

# SchizophreniaRounds

As presented in the Rounds of the Schizophrenia Program, Department of Psychiatry, Faculty of Medicine, University of Toronto

## Using Collaborative Practice to Improve the Health of Patients with Psychoses

By JOSE SILVEIRA, MD, FRCPC, and PATRICIA ROCKMAN, MD, CCFP, FCFPC

Those who treat schizophrenia (SCZ) and schizoaffective disorders are intimately familiar with the devastating impact these conditions can have on the lives of patients, families, and even society. It is accepted that approximately 1% of the population is affected, yet direct costs of these conditions account for over 1.7% of national health care expenditures in Canada.<sup>1</sup> Globally, schizophrenia accounts for over 2.8% years of life lived with disability, which places it among the top 10 most disabling conditions in the world.<sup>2</sup> Indirectly, SCZ increases a person's risk of developing cardiac and respiratory diseases; these disorders account for the greatest number of deaths worldwide. This inaugural issue of *Schizophrenia Rounds* reviews the evidence supporting the positive benefits of primary care in patients with SCZ, particularly in collaboration with specialized services. This issue provides practical information on initiating the enhancement of collaborative care within a daily practice involving patients with SCZ.

The range of biological, psychological, and social interventions for patients with chronic psychotic disorders is finite, and for many patients with treatment-resistant illness, treatment options are often exhausted within the first 2-3 years. What options are available to further improve the quality of life in patients suffering with psychotic disorders? At a systemic level, patients with SCZ consistently demonstrate greater rates of medical morbidity and mortality due to medical causes in comparison with the population as a whole.<sup>3-8</sup> It is likely that patients with neurocognitive impairments, including limited reasoning and judgment, are likely to suffer greater medical morbidity on the basis of health-related behaviours. Indeed, preventable risk factors such as tobacco smoking, obesity, and sedentary lifestyle are more prevalent among patients with SCZ. In addition, research suggests that SCZ patients attending primary-care clinics are more likely to have return visits, longer visits, and scheduled follow-up in comparison with patients from the general population; this supports the expectation that their medical care is at least adequate.<sup>7</sup> However, the evidence demonstrates that medical care for patients with SCZ is less than adequate. In a recent study from Nova Scotia, the mortality rate ratio was highest for patients with nonaffective psychoses (3.66, 95% CI, 3.20-4.19) in comparison with the general population.<sup>8</sup> The same investigators found that patients with SCZ who had their treatment consolidated within a primary-care setting (PCS) experienced significantly lower mortality rate ratios (1.25, 95% CI, 1.20-1.30) than patients treated by specialist mental health services (1.80, 95% CI 1.63-1.99).<sup>8</sup> The real-world relevance of the latter finding is considerable. It is well known that patients with SCZ who receive their psychiatric care exclusively within specialist psychiatric services have a tendency to visit their primary-care providers (PCPs) infrequently and often, in the more severely ill, not at all. This suggests the importance of collaborative care models where the mental health and addictions care of patients are consolidated within the PCS. Consolidating the care of patients within the PCS improves medical care and reduces mortality.<sup>8-10</sup> Another goal of a collaborative care



Centre for Addiction and Mental Health  
Centre de toxicomanie et de santé mentale

### Department of Psychiatry Schizophrenia Program

Z. Jeff Daskalakis, MD, PhD, FRCPC  
Research Section Head, CAMH  
Editor, *Schizophrenia Rounds*

Ofer Agid, MD  
Assistant Professor, CAMH

Tony P. George, MD, FRCPC  
Head, Addiction Psychiatry  
Program, CAMH

Gary J. Remington, MD,  
PhD, FRCPC  
Director, Medication Assessment  
Program for Schizophrenia  
(MAPS) Clinic, CAMH

Chekkera M. Shammi, MBBS,  
DPM, FRCPC  
Chief, Early Psychosis Unit, CAMH

Albert Wong, MD, PhD, FRCPC  
Associate Professor, CAMH

### Schizophrenia Program

University of Toronto  
Department of Psychiatry  
250 College Street  
Toronto, ON M5T 1R8

The editorial content of  
*Schizophrenia Rounds* is  
determined solely by the  
Department of Psychiatry,  
University of Toronto

Available on the Internet at

[www.schizophreniarounds.ca](http://www.schizophreniarounds.ca)

model is to improve the management of psychiatric disorders directly and at a population level. This is achieved through improving case identification by PCPs, which in turn, is facilitated by increased knowledge and experience with SCZ. In order for PCPs to gain experience and knowledge, they must directly manage more of their patients' mental disorders; to do this, they must have confidence that access to specialist services are consistent, easily accessible, and timely. Increased specialist support of PCPs also enhances the care of patients at a population level by reducing time to treatment initiation for both new-onset cases and relapse management. It is clear that coordinating integrated care between specialized psychiatric services and primary care makes sense, but how can psychiatrists actually achieve shared care?

### Shared care

PCPs often experience discomfort in caring for patients with SCZ because they seem different from other patients. Identifying similarities to other chronic medical conditions managed in primary care is useful for demystifying SCZ. For instance, patterns of recurrent nonadherence to comprehensive biopsychosocial treatment plans may result in a frequent deterioration of conditions (eg, diabetes and asthma) in a pattern that is similar to patterns with primary psychotic disorders. Another similarity is that the majority of patients with chronic diseases are managed almost exclusively by their PCPs, not only due to the availability of resources, but also because many patients prefer to have their medical care delivered primarily by their family physician. An important difference, however, is that psychotic disorders and their associated signs and symptoms tend to arouse greater discomfort and uncertainty in many physicians, including psychiatrists. Assisting the primary-care team to conceptualize psychoses using a chronic medical disease model is a useful way to help PCPs conceptualize care of SCZ within their daily practice.

For PCPs to achieve greater comfort, confidence, and time efficiency in managing patients with psychoses (even if the goal is simply to improve a patient's access to basic primary care), the primary-care context must be understood. Several important characteristics differentiate a specialist mental health service from the primary-care context that must be recognized for optimizing the effectiveness of collaborative care.

- First, *time* is indeed essential and PCPs often have patient loads of 1,500 to 2,000 patients with multiple problems and conditions.
- Second, the majority of mental health and addictions care already occurs within primary care in Canada, and the majority of the care is provided in the absence

of specialist support. There are several reasons: numerically, PCPs far outnumber psychiatrists; psychiatry is underserved in most communities; many patients prefer to be treated for their mental disorders by their family physician; stigma influences whether a patient accepts specialized psychiatric services; some patients have limited insight into their mental disorders and thus refuse psychiatric consultation; and finally, geographic distance to specialized services is a significant barrier in many isolated communities across Canada. Therefore, the argument against increasing the burden of an already strained primary care system does not hold true, since PCPs are already providing care to patients with SCZ, but currently, with only limited support from their expert colleagues. Providing PCPs with access to support for work they are already doing reduces the burden the PCP carries through sharing the care with other physicians.

- Third, PCP providers are more comfortable with and more likely to use colleagues with whom they have developed a relationship; they do not like to refer into a void.<sup>11</sup> The degree of comfort with asking a colleague for guidance increases proportionally with the depth of the relationship. PCPs are not simply looking for somewhere to “dump” their patients, but are seeking support they can trust to provide them with useful guidance; as well, the support is requested to be given in a manner congruent with their practice context and respectful of their efforts. In fact, most PCPs prefer to use human resources, such as corridor consultations, rather than a literature search.<sup>12-16</sup>
- The fourth connected point relates to important findings from the Ontario College of Family Physicians Collaborative Mental Health Care Network (OCFP-CMHCN); they report that the vast majority of questions are highly complex and multifactorial, and address issues that extend beyond the reach of the existing literature.<sup>17</sup> As such, these questions rely upon experts who can provide their clinical experience, theoretical knowledge, and the related evidence from the literature. A consultation that fails to address interacting comorbidities and the inherent challenges of a case and its management in the PCS is not likely to be useful. Family physicians across Canada have, in fact, consistently rated psychiatric consultations as the least useful in comparison with all other specialists.<sup>18</sup> This latter finding is worrisome because of the negative impact on psychiatrists' desires to provide support for PCPs in managing patients with SCZ.
- The fifth point psychiatrists should recognize is that PCPs may feel frustrated with SCZ patients because these patients may have difficulty adhering to treat-

ment recommendations and scheduled visits, they can disrupt a busy schedule, and create unexpected extra work for all who are involved in their care.

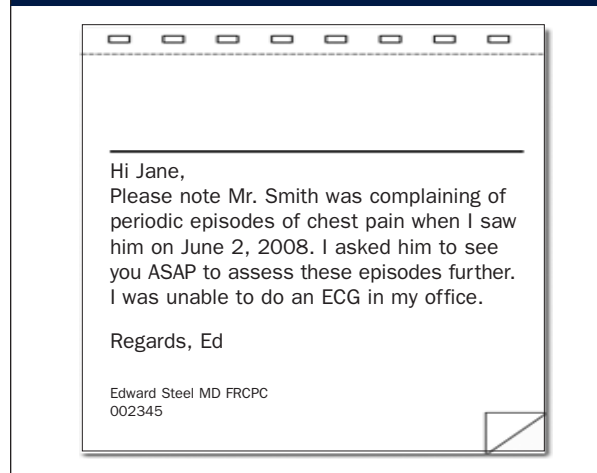
- Finally, safety concerns may also be issues that are perhaps present, but go unmentioned by PCPs.

The preceding set of challenges are rarely articulated by PCPs and, even when these questions are not essential in the referral note or discussion of the case, the psychiatrist should be aware of these issues and provide the PCP with suggestions on managing the relevant challenges. This is extremely important because these indirect challenges often determine whether a PCP will continue to treat a patient with SCZ and/or the level of care he/she provides; further, the psychiatric consult note must be most concerned with recommendations rather than an overly detailed history. Recommendations should focus on practical, realistically achievable objectives and the PCP should be given a clear and measurable set of outcome measures, including a rough timeline; this would enable the PCP to evaluate whether the implementation of the plan is achieving the objectives. The plan should also clearly delineate each caregiver role and a protocol for communication; for instance, who will be responsible for monitoring blood work, writing the prescriptions, assuring prescription refills, and also who will communicate with community resources, family, and other concerned services.

Given the importance of health status, the psychiatry consultant should become knowledgeable about the patient's medical status, medications, and medical investigations. Corroborating information should be obtained from the PCP to ensure that accurate and current medical information is obtained. Psychiatrists should invite the PCP to send quick updates when any new conditions are identified or changes made in medications. Similarly, it is advisable that the psychiatrist send brief notes to the PCP informing him/her of any laboratory findings or health concerns the patient may have expressed to the psychiatrist (Figure 1).

Psychiatrists should confirm that the patient follows up with the PCP. It is also useful to ask PCPs if they are encountering challenges in managing the patient's medical problems due to the patient's psychotic disorder or the treatment of the psychotic disorder. This is significant because treatment with current second-generation antipsychotics involves related metabolic risks; as well, reports mention that up to 78% of patients with SCZ smoke cigarettes.<sup>19</sup> The psychiatrist does not need to manage the patient's medical problems; in fact, it is preferable to ensure that experts in this regard (the PCP and other medical specialists) are properly utilized.

**Figure 1: An example of collaborative communication for patient care**



In summary, the more psychiatry specialists reach out to PCPs, the more convinced they will be of the desire by specialists to treat the patient jointly and recognize how psychiatrists value PCPs and depend on their care of the patient. If the exposure of medical colleagues to psychiatric patients increases in the context of supportive and collaborative relationships, then these colleagues will become more familiar, comfortable, and confident in treating patients with SCZ.

### **Transparency in collaboration**

Primary-care colleagues should also learn about the specialist's practice in order to optimize the effectiveness of collaborative care. There are a number of benefits to this transparency. Certainly, enhanced coordinated care of patients will increase the availability to see new patients, reduce wait times, and increase patient-management number capacity. In general, it is useful to inform PCPs that specialists are available for both direct and indirect consultation. Direct consultation is where the specialist interviews the patient directly in his/her office. An indirect consultation is through contact with the health provider who gives information about the patient relevant to the concerns and questions asked. A combination of direct and indirect consultations is considered by many to be the most realistic, effective, and efficient mode of collaborative practice.<sup>10,20-23</sup> In order to facilitate indirect consultation, a specialist should consider what mode of communication suits him/her the best. Both synchronous and asynchronous forms of communication could be involved, since each has advantages and disadvantages. Synchronous communication includes telephone and face-to-face contacts; this is an

efficient iterative form of communication that optimizes clarification of the issues in a relatively short time. The major challenge with this form of communication is that both parties must be available at the same time and this can be difficult given the hectic schedules of most PCPs and community psychiatrists. Certainly, a telephone discussion may be chosen for more urgent issues.

Asynchronous forms of communication (eg, email and fax) are advantageous because parties communicate on their own time schedule and with minimal disruption of their established calendar. In addition, having an email or fax becomes a quick method of documentation and does not require additional time to record the discussion. The PCP simply files the communication record in the patient file and the psychiatrist does the same in his/her respective file. It is useful for both the psychiatrist and the PCP to write the fax, email, or make the phone call with the patient in the office, to improve efficiency of communication and to ensure that the process becomes integrated within standard practice. Even for physicians practicing within salaried remuneration models that compensate providers for an activity performed even after the patient has left the office, physicians are less likely to complete a task if it is left for some time after the patient has gone. For psychiatrists, for instance, pending the complete consultation note, it is better to write a very brief summary of impressions and plans at the end of the consultation with the patient in the room. This allows one to write and review out loud with the patient these impressions and suggestions, which simultaneously informs the patient, and offers a sense of the level of the patient's agreement with the comments and plans. In addition, this offers opportunities for further adaptations in the plans. As a result, in one action, the psychiatrist has provided feedback to the patient as part of the assessment, written a brief note to the PCP informing him/her of the outcome of the visit and the next steps, demonstrated a commitment to communication with the PCP, and reduced any delay in initiating the complement of interventions, which ultimately reduces the time to achieving optimal treatment. Such an abridged note is a simple step with a large potential for positive patient and system outcomes.

Office staff will need to be informed of this alteration in practice and they should know to treat telephone calls, faxes, and emails from PCPs as a priority. With referrals, the specialist should ensure that the PCP is kept abreast of information that is

useful and should consider clarifying the referral even before booking the patient's appointment. This allows initial consultations to be more efficient in answering the real questions at hand and assists the PCP in learning what information to include; further, the PCP will become more comfortable in writing referrals in a manner that is more free flowing and descriptive of the challenges he/she is facing. Frequently, the direct consultation can be avoided completely by clarifying the PCP's question and providing an answer through indirect consultation.

### **Implementing change**

Many specialists may read this and think, "I don't have the time to do all of this!" Indeed, it would be unrealistic to expect that a change in practice, much less in a relationship with PCPs, could occur from one day to the next. Optimizing collaborative practice is something that is done within the fabric of everyday practice using small steps. The process must be sustainable for both the psychiatrist and the associated PCPs, with the ultimate goal to enhance the relationship between the two parties. All relationships develop over time based on repeated contacts and they require patience to achieve mutually satisfactory and complementary behaviours. In the end, professional satisfaction and patient outcomes all benefit.

Another concern expressed by many psychiatrists is that by making themselves more accessible, they will be drowned in phone calls, emails, and faxes. Experience in the OCFP-CMHCN has found that the fear of being inundated with phone calls and emails is unwarranted. The OCFP-CMHCN provides telephone, email, and fax support to PCPs managing mental health and addictions problems in their offices. Data collected prospectively over 7 years reveal that even the PCPs who have the highest utilization of services do not contact a mental health specialist >2 times per month and many PCPs contact  $\leq 1$  time/year.<sup>24</sup> Nonetheless, communication between providers should be brief and concise. The OCFP-CMHCN found that interactions between PCPs and psychiatric specialists are, on average, 5-7 minutes in duration.<sup>17</sup> These findings reveal that the expectations of an increased burden on providers due to collaborative practice are inaccurate. Some basic principles of collaborative practice defined by the Canadian Collaborative Mental Health Initiative (CCMHI) are listed in Table 1.<sup>10</sup>

Finally, several medical-legal questions often arise when psychiatrists and family practitioners discuss collaborative practice. A common question

**Table 1: Principles for collaborative practice<sup>10</sup>**

**Key elements** in building a collaborative service for people with SCZ include:

- Common vision and clearly articulated “shared” goals for collaboration
- Involvement of all partners as equals in the collaboration
- Mutual respect for the roles of each provider and the consumer
- Clear roles and responsibilities for PCP and psychiatrist
- Facilitating opportunities for PCPs to experience working with people with SCZ
- Clear protocols for sharing information

SCZ=schizophrenia; PCP=primary-care physician

is that of shared liability for the recommendations or suggestions made by the psychiatrist to the PCP. It is useful to begin by reviewing common practices in the standard consultation model. When a psychiatrist assesses a patient in consultation, the result is a series of recommendations for interventions that the PCP should consider implementing to treat the patient’s condition. Recommendations often are made in the absence of the psychiatrist’s plans to review the patient in the future. It would be considered very unusual for a psychiatrist to refuse to make treatment recommendations in order to avoid liability for outcomes based on a PCPs implementation of said recommendations. The reality is that the psychiatrist and PCP share liability on a sliding scale of responsibility. Similarly, liability is shared for indirect consultations both of new patients and of treatment changes made in response to a changing clinical presentation. Ultimately, regardless of the manner of practice chosen, specialists will shoulder a portion of the medical-legal liability. The important question is whether the preference is for a good relationship that fosters open information exchange with physicians who share patient care or to lack knowledge about the success or failure of assessments and recommendations. According to the Canadian Medical Protective Association (CMPA), better protection results from good communication and collaboration than not.<sup>25</sup> Furthermore, the Royal College of Physicians and Surgeons of Canada has clearly stated that the roles of “communicator” and “collaborator” are critical for specialists to demonstrate in order to be considered competent practitioners.<sup>26</sup>

Another issue to consider is the disclosure to patients of the possibility that their case will be discussed periodically with the PCP. For most jurisdictions in Canada, the principle of “circle of care” (or similar) dictates that informed consent is not required to communicate with another physician or designate concerning a patient in common care. In fact, physicians often may find themselves in trouble with their licensing bodies for failing to adequately communicate with one another. In the case of an indirect consultation concerning a patient that the psychiatrist has never seen, it is probably best for the PCP to inform the patient of his/her intent to discuss the case with a specialist. In the case of patients who disagree due to paranoia, the PCP can simply discuss the case with the specialist and provide no identifying information; however, the discussions must be summarized in the chart to provide a record.

## Conclusion

Patients suffering with psychoses have multiple psychiatric and medical needs; they are at particular risk of inadequate management of their medical health within our complex healthcare system. The enhancement of collaborative practice models is a simple extension of skills that most psychiatrists already possess; in addition, it is easy to do, it supports family physician colleagues, and it makes the psychiatrist’s life easier. PCPs feel more satisfied with consultations, and they feel less burdened by the care of patients with complex mental disorders. Psychiatrists find that their capacity increases and they find that they can rely on their PCP counterparts more frequently and for a greater proportion of the care of patients with SCZ. Ultimately, patients receive improved physical care and better health outcomes.

---

*Dr. Silveira is an Assistant Professor in the Department of Psychiatry, University of Toronto, University Health Network.*

*Dr. Rockman is an Assistant Professor in the Department of Family and Community Medicine, University of Toronto, University Health Network. Toronto, Ontario.*

---

## References

1. Statistics Canada. Canadian Statistics: Health expenditures by type. <http://www40.statcan.ca/101/cst01/health13.htm>. February 17, 2005.
2. World Health Organization. *World Health Report 2001: Mental Health: New Understanding, New Hope*. Available: <http://www.who.int/whr/2001/en>. May 27, 2008.
3. McDermott S, Moran R, Platt T, Isaac T, Wood H, Dasari S. Heart disease, schizophrenia, and affective psychoses: epidemiology of risk in primary care. *Community Ment Health J*. 2005;41(6):747-755.

4. Guthrie SK. Clinical issues associated with maintenance treatment of patients with schizophrenia. *Am J Health Syst Pharm.* 2002;59(17 Suppl 5): S19-24.
5. Fleischhacker WW, Cetkovich-Bakmas M, De Hert M, et al. Comorbid somatic illnesses in patients with severe mental disorders: Clinical, policy and research challenges. *J Clin Psychiatry.* 2008;69(4):514-519.
6. Lambert TJ, Velakoulis D, Pantelis C. Medical comorbidity in schizophrenia. *Med J Aust.* 2003;178(Suppl):S67-S70.
7. Daumit GL, Pratt LA, Crum RM, Powe NR, Ford DE. Characteristics of primary care visits for individuals with severe mental illness in a national sample. *Gen Hosp Psychiatry.* 2002;24(6):391-395.
8. Kisely S, Smith M, Lawrence D, Cox M, Campbell LA, Maaten S. Inequitable access for mentally ill patients to some medically necessary procedures. *CMAJ.* 2007;176(6):779-784.
9. Meadows GN. Overcoming barriers to reintegration of patients with schizophrenia: developing a best-practice model for discharge from specialist care. *Med J Aust.* 2003;178 Suppl:S53-S56.
10. Canadian Collaborative Mental Health Initiative. *Establishing Collaborative Initiatives Between Mental Health and Primary Care Services for Individuals with Serious Mental Illness.* A companion to the CCMHI planning and implementation toolkit for health care providers and planners. Mississauga, ON: Canadian Collaborative Mental Health Initiative; February 2006. www.ccmhi.ca ISBN 1-897268-01-7.
11. Raine R, Carter S, Sensky T, Black N. "Referral into a void": opinions of general practitioners and others on single point of access to mental health care. *J R Soc Med.* 2005;98(4):153-157.
12. Ely JW, Burch RJ, Vinson DC. The information needs of family physicians: case-specific clinical questions. *J Fam Pract.* 1992;35(3):265-269.
13. Chambliss ML, Conley J. Answering clinical questions. *J Fam Pract.* 1996; 43(2):140-144.
14. Ely JW, Osheroff JA, Ebell MH, et al. Analysis of questions asked by family doctors regarding patient care. *BMJ.* 1999;319(7206):358-361.
15. Smith R. What clinical information do doctors need. *BMJ.* 1996;313(7064): 1062-1068.
16. Connelly DP, Rich EC, Curley SP, Kelly JT. Knowledge resource preferences of family physicians. *J Fam Pract.* 1990;30(3):353-359.
17. Silveira J, Salach L, Hunter J, Burgoyne R, Rockman P. *The Nature of Case Consultations between Family Physicians and their Mentors From Psychiatry and GP Psychotherapy in the Collaborative Mental Health Care Network.* Presentation at: Harvey Stancer Research Day, Department of Psychiatry, University of Toronto (unpublished data) June, 2004.
18. Canadian College of Family Physicians. Results of the 2001 National Family Physician Survey. (Unpublished.) www.nationalphysiciansurvey.ca/nps/home-e.asp.
19. Crews C, Batal H, Elasy T, Casper E, Mehler PS. Primary care for those with severe and persistent mental illness. *West J Med.* 1998;164(4):245-250.
20. Kates N, Crustolo A, Farrar S, Nikolaou L. Integrating mental health services into primary care: lessons learnt. *Fam Syst Health.* 2001;19(1):5-12.
21. Meadows GN. Establishing a collaborative service model for primary mental health care. *Med J Aust.* 1998;168(4):162-165.
22. Davies JW, Ward WK, Groom GL, Wild AJ, Wild S. The case-conferencing project: a first step towards shared care between general practitioners and a mental health service. *Aust N Z J Psychiatry.* 1997;31(5):751-755.
23. Biderman A, Yeheskel A, Tandeter H, Umansky R. Advantages of the psychiatric liaison-attachment scheme in a family medicine clinic. *Isr J Psychiatry Relat Sci.* 1999;36(2):115-121.
24. OCFP CMHCN Annual Utilization Reviews (2002 - 2007). (Unpublished.) www.ocfp.on.ca/English/OCFP/CME/CMHCN.
25. Canadian Medical Protective Association. Collaborative Care: A Medical Liability Perspective. August, 2006. www.cmpaacpm.ca/cmpapd03/pub\_index.cfm?LANG=E&URL=cmpa\_docs/english/resource\_files/admin\_do cs/common/com\_collaborative\_care-e.html
26. The Royal College of Physicians of Surgeons of Canada. The CanMEDS Project Overview. 2005. rcpsc.medical.org/tools/sitemap\_e.php#opd.

## Abstract of Interest

### **How do general practitioners manage subjects with early schizophrenia and collaborate with mental health professionals? A postal survey in South-Western France**

VERDOUX H, COUGNARD A, GROLLEAU S, BESSON R, DELCROIX F.

**OBJECTIVE:** This study was conducted to explore how general practitioners (GPs) manage subjects with early psychosis and collaborate with psychiatrists in the care of such patients.

**METHODS:** Survey questionnaires exploring practice in patients with early psychosis were mailed to all GPs in South-Western France (n = 3,829).

**RESULTS:** The response rate was 23.6%. Half of GPs responding to the survey had actually diagnosed a possible case of schizophrenia during the previous year. In such cases, the most frequent decision was to refer the patient to a psychiatrist, despite the difficulties of convincing the patient and obtaining a rapid referral. According to GPs' answers, the relationships between primary care and the mental health team were characterised by a lack of communication: less than one out of three GPs had regular contact with a mental health team, and a large majority reported that they never or rarely had information about the diagnosis and treatment of subjects referred for early schizophrenia. Having regular contacts with mental health services had a major impact on GPs' management of subjects with early schizophrenia, in particular on reducing delays to obtain a psychiatric consultation and on level of information on diagnosis and treatment after referral.

**CONCLUSION:** Promotion of networking between primary care and mental health services is required to reduce delayed access to care in subjects with early schizophrenia. *Soc Psychiatry Psychiatr Epidemiol.* 2005;40(11):892-898.

## Upcoming Scientific Meetings

4 - 7 September 2008

### **58<sup>th</sup> Annual Conference of the Canadian Psychiatric Association**

Vancouver, British Columbia

CONTACT: Tel.: 613-234-2815

Email: conference@cpa-apc.org

20 - 25 September 2008

### **XIV World Congress of Psychiatry**

Prague, Czech Republic

CONTACT: Tel.: 42-0-284-001-444

Email: wpa@guarant.cz

This publication is made possible by an educational grant from

# Pfizer Canada Inc.

© 2008 The University of Toronto, Faculty of Medicine, Department of Psychiatry, Toronto, which is solely responsible for the contents. The opinions expressed in this publication do not necessarily reflect those of the publisher or sponsor, but rather are those of the authoring institution based on the available scientific literature. Publisher: SNELL Medical Communication Inc. in cooperation with The University of Toronto, Faculty of Medicine, Department of Psychiatry, Toronto. <sup>™</sup>Schizophrenia Rounds is a Trade Mark of SNELL Medical Communication Inc. All rights reserved. The administration of any therapies discussed or referred to in *Schizophrenia Rounds* should always be consistent with the approved prescribing information in Canada. SNELL Medical Communication Inc. is committed to the development of superior Continuing Medical Education.