Dr. Rémi Quirion is now in his second year as Scientific Director of the Institute of Neurosciences, Mental Health and Addiction (INMHA) of the Canadian Institutes of Health Research (CIHR). In early May, he made a presentation about his view of the state of research on mental illness and mental health in Canada to the Standing Senate Committee on Social Affairs, Science and Technology, which is conducting a study of mental health and mental illness in Canada. He made a case for increased investment in research about mental health and mental illness by the government, explaining why this area of research is chronically underfunded compared with other areas and illnesses and why there is a great need to increase funding in this area. The CPA followed up with Dr. Quirion after his presentation.

Although the burden of disease from mental illness is extremely high and is increasing, the investment in research for mental health and mental illness is lagging behind that of other diseases, such as cancer and heart disease, says Dr. Quirion. “It is not at the same level.” There are a number of reasons for this, he says, including the fact that it is much more difficult to diagnose a brain-related illness than high blood pressure. Often, he adds, it is diagnosis by default. “The brain is the last frontier. It is very interesting, but there is still a lot we don’t know about it. It is harder to study.”

The stigma that is attached to mental illness and addictions means that people are still embarrassed about suffering from a mental illness, and consequently they may hide their illness from their family and friends, meaning that the family then can’t be there to support the patient. Reducing the stigma and raising the awareness of the general public about mental illness may result in more support from the public, which will also help to further reduce stigma and to exert more pressure on the government to increase funding he says. In 2000, the Canadian Alliance on Mental Illness and Mental Health and the CPA Working Group for a Canadian Institute of Mental Illness and Mental Health Research pointed out that stigma was a barrier to securing more resources and building a vibrant psychiatric and mental health research community, not only in basic science but also in clinical practice, population health and systems research.

Because of stigma and discrimination of people suffering from mental illness, “there are not many strong charitable organizations that can really form an effective lobby at the government level,” says Dr. Quirion. “We are not exerting enough pressure on the various government levels, including the federal government, to provide adequate funding for research on mental health and mental illnesses.” He believes INMHA must play a significant role in finding ways to reduce the discrimination against people suffering from mental illness and addiction in Canada. “One of my goals is to make it easier for someone to say ‘I have depression,’ and then people will rally around that person,” he says. He hopes to make it as easy to talk about mental illness as it is to talk about cancer and heart disease without judging the person suffering from the mental illness.

He notes that there is a dichotomy between mental health and mental illness. “Nobody can be against mental health, everybody is in favour of health, obviously. Nevertheless, we must not forget about the people who suffer from mental illness. We, as the specialists in the field, must agree amongst ourselves . . . that mental illnesses are indeed brain diseases. These are truly physical illnesses, brain diseases,” says Dr. Quirion.

CIHR spends about $40 million yearly on mental illnesses, mental health and addiction research and about $50 million yearly on neuroscience research. Dr. Quirion says these amounts need to be increased. “We have to go farther. We need to invest much more on neuroscience, mental health, and addiction research.” Dr. Quirion explains that Canada is very strong, is in fact one of the world leaders in the area of neuroscience research, and is also quite strong in the area of mental health research; however, research about addictions in Canada is weaker and needs rebuilding.

Stigma, Underfunding Impact Mental Illness and Mental Health Research: Scientific Director

We, as the specialists in the field, must agree amongst ourselves . . . that mental illnesses are indeed brain diseases. These are truly physical illnesses, brain diseases.

—Dr. Quirion
Guidance Statement Available for Psychiatrists on Implications of Recent Supreme Court Ruling in Favour of Mentally Ill Man’s Right to Refuse Medical Treatment

As has been well publicized, the Supreme Court of Canada upheld Ontario Court rulings that a review board finding of incapacity was unreasonable and that the review board in question misapplied the statutory test for capacity. The case involved Scott Starson, a man with bipolar affective disorder who had been admitted to hospital after he was found not criminally responsible for uttering death threats. He argued his right to refuse prescribed medications after a psychiatrist found him incapable of making rational decisions about his medical treatment.

The case reached the Supreme Court in January 2003 after a series of appeals, beginning with the Ontario Consent and Capacity Review Board in January 1999, which upheld the original doctor’s decision. Starson appealed the Board’s decision in provincial court, and in November 1999, the Ontario Superior Court of Justice overturned the Board’s decision. Starson’s doctors appealed this decision to the Ontario Court of Appeal in August 2000. In June 2001, the Ontario Court of Appeal dismissed the doctor’s appeal, agreeing with the original judge’s decision. The Supreme Court looked at the decisions of the two lower courts to determine whether they applied the correct legal standards when they overturned the Ontario Consent and Capacity Review Board’s decision. In the June 6 ruling, the Supreme Court upheld the ruling of the Ontario Court of Appeal. A CPA working group was assembled immediately after the judgment was made to clarify the scope of its implications on psychiatric clinical practice. The resulting statement is printed in this issue of the Bulletin and is available on the CPA Web site at www.cpa-apc.org.


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Former CPA President honoured by U.S. medical college

Dr. Harry Prosen, chairman and professor of psychiatry and behavioural medicine at the Medical College of Wisconsin and Chief of Psychiatry at Froedtert Hospital was awarded the Medical College’s highest honour—a Distinguished Service Award—on May 16. He was honored for his commitment to psychiatric research and education and his advancement of mental health care. Dr. Prosen joined the College faculty in 1987 and has marshaled his department into a thriving clinical and academic research hub during his 16-year tenure as chairman, guiding it to among the top 20 of 126 U.S. academic psychiatry departments in 2002, in terms of National Institutes of Health funding.

Dr. Prosen is an honorary member of the Canadian Psychiatric Association where he served as president from 1978 to 1979. He is also a past president of the Royal College of Physicians and Surgeons of Canada and has held leadership roles in the American Psychiatric Association. A native of Canada, Dr. Prosen was head of the department of psychiatry at the University of Manitoba for 13 years before joining the Medical College faculty.

Ancien président de l’APC est honoré par un collège médical des États Unis

Le Dr Harry Prosen, président et professeur de psychiatrie et de médecine comportementale au Medical College, et chef de la psychiatrie à l’hôpital Froedtert, a reçu le prix du service distingué attribué par le Medical College du Wisconsin le 16 mai. Il a été honoré pour son engagement à la recherche et à l’éducation en psychiatrie, et pour l’avancement des soins de santé mentale. Le Dr Prosen a joint le corps professoral du College en 1987 et a fait de son département un centre de recherche universitaire et clinique prospère durant son mandat de 16 ans comme président, le haussant au rang des 20 premiers sur 126 départements américains universitaires de psychiatrie en 2002, en ce qui concerne le financement des National Institutes of Health.

Renewal of Canada’s Drug Strategy Neglects Effect on Psychiatric Illnesses and Comorbidity

In late May, Health Canada announced the renewal of Canada’s Drug Strategy, stating that the Government would be investing almost $250 million over five years to implement the strategy that will “take a balanced approach to reducing both the demand for, and supply of, drugs.”

According to the Solicitor General of Canada, Wayne Easter, the national drug strategy addresses addiction and promotes public safety concerns. While cannabis possession and production will remain illegal in Canada under the Controlled Drugs and Substances Act, the proposed legislative reforms introduced in the House of Commons on May 27 provide for alternative penalties in cases of possession of small amounts of cannabis and create new, tougher penalties to target large marijuana growing operations. According to Health Canada, rates of marijuana use are rising, while support for incarceration as a penalty for cannabis possession is falling.

Highlights of the new strategy include community-based initiatives to address prevention; health promotion, treatment and rehabilitation issues; public education campaigns on substance abuse with a specific focus on youth; and proposed legislative reforms regarding marijuana in the Cannabis Reform Bill.

“I’m glad that there continues to be a Canada Drug Strategy,” says long-standing CPA member Dr. Juan Negrete, Chair of the Addictions Section of the CPA and a professor of psychiatry at McGill University. “Regarding the major point that they have changed the law that controls cannabis, I think it is a positive measure not to burden the individual with a criminal record and to have them dealt with in the health-care system rather than the justice system. However, any relaxation in attitudes toward the use of cannabis is likely to result in an increase in use, and we can anticipate that more people will have cannabis-related problems. We will probably see more use of the system—but not just of addiction services—of the entire health-care system. That is a common mistake people make, believing it will only increase the burden of addiction services.

“What hasn’t been addressed by the drug strategy, and nobody seems to be talking about it, is the affect of cannabis use on psychiatric illnesses,” says Dr. Negrete. “If you take schizophrenia as just one example, persons with schizophrenia if using cannabis, their psychotic illness is less likely to respond to treatment; they are more likely to be readmitted to hospital.”

He says, listing a host of other negative effects of cannabis use for a schizophrenic patient, “and that is just one example; other psychiatric illnesses are affected by cannabis use too, such as depression, panic disorders and anxiety. The use of the drug complicates the course and presentation of those illnesses and increases the burden on the health care system and society. This issue of comorbidity needs to be addressed.

“Right now, addiction services and mental health services are still separate: if you are cared for in one system, and you have a dual pathology, one of your problems is poorly attended to or completely ignored. Mental health services must be better equipped to deal with addiction, so they can offer the more comprehensive treatment required by these patients.”

Dr. Negrete has submitted a brief to the Senate Mental Health Study on this topic of drug and substance abuse by people with psychiatric illnesses.


For more information on the Cannabis Reform Bill: http://www.hc-sc.gc.ca/english/media/releases/2003/2003_34bk2.htm DV

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INMHA is supporting new research initiatives, supporting team grants to train the next generation of scientists. This includes a study on suicide at the Université du Québec à Montréal; studies on autism at McGill and at Queen’s University; studies on tobacco abuse at Waterloo and Toronto universities; a study on mental health on First Nations (McGill); and health services research studies at UBC and McGill on how to improve treatment. INMHA also supports research programs addressing fetal alcohol syndrome and posttraumatic stress disorder, a national placebo initiative, and a program on discrimination and stigma. The latter is a key strategic area for the Institute. INMHA plans on supporting national research strategies on suicide, neurogenetics, gambling and addiction and first episode in brain diseases. Along with increased funding, INMHA would like to see a national action plan for research in mental illness, mental health and addiction. This national research strategy would include advertising and an antidiscrimination campaign. Dr. Quirion notes that the unique model, which is used at CIHR, incorporates neurosciences, mental health and addiction research under one umbrella and stimulates collaboration among scientists involved in brain research. Rather than having neurologists, psychiatrists and addiction specialists all working on their own, they are working together as much as possible, with the hope that the impact of their research will be much greater.

“I think we’re making progress,” says Dr. Quirion, “but we need more public champions to promote this cause, and we need to think about mental illness the same way we do about other illnesses.”

In June, the INMHA announced three requests for application (RFA) with fall deadlines for letters of intent to apply. The earliest deadline is the RFA for the New Emerging Team Grant Program for Neuroethics. See CIHR’s Web site for more details: http://www.cihr-irsc.gc.ca/institutes/inmha/funding2003_opportunities_e.shtml. DV
As a second-year psychiatry resident in 1984, Robin Reesal was asked to see a patient at the Royal Ottawa Hospital who had suffered from chronic depression for many years and had agreed to participate in a trial. The patient, who had given up hope of regaining his health, responded well to the experimental drug. Dr. Reesal recalls when the patient’s wife told him, “I’ve got my husband back. It’s been 20 years.” Dr. Reesal’s joy at finding a treatment that restored hope to the man and his family was bittersweet. Once the trial was complete, the medication was discontinued, and the patient deteriorated. Yet the patient’s participation in the trial eventually made the drug available to others.

Dr. Reesal’s story highlights the sweet-and-sour human side of clinical trials and illustrates that research participants are the unsung heroes of trials. “They’re willing to help with the development of new treatments for the future. They hope to get better themselves, but they’re taking the risk for the rest of us. They believe so much in the process that they’re willing to do that.”

With that case, Dr. Reesal “got the bug.” He resolved to use his skills to advance medicine to help individuals suffering from these ailments. “That’s what drives me—I’m someone who needs to know that what I’m doing is going to make a difference.”

Eleven years passed before Dr. Reesal focused more exclusively on the clinical trials to which Dr. Yvon Lapierre, a leading figure in Canadian psychopharmacology, had introduced him. After graduating in psychiatry from the University of Ottawa, where he obtained the highest standing in psychiatry within his graduating medical school class, he began his tenure at the Calgary General Hospital. There he held the positions of Director of the Mood Disorders Program, Director of the Psychiatric Emergency Department, Director of the Drug Investigation Unit and Director of the Psychiatric Ambulatory Clinic, along with an appointment as Clinical Associate Professor with the University of Calgary’s Psychiatry Department. As director of the outpatient program, he set up and ran a clinical trials program for depression and anxiety for seven years. In 1994, he gave up the security of his hospital position and university affiliation and founded a not-for-profit company known to Calgarians as the Centre for Depression and Anxiety. This private centre, a first in Canada, focuses predominantly on clinical trials in the area of depression and anxiety.

Why a private company? Not for the money, says Dr. Reesal. Setting up the centre as a not-for-profit corporation sent a clear message that this wasn’t his motive. In fact, he says that, as Medical Director of the centre, he earns the same as other psychiatrists. Much of the money the centre receives from the pharmaceutical industry for the drug trials goes into overhead such as staff, office space, pharmacy services and insurance—services that institutions cover for their researchers. Dr. Reesal, who usually spends three-quarters of his time on research and one-quarter on clinical work, increases his private consultations, takes on medical legal work and runs educational programs for family doctors and psychiatrists to balance the books when the centre doesn’t have enough trials to pay for itself. “One thing that’s different from most physicians is that you don’t know what next year is going to bring,” says Dr. Reesal. “You have to learn to juggle your practice.”

The centre was an opportunity to practice medicine differently. Dr. Reesal felt institutional settings were too inflexible, the patient load didn’t allow him enough time with individuals and administrative duties took up time he wanted to spend with patients. The centre’s clinical trials gave him more time with patients and the opportunity to teach and educate participants, their families and family doctors. It also allowed him to increase his knowledge and advance psychopharmacology in the area of anxiety and depression—as he had promised himself he would do. The flexibility of a small bureaucracy also permitted Dr. Reesal, along with the centre’s clinical trial nurse, to develop standardized progress notes and rating scales to increase the objectivity of the studies; these changes are difficult to implement in a hospital setting because they depend on whole departmental changes.

Dr. Reesal also founded the centre to create a patient-friendly environment. In the centre, institutional colours, old chairs and the feeling that patients had to fit into the system were replaced with warmly decorated offices, coffee and snacks for patients and a system that catered to the clinical-trial patient. At the centre, these patients are seen in the morning before work, at lunch hour and after work, and initial evaluations are often done on Saturdays to avoid conflicts with employment. The centre’s patients are not the most severely ill; they function—but not well. “Patients know when they come in they are the primary reason for us being there versus simply being plugged into a system. It allows them to have expectations of high-quality care versus accepting what they are given,” explains Dr. Reesal. The funding realities and inflexibility of institutions 10 years ago simply didn’t allow these changes.

The centre is rated one of the top five per cent of audited clinical sites worldwide by an independent auditor. Dr. Reesal will probably set aside the trials on the centre’s tenth anniversary. The emphasis will change to seeing patients with anxiety and depression on the clinical side as well as consultations with family doctors. He will also teach and provide consultation to industry and universities who run clinical trials or are establishing programs. In 2002, he became Adjunct Associate Professor at Queen’s University. The change in practice will allow Dr. Reesal the time to submit for independent grants and pursue other research. He also looks forward to a regular life—in the last 10 years he’s only taken holidays in one-week blocks from mid-week to mid-week...
in order to keep appointments and adhere to protocols. Dr. Reesal will continue his volunteer work. He participates in the annual “juggling life” seminar aimed at the public and sponsored by the Canadian Mental Health Association (CMHA). He also contributes articles to CMHA’s Balance Magazine and writes a monthly column in the Calgary Herald on mental health topics such as stigma, how to evaluate medications and therapies as a patient, mental disorders and community mental health issues.

In addition to founding the Centre, Dr. Reesal is also one of the original founding members for the Canadian Network for Mood and Anxiety Treatments. As part of this group he helped develop the guidelines for diagnosis and pharmacological treatment of depression for family physicians and the clinical guidelines for the treatment of depressive disorders for the CPA.

What does Dr. Reesal think about the state of research in Canada? Although he says the Canadian Institute of Health Research (CIHR) and the Institute of Neurosciences, Mental Health and Addictions (INMHA) have made strides in the right direction by striving towards global and multidisciplinary research cooperation, more clinical research is needed. “Psychiatric disorders take up such a large percentage of health-care costs that society is losing money by not helping research advance further. The more efficacious the treatments, the fewer people will be ill.” Dr. Reesal sees research as part of the health-care infrastructure that needs to be maintained, “You need funding to keep leaders who are creative and spawn new ideas in Canada.”

“Evidence-based research is important to objectively evaluate practices passed down from one generation of physicians to another,” says Dr. Reesal. Many patients expect an explanation and a justification for proposed treatments. “Rather than being defensive, I think it’s our responsibility to gain the knowledge to justify treatments.” This is one reason Dr. Reesal advocates for more research cooperation, more funding agencies, such as the CPA; consumer groups, such as CMHA; and universities could provide courses, such as grant writing, to clinicians and encourage collaboration between academics and clinicians to write papers.

The centre was an opportunity to practice medicine differently. Dr. Reesal felt institutional settings were too inflexible, the patient load didn’t allow him enough time with individuals and administrative duties took up time he wanted to spend with patients.

The more money to evaluate psychotherapies, the course of conditions and patient satisfaction with treatments. He suggests modifying existing regulations that require pharmaceutical companies reinvest a defined percentage of their profits into research so that a predetermined percentage of this fund goes into nonpharmacological research. Also, funding agencies, such as Health Canada, CIHR and INMHA; the government; professional associations, such as the CPA; consumer groups, such as CMHA; and industry need to partner and identify non–pharmaceutical-oriented research projects that benefit all parties. Dr. Reesal cites industry-sponsored studies comparing psychotherapy against their medications as such an example. Collaboration with consumer groups would add value to research submissions.

The goal is to do research for the sake of research.”

Dr. Reesal also sees a vital and untapped research resource—hospital and community clinicians. “Clinicians feel that what they’re learning on the front lines is valuable, and they have a contribution to make but don’t feel confident the avenues are available to them,”

As part of the Health Research (CIHR) and the Canadian Institute of Health Research (CIHR) Dr. Reesal feels institutional settings are available to them,”

He explains, “Ultimately, research is being done to improve treatments for the individual. The goal is not to do research on leaving one part of the heart and stroke foundation. Dr. Reesal replies, “fragmentation.” The belief that a particular medication or therapy is the only way has been divisive. It is better to emphasize that all of our approaches have their place—our skill is in determining which approach to use when,” says Dr. Reesal. Only when psychiatrists advocate for one another and articulate a cohesive, single-minded advocacy program with one voice can the public be solicited effectively, he says. “That’s why, as much as I believe in psycho-pharmacology, if our (clinical trial) research or the funding for psychopharmacology creates the means to fund other forms of therapy research, it’s part of my job as a CPA member to support my peers.”

Although Dr. Reesal understands the trepidation physicians feel about putting patients into higher-risk treatments and their hesitation about the relationship between clinical trials and the pharmaceutical industry, he feels it’s important that psychiatry participate in clinical trials. Not to do so, says Dr. Reesal, is to risk stifling the development of new pharmacological treatments that psychiatrists need in their clinical practice. He points out clinical trials are just another area of medicine and psychiatry, and it’s important “not to allow a halo effect about what you feel about the sales component and the pharmaceutical industry to taint the reputation of people who care as much about the patients as someone who is in clinical practice.”

Participation is a patient safety issue, says Dr. Reesal. “Rather than have clinical trials as a fringe component of psychiatry and medicine, it is better for physicians to be active participants to make sure that the standards are high and that the patients’ best interests are served and that only products that are safe and effective reach the market. As psychiatrists we have the opportunity to prevent ineffective agents from being put into the hands of our colleagues.”

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