Dear colleagues and friends,

As you know, Alberta’s first Academic Medicine and Health Services Program (AMHSP) for practicing Psychiatrists was officially launched on April 1st.

It has taken a lot of patience, teamwork and dedication to reach this point, by everyone involved from Alberta Health, the Department of Psychiatry and Alberta Health Services (AHS).

Ultimately, we hope to fill as many as 20 positions under the new AMHSP remuneration structure, and it is heartening to see the strong show of interest to date in these positions from prospective applicants.

Once the positions are filled, we truly believe the AMHSP will be a game-changer for both AHS and the Department of Psychiatry.

As noted in previous issues of Connections, for particular areas of AHS’s Addiction and Mental Health system, we expect the AMHSP to yield significant benefits.

For example, the AMHSP is expected to help AHS’s Urgent Care Clinics, the Inner City Team, and the Community Outreach or Crisis Teams to develop closer linkages with Psychiatrists, improving access to community-based assessments.

For the Department of Psychiatry, the AMHSP will help us to more effectively meet the needs and enhance the teaching programs for Undergraduate Medical Education, Psychiatry Residency and Sub-specialty Training.

The AMHSP is also expected to encourage Psychiatrists to become more involved in program development and Quality Improvement initiatives, while bringing more clinically-based research into the Zone’s unique practice environments.

Simply put, the AMHSP will yield many tangible benefits, helping to change the face of Psychiatry across the Zone.

But let’s be clear: this is not the end of the road. Far from it. In fact, it’s the beginning of a whole new process that will take months to complete. The rollout itself is a complex process. Indeed, we fully expected to encounter some bumps along the way.

As we have noted in past issues of Connections, the AMHSP is different from prior alternative funding programs. For most if not all of the previous programs, the head on the services side was also the head of the related university department.

(From left) Mark Snaterse, Executive Director for Addiction and Mental Health, AHS, Edmonton Zone; Dr. Xin-Min Li, Chair, Department of Psychiatry, U of A; and Dr. Daniel Li, Interim Zone Clinical Department Head – Addiction and Mental Health, AHS.

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(Continued...
That is not necessarily the case with the new AMHSP for Psychiatry. As a result, there are some unique wrinkles to this AMHSP in terms of how the process will actually unfold.

Secondly, AHS and the University of Alberta have distinct and often differing sets of rules and procedures under which the two organizations conduct their hiring practices. The need to better align these rules and practices for external hires is particularly important, especially if the AMHSP applicant is from outside the country and must apply for a Work Visa in Canada. This process alone often takes months to complete, and any errors or confusion resulting from the initial application can cause further lengthy delays before an individual is allowed to work in Canada.

While these issues around the hiring of external AMHSP applicants are being resolved, however, the internal hiring process for AMHSP applicants is already underway. For both the Department of Psychiatry and AHS, the rollout of the AMHSP is a crucial next step in our joint, ongoing efforts to ensure that strong academic programs and strong clinical practices go hand-in-hand.

We remain committed to ensuring that the AMHSP for Alberta’s Psychiatrists is a success, and we will continue to report on the progress of the rollout in the months to come. In the meantime, we thank you for your patience and understanding as our work on this important initiative continues.

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UBC’s Dr. Raymond Lam to Deliver Keynote Address at Department of Psychiatry’s Research Day Event May 15th

Renowned depression researcher Dr. Raymond Lam, Professor and B.C. Leadership Chair in Depression Research in the Faculty of Medicine at the University of British Columbia, will be the keynote speaker May 15th at the Department of Psychiatry’s 18th annual Research Day event.

The day-long symposium, which celebrates and showcases the research of the Department of Psychiatry’s Residents and Graduate students, will take place at Bernard Snell Hall in University of Alberta Hospital.

“I’m very excited about Research Day. We have a lot of posters this year from different departments – about 35 in all. That’s a big jump from last year, when we only had about 16 posters. And we’ll probably have 15 to 20 students presenting in the thesis talks,” says student organizer Daniela Gomez, whose Master’s research is focused on neurocognitive changes in HIV (Human Immunodeficiency Virus) patients.

“We’ll have people from the Department of Educational Psychology, from Computing Science, the School of Public Health and the Faculty of Nursing. So it’s going to be very interdisciplinary, offering different perspectives and different types of projects, from qualitative work to Machine Learning. That should stimulate some very interesting questions and conversations.”

“It’s hard to do anything in isolation now. You really need to take a team approach so you can get different perspectives,” says Research Day organizer and Psychiatry Master’s student Jessica Luki, whose research is focused on measuring the neurotransmitter levels in women with perimenopausal depression. Luki aims to recruit about 60 women for the study, including 30 healthy controls and 30 who are experiencing some symptoms of perimenopausal depression.

Jeff Sawalha, another Psychiatry Department Graduate student organizer, says he’s particularly interested in learning more about current research projects in Machine Learning.

“It’s good timing for this topic right now. Machine Learning has become a big buzzword and it has gotten a lot of media attention. But I think there are some misconceptions about the implications of Machine Learning, especially in the field of Psychiatry, and the fear that it’s somehow going to replace the role of human clinicians,” says Sawalha, whose PhD research is focused on using voice data analysis as a screening tool for military personnel and first-responders who may be at risk of developing Post-Traumatic Stress Disorder (PTSD).

“We’re trying to see if there are any predisposed biological markers in the voice data and other observational data that we’ll collect to detect if someone may be at risk for it,” he explains.

Dr. Lam, whose keynote address is titled Cognitive Dysfunction in Depression: Focus on Work Functioning, is Associate Head for Research and International Affairs in UBC’s Department of Psychiatry, and Director of the Mood Disorders Centre Research, Education, Awareness and Care Hub (MD-Creach) at the Djavad Mowafaghian Centre for Brain Health in Vancouver.

“My talk will mainly be about personalized medicine focusing on cognition as an...
Dr. Larry Pawluk has headed the Sleep Medicine Program in the Department of Psychiatry for over 25 years, and was instrumental in launching the Behavioural Sleep Medicine Clinic within the same program about two years ago.

As many as a hundred patients are seen by the program every week, seeking relief from Insomnia, Obstructive Sleep Apnea, Circadian Rhythm Disorders, Restless Legs Syndrome, Narcolepsy and various other common or unusual sleep disorders.

The steady parade of drowsy, heavy-eyed patients are referred by family Physicians, Psychiatrists, Neurologists, Pulmonary Specialists and even Cardiologists.

“Fortunately, most of these disorders are diagnosable and treatable, which is the most satisfying part of doing this work,” says Dr. Pawluk, whose team in the Behavioural Sleep Medicine Clinic includes Psychologists Dr. Laura Le Clair and Julie Burbidge – both Clinical Lecturers in the Department of Psychiatry – and Paul McCann, who has been a Sleep Nurse Clinician for almost 20 years.

“U of A’s Sleep Medicine Program is a Dream Come True for Dr. Larry Pawluk

Jeff Sawalha, Jessica Luki & Daniela Gomez

When we talk about personalized medicine we’re recognizing that the same treatment may not work for everyone, or work for all the depressive symptoms they have, and that’s why we have to look at specific symptoms like cognition.”

Since research shows there are differences in the brain structure of individuals who struggle with both depression and cog-

“You’re recognizing now that cognitive symptoms and deficits are separate from, and in some ways independent from, the other symptoms of depression, and should be managed differently than other symptoms,” he says.

Since individuals who suffer from depression often encounter difficulties with concentration, memory and executive functioning – or the ability to organize, multi-task and make decisions – this can have a major impact on their ability to function on a day-to-day basis, he notes.

“We used to think that the treatments typically used for depression, including antidepressant medications or psychotherapy, helped to improve all the symptoms of depression, including cognitive dysfunction. But now we’re recognizing that doesn’t always happen,” he explains.

“In fact, even when other symptoms of depression improve, people may still be left with cognitive problems, and that might be one reason why they don’t recover their functioning even if they’re feeling better.

“Fortunately, most of these disorders are diagnosable and treatable, which is the most satisfying part of doing this work,” says Dr. Pawluk, whose team in the Behavioural Sleep Medicine Clinic includes Psychologists Dr. Laura Le Clair and Julie Burbidge – both Clinical Lecturers in the Department of Psychiatry – and Paul McCann, who has been a Sleep Nurse Clinician for almost 20 years.

“Precision Medicine or Machine Learning in Psychiatry have been on the table for quite a few years but research in those fields has become more prominent,” says Gomez.

“We also have amazing Computing Science and Machine Learning programs here at the U of A. In addition, Dr. Lam has a lot of connections here at the U of A so we figured he’d be a perfect keynote speaker for Research Day this year.”

Jeff Sawalha, Jessica Luki & Daniela Gomez
There are other Sleep Medicine Programs in Canada, but typically they’re focused on either Sleep Apnea or Insomnia. There aren’t many that look at the all-encompassing aspects of sleep. That makes us somewhat unique.”

After earning his Medical Degree from the University of Alberta in 1987 he went on to complete his Residency in Family Medicine. “While I was doing that, I thought I would take an elective in Sleep Medicine. The first sleep lab in the world was started in 1973 at Stanford University, so I went to Stanford and I found that I just loved the interplay between biology and psychology in this field,” he says.

“Parts of it are very biological – such as dealing with people with sleep-disordered breathing – and parts of it are psychological in nature, like when you’re treating Insomnia. So I pursued a Psychiatry Residency and Dr. Bill Dewhurst, who was the Chair at the beginning of my Residency, said if I wanted to pursue a Sleep Fellowship after my training was finished, the Department would support it. They did, and that’s how this all came to pass.”

Dr. Pawluk completed his Clinical Fellowship in Sleep Medicine under the supervision of Drs. Mark Mahowald, Carlos Schenck and their colleagues at the multidisciplinary Minnesota Regional Sleep Disorders Center. In 1994, he became a Diplomate of the American Board of Sleep Medicine and a Fellow of the American Academy of Sleep Medicine.

“I still really enjoy working in this field all these years later,” says Dr. Pawluk, who took a rare break from treating patients to grant an interview in his office at University of Alberta Hospital.

“We’re really happy that we’ve been able to set up the Behavioural Sleep Medicine Clinic here, and we’re hoping this will fast-track Insomnia referrals from family Physicians and others. We’re also hoping to attract other people to this field. I’ve been doing this largely on my own for almost 25 years, so it would be great to have other sleep experts join us who have a background in Psychiatry or Neurology, so we can continue to build our program.”

Insomnia is the most common sleep disorder Dr. Pawluk and his colleagues treat. But other sleep disorders are also common. They include Narcolepsy – a neurological disorder that causes excessive daytime sleepiness and periodic, uncontrollable episodes of falling asleep in the daytime – as well as a disorder known as CNS (Central Nervous System) Hypersomnolence. The latter causes severe daytime sleepiness, despite normal sleep patterns at night.

“We also see a lot of Parasomnias which involve unusual behaviours during sleep, including things like night terrors, sleepwalking, sleep-related seizures, and even things like head banging, body rocking, grinding your teeth, or acting out your dreams at night,” he explains.

“Sleepwalking is fairly common in children, and a child might sleepwalk a handful of times before things settle down. But I also see (adult) patients who might do this a couple times a night. Sometimes it can be quite complex. They may try to leave the house, or potentially be violent towards their bed partner. People have even been known to drive in their sleep. That may sound impossible, but when you’re sleepwalking your brain is both awake and asleep simultaneously, enabling you to do complex behaviours even if you don’t have full recognition of what you are doing.”

Once a patient is referred to Dr. Pawluk’s clinic, the diagnostic process is detailed and complex. Sleep disorders can arise from multiple causes – biological, psychological, neurological, environmental – and co-morbid conditions are common.

“If someone with, let’s say, Insomnia comes to us, they first undergo a comprehensive sleep evaluation. So I’ll spend at least an hour or more interviewing the patient to obtain a description of their problems, and what they perceive to be the daytime consequences of not sleeping. I also ask what they’ve tried, what’s worked, what hasn’t, or if they’ve been prescribed medications. Then we run through a list of other possible co-existing sleep disorders that may be impacting their Insomnia,” he explains.

Once that information is compiled, Dr. Pawluk asks an extensive series of questions about the individual’s sleep habits; their bedroom environment; whether they use a smartphone or tablet computer in bed; whether any household pets share the bedroom; if their bed partner snores; whether they consume alcohol, nicotine or other...
substances; whether they use any prescription medications; and whether they’ve experienced any psychiatric problems.

“The list of potential factors is lengthy, so we really need to spend the time to review all the possible contributing factors to their Insomnia. It’s usually not just one thing. For a lot of people, they have what is known as Conditioned Insomnia. It’s the idea that ‘When my head hits the pillow my brain turns on and the more I try to sleep the worse it gets.’ That is a key component in almost all cases.”

Unless the patient also has a major medical condition, or an untreated psychiatric issue such as psychosis or depression, the first line of treatment is Cognitive Behavioural Therapy for Insomnia (CBTI).

“CBTI is offered in individual or group formats, and involves a series of non-medication strategies designed to break the pattern of not sleeping. It includes things like sleep consolidation – where patients are instructed to temporarily cut down the number of hours in bed to maximize their actual sleeping time in bed – and stimulus control, where the person is instructed to get out of bed, do something relaxing, and return to bed when they feel sleepier,” he explains.

The Sleep Medicine Program also includes a sleep lab, where patients are observed while sleeping overnight – specifically, the Alberta Health Services (AHS) sleep lab at Edmonton General Hospital.

Other sleep disorders, such as Restless Legs Syndrome, may be more challenging to treat.

“Iron is a factor that’s responsible for the production of Dopamine, and some people with Restless Legs Syndrome tend to have low iron stores. So one of the first things we do is check the person’s iron levels to determine whether to introduce iron supplements. If that doesn’t work we look at other possible factors,” he says.

“Sometimes Restless Legs is induced by medications. It can be made worse by certain medical problems like Renal Failure, and sometimes occurs in people with Peripheral Neuropathy or people with Varicose Veins. Sometimes, treating those underlying medical factors is really the key.”

So how does Dr. Pawluk see the Sleep Medicine Program evolving and growing from here?

“It would be great to train other sleep experts who might join us to help build our program. We’d also like to develop more of a research component to the program. That’s been lacking over the years. And then ultimately, we’d like to see if we can develop a Fellowship here that would include my sleep Physician colleagues in Pulmonary Medicine, so we’d have a comprehensive Fellowship where people could be exposed to all aspects of sleep medicine,” he says.

“If we could achieve that it would be unique in many ways in Canada. There are not too many places where you have this kind of collegiality among Respirologists, Psychiatrists and Neurologists, such that you could set up a joint program together. But we have that here so I think it’s just a question of time and manpower before we are able to set something like that up.”

Research News:

Dr. Andrew Haag to Present Findings on Mental Health Courts at 5th Biennial Alberta Criminal Justice Symposium

Edmonton Mental Health Court (EMHC) has been operating for a little more than a year now. The court – the first of its kind in Alberta – offers a therapeutic, collaborative, healing-based alternative to the traditional punitive judicial model in cases where an accused person’s mental health issues are deemed to have played a role in the charges against them.

Four Provincial Court Judges – including Assistant Chief Judge Larry Anderson, who played a key role in launching the special court – preside over EMHC. They’re assisted by Forensic Psychiatrist Dr. Peter Rodd, Lead Psychiatric for EMHC, as well as a Social Worker and Legal Aid Navigator.

Although EMHC is unique in Alberta, there are 47 mental health courts across Canada, and many more in the U.S., where the first such court was established in the late 1990s.

Yet, until now, there have been few attempts to assess the effectiveness or outcomes of these courts in any comprehensive way.

Enter Dr. Andrew Haag, an Assistant Clinical Professor in the Department of Psychiatry, a Sessional Instructor in the Department of Psychology at the University of Alberta, and the Director of Forensic Research for AHS’s Northern Alberta Forensic Psychiatry Service at Alberta Hospital Edmonton. The U of A and AHS have been key partners in the Justice-led initiative to research the EMHC.

On May 8th, at the 5th Biennial Alberta Criminal Justice Symposium at Grant MacEwan University, Dr. Haag will discuss the findings of an extensive review of the academic literature on mental health courts across North America.

“It’s surprising how many mental health courts we now have (in Canada), but we’re really the first persons that I know of who have systematically tried to examine the impact of these alternative or diversion courts,” says Dr. Haag.

His presentation to the symposium is titled: A Review of Mental Health Courts in North America: Where Are We At?

“When Edmonton Mental Health Court was established last year, funding was also provided by the Alberta government to research the workings and outcomes of the court. As a first step since then, we’ve conducted a pretty thorough review of the litera-
Research News
Continued from page 5

ture on these courts in general, and we’ll soon publish our findings in a journal,” he says.

Tyler Dunford, a PhD student in the Department of Sociology at the University of Alberta, assisted Dr. Haag in his research. Dr. Andrew Greenshaw, Professor and Associate Chair in the Department of Psychiatry at the U of A, also consulted on the project.

“We’re almost ready to start interviewing people on the front lines of the mental health courts. By that I mean persons who are using the mental health court or are accused in mental health court, and we’ll compare that to the treatment they’d get in typical docket court,” says Dr. Haag.

“But when I’m talking at the Alberta Criminal Justice Symposium, I’ll be discussing our review of mental health courts across Canada, and comparing that to mental health courts in the U.S.”

The U.S. initiated the concept of mental health court, with the first such court established in Florida in the late 1990s. Canada’s first mental health court was launched in Toronto shortly thereafter.

Today, mental health courts exist in many large – and some small – communities across Canada. Some major centres, such as Calgary, still don’t have a mental health court, however.

“We’ll look at the crimes or events that brought accused persons to the court in the first place. But mental health court should also be a place where your mental health needs are considered, with the goal of reducing recidivism and improving mental health outcomes – or to put it in more colloquial language, to stop the revolving door,” says Dr. Haag.

On that score, his assessment thus far is a positive one.

“Generally speaking, our research shows that if people make it through mental health court successfully, and make use of the services available to them, they will experience reduced recidivism. That’s one of our general findings. And if someone doesn’t make it through mental health court successfully, they typically don’t do as well,” he says.

So how would he explain that?

“I would attribute that to the court itself, to the court meaningfully addressing the person’s needs – in this case their mental health needs – but also their needs in a more global sense. The court wouldn’t just look at the individual’s mental health needs, they’d also look at related issues like substance abuse or homelessness. This kind of hands-on approach is common in mental health courts,” he explains.

“We’re hoping that as a result of this research, we can present a clearer picture of how mental health courts can be most beneficial, within the context of the overall criminal justice system. That’s our goal – to assist as many people as possible to enjoy better lives. Ultimately that’s in everybody’s best interests.”

The word ‘crisis’ is often overused in a world where hyperbolic news headlines scream at us 24/7. But it’s hard to overstate the magnitude of the fentanyl crisis.

Hundreds of Albertans die from fentanyl overdoses every year. In 2018, the province’s fentanyl death count averaged almost two a day.

Alberta’s Opioid Dependency Program (ODP), operated by Alberta Health Services (AHS), gives users a fighting chance to beat their addictions to opioids like fentanyl, heroin, oxycodone and Percocet.

By providing methadone and suboxone (both synthetic opioids) as well as Kadian (morphine) maintenance treatments – a process formally known as Opioid Agonist Therapy (OAT) – the ODP’s nurses, psychiatrists, social workers and others do their best to keep some 700 opioid users who live in the Edmonton Zone alone alive.

“People can come here on a short-term or a long-term basis, but our recommendation is to come for at least six months,” says Ali Thompson, a Registered Nurse at the ODP’s main downtown Clinic, near Edmonton City Hall.

“While these medications help to keep them from being sick or in withdrawal, we can also work on their psychosocial, physical or psychiatric issues as well. It’s very rewarding when you see people go from rock bottom to progressing in treatment to getting some quality of life back.”

Unfortunately, such treatments don’t work for everyone. For the most severe opioid addicts, an even more aggressive and intense approach is needed.

That’s why Alberta’s second Injectable Opioid Agonist Treatment (iOAT) Clinic will be opening its doors at AHS’s Forensic Assessment & Community Services (FACS) office on 106 Street in May. The first opened in Calgary earlier this year.

Continued...
Before now, Edmonton’s iOAT Clinic operated on a temporary, small-scale basis at the ODP’s downtown site.

“If all these other mainstay treatments have failed then the Injectable Opioid Agonist Treatment is the alternative,” says Psychiatrist Dr. Avininder (Avi) Aulakh, Clinical Lead for AHS’s Opioid Dependency Program in Edmonton, and AHS Edmonton Zone Clinical Site Chief, Addiction Medicine.

“The iOAT Clinic is targeting individuals who have been using opioids intravenously for years, so they typically have multiple other medical co-morbidities like HIV or Hepatitis C. These are very high-risk individuals for whom the mainstay treatments have not been successful,” says Dr. Aulakh, who is also a Clinical Lecturer in the Department of Psychiatry at the University of Alberta.

“So these individuals will come to the iOAT Clinic three times a day, where they’re given high doses of hydromorphone (Dilaudid). They inject themselves, and the nurses are there to supervise so there are no adverse events or overdoses,” he explains.

“After the third dose each day they are also given a dose of Kadian or methadone, so that dose lasts overnight, and they still have some opiate in their system until the next day.”

The goal is to keep severely addicted people alive and off the street, so they’re not constantly looking for illicit drugs to feed their habit, and are also relieved of the unending pressure to find cash – legally or illegally – to pay for those drugs.

In total, somewhere between 50 and 100 users are expected to seek treatment at Edmonton’s new iOAT Clinic once it’s fully up and running.

“It a fairly small number but we anticipate that the numbers will go up once we have fully transitioned to the new space at FACS. At the ODP Clinic downtown we just haven’t had the capacity to treat more than maybe 10 people because of space and staffing limitations,” says Dr. Aulakh, one of several psychiatrists who will staff both the iOAT Clinic and the long-established ODP Clinic.

Others include Dr. Krishna Balachanddra – an Assistant Clinical Professor in the Department of Psychiatry – as well as Dr. Neil Parker, Dr. Lovneet Hayer, Dr. Roshan Hegde, and Dr. Mohit Singh, a Clinical Lecturer in the Department of Psychiatry.

The Providence Crosstown Clinic in Vancouver’s Downtown Eastside, where many heavy drug users reside, has offered Injectable Opioid Agonist therapy for about five years now.

Studies have found that patients in the program have cut back their use of illicit street drugs significantly.

“Canada’s western provinces have been affected the most by the fentanyl crisis, and B.C. has historically been home to about half of the heroin users in Canada, so they are leaders in some of these treatments,” says Dr. Aulakh.

About 150 chronic drug users were receiving iOAT Treatments at the Vancouver clinic as of a year ago, according to one news report, with a retention rate of more than 80 per cent. About one in five patients had graduated to less-intensive treatments such as methadone.

“Alberta is just the second province after B.C. to offer Injectable Opioid Agonist Treatments. This is a government-funded program and the Opioid Emergency Response Commission has set aside $5 million a year for the next three years to support it,” he says.

The iOAT Clinic in Edmonton is likely to treat more males than females, and the average age is expected to be fairly young.

“Based on the experience of the OAT Clinic in Edmon-
ton, I would say the male-to-female ratio is likely going to be about 60:40. This might change over time but we’re dealing with more males right now in this area. And since the iOAT Clinic is only for severe users, we anticipate the users will be mainly in their 30s or above,” he notes.

“This is not the program for people who have just started to use or have never tried any other treatment. This is only for severe or chronic users for whom nothing else has worked.”

Since the iOAT Clinic will treat the most severely addicted opioid users, its metrics for measuring success will differ from those used by the ODP Clinic.

“At the ODP Clinic, I’ve seen people who have been treated successfully going from situations where they are literally homeless and living on the streets to going back to school, completing their education, having productive jobs and having a family. In cases like that we might see a turnaround within a few months,” he says.

“But for the injectable patients, they are severe users and they’ve been affected by their use for years. So how we measure our success will be different. Success will be that they are not using anything else, they are not visiting the hospital so frequently, they are not involved with the law, or they are getting the treatment they need for infectious diseases.”

Tara O’Mara, a Family Nurse Practitioner who has worked closely with Dr. Aulakh at the iOAT Clinic, shares his high hopes for its success.

“We have one patient who has been travelling (to the existing downtown ODP Clinic) 45 mins each way, three times a day, just to get treatment. That’s a big commitment. But on the flip side, heavy users are probably spending lot of time obtaining substances or committing crimes to get those substances. So the new iOAT Clinic takes the need for all that away. If you were spending say, $400 a day on illicit substances just to feel well, imagine what you’d have to do to fund that.”

**AHS Spotlight**

Continued from page 7

**Don’t Forget to Save the Date: Oct. 9-10, 2019**

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**UNIVERSITY OF ALBERTA**

**FACULTY OF MEDICINE & DENTISTRY**

18th Annual

Department of Psychiatry

Research Day

“Cognitive Dysfunction in Depression”

Keynote Speaker

Dr. Raymond Lam

University of British Columbia

SAVE THE DATE

Wednesday, May 15, 2019

Bernard Snell Hall