program is suitable for mental health professionals with graduate training, as well as students training in these disciplines.

Contact information: Leading Edge Seminars Inc., 88 Major Street, Toronto, ON,  
M5S 2L1, toll-free at 1-888-291-1133 (in Toronto 416-964-1133) Fax: (416) 964-7172, website: www.leadingedgeseminars.org

### A Dialogue on Difference

May 2 - 4, 2003

Held by the Society for the Exploration of Psychotherapy Integration (SEPI). New York City, the aim of the conference is to establish an open dialogue that emphasizes the exploration of differences as well as unrecognized similarities among the wide variety of perspectives on theory and technique.

Contact information and submission guidelines: [jcmuran@bethisraelny.org](mailto:jcmuran@bethisraelny.org) website, <http://www.cyberpsych.org/sepi/>

### Buprenorphine & Office Based Treatment of Opioid Dependence

May 4, 2003

Sheraton Centre, Toronto

The target audience includes physicians who wish to qualify to use buprenorphine in office-based treatment. Interested physicians to prepare for office-based treatment by getting appropriate training and putting in place the elements needed for safe and effective treatment. Attendance at the course is limited; places will be confirmed on a first come, first served basis.

Contact information: Call the ASAM Office at 301-656-3920.

Website: [www.asam.org](http://www.asam.org)

### Mental Health Week

May 5 - 11, 2003

Respect, Don't Reject

Part of creating a mentally healthy society is enabling people to find acceptance, support and appropriate treatment for their illness and creating an attitude of acceptance. A public campaign that challenges attitudes about mental illness will help to create a more open and supportive work, family and community environment for people dealing with mental illness. During Mental Health Week 2003, our goal is to reduce the shame and social isolation associated with mental illness so that people can comfortably seek help and not fear losing their friends, family, work opportunities and other areas of support.

Contact information: Canadian Mental Health Association, 2160 Yonge, 3rd floor, Toronto, ON M4S 2Z3, Tel.: (416) 484-7750, Fax: (416) 484-4617, Email: [national@cmha.ca](mailto:national@cmha.ca)

### Accessing Mental Health and Addiction Services

May 6, 2003

6:30 - 8:30 pm - Centre for Addiction and Mental Health

This forum will address the common difficulties many face when trying to get help for a mental health or addiction problem. Free admission - no registration required. Contact information: CAMH, Phone: 4169794251, [www.camh.net](http://www.camh.net)

### Mental Health Tune Up 2003

May 6 & 7, 2003

Barbara Frum Atrium, CBC Broadcasting Centre, 250 Front Street West, Toronto Canadian Mental Health Association, Ontario Division & Ontario Psychological Association present a free Public Education Forum and Community Resource Fair.

Taking place during National Mental Health Week, it will feature exhibits, lectures/speakers and representatives from over 40 community service organizations in the GTA. Don't know where to go to look for help? Featured experts will address such issues as emotional intelligence in the workplace, balancing work and family responsibilities, challenges to personal success, responsible parenting, stress, child and adult depression, productivity, mental health tips and numerous other subjects affecting mental health. Booths, printed materials, videos, 'Lunch and Learn' seminars, on-site experts and practitioners ("Talk with a Doc") will provide a broad range of experiences for the public of all ages. Contact information: website: [www.mentalhealthtuneup.ca](http://www.mentalhealthtuneup.ca), Phone: 416-813-2282 ext 201

### Tourette Syndrome Foundation of Canada - London Chapter Presents

Conference 2003 Growing Awareness

May 9 -10, 2003 - London, Ontario

Contact information: Gillian Lachance, Phone: 416-861-8398 or Toll Free: 1-800-361-3120 or Email: [tsfc@tourette.ca](mailto:tsfc@tourette.ca) Special one-day educator rates available

### Cognitive Behaviour Therapy for Anxiety Disorders and Depression

May 12, 2003

Metro-Central YMCA, Toronto

Millions of Canadians are affected by depression and anxiety disorders, which lead to significant impairment across a wide range of life domains including work and school, social functioning, and family life. For many individuals anxiety and depression occur together - leading to even greater suffering. The most salient features of the anxiety disorders include panic attacks, tension, fear and a tendency to engage in compulsive behaviours. Depression is associated with feelings of sadness, loss of interest, low energy, sleep problems, feelings of worthlessness, and suicidal ideation. Fortunately effective psychological treatments have been developed for dealing with these conditions. This workshop provides an overview of Cognitive-Behavioural Therapy (CBT) for anxiety disorders and depression. Contact information: Leading Edge Seminars Inc., 88 Major Street, Toronto, ON, M5S 2L1, toll-free at 1-888-291-1133 (in Toronto 416-964-1133) Fax: (416) 964-7172, website: [www.leadingedgeseminars.org](http://www.leadingedgeseminars.org)

### Canadian Association for Suicide Prevention Annual Conference - Sivumut Moving Forward

May 15 - 18, 2003

Inuksuk High School, Iqaluit, Nunavut

The conference will focus on sharing, skill-building and mutual learning. All participants will be invited to express ideas, share concerns, gather knowledge and discuss programs. Five areas will be emphasized; community development/crisis services, schools, youth, research/understanding, survivors and bereavement and special issues.

Contact Information: CASP 2003 Conference Committee, Phone: (867) 979-5281 Email: [integral@magma.ca](mailto:integral@magma.ca)

### 156th Annual Meeting of the American Psychiatric Association The Promise of Science and the Power of Healing

May 17 - 22, 2003

Depression and cardiovascular disease, new treatment strategies for Alzheimer's addiction treatments, and the genetics of bipolar disorders are among the cutting-edge research topics to be presented at the American Psychiatric Association's 156th Annual Meeting in San Francisco, CA.

Contact information: [www.psych.org](http://www.psych.org)

### VIIIth European Conference on Traumatic Stress

May 22 - 25, 2003 - Berlin

In recent times there have been efforts by German development aid organizations to focus on traumatizing events for development workers in war and crisis regions world-wide. Comparison of European and international peace supporting task forces, working with traumatized communities, would be one of many trauma issues on the Berlin conference. The Scientific Program promises to be wide ranging, and will offer participants the opportunity to enhance their knowledge of new developments and advances in the fields of extreme stress and psychotraumatology. Contact information: [www.trauma-conference-berlin.de/pages\\_trauma/welcome.htm](http://www.trauma-conference-berlin.de/pages_trauma/welcome.htm)

### The Brief Therapy Network, 2nd Annual Conference 2003

May 27 - 30, 2003, Toronto

The innovative multi-track interdisciplinary program will allow you to gain ideas and skills specific to your needs and learning goals.

Contact information: Training Department, 114 Maitland St., Toronto, 416972-1935 or visit: [www.brieftherapynetwork.com](http://www.brieftherapynetwork.com)

### 17th Annual Forensic Conference: Violence and Emotion

June 11, 12, 13, 2003

Highland Inn, Midland, Ontario

Organized by Mental Health Centre Pentanguishene. A major conference offering the latest research results and practical information for professionals working in the forensic mental health system and criminal justice field.

Contact information: [www.mhcv.a.on.ca/forensic/index.htm](http://www.mhcv.a.on.ca/forensic/index.htm)

### Trauma and Comorbidity: An Integrative Treatment Approach

June 13, 2003

Metro-Central YMCA, Toronto

A growing body of evidence indicates a high prevalence of trauma among persons with severe mental illness. Moreover, the impact of victimization is often underdiagnosed and goes untreated.

A critical and scholarly evaluation of various models of intervention will be offered, including the Stages of Change Model, EMDR, and Critical Incident Stress Debriefing. A program goal is for the participants to become more critical consumers, and, at the same time, more sensitive and effective therapists. Contact information: Leading Edge Seminars Inc., 88 Major Street, Toronto, ON, M5S 2L1, toll-free at 1-888-291-1133 (in Toronto 416-964-1133) Fax: (416) 964-7172, website: [www.leadingedgeseminars.org](http://www.leadingedgeseminars.org)

#### 20th Annual Cape Cod Summer Symposia

June 16 – August 22, 2003

The 20th 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 16 through August 22. Each symposium will convene at the Sheraton, Four Points Hotel, Eastham, 9:00 a.m. – 12:15 p.m., Monday through Friday.

Contact information: New England Educational Institute, 92 Elm Street, Pittsfield, MA, 01201, Phone: 413-499-1489, fax: 413-499-6584, website: [www.neei.org](http://www.neei.org), email: [educate@neei.org](mailto:educate@neei.org)

#### 4th National Shared Care Conference

June 21 & 22, 2003 - Halifax, N.S.

This is the first time the National Shared Mental Health Care Conference will be held in Atlantic Canada. Invited speakers from Canada and overseas will examine relationships between primary care, specialist mental health services, community services, consumers and carers. Our focus this year will be on services for marginalised groups and the programme will include visits to local services.

Contact information: Donna Fraser, #508, 5651 Ogilvie St., Halifax, NS, B3H 1B9, email: [dfraser@sprint.ca](mailto:dfraser@sprint.ca), Fax: 902-425-5884

#### Institute on Addiction Studies - Personal Focus for Professional Development

July 6 - 10, 2003 - Barrie, Ontario

Hosted by Alcohol and Drug Concerns Inc., this 5-day accredited conference targets Addiction Workers, First Nations Support Workers, Employee Assistance Providers, Social Workers, Educators, Medical and Health Care Professionals, Clergy and Spiritual Counsellors, Problem Gambling Prevention Workers, Emergency Response Workers and Corrections Workers.

In interactive workshops and seminars, delegates learn the most current information on alcohol and drug prevention, treatment and aftercare from North America's leading specialists. The Institute also provides self-care opportunities for delegates and speakers.

Contact Information: Kari Sutoski, Phone: 416-293-3400, Email: [k.sutoski@concerns.ca](mailto:k.sutoski@concerns.ca) Website: [www.concerns.ca/ioas\\_2003.htm](http://www.concerns.ca/ioas_2003.htm)

#### The Unconscious in Cognitive Neuroscience and Psychoanalysis

July 25 - 28, 2003 – Toronto

Program consists of an 'Optional Educational Day' providing introductory information; a 'Congress' where recent findings will be presented in a systemic, integrated programme of interdisciplinary papers by leading authorities in discussion with the audience; and an 'Optional Research Day'. Information about submissions for the Optional Research Day may be obtained from Dr. Oliver Turnbull, [o.turnbull@bangor.ac.uk](mailto:o.turnbull@bangor.ac.uk)

Contact information: Paula.Barkay@neuro-psychoanalysis.org

#### International Psychogeriatric Association 11th Congress

August 17 - 22, 2003 - Chicago

Enhancing the Human Connection in the Age of New Technologies: Implications & Opportunities for the Aging.

Contact information: 1-847-784-1701; fax: 1-847-784-1705; e-mail, [chicago2003@ipa-on-line.org](mailto:chicago2003@ipa-on-line.org); website, [www.ipa-online.org](http://www.ipa-online.org)

#### New Two Year Training Program in Psychotherapy

September 2003

The Institute for the Advancement of Self Psychology is offering a two year clinically oriented training program in psychoanalytic psychotherapy. The program will consist of weekly seminars and case supervision. Some experience of personal psychoanalytic psychotherapy is expected of candidates.

Contact information: Rosemary Adams 416-690-3722 or [rosemary.adams@sympatico.ca](mailto:rosemary.adams@sympatico.ca)

#### Royal College of Physicians and Surgeons Annual Conference on Achieving Quality Health Care through Education, Professional Development and Research

September 11-13, 2003

Halifax, Nova Scotia. Changes in Health Care: Charting a New Course.

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

#### Making Gains: Research, Recovery and Renewal in Mental Health and Addictions

September 28 to October 1, 2003

Hilton Niagara Falls Hotel, Niagara Falls, Ontario  
CMHA Ontario Division, CAMH, OFCMHAP, ADRAO

Four of the leading organizations in mental health, addictions and substance abuse in Ontario are hosting a major conference to talk about the newest developments in mental health and addictions.

Conference streams will focus on the following topics: Recovery, Dual Diagnosis, Organizational Strategies in Times of Change, Evidence Based Practices in Mental Health and Addictions, Concurrent Disorders and Addictions.

Contact Information: Rachel Gillooly, Phone: 7054548107, Fax: 7054549792 website: [www.ontario.cmha.ca](http://www.ontario.cmha.ca)

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

## AGENDA OPA Council November 15th, 2002

### 1.0 Remarks from the President

Approval of Agenda

### 2.0 Approval of Minutes of September 20, 2002 OPA Council

### 3.0 Business Arising

- 3.1 2003 Elections
- 3.2 Mental Health Implementation Task Forces/Authorities
- 3.3 AGHPS Nov. 30 event on Suicide Prevention
- 3.4 JPPC/OPA Joint Meeting Sept. 10

### 4.0 Treasurer's Report

### 5.0 Reports of Task Forces and Committee

- 5.1 Advocacy Committee
- 5.2 Communications Committee
- 5.3 Continuing Education Committee
- 5.4 Finance/Audit Committee
- 5.5 Member Services Committee

### 6.0 Standing Reports

- 6.1 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 CPA Standing Committee on Education

### 7.0 New Business

- 7.1 Guest Speaker: Dr. John Carlisle, Deputy Registrar, The College of Physicians and Surgeons
- 7.2 Strategic Planning/Governance
- 7.3 Rapid Access to Information for Psychiatrists re: Civil Emergencies
- 7.4 Child Psychiatry Task Force
- 7.5 Annual General Meeting – January 31, 2003
- 7.6 Implementation of new Bulletin section - CPA Forum

# AGENDA OPA Council January 29th, 2003

## 1.0 Remarks from the President

Approval of Agenda

## 2.0 Approval of Minutes of November 15, 2002 OPA Council

## 3.0 Business Arising

- 3.1 2003 Elections
- 3.2 AGHPS "People at Risk of Suicide" Conference
- 3.3 Mental Health Implementation Task Forces/Authorities
- 3.4 Child Psychiatry Task Force
- 3.5 Annual General Meeting
- 3.6 OPA Privacy Policy
- 3.7 Implementation of new Bulletin Section
- 3.8 JPPC/OPA Joint Meeting

## 4.0 Treasurer's Report

- (i) 2002 Financial Statements
- (ii) 2003 Budget
- (iii) 2004 Membership Dues

## 5.0 Reports of Task Forces and Committee

- 5.1 Advocacy Committee
- 5.2 Communications Committee
- 5.3 Continuing Education Committee
- 5.4 Finance/Audit Committee
- 5.5 Member Services Committee

## 6.0 Standing Reports

- 6.1 OMA Tariff/RBRVS
- 6.2 CPA Report
- 6.7 Working Group on Mental Health Services
- 6.8 Coalition
- 6.5 Council of Provinces
- 6.6 Alliance for Mental Health Services
- 6.7 CPA Standing Committee on Education

## 7.0 New Business

- 7.1 Strategic Planning/Governance
- 7.2 Review of OPA Liaison

## Documentary on Depression Evokes 'Overwhelming' Response

Viewer response to the W-FIVE documentary *Depression: Fighting the Dragon* was "overwhelming" according to the Mood Disorders Association of Ontario (MDAO). The one-hour documentary, which aired on November 22 on CTV, discussed the illness of depression, featured the personal stories of several Canadians who have struggled, often for many years, to overcome this debilitating disease, as well as the research scientists who work to understand both its causes and its cures. Canadian scientists are among the world leaders in pioneering this research.

While statistics peg depression as affecting one in ten people, the vast majority of sufferers never seek treatment, and slide further and further into the illness. Antidepressants are the most common treatment for those who do seek help, but they offer relief in only about 60 per cent of cases.

During the last century, depression has grown with every passing generation. When prominent public figures come forward with their personal stories about the tragic impact depression has wreaked on their families, the door is left open for others to raise their voices.

The Mood Disorders Society of Canada's website, which was mentioned in the documentary, received 80,000 hits between 9 pm and midnight on the Friday evening the documentary aired, and over 300,000 by Sunday evening, as well as more than 600 e-mails at [www.ctv.ca](http://www.ctv.ca). Copies of the documentary can be ordered from Moving Images Distribution, at [www.movingimages.ca](http://www.movingimages.ca).

## CENTRE FOR ADDICTION AND MENTAL HEALTH INVITES PUBLIC INPUT ON FUTURE OF HISTORIC ASYLUM WALL:



### Call for entries for innovative design competition

Artists, designers, historians, people who have experienced the mental health system and members of the public are invited to help determine the future of the historic wall that runs along the east side of the property of the 1001 Queen Street site of the Centre for Addiction and Mental Health (CAMH). The south and west walls built in the 1850s by patients of the Provincial Lunatic Asylum, will essentially be retained in their current form. All three sides of the wall have been designated under the Ontario Heritage Act.

One of Toronto's most significant urban redevelopments, CAMH's proposed plans will transform the site from a traditional psychiatric facility, set apart from the neighbourhood on its 27-acre site, to a centre of research, education, prevention and care, integrated with the surrounding community. The site will be designed as an urban village with streets running through the property and a mix of CAMH and non-CAMH uses and activities. Green spaces, including a large public park at the corner of Queen and Shaw Streets, will provide a welcoming and healing environment for both neighbours and clients.

All ideas for the Shaw street wall will be welcome. CAMH's challenge will be to balance the preservation of the history of the wall, while at the same time, creating a neighbourhood environment that is pleasant, interesting, safe, welcoming and open to everyone.

A jury, made up of a wide range of stakeholders with differing viewpoints on the wall, will judge the entries. The jury will review the submissions and select a winner, a runner-up, and three honourable mentions, all of whom will receive a cash prize.

A competition brief which includes a complete set of competition rules and submission requirements is available at the 1001 Queen Street, Administration Building, Reception, and the library at 33 Russell Street or downloaded from the CAMH website at [www.camh.net](http://www.camh.net). Deadline for submissions is March 31st.

For further information: Media Contact: Anne Ptasznik, Media Relations Coordinator, at (416) 595-6015. ■

# Ontario Psychiatric Association President's Report

## January 2003

Dr. Margaret Steele, President

I would like to start by thanking my fellow Council Members who have made this past year extremely enjoyable and rewarding. I would like to thank Dr. Keith Anderson, Past President, who has been steadfast in his goal to further the views of Ontario psychiatrists. Dr. Anderson has taken the lead on the issues pertaining to the Mental Health Implementation Task Forces. I would like to wish Dr. Bob Buckingham well as he begins his Presidency year. Dr. Buckingham has been a very effective OPA member and will no doubt serve our organization exceptionally well. Ann Thomas is to be congratulated for her untiring efforts in the planning and execution of another great Scientific Programme. I want to particularly thank Ranjith Chandrasena, Mamta Gautam and Doug Wilkins who have completed their three-year terms as Council Members and Khrista Boylan who has completed her two-year term as Resident Representative. And finally, I would like to thank Mrs. Elizabeth Leach, Director of Policy and Planning, and Mrs. Lorraine Taylor, Executive Assistant, who have both been tremendously helpful and patient with me over this past year.

The Ontario Psychiatric Association (OPA) has been busier than ever over the past year. I would like to provide a summary of the OPA's activities in 2002 and the early part of 2003.

Mental Health Reform in Ontario continues to be of prime importance. The nine Mental Health Implementation Task Forces submitted recommendations to the Minister of Health and Long-Term in December 2002. From what we have been able to ascertain (the Task Force reports are confidential), should the government choose to implement these recommendations, access to and utilization of community mental health services will be improved. The OPA co-signed a letter with the Canadian Mental Health Association - Ontario Division, the Ontario Medical Association, the Ontario Hospital Association, the Association of General Hospital Psychiatric Services, the Mood Disorders Association of Ontario, and the Ontario Federation of Community Health and Addiction Programs which outlined our priorities - the need for an immediate investment in building the system's capacity to serve people, ensuring that scarce resources are not used to fund reorganization exercises, and the need to proceed with the divestment of the remaining provincial psychiatric hospitals. In addition, the OPA sent a letter to the Minister to specifically address our concerns about Mental Health Reform - namely, the lack of meaningful dialogue with the OPA even though psychiatrists will need to be able to support the implementation of those Task Force recommendations that are approved by the government. While very supportive of the goals of mental health reform and the need to ensure that people with mental illness and their families have access to a broad range of community-based services and supports, the OPA expressed concern regarding the proposed governance structures (regional mental health authorities/boards) to achieve the local systems of care. Our view is that mental health should not be hived off from health.

The OPA began to forge linkages with the Ontario College of Family Physicians in 2002. We had an opportunity to discuss shared mental health care with Dr. Nick Kates and reviewed information regarding the Collaborative Mental Health Care Network (CMHCN), which was initiated to provide much needed support for family physicians and GP psychotherapists, who work in isolation from one another and from psychiatrists. The Mentors are psychiatrists or family physician psychotherapists and the mentees are family physicians with an interest in mental health care. Detailed information regarding shared mental health care, the CMHCN, and the need for additional psychiatric mentors, was provided in the OPA's newsletter *Dialogue*.

OPA Council worked to solidify our new organizational structure by approving new terms of reference for our five standing committees - Advocacy, Communications, Continuing Education, Finance/Audit and Member Services. An OPA Section Task Force completed, and Council approved, a document that contains the rules and procedures for our six Sections (Child and Adolescent, Community, Consultation-Liaison, Geriatrics, Psychotherapy and Residents). During 2002, the OPA continued to provide its Peer Mentoring Program, which was first introduced to our members at the beginning of the year. In September, the OPA co-hosted a meeting with some members of the Joint Policy and Planning Committee of the Ontario Hospital Association to determine if there was a desire to develop a child assessment tool. A number of child psychiatrists from Ottawa, Kingston, Toronto, Hamilton and London attended the meeting. The consensus of the group was that further exploration of the development of a tool for child psychiatry would be useful. We are currently exploring ways to determine how to best achieve this.

OPA continues to be an active member of the Coalition of Ontario Psychiatrists with the OMA Section on Psychiatry

2003 has started off with an excellent program for our Annual Meeting "Psychiatry Across the Life Span" on January 30, 31 and February 1, 2003. It provided the opportunity for the Sections to meet over lunch and hear from invited lecturers, decide who will Chair (or Co-Chair) the Section, and discuss next steps. In 2003 we will be supporting two OPA members who will be participating on a newly created Children's Mental Health Working Group, by the Ministry of Community, Family and Children's Services (formerly Ministry of Community and Social Services) which will develop a policy framework for children's mental health in Ontario.

I have been very fortunate to serve the OPA as a Council Member, Treasurer and President and I have enjoyed my experience immensely. I would like to thank everyone who has in some way contributed to the OPA.

## NEW REPORT: Outcomes and Effectiveness: The Success of Community Mental Health and Addiction Programs

The Ontario Federation of Community Mental Health and Addiction Programs (OFCMHAP), which represents 216 community based organizations, recently released their 18-page report, entitled, "Outcomes and Effectiveness: The Success of Community Mental Health and Addiction Programs. The OFCMHAP states that:

- the cost of mental health and addiction problems to the Ontario economy is enormous
- the number of people affected by mental health and substance use problems is on the rise
- the cost of managing those problems in the community by members of OFCMHAP is significantly less than the alternatives

- members of OFCMHAP are unable to offer enough service to many of the people who come to us for help
- the community based addictions and mental health sector can demonstrate the success and effectiveness of the services they provide

The report includes statistics from a variety of sources. A copy of the report is on file at the OPA office. For more information contact: David Kelly, Executive Director, OFCMHAP, 250 Consumers Road, Suite 806, Toronto, Ontario M2J 4V6, tel: (416) 490-8900 ext. 22, fax (416) 490-8902, email: dkelly@ofcmhap.on.ca, website: www.ofcmhap.on.ca ■



# Ontario Psychiatric Association Presidential Address

## January 2003

Margaret Steele, HBSc, M.D., FRCP(C)

Psychiatry is a fascinating profession, one in which practitioners are able to try and understand their patients in context to their development, their families, their friends and their community. To best understand their patients, psychiatrists need to have an understanding of the histories of their patients and how their histories may unfold as they age. I chose the theme "Psychiatry Across the Life Span" due to my view that we have to address the mental health needs of our patients from infancy to their senior years. Being a child psychiatrist, I am particularly intrigued by people's early histories and ongoing development. In order to be qualified, psychiatrists must have training in managing the mental health needs of individuals of all ages.

Mental illness affects each and every one of us. In the document entitled "Health Canada: A Report on Mental Illnesses in Canada" published in Ottawa, Canada 2002 it states that "approximately 20% of individuals will experience a mental illness during their lifetime, and the remaining 80% will be affected by an illness in family members, friends or colleagues" (1). Therefore, it is important to emphasize to our patients, our colleagues, and government officials the importance of prevention, early intervention, and effective treatment of mental illness in order to optimize not only individuals and their families' well-being but also the community at large. When advocating, unfortunately it is always important to stress the economic burden to society of mental illness. The Health Canada report indicates that "the economic cost of mental illnesses in Canada was estimated to be at least \$7.331 billion in 1993" which is an astounding figure (1). Psychiatrists must continue to advocate for the needs of our patients and their families.

I have decided to take a different approach from my predecessors with respect to my speech. I would like to tell you a story of a family who has been in my practice for several years. I hope that I can emphasize why it is important for all psychiatrists to understand the needs of children, adolescents, adults and seniors in order to better serve our patients but also to be able to advocate for a better mental health delivery system.

I would like to tell you about a young boy, his mother, his father and his maternal grandmother and how mental illness has affected each and every one of them. I would like to acknowledge and thank the family who allowed me the privilege of telling their views about living with, and with someone who has a major mental illness, bipolar disorder.

I first met "Peter" when he was 8 years of age. Prior to seeing me, he had seen several physicians and a therapist. He had originally been diagnosed with attention deficit with hyperactivity disorder but the medications and interventions were not working and he was struggling at home, at school and with peer relationships. My first recollection upon meeting Peter was his intense interest in shoes. He knew the brand names of every shoe ever made, he traded shoes and he talked incessantly about shoes. Peter was an engaging boy who was an only child and his parents were extremely committed to him. His maternal grandparents were also actively involved in his life. During the initial consultation, his mother revealed she was in individual psychotherapy and had been treated intermittently over the past several years for depression. After seeing Peter on a few occasions, it became clear that he was experiencing the symptoms of early onset bipolar disorder and he was becoming psychotic. He thought he was a prisoner and he would ask his mother to lock him in his cell every night. His parents interpreted his delusion as having a child with a very vivid and creative imagination. He reported seeing scary figures and hearing voices. He would talk quickly, fidget and explain that his thoughts were like having a ping pong ball in his head. As my involvement with Peter continued, I wondered whether his mother had undiagnosed bipolar disorder and I referred her to an adult psychiatrist who confirmed the diagnosis in Peter's mother.

In thinking about this boy and his family a myriad of questions came to mind. Could we have done anything sooner to help Peter and his mother? How could we help Peter and his mother so that both could experience rewarding mentally healthy lives? What would Peter's future be? What were the implications for Peter of having a mother with bipolar disorder? What other supports could be provided to this family?

Current psychiatric literature emphasizes the importance of early diagnosis and intervention to provide individuals with better outcomes. Peter's mother, however, was undiagnosed for many years. She explained "The main way I believe bipolar disorder has affected my life is it has held me back. It continues to do so... It was not until my 30's that I was diagnosed as having bipolar. Until that time I suffered from what I called chronic depression, only to be visited later by "the witch". This "witch" truly seemed to be a different identity that slowly took me over. I later learned what I named the "witch" was in fact a stage of bipolar called black or dark mania. ... I truly believe my lack of early diagnosis and treatment has had a huge impact on my feelings of low self esteem and self worth. .... Those years between 18 to 25 are so important for establishing yourself, finding out who you are as your own person, how you can fit in the world and build confidence within yourself, in the world, by experiencing it. I feel that because of going through the throws of untreated bipolar I missed out on a lot of these developments... When I get ill I am not able to carry out my duties the same and this really bothers me. I pride myself on being a really good mother but when I am ill I cannot be as an effective parent (sic). Out of everything this bothers me the most." I believe her words clearly indicate the reasons why early diagnosis and intervention are important as bipolar disorder has affected this woman's overall sense of self.

Perhaps her current life situation might have been better if she was diagnosed when her symptoms began as an adolescent. She may have also made a more informed decision about having children. We know that twin studies (2, 3), adoption studies (4) and family studies (5, 6, 7, 8, 9) all argue for a strong genetic component to bipolar disorder. In addition, knowing that Peter would be at higher risk for the development of bipolar disorder, perhaps identification of his illness may have been made sooner.

Numerous studies have demonstrated that children of bipolar parents are not only at risk biologically for the development of bipolar disorder they are at risk for other mental health problems (10). As well, there appears to be differences in the functioning of children who have parents who are lithium responders and children of parents who are lithium non-responders. Children of parents who are lithium responders have been shown to manifest psychiatric illnesses that cluster in the affective domain with few comorbid illnesses and an episodic course. Conversely, children of parents who are lithium non-responders have been shown to manifest a broad range of psychopathology, more comorbid illnesses and a chronic course of illness (11). This finding suggests that children of parents who are lithium non-responders may be at greater risk for psychopathology due to other environmental factors they experience as a result of having a parent whose illness is not well controlled.

Early identification and treatment is becoming increasingly important because the age at onset of the bipolar disorder appears to be decreasing over time (12). The reasons for this effect are not clear but may be a result of earlier detection of bipolar disorder and/or assortative mating i.e. bipolar people marry bipolar individuals.

Multiple studies have assessed differences in functioning between children of bipolar parents and children of other high risk groups (e.g., schizophrenia, depression, chronic medical illness) and with healthy controls (10, 11, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27). Based on comparison studies,

children of parents with bipolar disorder are definitely at high risk for depression and a variety of other psychiatric disorders. Many factors need to be considered when looking at the mental health of the offspring of a parent with bipolar disorder. These factors include: the severity of the illness of the bipolar parent; the presence of psychoses in the bipolar parent; the course of the bipolar parent's illness; the level of functioning of the bipolar parent; the interaction between the parents and their offspring; the personal resources of the children; the children's support system; the age of the children; and the presence of psychopathology in the non-bipolar parent.

Parents who have bipolar disorder can be exceptional parents but they need to understand their illness and the impact it has on the remaining family members. If they are ill, they need to obtain help for themselves and engage supports so that their functioning and the functioning of other family members is optimized. Peter's mother identifies the role her illness plays in her relationship with her son as well as the role of his illness on her. She indicated "As a mother I will always feel deeply for my child. I think I will always feel the most joy when he is happy and feel the most sorrow when he is sad. He will have more ups and downs and; therefore, so will I. I will always try to strike the right balance in parenting him and I will always try and make the decisions for him. I will always advocate for him and when he gets older, although I will always be in his corner, I will teach him to do some of these things for himself. I appreciate the good times because I know some times will be distressing for my son and us as a family. During the stressful times I will remember what I have learned so that I can be helpful to me and to my son. I feel I understand my son at a very deep level. Perhaps this is because I have bipolar myself, perhaps it is just because I am his mother, or perhaps simply because I love him so much..."

Peter has struggled with many things over his young life. Peter is now thirteen and is functioning the best he ever has. He has been in the same school for two years and is progressing well academically despite having a significant non-verbal learning disability. He has friends, and he continues to live with his parents and has ongoing contact with his maternal grandparents. Now Peter is trying to separate and individuate from his family which I believe has been more difficult for him than other adolescents because his family has been an extremely integral part of his life, due to his tremendous need to rely on his parents. In discussing his experience of being depressed Peter stated: "When I become depressed I have no emotions at all. You could tell me the world was going to end tomorrow and I would have no emotion toward it." In terms of his manic periods, Peter described the difference between "Good Mania" and "Bad Mania". "When I have this it feels like an amazing surge of energy flowing through my body that I need to let go. If I am in an area where I can let that energy flow it can feel like an amazing flow of energy where I can laugh non-stop or feel complete relaxation so that I feel like I am sitting in a valley with trees, and grass and sunshine. The bad mania happens when I am in a situation where I have to bottle the energy up so that it feels like it is screaming to get out. I start to get very frustrated like I want to bring my foot back and bust open a door."

In reflecting back on his life experience Peter says "When I look back on those past 4 or 5 years I cannot recognize myself. Now I look back from this joyful stage of my life and those past years seem like a horrific dream." As you can imagine he worries about being sick again and how he will cope. For Peter and other children with bipolar disorder we need to learn more about treatment interventions and their effectiveness. We need to be able to prevent individuals from experiencing more symptoms of their illness so they can go on to live healthy, rewarding lives.

The other significant person in Peter's life is his father and it is important to understand how he copes with having a wife and son with bipolar disorder. He too is at risk for the development of mental health difficulties and he is key as he is a major support if his wife and/or son becomes ill. Peter's father wrote: "Living with both a wife and a son with bipolar illness has been quite a challenging lifestyle. Often confused or saddened by their illness and the effects that it has had on them and myself, I am led to believe that awareness is the key issue in this circumstance..." I think what Peter's father most emphasizes is the need for education for himself, his wife, his son, the school, and the community at large. We, as psychiatrists, need to educate all these different individuals as well as the

politicians so that money will be available for resources for these individuals and their families and for education and research in the area of mental illness. The other person who has been substantially effected is Peter's maternal grandmother who has been actively involved in the lives of her daughter and her grandson. She has also sought counseling, as a senior, to help her cope. She writes: "The effect of having a daughter and a grandson with bipolar is significant both financially and emotionally. In trying to reduce stress (in my daughter's) life we ended up relieving her of normal family responsibilities resulting in her becoming dependent, frustrated and resentful. I wish I could have done more to change the situation with (my daughter) and her family. Looking back twenty years I wonder what could have been done better and brought more happiness to (my daughter's) life. She is lonely, sad and angry. She has often said she would be better if I was a nicer person. Looking over (my grandson's) thirteen years I know that I have been good for him. I know I have added happiness to his life. He has been good for me. I am much closer to him than to my other grandchildren because I have spent so much time with him."

The Ontario Psychiatric Association must continue to represent the voice of all psychiatrists whether they treat children and adolescents, adults or seniors. As an organization we need to be actively involved in the planning of services for all individuals with mental health problems. We need to continue to educate our patients, their families, the community, other physicians and the government about the unique difficulties that individuals with mental illness experience. We need to continue to be vigilant of what the various Ministries (the Ministry of Health and Long Term Care, the Ministry of Community, Family and Children's Services (formerly the Ministry of Community and Social Services), the Ministry of Education and the Ministry of Public Safety and Security) are doing when it comes to developing policy, structuring services and funding resources for those with mental illness. We need to be at the table. We need to ask the hard questions. We need people to be anticipating the answers to the questions before we ask. For example, when I became a participant on the OPA Council 8 years ago I would constantly raise questions about children's mental health. I asked so often that as soon as I raised my hand to ask a question fellow council members would speak to the issues of children and adolescents even when what I was going to ask was not about children's mental health.

I am immensely proud of being a member of the OPA. I continue to be impressed with the people who work so diligently and on a volunteer basis to promote better mental health for the people of Ontario. This year one of my goals was to revitalize the various Sections in the organization. The new Sections represent "Psychiatry Across the Lifespan." The Sections include Child and Adolescent, Community, Consultation-Liaison, Geriatric, Psychotherapy. Possible goals for the Sections are to have groups of psychiatrists who can follow the pulse of the issues in their area of interest and expertise, represent the OPA on these issues, contribute to the Annual Meetings and develop position papers when necessary.

The other way to envision "Psychiatry Across The Lifespan" is to address the issues of psychiatrists as they move along their professional career. We all started as medical students with some kernel of interest in mental health. We need to nurture and mentor them and encourage medical students to join the OPA. We need to be committed to our residents who are bright, energetic, and creative. They have much to offer to revitalize the profession and we as psychiatrists have much to offer the residents. We have to assist early career psychiatrists who are finding their way as they begin their practice. We have to keep psychiatry exciting and interesting for those of us in our middle years of practice. We have to value the senior psychiatrists who have much to teach us about their experiences.

So in closing, I would like you to think of your patients and their families in the context of their life history, what happened to them before, what is happening now and what will happen to them in the future. Then think, what can I as a psychiatrist and we as a profession do to meet the needs of all patients from infancy to their senior years.

*The noted references are available by contacting the OPA office at; ph (905) 827-4659, email:opa@bellnet.ca ■*

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# INTRODUCING Dr. Robert Buckingham

## OPA 2003 President

Dr. Buckingham is Clinical Director of the Department of Psychiatry at the University Health Network and an Associate Professor at the University of Toronto. For many years he has been involved in providing emergency psychiatric services and managing a psychiatric intensive care unit within a general hospital. Throughout his career he has participated in community mental health planning including the development of the Gerstein Centre mobile crisis program and serving as co-chair of the Psychiatric Patient Advocate Program's Advisory Committee.

He is a past-president of the Association of General Hospital Psychiatric Services and a current member of the Ontario Review Board. He was a member of OPA Council from 1998-2000 and served on Council as President-elect in 2002.

### Presidential Theme: Destigmatizing Mental Illness

Stigma associated with mental illness continues to be a strong deterrent to seeking mental health care. Insufficient treatment, bizarre behavior in the mentally ill, and the belief that mental illness is a character defect contribute to this stigma. The result is lack of housing and jobs, and barriers to getting the best treatment, or any treatment at all. This year's T.A. Sweet Award recipient, Lieutenant-General (Ret.) Romeo Dallaire, has spoken out about stigma in the military. "While a soldier who loses a leg in battle is seen as having an "honourable" injury, no such respect is paid to those who come home bearing scars to their psyche and spend years battling mental demons... The stigma is so strong that soldiers tend to either lash out or bury the problem deep inside." The OPA can do much to reduce stigma by educating ourselves and the lay public, by advocating for our patients to have access to treatment, housing, and jobs, and by encouraging increased research into diagnosis and treatment of psychiatric illnesses

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## Annual Treasurer's Report

### 2002 FISCAL YEAR

## January 2003

Jane Howard, M.D., FRCPC(C)

In a year of general fiscal upheaval, the association's finances remain relatively stable.

The Association had \$33,687 in its bank account at December 31/02 and net assets totaling \$99,867.

In comparison to 2001, general revenues were decreased. The income reduction was mainly related to decreased Membership Fees and decreased Newsletter subsidy.

Total expenditures were also lower in comparison to 2001.

Once again, the 2002 Annual Meeting was very successful with excellent attendance and continued to pay for itself.

In accordance with our revised Association Bylaws for occasional for periodic audits of our financial records, our financial statements for 2002 were reviewed, but not audited by our Accountant.

Thank you to Lorraine Taylor, and Beth Christie, bookkeeper, for their help during this second year of my 3-year term as Treasurer. Thanks also to the members of the Finance and Audit Committee, Dr. Margaret Steele, Dr. Bob Buckingham and Elizabeth Leach for their assistance over this past year.

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## R. JOHN HARPER

### named as New Chair of Consent and Capacity Board

R. John Harper was appointed Chair and Chief Executive Officer of the Consent and Capacity Board of Ontario on January 1, 2003. He has been a member of the Board since 1997 and served as Senior Vice-Chair and Regional Vice-Chair for Hamilton, Niagara Region, Kitchener and Guelph.

In 1998, he was appointed legal consultant member to the Child Advocacy and Assessment Program, Department of Psychiatry, McMaster University, and in 1999, joined the Department of Psychiatry and Behavioural Neuroscience, McMaster University as an Assistant Professor. Mr. Harper is co-author of two book chapters ("The Expert Witness", with Dr. Steven Hucker and "Child Abuse and Forensic Psychiatry" with Dr. Harriet MacMillan) in Dr. Hucker's textbook entitled, "Forensic Psychiatry". Mr. Harper is co-author of the 1999 Consent and Capacity Board of Ontario paper entitled, "Dispute Resolution and Mental Health" and has lectured on this topic at the 2000 World Congress on Mental Health, at Queen's University and at Grand Rounds at Kingston Psychiatric Hospital.

Mr. Harper is a Senior Partner in the Hamilton law firm of Harper Jaskot where his practice is restricted to family and child welfare law.

Mr. Harper replaces long-time Chair and CEO Michael Bay who was instrumental in the establishment of the Consent and Capacity Board in 1995, and, until December 2002, served as its Chair.

The Consent and Capacity Board hears and decides cases under the Mental Health Act, the Substitute Decisions Act, the Health Care Consent Act, and the Long Term Care Act. It is an independent tribunal affiliated with the Ministry of Health and Long-Term Care. For more information about the Board, please visit [www.ccboard.on.ca](http://www.ccboard.on.ca). ■

# Celebrating OPA Life Members

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

Members beginning their Life Membership in 2003 are;

Robert Buie  
Jerry Cooper

Caridad Cruz  
Marcel Lemieux

David Norman  
Ed Pakes

Morton Rapp  
Balbhadar Sood

Jennifer Steadman  
George Voineskos

## Meet A Council Member: An Interview with Dr. Rosemary Meier



Dr. Rosemary Meier, MB ChB MSc FRCPsych FRCPC is currently Head, Geriatric Psychiatry, Mount Sinai Hospital, Toronto

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

**Rosemary:** I am a member of the OPA Council and I serve on the Continuing Education Committee and also have an interest in the recent updating of the Sections, particularly the Geriatric Section

**OPA:** Tell us a bit about your background

**Rosemary:** After growing up in Aberdeen, Scotland, studying Medicine at Aberdeen University, Internship in London, England, and in Toronto at Women's College and HSC, Traineeship in General Practice in Inner London, I had the exceptional experience of entering psychiatry and continuing an interest in Social Medicine and Epidemiology, by working with Dr. Tom Arie in his pioneering geriatric psychiatry service. Back in Toronto with our son shortly before our daughter was born, my husband changed his focus and requalified as a Lawyer in Ontario. Fortunate to work on an MSc in Psychiatric Epidemiology with Dr. Robin Eastwood, with Dr. Harvey Moldofsky in starting a geriatric psychiatry program at Toronto Western, with Dr. George Awad in heading the Consultation-Liaison program at the Wellesley and recently with Dr. Joel Sadavoy in heading geriatric psychiatry at Mount Sinai, I continue an interest in cultural aspects of psychiatry and mental health services, and in medical education.

**OPA:** When did you join the OPA and why?

**Rosemary:** On requalifying as psychiatrist, here in Ontario, I joined the OPA as the organisation which represented the wide range of concerns of those practising psychiatry across this large province.

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

**Rosemary:** What comes to mind is the earliest encounter, when I survived presenting my first paper at a conference, which was the OPA Annual Meeting

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

**Rosemary:** The OPA has recognised that the organisation should represent a range of interests, so that changes may have been less evident, withstanding some of the prevailing winds of change and with deliberation before making changes. Communication with other groups associated with mental health and with government departments and agencies, and with the membership, has increased, but it took coming on to Council for me to understand the amount of activity undertaken by the OPA.

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

**Rosemary:** Their identity as Physicians and the continued place of psychiatry in the field of Medicine, with the privileged perspective that can provide a comprehensive view, including in formulation advances in knowledge from the intracellular to population levels, but also the continued responsibility to attend to the consequences of interventions beyond those intended, as conditions are being considered to be psychiatric without a rigorous classification process.

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

**Rosemary:** An Historian: I would study History, 13th to 14th centuries in particular, with the relationship between the individual and society, and ideas of community: perhaps this is the fantasy of being an Historian.

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

**Rosemary:** In addition to peace in the world, more time for spontaneous occasions with family and friends, and singing better in the choir

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

**Rosemary:** To continue to attract and mentor lively and self-directed young recruits, to engage in public education in order to reduce the stigma of mental illness, and to have sustained government support in order to increase the accessibility, availability and acceptability of mental health services. ■

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.

The delivery of your December issue of *Dialogue* was delayed due to the volume of mail at Canada Post prior to Christmas.

# MEMBERS ON THE *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 Office, 1141 South Service Rd. W., Oakville, ON, L6L 6K4 or by email to: opa@bellnet.ca or by fax to: (905) 469-8697.

## Lieutenant Governor Becomes CMHA Ontario's Honorary Patron

The Hon. James K. Bartleman, Lieutenant Governor of Ontario, is the Honorary Patron of the Canadian Mental Health Association, Ontario Division.

Mr. Bartleman had a distinguished career of more than 35 years in the Canadian Foreign Service before becoming Ontario's 27th Lieutenant Governor on March 7, 2002. His Honour grew up in Port Carling, Ontario and is a member of the Mnjikaning First Nation.

Mr. Bartleman's dedication to mental health issues is informed by his own experience with post-traumatic stress disorder and depression, after he suffered a violent attack and robbery in South Africa while he was serving as Canadian High Commissioner to that country. He has chronicled his personal journey, including his childhood in Muskoka, in his 2002 memoir, entitled, "Out of Muskoka".

For more information about the Lieutenant Governor, visit his official website at [www.lt.gov.on.ca](http://www.lt.gov.on.ca).

## 2003 OPA ANNUAL MEETING SUMMARY

By: Ann Thomas, MD, FRCPC, Chair, Continuing Education Committee



The 2003 Annual Meeting of the Ontario Psychiatric Association was a great success from many standpoints. The registration exceeded that of 2002, with 205 registrants. All the speakers on the programme were of high quality. We regret that three speakers had to cancel at the last minute due to illness. It is a good complaint when people say they have a hard time deciding which session to attend.

The President's Dinner/Dance, Sands of Time, was well attended and was probably the best party I have seen since my time on the OPA Council. The food was served buffet style and featured food from the Mediterranean, North America and the Pacific Islands. There were many choices for even the pickiest of palates. Mamta Gautam served as Mistress of Ceremonies and her slide show provided many a chuckle. She guided the proceedings through the presentation of awards and door prizes and the installation of our new President, Dr. Robert Buckingham. The band played great music and quit promptly at 10:30 p.m. so we could all prepare for the Saturday sessions. There was a great deal of mixing, networking and socializing amongst the attendees and I think a good time was had by all.

A new addition to this meeting was the OPA Section Luncheon Meetings held on Saturday, February 1st. Invited lecturers addressed the Sections - Dr. Mamta Gautam presented "Successful Psychiatric Practice" to the Residents Section, Dr. Kenneth Shulman presented "Geriatric Psychiatry and the Future of Clinical Neuroscience" to the Psychogeriatrics Section, Dr. Ron Charach addressed the Community and Psychotherapy Sections jointly with his poetry and Dr. Mary Kay Nixon discussed "Affect Regulation and Addictive Aspects of Repetitive Self-injury in Hospitalized Adolescents" with the Child & Adolescent Section. We will be reviewing and evaluating the section meetings.

The T.A. Sweet Award was established in 1975 in memory of Dr. Theodore Allen Sweet. Dr. Sweet became Secretary of the Ontario Neuropsychiatric Association in September, 1946 and continued in this capacity until 1959. This award is

presented each year to an individual in recognition of their important contribution in advocating for those with mental illness. The 2003 T.A. Sweet Award recipient, Lt. Gen. (Ret.) Roméo Dallaire, was unable to attend, having had unexpected eye surgery, but his credentials, that were read out during the evening, left everyone with the feeling he was a very worthy recipient. If you know of someone who you feel should be considered for the T.A. Sweet Award in 2004, please contact me at my email address below.

Other awards included: Best Resident Paper by Dr. Amer Burhan of London for "The influence of Apolipoprotein E (ApoE) genotype on anterograde memory recovery after electroconvulsive therapy (ECT) in the depressed elderly"; Best Member Paper by Dr. Verinder Sharma of London for "Sleep Deprivation and Postpartum Psychosis" and; Best Poster by Nancy L. Pitre and Sandra Stewart of North Bay for "The Use of Puppets with Elementary School Children to Reduce Stigmatizing Attitudes towards Mental Illness".

Dr. Ed Rzdaki of Toronto, Dr. Sushama Pendharkar of Mississauga and Ms. Pearl Isaac of Toronto won Exhibitor prizes provided by Organon Canada Ltd. and Dr. Lucien Faucher of Vanier won the 2 Volume set "New Oxford Textbook of Psychiatry" provided by Oxford University Press.

The Continuing Education Committee for 2003 includes Dr. Krishna Balachandra, Dr. Jane Howard, Dr. Rosemary Meier, Dr. Roumen Milev, Dr. Leo Murphy and Dr. Michael Paré. We will bring forward another great program. Dr. Buckingham has chosen as his theme for 2003, "Destigmatizing Mental Illness". This theme will be featured at the 2004 Annual Meeting, which will be held at the same location, the Toronto Marriott Eaton Centre Hotel. Moving the conference date to later in the year seemed to be appreciated, so the dates chosen for the 2004 Annual Meeting are January 29, 30 and 31, 2004. Mark your calendars now and plan to attend.

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

# OMA Section on Psychiatry – UPDATE

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

## *Mental Health Reform and Mental Health Implementation Task Forces*

Mental Health Reform and Mental Health Implementation Task Forces have been on the Section's agenda for a number of years. December, 2002 was the deadline for the Task Forces to report to the Minister of Health and Long-Term Care. The Section, the OPA and the Coalition of Ontario Psychiatrists have worked hard to oppose the idea of Regional Mental Health Authorities. We have had excellent support from central OMA including Dr. Elliot Halparin, OMA President, who wrote letters to the Minister, expressing concern that mental health programs had not had an operational increase in over a decade and that acceptable implementation plans must call for an immediate investment in building the system's capacity to serve people. Scarce resources must not be used to fund reorganization exercises that further destabilize limited existing services and do not directly correlate to better client outcomes. Doing so would erode public confidence and further contribute to an already demoralized workforce.

## **Tariff Issues**

For the last few years our Tariff Chair, Dr. Sonu Gaiand, has worked persistently to convince the OMA Central Tariff Committee (CTC) to increase the K Codes to correct fee inequities. Last fall we asked Ontario Psychiatrists to write Dr. Halparin urging him to make sure that the CTC, which agreed with the need to correct fee inequities, implemented their own recommendations. Over 450 Ontario Psychiatrists sent in letters! Dr. Halparin continues to be open and receptive to our concerns.

At the November 2001 OMA General Council meeting, two resolutions were passed: "That the OMA recognize that across-the-board fee increases to the Schedule of Benefits perpetuate existing fee inequities, and that fee increases must be allocated in a more equitable fashion." and; "That the OMA make it a priority to implement the outstanding CTC recommendations from the CTC 2000 & 2001 Reports when it considers fee increases for April 1, 2003 or sooner if additional funding becomes available."

The revision to the Schedule of Benefits (OHIP), which should occur April 1, 2003, will likely see an increase of 4.54% to the K codes. In addition, there should be an increase to Subsequent Visit Codes which would go from the current fee of \$18.25 to a new fee of about \$29.00.

The OMA is currently getting ready to negotiate the fee increase for April 2003. The 2000 joint OMA/Ministry of Health and Long-Term Care Agreement provided for a 2% increase to the "globe" which would pay for the increases that result from the CTC recommendations; however, a general fee increase for all codes will be determined by the negotiations which are currently underway.

## **Resource-Based Relative Value Schedule (RBRVS) Commission of Ontario**

The Resource-Based Relative Value Schedule Commission of Ontario was established by agreement between the Ontario Medical Association (OMA) and the Ministry of Health and Long-Term Care (MOHLTC) in May 1997 with a mandate to recommend a Resource-Based Relative Value Schedule 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 RBRVS Commission released its Final Report in July 2002. The Executive of the OMA Section on Psychiatry made numerous submissions to the RBRVS Commission and, with the support of the Coalition of Ontario Psychiatrists, engaged appropriate experts to help prepare the submissions and to understand the various documents

the Commission has produced in the last 5 years.

Psychiatric services were identified in the Final RBRVS Report as being inadequately compensated. We met with members of the Executive of a number of other Sections identified by the Commission as being undervalued. We were aware that the OMA Council would not endorse the RBRVS Report. The Section on Family Practice was very unhappy with the report and about half the Specialty Sections would see their income reduced if the Report were implemented in a "revenue neutral" fashion. Along with the other undervalued Specialty Sections, we tried to influence OMA Council to adopt the following positions:

1. That the OMA stop giving across-the-board fee increases.
2. That the OMA freeze the present fee schedule and all new money be used to address the inequities identified in the Final RBRVS Report.
3. That the OMA Council acknowledges the inequities identified in the Final RBRVS report and make correcting inequities to be the next important step.
4. That a committee or task force come up with options and report to the Spring 2003 OMA Council Meeting so that an implementation plan can commence no later than with the new 2004 agreement with MOHLTC.

The Board made a number of motions that were passed by Council. Those motions are:

- Motion #1 That Council continue to acknowledge that fee inequities exist within the Schedule of Benefits.
- Motion #2 That Council express its conviction that fee relativity cannot be accomplished in an atmosphere of revenue neutrality.
- Motion #3 That Council express significant reservations about the July 2002 RBRVS Final Report to the Ontario Ministry of Health and Long-Term Care and the Ontario Medical Association.
- Motion #4 That Council express its opposition to implementation of the July 2002 RBRVS Final Report to the Ontario Ministry of Health and Long-Term Care and the Ontario Medical Association.
- Motion #5 That the Board of Directors will, after broad consultation, recommend to Council at its next Annual Meeting options to address fee inequities. (The next Annual Meeting is April 26-27, 2003 in Hamilton)

Council is committed to do something about fee inequities, but there was no support to say anything positive about the RBRVS Final Report. We now have to see if the OMA Board will deliver and how we can be involved in that process. We are going to meet again with the Sections identified by the RBRVS Commission as being undervalued and work to see that this issue is not delayed as it has so often in the past. The OMA Board of Directors has formed an RVS Options Committee to develop a variety of options to address fee inequities.

## **Schedule of Benefits Rules – K codes**

At our 2002 AGM, Dr. Henry Phillips of the MOHLTC stated that his interpretation of the existing Schedule of Benefits rules was that psychiatrists could not add together separate times spent assessing the same patient through the day in calculating total time billable for in-patient psychiatric care.

In June, Drs. O'Mahony, Buckingham Gaiand and I met with Mr. Michael McCarthy, political assistant to the Minister and Ms. Susan Fitzpatrick, Head of Provider Services, OHIP to discuss issues related to recording start and stop times as they affect psychiatrists working with inpatients. This meeting led to a conversation in August between Dr. Phillips and myself about what might be done to solve the problems around these issues.

We talked about two problems. First, the interpretation of OHIP regulations that psychiatrists cannot bank time in a day to arrive at a total time for a K code for inpatients, and the difficulty, in general, of recording the times in patient charts and how start and stop times are difficult to do with inpatients.

After a number of discussions with OHIP, we reached a tentative agreement that there would be a change in the regulations. These changes were approved and you will receive a Bulletin in February that will announce a change to the regulations that will allow psychiatrists to accumulate time, and, as long as a minimum of 20 minutes in one day is spent doing psychiatric care, K199 –psychiatric care can also be billed. However, you will no longer be able to bill a K code and a Subsequent Visit on the same day. Currently about \$378,000 is billed in a year for Subsequent Visits on the same patient on the same day as a K code. To make up for 60% of that money, the regulations will also change such that K199 will increase by about \$0.60 to make up for the money currently being billed for Subsequent Visits (C codes) on the same day as a K code. Not all psychiatrists bill K codes and C codes on the same day for the same patient; of about 600 psychiatrists who bill an inpatient K code, only 183 bill concurrent K and C codes on the same patient on

the same day. The other issues relating to start and stop times are still under discussion and I would be interested in your comments, especially in terms of the extent of the problem.

#### Sessional Fees

In November 2002, the Association of Ontario Physicians and Dentists in Public Service, on behalf of Psychiatrists working in Provincial Psychiatric Hospitals, completed negotiations and obtained a 15% increase to their sessional rate from \$311 (\$103.67 per hour) to \$358 (\$119.33 per hour). This increase has not yet been implemented, but when it is, I am confident all other sessional rates will be increased, either at the same time or shortly thereafter, so that all sessional rates are the same. Previous meetings with senior Ministry officials indicate that they are in agreement with consistency, as suggested by the OMA Section on Psychiatry and the Association of General Hospital Psychiatric Services representatives. Sessional Fees for 2001/02 accounted for \$20 million. The 15% increase means another \$3 million for Ontario Psychiatrists who currently are receiving sessional monies.

## The Health Services Research Advancement Award

The Health Services Research Advancement Award, an initiative of the Canadian Health Services Research Foundation, recognizes any individual, team, or organization that has contributed significantly to the advancement of health services research in Canada. Nominations are accepted until March 31, 2003 at 5:00 p.m. EST. Winners of this prestigious award will receive \$10,000.00 as well as a certificate commemorating their efforts.

#### Who is eligible for this award:

- 1) Men or women and teams or organizations that have either made many contributions over many years to health services research or a single major contribution with ongoing relevance.
- 2) Nominees may have made their contribution as a manager, policymaker or other decision maker, a funder of research, a researcher, a methodologist, a communicator, an educator, an author, a champion, or any other role deemed appropriate by the selection committee.

#### What you can do:

- 1) To nominate a person or organization for this award, please provide the name, address, telephone number, fax number, and e-mail address of the nominator(s) and similar contact details for the nominee.
- 2) Please write a maximum of 500 words identifying the nominee's stature and the nature of his, her, or their main contributions to infrastructure development (people, institutions, processes); leadership/championing; and influence/impact. To obtain a nomination form, please contact Lorraine Taylor at the OPA office.

- 3) Submit your nomination: via fax: (613) 728-3527; via e-mail: [hsraa@chrsf.ca](mailto:hsraa@chrsf.ca); or via post: Canadian Health Services Research Foundation, 11 Holland Avenue, Suite 301, Ottawa, Ontario, K1Y 4S1.

The deadline for nominations is 5 p.m. on March 31, 2003. A shortlist of nominees will be selected by a selection panel composed of health services researchers and decision makers. Short-listed nominees will be contacted by the foundation shortly thereafter.

For more information on the awards, please contact Brigitte Dugal at the Canadian Health Services Research Foundation by phone at (613) 728-2238 or by e-mail at [hsraa@chrsf.ca](mailto:hsraa@chrsf.ca).

#### Last year's winners:

Last year's co-winners were presented with their awards at the Canadian Health Economics Research Association conference, which took place in Halifax last June. The winners for the Canadian Health Services Research Foundation's Health Services Research Advancement Award 2002 were the Centre for Health Services and Policy Research at the University of British Columbia and Robert G. Evans, professor of economics. For more information on the co-winners and for a nomination form, please contact Lorraine Taylor at the OPA office.

## 2003 Elections Report

Dr. Doug Wilkins, President-elect  
Dr. Elizabeth Esmond, Council Member  
Dr. Leo Murphy, Council Member  
Dr. Robert Swenson, Council Member  
Dr. Andrew Moulden, Resident Representative

Information on Community Programs  
will be in future issues of *Dialogue*.  
If you have some information to share,  
please forward it to the Editor.  
Please forward any submissions/articles for  
future issues of *Dialogue* to the Editor by email:  
[opa@bellnet.ca](mailto:opa@bellnet.ca) or by fax: (905)469-8697

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# 2nd Annual CME Conference for the Collaborative Mental Health Care Network

The Ontario College of Family Physicians (OCFP) has developed a mentoring program that links Psychiatrist and GP Psychotherapist mentors with Family Physician mentees in a collaborative relationship to enhance provincial mental health care. Advice in the areas of diagnosis, psychotherapy and pharmacotherapy is provided to mentees by email, fax, telephone or face-to-face as needed. Since the inception of the Network, the Steering Committee organizes a CME conference for both mentees and mentors. The topics are derived from the needs assessment and evaluation the family physicians completed.

This conference took place on January 10-12th 2003 in Toronto and it was extremely well attended. There were approximately 160 family physician mentees who attended the conference. 27 mentors from the Network attended, about half were psychiatrists and half were GP psychotherapists. Dr. Pat Rockman, chair of the Collaborative Mental Health Care Network, provided an overview of the Network as well as a summary of the evaluation and the research. Dr. Rockman is a very dynamic, engaging woman who has extreme dedication to enhancing linkages between family physicians and psychiatrists. The talk was followed by small group discussions where the mentees and mentors discussed how they would communicate with each other over the subsequent year.

On Saturday, January 11, 2003 the day was intensive, and combined didactic lectures with case based small group work. The topics included The Difficult Patient: Theories and Strategies with Dr. Jon Hunter and Dr. Michael Cord; Treating Post Traumatic Stress Disorder with Dr. Ari Zaretsky; Mental Health and The Law with Dr. Ty Turner; Innovative Small Group Session Ideas with Dr. David Gotlib (lunch sessions); and Antipsychotics with Dr. David Gotlib. On the Sunday there was a talk on Practical Office Management of Comorbid Alcohol and Anxiety Disorders with Dr. Jose Silveira. In addition, an optional session on the treatment and management of Attention Deficit with Hyperactivity Disorder and Disruptive Behaviour Disorders was offered to mentees and mentors. The speakers were Dr. Rick Andreychuk, a child psychiatrist in London; Dr. Heather Sylvester, a family physician in Stratford, and Dr. Margaret Steele, a child psychiatrist in London.

The Collaborative Mental Health Care Network is growing and continues to look for psychiatrists as mentors. If you are interested please contact Lena Salach by phone at (416) 867-9646 or by email at ls\_ocfp@cfpc.ca.

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## The Office of the Public Guardian and Trustee Making Substitute Health Care Decisions

### Questions and Answers

#### 1. What is the Office of the Public Guardian and Trustee's (OPGT) role in making health care decisions?

Under Ontario law, no one may be given medical treatment or be moved to a regulated long-term care facility without consent, unless it is an emergency. Capable people make their own decisions, but if a person is not capable, a health practitioner or Community Care Access Centre must turn to a substitute—usually a relative—for a decision. A person who has been appointed the guardian or attorney for personal care has first priority.

If there is no such appointment, which is usually the case, then the health practitioner determines if there are relatives that are willing, capable or available to make the decision. People who are not relatives, such as close friends, may apply to the Consent and Capacity Board, an independent body, to be appointed for this purpose. If none of the above alternatives apply, then the OPGT must make the decision on the incapable person's behalf. The office's Treatment Decisions Unit handles this work.

#### 2. What is the purpose of the OPGT's role in making substitute health care decisions?

The OPGT's role is to serve people who are incapable of making their own decisions about treatment and admission to long-term care. The OPGT provides these people the benefit of informed decision-making about these matters if there is no one else who is available to do this for them.

#### 3. Does the law require the OPGT to provide this service?

Yes. The Health Care Consent Act, which is administered by the Ministry of Health:

- requires consent for treatment or admission to long-term care, except in an emergency
- says who can give or refuse consent if the person is incapable
- sets out the rules for making these decisions for an incapable person
- requires the Office of the Public Guardian and Trustee to make these decisions as a last resort when there is no alternative.

#### 4. What is "treatment"?

Most things that are done for a "health-related purpose" are included in the definition of "treatment" in the Health Care Consent Act. If something is a "treatment" it means that the rules in the Health Care Consent Act apply, including the rule that consent is required from the patient or by someone else on his or her behalf. Some of the things that are not included in the definition are:

- assessment of a person's capacity
- examination to determine a person's general condition
- personal assistance services such as feeding or bathing
- treatments that, in the opinion of the health care practitioner, pose little or no risk to the person



## 5. What are “long-term care facilities”?

Long-term care facilities are commonly referred to as “nursing homes” or “homes for the aged”. These facilities are regulated by the government. All applications and admissions to these facilities are handled through agencies called Community Care Access Centres (“CCAC”).

## 6. When is a person considered to be “mentally incapable” of making decisions about Treatment and admission to long-term care?

A person is incapable of making a decision about treatment or admission to a long-term care facility if he or she cannot understand the relevant information or appreciate what could happen as a result of making, or not making, the decision.

## 7. Are children under a certain age automatically considered incapable?

No. There is no specific “age of consent”. Minors of the same age can have very different levels of mental capacity. Health practitioners therefore assess each situation on an individual basis.

## 8. Who decides whether a person is mentally incapable?

The health practitioner who is proposing the treatment makes this determination. The law says that people are presumed to be capable of making health care decisions. A health practitioner may rely on that presumption unless it is not reasonable to do so in the circumstances.

In the case of admission to long-term care, an “evaluator” makes this determination. Many health professionals (e.g. physicians, nurses, registered social workers, physiotherapists, occupational therapists, speech language pathologists and psychologists) are authorized to act as evaluators. [Note: an “evaluator” is not the same thing as a “capacity assessor”. A capacity assessor is a health professional who has been trained and certified to assess other types of capacity, such as capacity to manage property. These subjects are covered in the Substitute Decisions Act.]

## 9. Can a person challenge the finding of incapacity?

Yes. He or she can apply to an independent body called the Consent and Capacity Board for a hearing to review this finding. Information about the Consent and Capacity Board and how to apply is available at [www.ccboard.on.ca](http://www.ccboard.on.ca) or by calling the Ministry of Health Info-Line at 1-800-461-2036.

## 10. How does the person know about this right?

The law requires that the person be informed of the right to apply for a review of the finding of incapacity. Health practitioners and the CCAC must make sure this happens.

## 11. If a person cannot make a decision about one type of treatment does that mean the person can't make a decision about any other type of treatment that may be proposed?

No. A person may be capable of making a decision about one treatment but not another. A person may be capable of making a decision about a treatment at one time but be incapable of making the same decision at a different time. It all depends on the complexity of the particular treatment and the person's level of capacity at the time.

## 12. Who is authorized to make decisions when a person is mentally incapable?

Substitute decision-makers are ranked in a hierarchy. The health practitioner—or the CCAC staff, in the case of admission to long-term care—goes down the list until a substitute who is available, capable and willing to make the incapable person's decision is found. The order is:

1. A guardian appointed by the court if the court order authorizes the guardian to make health care decisions
2. A person with a “power of attorney for personal care” authorizing him or her to make health care decisions
3. A representative appointed by the Consent and Capacity Board (any person may apply to the board to be appointed as the substitute decision maker)
4. A spouse or partner
5. A child or parent (custodial parent if the patient is a minor)
6. A parent who has access rights (if the patient is a minor)
7. Any other relative
8. The OPGT.

## 13. Who is responsible for locating the right substitute decision-maker?

The health practitioner who is proposing the treatment or the CCAC handling the admission to a long-term care facility is responsible.

## 14. What happens if there is more than one equally ranked person authorized to make a substitute decision and they cannot agree?

There are two options in this situation. One of the equally ranked decision makers, or another person, may apply to the Consent and Capacity Board to be given the right to make decisions. Alternatively, the OPGT will make the decision if all other efforts to resolve the conflict fail.

## 15. What happens in an emergency?

Treatment may be given without consent in an emergency, unless the practitioner is aware of instructions to the contrary that the patient gave while capable or if there is a substitute present at the time.

An emergency is defined as a situation in which the person for whom treatment is proposed is apparently experiencing severe suffering or is at risk, if the treatment is not administered promptly, of sustaining serious bodily harm.

Similar provisions enable the Community Care Access Centre to admit a person to a long-term care facility without consent in a crisis.

## 16. What if a person regains his or her capacity during a course of treatment?

If this happens, the person then has the right to choose whether to continue the treatment or withdraw consent.

## 17. What principles does the OPGT follow in making a treatment or long-term care admission decision?

The OPGT abides by the rules governing all substitutes that are set out in the Health Care Consent Act.

If the person has, while capable, expressed wishes about the matter then the OPGT must follow these wishes. These may have been expressed orally or in writing. The terms “advance directive” or “living will” are often used to refer to the wishes a person expresses while capable.

If there do not appear to be any such wishes, the decision is made in the person's best interests. In determining what is in the person's best interests, the OPGT – like all substitutes – must take into consideration:

- the values and beliefs the person held while capable
- the person's current wishes, if these can be ascertained
- the potential benefits of the treatment or admission
- whether the benefits outweigh the risks
- whether there is a less restrictive or less intrusive solution

## 18. Are there any circumstances in which a person's “capable wishes” would not be followed?

If it would be impossible, in the circumstances, to follow a person's prior capable wishes, then the substitute is not bound by them. In any other situation, the

Consent and Capacity Board's permission must be obtained before a substitute decision maker can depart from such wishes. No one is allowed to "change" a person's prior capable wishes or make them on the person's behalf. A substitute decision maker cannot, for example, make a "living will" or "advance directive" on behalf of an incapable person.

### **19. Will the OPGT make a substitute decision in advance of a health problem arising for an incapable person?**

No. The law does not allow a substitute to make an "advance directive" on an incapable person's behalf. A substitute can only make a treatment decision after a specific health problem has arisen and a particular treatment has been proposed. However, decisions may be made about a "plan of treatment". This means that if a health practitioner is proposing a specific treatment and anticipates, based on the person's current health condition and the nature of the proposed treatment, that other health problems are likely to arise, the OPGT may make a decision about these other issues in advance as part of the overall plan of treatment.

### **20. What information is the OPGT entitled to obtain before making a decision?**

The OPGT – like all substitutes – is entitled to obtain all the information needed to comply with its' legal duty to make an informed decision. This includes information about the:

- nature of the treatment
- expected benefits of the treatment
- medical risks of the treatment
- medical side effects of the treatment
- alternative courses of action
- likely consequences of not having the treatment

### **21. What is the process for obtaining a decision from the OPGT?**

When a health practitioner calls the OPGT's Treatment Decisions Unit, staff will ask for confirmation that the patient is incapable with respect to the treatment and that there are no other substitute decision makers available to make the decision.

Once this issue is settled, staff will ask for detailed information about the proposed treatment — so that an informed decision can be made on the incapable person's behalf. Staff will need to speak directly to the health practitioner who is proposing the treatment if other members of the health team, such as the nurses, cannot provide sufficient information. In many cases OPGT staff will visit the patient. Treatment staff also collect information about the incapable person's values and beliefs, if available.

Once OPGT staff believe they have enough information to make an informed decision, the health practitioner, or another member of the patient's health care team will be verbally advised of the decision. This will be followed by a letter.

### **22. What is the process for obtaining a decision about admission to long-term care from the OPGT?**

Decisions regarding admission to a long-term care facility are made almost the same way as treatment decisions. CCAC staff usually communicate with the OPGT by telephone or by fax. They are asked to confirm that the person has been found incapable of making the decision about admission and that there is no higher ranked substitute available. They will be asked to explain why admission to long-term care is being proposed and for details about the alternatives that have been considered. Relevant personal information such as marital status, religion, language and cultural preferences will be requested so that the OPGT can make a decision that is sensitive to the needs of the particular individual. OPGT staff will visit the person for whom admission is proposed.

### **23. How does the health practitioner contact the OPGT?**

The health practitioner calls the Treatment Decisions Unit in his/her area of the

province. Treatment Decisions Consultants (TDC) work in each of the OPGT's regional offices, including London, Hamilton, Toronto and Ottawa. Northern Ontario is serviced through the Ottawa office.

Greater Toronto Area Call: (416) 314-2788, 1-800-387-2127,  
Fax: (416) 314-2637

Hamilton Region, Call: (905) 546-8300, 1-800-891-0502, Fax: (905) 546-8301  
Ottawa Region and Northern Ontario, Call: (613) 241-1202, 1-800-891-0506,  
Fax: (613) 241-1567

London Region, Call: (519) 660-3140/(519) 660-3140, 1-800-891-0504,  
Fax: (519) 660-3148

### **24. How long does it take for the OPGT to make a decision?**

This depends on the nature and complexity of the proposed treatment and the speed with which the practitioner is able to provide all the information needed. These are critically important decisions. The OPGT takes its responsibility to the incapable person very seriously.

Some decisions can be made within a few hours. Others may, of necessity, take a number of days.

### **25. What hours does the program operate?**

The program operates from 8:00 am to 6:00 pm seven days a week.

### **26. How can I get more information?**

You can access the OPGT's website at:

[www.attorneygeneral.jus.gov.on.ca/html/PGT/pgthome.html](http://www.attorneygeneral.jus.gov.on.ca/html/PGT/pgthome.html).

To access general information on mental health and a publication entitled Rights and Responsibilities – Mental Health and the Law, you can link to the Ministry of Health and Long Term Care website at:

[www.gov.on.ca/health/english/pub/pub\\_links/pub\\_mental.html](http://www.gov.on.ca/health/english/pub/pub_links/pub_mental.html)

A copy of the Health Care Consent Act can be obtained from Publications Ontario on-line at [www.gov.on.ca/MBS/english/publications/index.html](http://www.gov.on.ca/MBS/english/publications/index.html) or by mail or phone at: Publications Ontario, 50 Grosvenor Street, Toronto, ON, M7A 1N8, 1-800-668-9938 Toll Free in Ontario or (416) 326-5300.

To request an information session from OPGT staff, contact the Treatment Decisions Unit of the OPGT office closest to you. Telephone numbers are listed on this page.

*The OPGT cannot give individuals, professionals, facilities or organizations legal advice about specific cases or their own legal obligations. These questions should be directed to a lawyer. The Law Society of Upper Canada operates a Legal Referral Service and can be reached by calling 1-900-565-4577. Telephoning this number generates a \$6.00 charge on your phone bill in the month following your call. Lawyers participating in the Service will offer you up to a half-hour free consultation that may be over the phone or in person.*

*This article provides a very general overview of the mandate and operation of the Office of the Public Guardian and Trustee in relation to substitute decision making for health care. It does not include all of the details of the law, policies, procedures or exceptions that may apply in a particular case. For information about the law please refer to the applicable statutes and contact your lawyer. ■*

# GUEST COLUMN

## SOUND MIND RADIO: INSPIRING THE MENTAL HEALTH COMMUNITY AND ERASING STIGMA

By: Jayne Holowachuk, Sound Mind Writer/Co-Producer

Sound Mind is Ontario's only radio program that discusses mental health issues, such as maintaining good mental health, and recognizing, treating, and coping with mental health problems. Now in its 11th year on the air, Sound Mind began as a 15-minute segment of another program that aired every two weeks. As a result of demand, Sound Mind now has its own weekly, half-hour slot on CKCU 93.1 FM, a Carleton University campus and Ottawa community radio station.

The mandate of Sound Mind is to educate, sensitize, inspire and entertain listeners and decrease the stigma associated with mental illness, thereby increasing quality of life and promoting personal wellness and independence. Sound Mind provides information on resources available in the community, and we encourage and help listeners to stay informed, help themselves, and to seek help if necessary. We try to empower listeners by providing them with education and options. Our aim is to bring mental illness out of the shadows. The shows are written and produced by six volunteers, all of whom have personal experience of mental health problems.

Sound Mind's target audiences include people with mental health problems; family members and friends; members of support groups; medical and counseling professionals, including alternative practitioners; mental health organizations; the general public and the Carleton University community. Sound Mind's weekly calendar of local mental health related events encourage listeners to develop and maintain connections within a community of support.

In general, the weekly broadcasts revolve around the spectrum of mental health issues:

- Research and medication news
- Types of psychotherapy (e.g. CBT)
- Alternative treatments, such as art, aroma and music therapy
- Poetry and short stories by consumers
- "Psychiatric humour"
- Coping strategies, including nutrition and exercise tips

- Mental health reform and mental health policy, income issues, and advocacy
- Spirituality
- Reviews of books, theatre, movies and magazine articles
- Interviews with consumer/survivors and experts

During the past year, we have featured stories on many disorders, including obsessive-compulsive disorder, borderline personality disorder, bipolar disorder, schizophrenia, SAD and phototherapy, ADHD, anxiety disorders, agoraphobia, PTSD, delusional disorder, and post-partum depression.

Other recent topics include self-harm; children and psychiatric drugs; dementia and psychiatric problems; suicide and prevention; medical records and privacy; access to treatment; and homelessness, poverty and housing, and popular issues such as dealing with stress, improving relationships, and self-esteem.

Recently reviewed books include *The Noonday Demon*, *Prozac Backlash*, *The Last Taboo: A Survival Guide to Mental Health Care in Canada*, *Skin Game*, and *Of Two Minds: The Growing Disorder in American Psychiatry*. The show also provides reviews of many Hollywood and international films relating to mental health, for example, *Lantana*, *K-PAX*, *Iris*, *Camille Claudel*, and *Don't Say a Word*.

Funding for the show's production comes from Ottawa's Depression and Manic Depression (DMD) Mutual Support Groups and the Discovery 2000 Program, which receives funds from Ontario's Ministry of Health.

Sound Mind airs every Wednesday from 9:30 to 10:00 a.m. on CKCU 93.1 FM. Listeners around the world can also tune in live (ie, at local broadcast time) using Real Audio® at [www.ckcufm.com](http://www.ckcufm.com).

Sound Mind can be contacted at: E-mail: [soundmind@look.ca](mailto:soundmind@look.ca), Phone: (613) 820-9425, Fax: (613) 234-7500, Website: [www.ckcufm.com](http://www.ckcufm.com)

## 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.

Look for John Deadman's review of "Beyond Crazy: Journey's Through Mental Illness" written by Julia Nunes and Scott Simme in the June 2003 issue of *Dialogue*.

## NEW GUIDE TO PROGRAMS AND SERVICES FOR ONTARIO SENIORS

A user-friendly 200-page guide to programs and services for seniors in Ontario is now available. The "Guide to Programs and Services for Seniors in Ontario" is available in HTML or PDF format at [www.gov.on.ca/citizenship/seniors](http://www.gov.on.ca/citizenship/seniors). A free copy

is available by calling the Seniors INFOline at 1-888-910-1999 (416 326-7076 in the Toronto area).

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## The following article (VOLUME 38, NO. 30, AUGUST 27, 2002) was downloaded from the website: [www.medicalpost.com](http://www.medicalpost.com)

Information on provinces other than Ontario is available at [www.medicalpost.com](http://www.medicalpost.com) or by contacting the OPA office at (905) 827-4659

### NATIONAL ROUNDUP: MENTAL HEALTH CARE IN CANADA

This national mental health care roundup was compiled by Medical Post senior staff writer Celia Milne and written by Susannah Benady, Pamela Clarke, Jennifer Crump, Deana Driver, Lynn Haley, Barbara Kermod-Scott, Jenny Manzer, Celia Milne, Mark Quinn and David Square.

### CATASTROPHES WAITING TO HAPPEN

*Mental health help for children and teens sorely underserved across the nation*

By Celia Milne

"It is a national crisis," says Dr. Marshall Korenblum. He is talking about one of the most important issues in society today: the mental health of children. "As few as 20% to 40% of kids who need help get it," says Dr. Korenblum, psychiatrist-in-chief at the Hincks-Dellcrest Centre for Children and an associate professor in the department of psychiatry at the University of Toronto. Children and teens who do receive help often have to wait a very long time, often getting sicker in the process.

"In Toronto, which is a relatively richly resourced place, the average wait for run-of-the-mill, non-urgent cases is six to nine months for an assessment and then six to nine months to get treatment," says Dr. Korenblum. "It is pretty scary. You could wait a year and a half to get treatment for your kid." Kids who are suicidal, homicidal or psychotic go to the top of the list, but it still may take two to four weeks for them to be seen. In rural areas, of course, waits would be far longer. "I've been practising for about 22 years and the kids are getting sicker. The kids and families I see are very, very sick. Their illnesses have gone on longer and are harder to turn around. Often they are so disturbed by the time they get to us we have to recommend residential or inpatient care to prevent a catastrophe," he says.

The source of the problem is simply a lack of manpower. "There is a woeful lack of child psychiatrists," says Dr. Korenblum, who sits as chairman of the education committee of the Canadian Academy of Child Psychiatrists (CACP). In all of Canada, he says, there are only about 375 members of the academy, "which is a pittance." Meanwhile, 18% of children and youth have a diagnosable psychiatric illness, he says. Exacerbating the problem are cutbacks in the education system, which have depleted support staff, special education programs and school psychologists.

Child psychiatry is not something that can be done by other practitioners, says Dr. Korenblum. Assessment is complicated and takes two to three times as long as regular psychiatric assessment because it involves more than a doctor-patient relationship. Child psychiatrists interview not only the patient but also the parents and often the siblings, and also co-ordinate efforts with school officials and teachers.

The CACP and the Royal College of Physicians and Surgeons of Canada recommend one child psychiatrist per 16,000 population, or about one for every 4,000 children, but no jurisdiction in Canada has anywhere near that kind of coverage.

Training child psychiatrists in greater numbers would help but that requires money. "It's not so much that we have trouble attracting people to the field. It's that there aren't enough funded spots," says Dr. Korenblum, who is the director of post-graduate education for the division of child psychiatry at the University of Toronto. "In Toronto we graduate only five child psychiatrists a year, and this is the largest centre in the country. It's pitiful."

Good news is on the horizon in several forms. One is a new handbook developed by the Canadian Psychiatric Research Foundation, called "When Something's Wrong". It was created to help teachers recognize the earliest signs

of mental illness. It is being distributed in Ontario and plans include national distribution.

Another progressive step is tele-psychiatry, by which psychiatrists can service outlying areas. "Kids like the technology. They think it's cool," says Dr. Korenblum, who has interviewed children hundreds of kilometres away.

### ONTARIO

Fewer than one in six kids gets help.

Many young people in Ontario with mental health problems aren't getting treatment, which can adversely affect them as adults, warns a Toronto pediatrician.

Dr. Diane Sacks says the assessment, diagnostic and treatment needs of children and teens with mental health problems are not being met in Ontario, "not at all." She says if left untreated, many psychiatric disorders persist into adulthood. "Emotional disease, like anxiety and depression, holds kids back from reaching developmental milestones, and makes it hard for them to function as adults."

Dr. Simon Davidson, chief of psychiatry at the Children's Hospital of Eastern Ontario, estimates less than one out of every six young people with psychiatric illnesses is getting help.

More funding alone won't solve the problem, and new approaches to service delivery in Ontario are needed, he says. For example, several different ministries currently fund mental health services for children and youth, he says. "Any ministry can cut funding without doing it in a way that's integrated with the other ministries, so it creates even more fragmentation of services," he says, stressing the system must become more integrated.

There is a tremendous shortage of people counselling children in Ontario, in part because it's not an area that pays well, says Dr. Sacks. The psychiatric and behavioural component of pediatrics is also relatively new, and few physicians are well trained in it, she adds.

Dr. Davidson says while family doctors receive training in adult psychiatry, few are schooled in pediatric mental illness. Child psychiatrists need to collaborate more closely with pediatricians and family doctors to share the benefits of their special training, and allow others to take over more of the care, he says.

As it stands, Dr. Sacks says there are parents who sit with their suicidal child for 24 hours a day, waiting for somebody qualified to do treatment and assessment, or for an inpatient bed to become available. "It may be days," she says.

The number of children and youth with psychiatric problems turning up at emergency seems to be increasing, says Dr. Davidson. A child may present with the features of depression, but unless they are also suicidal, it is difficult to arrange to have them admitted, he says. "It's almost like the only children and youth that get admitted are those who are in a crisis already."

Dr. Sacks, who has practised for 30 years, said young patients with mental health problems appear to be doing more poorly than in the past. "Now, with dysfunctional families and dysfunctional schools, the kids really break down earlier, and really stop functioning earlier. We don't have the support services of a strong family and strong community that we used to.

*Editor's Note: "When Something is Wrong" is a brief guide that helps educators to identify depression, schizophrenia, and anxiety, eating and impulse-control disorders in students. You can obtain this brochure at an all inclusive cost of \$10.00, by contacting the Canadian Psychiatric Research Foundation at 416-351-7757 or by email at [cprf@interlog.com](mailto:cprf@interlog.com) or by completing an order form at [www.cprf.ca](http://www.cprf.ca). ■*



# THE DOMINO EFFECT ON CHILDREN'S MENTAL HEALTH

By: Lynn Eakin

It is the cumulative impact of service shifts that began in the 1990's that has exacerbated the situation in the already under resourced children's mental health service sector. Waiting lists for service at children's mental health centres are longer than ever. At last count 12,000 children and their frantic parents were waiting for service. A wait of months can seem like forever when you are an unhappy child or desperate parent. In the case of residential care and other specialized services, such as services for autistic children, the wait is sometimes so long that the child is too old for the program by the time his/her turn arrives.

It is easy to understand the full dimensions of the problem if one tracks the cumulative shifts in service that have occurred in the past decade. The 1990's were the decade of service cutbacks followed by service "reform". These shifts have had a devastating impact on community support networks for children and families. Today one of the few services remaining in communities for families and children is the local children's mental health service.

The major service cuts were made in Ontario in the early 1990's to welfare, ethnically focused settlement and family support services, women's shelters and funding for family counseling in family service agencies. The welfare cuts have caused many children to sink deeper into poverty and the number of children whose families are homeless has soared. In the high immigration areas of the province, cities like Toronto, Ottawa and Hamilton, the cuts to the ethnically based community support organizations has made it harder for those communities to help new arrivals. Women's shelters lost their capacity to support women and their children after they left the shelter and, at the same time, the ability of family service agencies to help families of limited means was drastically reduced. The result of these cuts was families had reduced ability to help themselves and far fewer places to turn when they needed assistance.

In addition to cutting the more local community services, major reforms were undertaken in the children's service systems. The focus of the reforms was to return those systems to their "core businesses". In most cases this meant cutting back on supports to families and children as these were typically ancillary services that the major service systems such as child welfare and education had developed over the years. Child Welfare agencies used to spend almost as much time working with children and families at risk as they did on child protection activities. Post reform, child welfare services are focused almost exclusively on child protection activities and the agencies report soaring rates of children coming in to care. Major reforms to education have also greatly reduced the capacity of the school

system to support and counsel children seeking help. Non-teaching staff in most school boards has been reduced including social workers, psychologists, secretaries, care takers, lunchroom monitors, and vice principals – those personnel that traditionally had time to listen to a young person and direct them to the help they needed. Moreover, tough new strict discipline policies have worked to exclude some of the more troubled youth from school altogether.

Children's mental health centres have been struggling to respond to the increased requests for service and, to what they report, as an increase in the problem severity level of the young people they see. The past decade was a tough one for families on the edge and the results can be seen in the soaring numbers of children being taken into care of the child welfare agencies and in the growing line up for help from children's mental health centres.

Lynn Eakin is a consultant who works extensively in the children's service sector including Children's Mental Health Ontario and member agencies.

*Editor's Note: Children's Mental Health Centres assess, manage and reduce the risk for troubled children; keep children in school, at home and in their own communities; keep children out of the young offenders and child protection system; help teenagers find and keep jobs; provide consultation, prevention and treatment services; improve communities by lending their expertise in family and child development and by teaching parenting skills; form partnerships with other agencies to provide services. Parent advisory groups now exist in many children's mental health centres.*

*Children's Mental Health Ontario (CMHO) represents 87 centres that serve 148,000 children and their families throughout Ontario. CMHO provides a central source of information for its member centres and for funders, parents and other health professionals. Their standardized client information system, designed specifically for Ontario's children's mental health centres, is a means of assessing the emotional and behavioural problems of children as they enter and leave treatment. Professionals across the province use it in creating treatment plans and monitoring results.*

*CMHO serves as the voice of its member centres in relations with government, funders and the public. For more information, please visit [www.cmbo.org](http://www.cmbo.org) or contact Children's Mental Health Ontario by telephone at 416-921-2109, by fax at 416-921-7600 or by e-mail at [info@cmbo.org](mailto:info@cmbo.org).*

## Ministry's Health Care Programs Division



Into Two

The Health Care Programs Division of the Ontario Ministry of Health and Long-Term Care will split into two divisions, Community Health and Acute Services, as of February 3, 2003. Mary Kardos Burton will oversee the Community Health division as Assistant Deputy Minister. Hugh Macleod will be the new Assistant Deputy Minister, Acute Services.

Mary Kardos Burton currently serves as Assistant Deputy Minister, Health Care Programs. She has been with the Ministry since 1998, working on the reform of

the community home care system, and serves as the Federal/Provincial/Territorial Chair for the National Advisory Committee on Population Health. She has also worked in the Ministries of Community and Social Services, the Environment, and Education. Hugh Macleod is currently serving as Senior Vice-President of the Vancouver Health Authority, and has experience in diagnostic, laboratory, pharmacy, and property management services. ■

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The following editorial is reprinted, with permission, by the author and Editor of the Ontario Branch APA Newsletter D. Ray Freebury. This editorial, dealing with international issues, was in the most recent edition of the newsletter and is being published at the request of an OPA member who asked for APA news to be included in *Dialogue*. APA news items will appear in future issues of *Dialogue* as appropriate.

"The APA eliminated the International office over three years ago. With it has gone the International Council, partly the consequence of financial woes but also a consequence on the US governments isolationist propensities a few years back. The APA circled the wagons in like fashion. President Bush has, more recently become an international figure and is keen to win friends and influence others. Perhaps it is time for APA to follow suit. Take a look around the world and tell me that we are unaffected by international events. Terror is no longer something that only occurs in some distant part of the world for which we have no responsibility. The roots of terrorism lie in poverty and despair, in homelessness, statelessness and powerlessness. The victims of these circumstances are prime targets of the criminal despots seeking a cause through which to achieve their own personal needs for vengeance and power. In Israel a particularly obscene form of terror has emerged in the threat of the suicide bomber. Here depressed and rootless youth are conscripted with promises of posthumous glory on earth and paradise in the hereafter.

The endless cycle of bombing and retaliation defies rational thought. How are we to intervene? Is it by the present means which seem solely aimed at finding those who organize such activities and eliminating them? Perhaps it cannot be done without such activity but surely that alone is never going to dry up the source of people with no reason to expect any pleasure in this life. The latter will only be corrected when the wealthy nations on this earth take serious steps to eliminate poverty and the ensuing despair.

It is not only terror that should concern us. As psychiatrists we have a particular interest in the ethical and humane practice of our discipline. In the past APA has joined others in the fight against the misuse of psychiatry by totalitarian

governments to control political dissidents in their midst. This practice has not ended. It still occurs in some of the independent states that have emerged from the Soviet Union but not from its immorality. It is happening in Cuba and most significantly in China where it is occurring on a widespread scale. This was acknowledged at the recent meeting of the WPA in Yokohama, where a resolution was passed to instruct the Review Committee to undertake an investigation of the serious allegations of political abuse of psychiatry in China. Research by noted China scholar Robin Munro indicates that abuse has spread beyond the Anhang, the police run forensic psychiatric units, into general psychiatry departments.

Whether we will see a serious investigation is in some doubt because subsequent comments by World Psychiatric Association President Juan Lopez Ibor suggested that the proposals put forward by the British society have been considerably watered down and are deferent to rather than demanding of the Chinese Society of Psychiatrists. Whilst we can have sympathy with the majority of ethical psychiatrists in that country, it does them no service to ignore the unethical behavior of a few. The fact is that there are many substantiated reports of the incarceration of people whose only offence is that they are members of the Falun Gong or are political dissidents, union leaders or student protesters. A subsequent issue of *Epigram* will carry another chapter of Robin Munro's monograph which outlines the evidence of systematic misuse of psychiatry."

For additional information on the Ontario Branch of APA please contact:  
Mrs. Linda Young, Executive Secretary, 89 Willows Lane, Ajax, Ontario, L1S 6E7  
odbapa@rogers.com, Ph.(905)683-9898, Fax(905)683-5593

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## Ontario Ministry of Health and Long-Term Care changes Vision to Reflect Growing Awareness of Mental Health

The Ministry of Health and Long-Term Care has included mental health in their revised vision statement. The vision statement now reads: 'Advancing healthcare, and enhancing physical and mental health in all life's stages, through a high-quality system that is easily accessible for all Ontarians.' The previous vision statement read: 'Our vision is clear: a health system that promotes wellness and improves health through accessible, integrated and quality services at every stage of life and as close to home as possible.'

In its review of 2001-02, the Ministry reported the following activities related to mental health:

Bill 68, 'Brian's Law,' was implemented. More than 2,000 authorized leaves of absence and 100 community treatment orders were issued.

A total of 1,046 supportive housing units were put in place under Phase 2 of the Mental Health Homelessness Initiative.

Nine community mental health projects received a total of \$5 million from the Transfer Payment Capital Projects Initiative for community mental health programs. The \$26.4 million initiative was announced in the 2001 budget to be allocated over a three-year period, ending in 2003-04. Projects in Barrie, Welland, Oakville, Cornwall, Bracebridge, Southampton, Strathroy, and Toronto were funded.

Children's Treatment Centres (CTCs) were awarded an additional \$20 million in annual funding, increasing services to children in existing CTCs and undertaking local system planning in the non-CTC areas of North Bay/Nipissing and York/Simcoe.

The Ministry also identified its commitments for 2002-03 to meet its objectives. Those that may have an impact on psychiatry and mental health are:

The government will consider and respond to both the Kirby and Romanow reports.

The government will continue to consult on its Patients' Charter of Rights and Responsibilities.

They will review the regulated health professions legislation.

They will continue to expand primary care reform in Ontario through Telehealth, family health networks, community health centres and other mechanisms.

An expansion of the nurse practitioner program.

Phase 2 of the Mental Health Homelessness Initiative will continue to be implemented with an additional 1,594 supportive housing units by March 2003, for a total of 3,600 new units since 2000-01.

The government will review the nine mental health implementation task force reports due by December.

The business plan is available at [www.gov.on.ca/health](http://www.gov.on.ca/health). ■

# THE RAI-MH PROJECT

## MOVING FROM RESEARCH TO APPLICATION

By Mounir Marhaba

This article will mark the last part of a series of update articles on the RAI-MH that appeared in OPA newsletters over the last two and a half years. March 28, 2003 will mark the successful conclusion of the work of the Resident Assessment Instrument - Mental Health (RAI-MH) Project of the Psychiatric Working Group (PWG) of the Ontario Joint Policy and Planning Committee (JPPC). With this comes the completion of Version 2.0 of the RAI-MH, which is the version that the PWG will be recommending to be implemented province wide by the current "unofficial" MOHLTC implementation target date of April 2004. In the fall of 2002, three independent, renowned reviewers stated that the RAI-MH "represents pioneering work, breaking new ground in the assessment and treatment of persons with mental illness."

We are very pleased to provide the Schedule I facilities under the Ontario Mental Health Act, with designated adult inpatient mental health beds, with this new Mental Health instrument. It replaces the varied, overlapping assessment and care-planning tools used in most mental health settings today. Unlike traditional methods, the RAI-MH is comprehensive and integrated. It is anticipated that the RAI-MH will facilitate the ability to more effectively manage patient care, outcomes, and costs. All of the Schedule I facilities in Ontario were invited to a two-day RAI-MH Invitational Education Symposium in Toronto on March 5th and 6th, 2003. This symposium assisted hospitals in their preparation and readiness; over 200 mental health service providers were invited to view the latest version of the instrument, the training manual and resource guide. In addition, they were invited to hear about current RAI-MH research activities, network and learn from their peers and have the opportunity for hands-on training in the use and application of the instrument.

### BACKGROUND

The JPPC PWG, in collaboration with interRAI, launched the RAI-MH Project in 1996, which became known as a Canadian-led international research and development initiative in psychiatry, finance and health services informatics. The RAI-MH is defined as a standardized data collection system for mental health, and it is intended to identify key clinical issues related to patient care planning, quality improvement and outcome measurement, all of which are ultimately linked to resource utilization and funding.

The RAI-MH Project represents a unique collaboration and involves a substantial investment of funds for mental health evaluation at an individual, hospital and systems level. This methodology aims to combine care planning and quality improvement with case costing and outcome measurement.

The RAI-MH is designed for use in an integrated health services delivery environment. Special attention has been paid to:

- clinical utility for frontline staff,
- providing standardized aggregate data about patient severity,
- quality and outcome of care, and
- providing a better understanding of hospital utilization and funding.

To this end, efforts included extensive frontline clinical validation that were carried out by mental health professionals in Ontario, Alberta, Manitoba and Newfoundland through a number of planned Clinical Validation Focus Groups. The emphasis was on assessment, clinical review, clinical care planning practices, interventions and the development of a new case-mix funding system, that is "patient" focused, irrespective of the provider.

The development of the RAI-MH includes:

- a) the development of quality indicators that can be used to prevent gaming of the case-mix algorithm, and
- b) the development of Outcome measurements

The latter can be used by Quality Improvement professionals to identify priority areas for internal QI initiatives, and by regulatory agencies in conducting accreditation reviews. The information is also useful in the development of training programs. Outcome measures, combined with the care planning applications, can be used by front line clinicians and by researchers to conduct outcome evaluations and to identify best practices in mental health.

The design of a number of detailed training programs constituted important developments during each of the two phases of the RAI-MH Project, and was based on motivational design principles. In addition, software was developed and used in the training of over 1,500 clinicians in 40 different mental health facilities. By August 2000, over 5,000 psychiatric inpatient assessments were completed. In addition, a secondary training effort took place relating to Staff Time Measurement (STM) activities to gauge resources utilization to meet the identified patient needs. The combined activities resulted in the development of a new Case-mix algorithm, now known as the System for Classification of In-Patient Psychiatry (SCIPP): A New Case-mix Methodology for Mental Health was developed.

The training design incorporated the principles of motivational design in its instructional approach. The motivational design framework structured training in a way that considers:

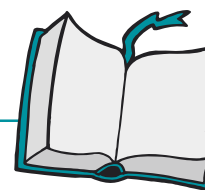
- i. Interest— Clinicians, such as nurses, social workers and psychiatrists etc., must enjoy the learning process in order to be motivated to use the RAI-MH;
- ii. Relevance — It must be clear to clinicians, administrators and policy-makers how they can use RAI-MH data in their day-to-day work;
- iii. Learning Expectations — That recipients of the training should have a clear understanding of the applications of RAI-MH, what their learning objectives will be and what they will need to do to build their skills as they become more experienced with the RAI-MH.

A working group of experts was convened to develop clinical quality indicators for the RAI-MH based on extensive consultation with front line clinicians in Ontario and across Canada. Pre-existing outcome measures from other RAI instruments (i.e., Cognitive Performance Scale, ADL Hierarchy Scale, and the Index of Social Engagement) were validated against gold standard measures in mental health settings. In addition, new outcome measures were developed and validated (e.g., a depression scale, index of behaviour disturbance, psychiatry co-morbidity index).

For additional information until March 28, 2003, please contact Mounir Marhaba, Director, Resident Assessment Instrument - Mental Health (RAI-MH) Project, Ontario Joint Policy and Planning Committee (JPPC), 415 Yonge Street, Suite 1200, Toronto, Ontario, M5B-2E7, Tel.: (416) 599-JPPC (5772), ext. 235, Fax: (416) 599-6630, E-mail: [jppc@interlog.com](mailto:jppc@interlog.com), Web Site: <http://www.jppc.org> ■



# RESIDENT'S REVIEW



The following article is based on Dr. Mamta Gautam's presentation, entitled, "Successful Psychiatric Practice: Everything You Need to Know to Have One", to the Resident Section on Saturday February 1, 2003 at the OPA 83rd Annual Meeting, and is primarily based on Dr. Gautam's personal experience, that of her colleagues, and information offered to residents on practice management by MD Management.

Congratulations! You are near the end of the residency! But, then what? Do you know the four phases for determining what your practice will be like?

- Thinking About a Practice
- Setting Up a Practice
- Starting a Practice
- Maintaining a Practice

## 1) Thinking About a Practice – Remember Medicine is a Business!

- Consider your area of focus - general or specialized?
- Consider the age group – children, adults, geriatrics?
- Consider the structure of your practice - private practice (home office, mini-office, sublet office space, private office (owned or leased) – solo or group – and/or hospital based – inpatient/outpatient, academic involvement (blended financial arrangements, need to negotiate income, benefits, office space, support, etc), research, teaching or administrative.

## 2) Setting Up a Practice

- Consider – size of town or city, type of patient population, family needs (cultural, social, school), facilities for hospital admission, research, labs, ambulance, consultants available. Could you live here for 20 years?
- Resources for Opportunities – Program Director's Office, PAIRO – Practice Opportunities Listing, Provincial and National specialty meetings, job fairs, or try a community as a locum if unsure.
- Set up an Advisory team (real estate broker, accountant, financial planner, lawyer, insurance broker, bank manager)
- Look for office space – consider location and layout - arrange financing, negotiate a lease, hire a lawyer, get office insurance, review accounting needs
- Get all necessary papers – Get a billing number from Ministry of Health, ensure you pay CPSO for your license.

## 3) Starting a Practice

- Furnishings – ensure that office is background, not an interruption, to therapy; furnishings reflect your style; consider lifestyle of your patients; carefully consider your choices of art, colour, furniture style, plants and magazines.
- Office Equipment – furniture, art, phones, answering machines, fax, copier, computer, shredder, security systems (determine what you will buy and what you will lease and use a separate business credit card)
- Office Staff – receptionist (needs careful training by you), answering machines (be professional, include information on when you are available, when you check messages, emergency contact), answering service (real person), bookkeeper (can be cost-effective), full-time vs. part-time, know job descriptions, advertising, interviews, hiring, contracts, payroll, employer #, benefits, deductions, taxes, letting staff go. Staff need AIR (appreciation, information, remuneration).

- Office forms – office policy brochure, new patient intake forms, Forms 1 + 14, letters for consultations, referrals, end therapy.

## 4) Maintaining a Practice

- Scheduling patients – determine timing and length of sessions, discuss cancellation policy, schedule new patients when others are around, schedule time for paperwork, meetings and time off
- Time management – code mail, touch paper once (patient related/immediate, patient related/less urgent, office operations, educational material, junk mail, patient info sheets, test results), schedule time to call back, call pharmacy.
- Office files – keep accurate, complete, legible records; include date and length of visit, start and stop times, highlight session content and MSE
- Medication records – visible, accurate, updated.
- Keep files in locked cabinet, limit access, ensure confidentiality
- Billing OHIP – self or billing service; cards, computer, modem; shop around for billing program; keep accurate records and reconcile payments; know billing rules and codes.
- Billing Patients – clearly outline policy to patients in advance and document; use a brochure; determine if and what to charge for missed appointments, sick notes, pharmacy calls, wrong OHIP numbers; charge lawyers and insurance companies reasonable rates based on OMA hourly rates; consider block billing.

Remember to avoid isolation – plan time to meet with colleagues, organize journal clubs, attend rounds, meetings and conferences – and – balance your life - take care of yourself, indulge in exercise, nutrition, hobbies and interests, make time for families and friends, set and maintain limits at work, watch for burnout, take holidays and live within your means.

Mamta Gautam, MD, FRCP, is a psychiatrist in private practice in Ottawa, and an Assistant Professor in the Department of Psychiatry, University of Ottawa. She is a specialist in Physicians Health and Well-being. Hailed as "The Doctor's Doctor"; physicians make up her entire patient population. Dr. Gautam is the founding Director of the University of Ottawa Faculty Wellness Program. She is on the faculty of several medical leadership programs, including the Foundation for Medical Excellence Leadership Course, the University of Ottawa Medical Leadership Course, and the CMA Leadership Workshop of Medical Women. She has created videos on Physician Stress and authored several articles and book chapters on this topic.

Dr. Gautam is an internationally known speaker and has given over 250 keynote presentations and workshops in the area of physician's stress and mental health, and issues specific to women physicians and physician's spouses. She serves as a consultant to multiple local, national and international advisory committees on physician's well-being.

Dr. Gautam was a member of the OPA Council from 2000-2003.

Please forward your comments and ideas for Resident's Review to Krishna Balachandra at [kbalacha@uwo.ca](mailto:kbalacha@uwo.ca)