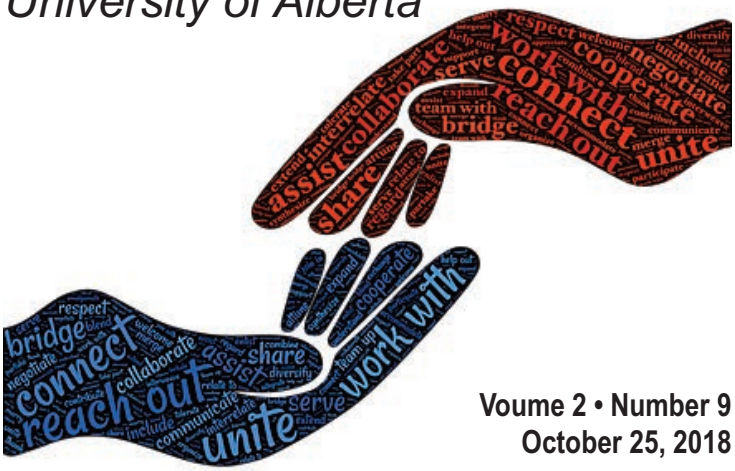
CONNECTIONS

A monthly newsletter published by the Department of Psychiatry, University of Alberta



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UNIVERSITY OF ALBERTA

Message from the Leadership Team



(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.

Dear colleagues and friends, As you know, developing innovative services in the field of mental health and addictions takes courage, vision, commitment and teamwork.

The process of working through new ideas and services isn't always easy, predictable or smooth, and it can sometimes lead to shifting professional roles.

The recent restructuring of leadership roles within Alberta Health Services, Edmonton Zone reflects this.

That said, we are confident these changes will lead to an even more cohesive relationship between the Department of Psychiatry, AHS and our many partner organizations throughout the community, as we pursue our shared vision.

As many of you are now aware, Dr. Daniel Li was recently appointed Interim Zone Clinical Department Head – Addiction and Mental Health.

A widely respected consultant psychiatrist at Alberta Hospital Edmonton (AHE) and Clinical Associate Professor in the Department of Psychiatry, he previously served as President of the Medical Staff Association, Acting Medical Director and Acting Clinical Director at AHE. He also chaired the Medical Advisory and Credentialing Committees and was the Lead Physician of the Governance Committee at AHE. In addition, he currently Co-Chairs a committee overseeing plans for a Zone-wide Day Hospital at AHE.

In his new role with AHS, Dr. Daniel Li will oversee the AHS AMS department's strategic direction, operational planning, evaluation and quality management, while collaborating and engaging closely with medical staff across the Zone.

In tandem with his operational dyad partner, Mark Snaterse, he will ensure that Edmonton continues to lead the way in offering high-quality Addiction and Mental Health services.

Simultaneously, Dr. Pierre Chue, previously the Zone's Clinical Department Head for Addiction and Mental Health, has accepted a new role, effective Oct. 5th, as Senior Medical Advisor, Mental Health Strategic Initiatives (SMA) in the AMH portfolio.

Dr. Chue will play a key role in supporting strategic initiatives of high importance to the AMH portfolio. The SMA will facilitate the goals of the AMH Portfolio by supporting the development of effective processes to encourage best practices and improve clinical outcomes/quality.

Continued...

Message from Leadership Team

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Dr. Chue's expertise, his extensive academic credentials, and his broad, system-wide experience ensures that he will continue to play a vital role in the development of AMH services in his new position. We thank him for his dedication and leadership as Zone Clinical Department Head.

These are exciting changes that herald a new era for the Zone – a new era that will soon feature the province's first Academic Medicine and Health Services Program (AMHSP) for Alberta's practicing psychiatrists.

After more than a year of negotiations, we are very pleased to announce that the new AMHSP is now expected to be finalized by the end of December.

Peter MacLeod, Director of the Alternative Compensation Delivery Unit at Alberta Health's Provider Compensation and Strategic Partnerships Branch, recently confirmed the news in a letter to the Chair of the Department of Psychiatry.

Important additional information regarding the planned rollout of the AMHSP is contained elsewhere in this edition of the newsletter.

As excited as we are about these developments, we realize change can be hard at times. In the midst of driving forward with our shared vision, there can sometimes be unintended consequences, including torn relationships and broken trust. We must strive to mitigate this, and work hard to retain the spirit of collegiality we have all built over the years.

In this regard, the AHS Our People strategy is a high calling to engagement aimed at building healthy teams. It is about leadership and working in healthy collaboration with the grassroots while practicing values of compassion, accountability, respect, excellence, and safety.

We resolve to do our very best to continue to grow a culture of listening, engagement, and collaboration that will leverage the strengths of each site in the Zone, while adhering to our core values.

There is also a need to ensure effective practical governance so that decisions are made in the right way – always respecting and valuing the need for a healthy exchange of perspectives. We endeavor to learn from our past successes – and our mistakes – so we can all move forward together.

This work may seem painfully slow and measured at times, but it is worth the effort if it leads to reconciliation and healing where needed. It will also become the future foundation upon which our gifted multi-site teams – and the graduating Residents to come – will transform the mental health system in Edmonton into a more tightly coordinated force for public good.

With our compass firmly in hand, we intend to set in motion a process of renewing partnerships among AHS Clinical-Administration, and all Academic-Teaching teams across the Zone. Our shared mission will be to build resilient teams that can creatively develop goals to meet our Zone-wide strategic directions for patients and their families.

Our goal is also to ensure that the University of Alberta's Department of Psychiatry be more broadly recognized as one of the best in Canada, by involving all Zone sites so that research and teaching flows naturally from our clinical activities, in partnership with our Department Chair and his teams.

Indeed, the individuals and teams working within Addictions and Mental Health – Edmonton Zone are uniquely gifted with diverse competencies in patient care, teaching, and research. We also have a unique blend of impressive Canadian and international talent in our workforce that is unmatched in this country.

We want to express our deepest appreciation to all of you who have demonstrated excellence in patient care, a passion for teaching, and a devotion to your colleagues. There are many exemplary stories to illustrate this, and we will continue to showcase them in this newsletter, in town hall meetings and other forums.

There is much at stake, as we all know, and we ask for both your patience and your ongoing commitment. The status quo is not an option. As we develop our strategies for further multi-level engagement, we invite you to contact us if you have any ideas you'd like to share with regard to services, academic or teaching innovations.

As always, we look forward to your valuable input. **c**

Update on AMHSP Launch Plans:

Alberta Health Confirms Plans to Launch new AMHSP for Province's Psychiatrists by end of 2018

After more than a year of negotiations, a new Academic Medicine and Health Services Program (AMHSP) for Alberta's practicing psychiatrists is now expected to be finalized by the end of December.

Peter MacLeod, Director of the Alternative Compensation Delivery Unit at Alberta Health's Provider Compensation and Strategic Partnerships Branch, confirmed the news in a letter to Dr. Xin-Min Li, Chair of the Department of Psychiatry.

"Based on our most recent assessment of the status of the new arrangements, the goal is to have final approvals and required program funding available for the Psychiatry (AMHSP) arrangement by the end of the calendar year," he wrote.

The provincial AMHSP Strategy Committee is currently formulating a remuneration framework and methodology before finalizing compensation levels for psychiatrists who wish to apply for the program.

"As part of that exercise they are referencing AMHSP remuneration levels in other provinces. Although details of the Alberta compensation plan are not yet finalized, the target date is to release this information before Christmas," says Dr. Li.

"Whatever the final numbers are, remuneration levels will be consistent for Edmonton and Calgary. It is important that we remain competitive for recruitment purposes, for the sustainability of the AMHSP program, and to ensure that those who par-

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Launch of new AMHSP

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ticipate enjoy their careers and don't feel financially penalized."

Pursuant to the terms of the 2016 Amending Agreement – which reset the relationship between the province's 10,000 physicians and Alberta's NDP government, as part of a plan to stabilize rising health care costs – negotiators began discussing how to design AMHSPs for psychiatry professionals last year.

In addition to the University of Alberta's Department of Psychiatry, the multi-party AMHSP talks involved representatives from Alberta Health, Alberta Health Services (AHS), the Alberta Medical Association (AMA) and the Department of Psychiatry at the University of Calgary.

The objective with AMHSPs – traditionally referred to as Academic Alternative Relationship Plans (AARPs) – is to ensure that physicians who teach, do research, or assume leadership and administrative roles at Alberta's faculties of medicine are not financially penalized for taking on such activities, compared to traditional fee-for-service work.

"Now that the letter (from Alberta Health) has given us the green light to go ahead with the AMHSP by December, we're hoping the first AMHSP position will be filled sometime early in the new year," says Dr. Alberto Choy, Associate Chair, Academic Affairs in the Department of Psychiatry, and one of the participants in the negotiations.

"We've already notified all of our clinical academic colleagues and various people at the University of Alberta. The next steps include following what the provincial AMHSP Operations Committee – which oversees this, through Alberta Health and AHS – lays out for us in order to make this happen."

The process includes an AMHSP Arrangement Management Committee, centered in the Department of Psychiatry. Committee members will include Dr. Li and Mark Snaterse, AHS's Executive Director – Addiction and Mental Health, Edmonton Zone, along with other senior Faculty members from the Department.

"This all has to be coordinated with Calgary because we need to have parallel systems," says Dr. Choy. "So there is a committee for the northern part of the province and a committee for the south, and the application process for an AMHSP will include both AHS and the university. The committee will work with physicians to develop the contracts."

Dr. Alberto Choy

The contracts – or Individual Service Agreements (ISAs) – will be reviewed annually, and outline in detail the tasks and duties for which an individual psychiatrist is remunerated.

"The ISAs are truly that – they're designed on an individual basis. In the old system you could teach and also perform leadership or administration roles, but that was time you weren't spending with patients and earning income from that. Now, rather than being penalized, we can build those activities into an ISA that works for the clinician and for the university," says Dr. Choy.

To that end, negotiators created five distinct physician profiles that stipulate the average amount of time individual physicians are expected to spend on clinical work, research, education, and administration and leadership functions. The profile types fall under the following categories: Clinician Teacher, Clinician Educator, Clinician Investigator, Clinician Primary Research, and Clinician Leader.

"Generally speaking every AMHSP position slots into one of those five categories or physician profiles, and in broad strokes, each one of them stipulates what a particular job within the AMHSP structure is going to look like from year to year," says Dr. Choy.

"Now that we've got a target date in mind to roll this out, a key priority over the next little while is to strategize on how best to get the message out about this, so we can start offering these AMHSP positions for physicians. Then those who are interested can start thinking in more detail about what their AMHSP job profile might look like."

Dr. Choy says it's too early to predict with any accuracy how much demand there will be among psychiatrists to apply for an AMHSP position.

"Since we began sharing the letter (from Alberta Health) I've already had people contact me to say they're very interested in something like this. So clearly there are people who want to be able to work within the AMHSP and want to see their careers moving forward with this strong connection both with the university and with AHS. A number of individuals, some of them educators and also researchers, have expressed interest," he says.

"But I don't think we'll see a stampede. I think the AMHSP concept appeals to a specific set of individuals. It's not the same as billing on a fee-for-service basis. This is something that may appeal to some based on their career aspirations or perhaps lifestyle issues. We'll soon see how it unfolds." **C**

AHS News: LOCUS to Debut Soon

With new Access 24/7 Centre Set to Open in January, AHS Gears up to Launch LOCUS Clinical Decision Support Tool

Imagine a clinical tool that gives mental health professionals the ability to offer every patient customized treatment options tailored to meet their own specific needs, abilities and circumstances.

Now imagine all of Alberta Health Services' mental health and addictions personnel in the Edmonton Zone having access to the same clinical decision support tool whenever they interact with one of their 45,000 clients, or recommend any of the Zone's 160 related treatment programs.

Sound too good to be true? Think again. In fact, it will soon be a reality. The tool is called LOCUS – or Level of Care Utilization System – and plans are well underway for a full rollout of LOCUS across the Edmonton Zone over the next six months.

More immediately, LOCUS is expected to be implemented at AHS's Addiction and Mental Health Access 24/7 – a new central information, assessment and navigational hub specifically designed to serve the region's addictions and mental health patients – when it opens its doors in January.

Access 24/7 will be located at Anderson Hall, just east of the Royal Alexandra Hospital's Emergency Department on 102 Street.

"LOCUS really piggybacks on our Access 24/7 initiative. The whole point of Access 24/7 is to direct our clients into programs offering the right level of care at the right time, and LOCUS is a big part of that," explains Mark Snaterse, AHS's Executive Director – Addiction and Mental Health, Edmonton Zone.

Mark Snaterse

"If you look at all the AHS programs across the Edmonton Zone as well as programs delivered by our partner organizations you'll see that different programs offer varying intensities of treatment, ranging from daily psychotherapy groups to programs where clients may attend every week or two. It's all part of our philosophy of 'stepped care,' so people can access whatever level of intensity they need," he says.

Created by the American Association of Community Psychiatrists in 1996, LOCUS has been updated multiple times, with the latest version released in 2016.

Several healthcare organizations across Canada and the U.S. already use it, including Toronto's Centre for Addiction and Mental Health (CAMH), the Saskatchewan Health Authority and Vancouver Coastal Health. Several of these organizations report positive experiences with LOCUS.

The Ontario Shores Centre for Mental Health Sciences, in Whitby, Ont., reported that patient readmission rates in the 30-day period after discharge declined after it began using LOCUS. It also reported a sharp increase in the number of patients admitted to hospital from its waiting list.

"In Ontario they've also found that LOCUS has helped to increase the flow of patients out of hospital in a more timely manner," says Kimberly Poong, AHS Program Manager, Performance, Edmonton Zone. "And in Saskatchewan they've been able to compare data from region to region in terms of the needs of the local population base and reallocate services in the community more effectively, based on those findings."

Here's how LOCUS works. First, it evaluates each patient or client based on six dimensions. It then applies a rating scale – ranging from a low of one (minimal problem) to a high of five (extreme problem) – to score each individual on each dimension. The six dimensions include:

- **Risk of Harm:** A measure of suicide and homicide risk as well as impairment of perceptions, judgement or impulse control.
- **Functional Status:** A measure of the individual's ability to fulfill obligations at work, home and school; their ability to interact with others; and their eating, sleeping and hygiene habits.
- **Co-Morbidities:** An assessment of all medical, substance use or mental health disorders.
- **Recovery Environment:** The client's level of ongoing support / level of stress.
- **Treatment and Recovery History:** A review of the patient's past exposure to and use of treatment, and history of maintaining recovery.
- **Engagement and Recovery Status:** The patient's under standing of their illness and desire to engage in treatment and recovery.

The score assigned to each of these six dimensions is based on a combination of factors, including patient interviews, clinical judgement, records, third-party reports, history and observation.

"Following that process, there's a very complex algorithm that takes all of the individual dimension scores and outputs what we call

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Access 24/7 Centre

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a level of care recommendation," says Poong. "So it's quite complex."

"If a patient does really well after a brief series of treatments using cognitive behavioural therapy, we don't want to put them in some kind of intensive program. Nor would we want someone going into an 18-week, five-day-a-week intensive psychotherapy program if they would do well with a single session, solution-focused therapy," Snaterse explains.

"For group therapy alone we've identified about 168 different groups that are ongoing across all of our programs in the Zone. In addition there is individual counselling, assertive community treatment and outreach and a broad range of other services that reflect our 'stepped care' model."

LOCUS will allow for all of these programs to be divided by level of service intensity offered. To better match patient needs with services offered, programs will be organized using the following six categories:

Kimberly Poong

LEVEL ONE – These programs offer treatment to clients now living independently or with minimal support in the community who have achieved significant recovery from past episodes of illness.

LEVEL TWO – These programs are geared to treatment for non-complex clients with mild to moderate symptoms who typically have one presenting issue and fairly supportive recovery environments.

LEVEL THREE – For clients who need intensive support and treatment several times per week, but who are living independently or with minimal support in the community.

LEVEL FOUR - For clients capable of living in the community – either in supportive or independent settings – but whose treatment requires intensive management, possibly involving partial hospital programs.

LEVEL FIVE – Care at this level is typically provided in non-hospital, free-standing residential facilities based in the community.

LEVEL SIX – This is the most intensive level of care and is typically provided on an inpatient basis in a hospital setting.

"Our vision in introducing LOCUS to the Zone is to give people more treatment options to choose from. So those options might be delivered on different days of the week, at different times of day, and in different parts of the city, depending on what best meets the needs of each client," explains Snaterse.

At present, Snaterse and his colleagues at AHS are running training workshops and seminars on LOCUS in order to prepare mental health and addictions staff for the upcoming rollout.

"We all need to be talking the same language about the level of intensity of treatment that a patient may need. And we all have to be on the same page regarding the actual intensity of programming that each one of our services offers. In other words, we all have to be using the same triaging tool," he explains.

"After that, the next challenge is to make sure that all of the programs in the community that are receiving these patients are also speaking the same language. It's important that we're using it at all the points of entry where people may be coming into our system, but our first priority is going to be those who are impacted by the new Access 24/7 Centre." **C**

Spotlight on Alberta's NCR Population

Individuals Found Not Criminally Responsible (NCR) by the Justice System Show Very Low Rates of Recidivism, New Study Shows

Recidivism rates among Alberta's NCR population – accused individuals found Not Criminally Responsible due to a Mental Disorder – are extremely low compared to the general criminal population.

That's one of the central findings of a study published in October in the Journal of Community Safety & Well Being by Dr. Andrew Haag, Assistant Clinical Professor in the Department of Psychiatry and Sessional Instructor in the Department of Psychology at the University of Alberta, and two student researchers.

The recidivism study, which followed a total of 528 cases, expands on the findings of a landmark longitudinal NCR study Dr. Haag published in the same journal in 2016 along with two student researchers.

The 2016 study tracked the trajectory of some 560 individuals in Alberta who were found NCR (or as it was previously known, insane) dating as far back as 1941, when the earliest recorded case in the province occurred.

The Alberta NCR Project, as it's known, is believed to be the most comprehensive long-term study of the NCR population ever conducted in Canada. The recidivism study builds on Dr. Haag's earlier work.

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Very Low Rates of Recidivism

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"This is a profoundly understudied group. There have only been a couple of really large-scale studies of the NCR population in Canada or even worldwide. So we undertook the monumental task of identifying and tracking every single person who was ever found insane or NCR in Alberta's history – not just a cohort, but the entire population – and I'm confident we've done that," says Dr. Haag.

The authors examined the records of everyone in Alberta who was found to be NCR since 1941, what their diagnoses were, how long they were classified as NCR, and relevant details of their family backgrounds and other sociodemographic data. A key focus of the study was to assess the risks posed by the NCR population to public safety.

"In Canada, public safety is a paramount concern for the provincial Review Boards that oversee individuals found to be NCR. (Despite this) there is limited research on recidivism rates for NCR populations to assist public policy and institutional practices," the authors state.

Dr. Haag's research assistants for the follow-up study included Kayla Richer, a Master of Science student in the Faculty of Rehabilitation Medicine at the University of Alberta, and Jeremy Cheng, a Clinical Psychology PhD Student at the University of Saskatchewan.

"In response to this gap (in the data), the authors examined the recidivism characteristics of the population of NCR individuals who have passed under the Review Board of Alberta. The maximum follow-up period was 35 years and included 528 cases between October 1941 and December 2015," they wrote.

For various reasons, a small number of cases were excluded from the recidivism study. Some individuals died prior to any supervised release, some had never had an unsupervised release, and some transferred out of province. In instances where individuals died or were deported after release, their cases were included until the applicable date, and then excluded.

"Results indicated that the overall general recidivism rate of NCR individuals was 19.7%" over 35 years, the researchers found. "To put this in context, the NCR recidivism rate of just 19.7% is an exceedingly low number. For the general criminal population, it's not unusual to see recidivism rates of 20% within just a few months' time," says Dr. Haag.

Dr. Andrew Haag

Of the total number of convictions for subsequent crimes, 4.6% related to a "major" violent conviction, 12.6% stemmed from a less serious violent offence, and just 0.75% – or four cases out of 528 – related to a conviction for a sexual offence, the authors found.

"What we can say, after looking at all of the NCR data, is that this is one part of the criminal justice system that is not broken. We will not release people when it is deemed unsafe for the community. We just won't."

The standard set out by the Criminal Code is that a person is to remain under the Alberta Review Board until such time that they are deemed to no longer pose a significant threat to the public. The evidence collected in this study suggests that the Alberta Review Board has taken this duty of public safety seriously, says Dr. Haag.

The presence of a mood or psychotic disorder resulted in a slightly lower likelihood for recidivism among the NCR population, whereas those with longer criminal histories were more likely to reoffend.

"Most recidivism studies follow people for up to five years, and that is generally considered to be pretty good data. We followed people for up to 35 years, so I'm pretty confident in our data," says Dr. Haag, who also serves as a Forensic Psychologist at Alberta Hospital Edmonton with Alberta Health Services.

Data was collected from CPIC (Canadian Police Information Centre) records and patient files. CPIC records were collected from the RCMP in December 2015 and coded for the date and type of conviction across four categories: sexual, major violent, violent, and general.

Sexual offenses involved any crime of a sexual nature, such as sexual assault, sexual harassment, sexual indecency. Major violent offenses included assault causing bodily harm, aggravated assault, assault with a weapon, homicide, and attempted homicide.

Violent offenses included sexual violence and robbery. General offenses included a conviction for any crime. Of the total of 528 cases, 84% were male and 16% were female, with an average age of 35.3 years when the NCR verdict was issued.

Dr. Haag and his research team also assessed the relative prevalence of particular

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Very Low Rates of Recidivism

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diagnoses among NCR patients found to have psychotic disorders, mood disorders, substance use disorders or antisocial personality disorders.

"Psychotic disorders or at least some disorder where psychosis was present, was found in about 75.6% of the cases. Mood disorders were present about 29% of the time, so those would be the two most common disorders we found. Some individuals had overlapping disorders, which is why the percentage figures don't add up to a hundred."

Dr. Haag stresses that the number of persons found NCR in Alberta in any given year is tiny – typically numbering between 10 and 20 cases annually. That compares with some 50,000 or more cases that are dealt with by the provincial justice system each year.

"The rate across Canada tends to be about seven to nine people who are found to be NCR out of every 10,000 individuals, so this is an exceedingly rare finding in the criminal justice system," he notes.

Roughly half of all individuals who are designated NCR by the courts had no prior exposure to the criminal justice system. About 7% were classified as "frequent users" of the justice system – defined as having had 10 or more sentencing dates before a judge previously.

"The other thing I found really striking with the NCR population was their level of educational achievement. The overwhelming majority – about 70% – have less than a grade 12 education. That points to a tremendous basic need in this population," he says.

"Why they didn't make it to grade 12 is usually for a whole host of reasons. It's not unusual for these individuals to have incredibly disjointed childhoods, fragmented families and some mental illness in the family. All of these things can be potential barriers to completing school." **C**

Profile: Forensic Psychiatry Subspecialty Residency Program

Forensic Psychiatry Subspecialty Program Offers Residents Wide Range of Learning Experiences

When Dr. Lenka Zedkova entered the Department of Psychiatry's Residency Program in 2005, she was still unsure about her long-term career plans.

After completing medical school at Charles University in Prague in the late 1990s and earning a PhD in the Department of Psychiatry Graduate Program in 2003, she knew only that she wanted to focus on clinical psychiatry with adult patients.

"I knew nothing about Forensic Psychiatry back then. I was part of a cohort that didn't even have to be exposed to the field of Forensic Psychiatry during Residency, so I really wasn't thinking about it," she recalls.

"Then in my fourth year of Residency I was assigned to do my rotation in rehabilitation psychiatry with forensic patients. I was a bit nervous because I really didn't know what I'd be dealing with, but it turned out to be a great experience. I loved learning about the legal system, the intellectual exercise associated with court-ordered assessments and so on."

That led Dr. Zedkova to pursue a Forensic Psychiatry Fellowship in 2010, a year after the Council of the Royal College of Physicians and Surgeons of Canada finally recognized Forensic Psychiatry as a Subspecialty of Psychiatry.

She became a Certified Forensic Psychiatrist in 2014 and since 2017 she has served as Program Director for the Department of Psychiatry's Forensic Psychiatry Subspecialty Residency Program, working mainly out of Alberta Hospital Edmonton (AHE).

"We're now one of seven accredited Forensic Psychiatry Subspecialty Residency Programs in Canada, and there are others applying as well. We were accredited in 2013 under the directorship of Dr Alberto Choy, who is now the Edmonton Zone Section Chief for Forensic Psychiatry."

The program offers Residents exposure to a broad range of training experiences in all areas of Forensic Psychiatry, including court-ordered assessments and report writing, continued treatment and rehabilitation of forensic patients during recovery and reintegration into the community, and civil assessments.

AHE, which has over 100 forensic psychiatry beds including maximum security designated forensic units at the Helen Hunley Pavillion, is the largest and most fully staffed forensic treatment facility in the province.

"There is a progression here, ranging from acute units to a medium security unit, where patients are typically more stable, have access to more programs and liberties, and if they're well, can walk on the grounds or in the city unsupervised. We also have two open rehabilitation units, which should theoretically be the last step before patients are released into the community."

Outpatient forensic services programs – which are provided at Alberta Health Services' Forensic Assessment and Community Services (FACS) office in downtown Edmonton – offer subspecialized assessment, ongoing treatment and outreach services.

The Forensic Psychiatry Subspecialty Program also offers Residents exposure to young patients through its Young Offender programs. These programs feature inpatient and outpatient programs that have been recognized for leadership in the rehabilitation of youthful offenders.

The Turning Point Program – designed around a 17-bed adolescent forensic unit at AHE – is a key element of this. It gives trainees exposure to young offenders who have been admitted for a variety of court-ordered assessments or treatment.

"We also offer outpatient young offender services through our Centre Point Program, which involves assessments and referrals for treatment from the courts, probation, parole officers and so on."

Continued...

Forensic Psychiatry Subspecialty Program

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The Edmonton Remand Centre and various provincial and federal correctional facilities in the area also provide Residents with exposure to court-ordered assessments and opportunities to participate in correctional clinics.

"This is a small program, in terms of numbers. The PGME (Postgraduate Medical Education Office) has so far funded up to two spots but we typically have one Resident in the program," says Dr. Zedkova.

"But we offer quite a variety of training experiences here at AHE. Residents start their curriculum on the Acute Assessment Unit, and first learn what we call the bread and butter of forensic psychiatry," she explains.

That includes conducting pre-trial assessments of a patient's fitness to stand trial, their criminal responsibility under the law, and report writing, a key competency for forensic psychiatrists.

"From there Residents continue on to one of the Forensic Rehabilitation Units where it's a bit of a different setting. These units are for individuals who are already found unfit or NCRMD (Not Criminally Responsible due to a Mental Disorder) by the courts, and are now under the jurisdiction of the Alberta Review Board," she says.

"They provide treatment and rehabilitation for these patients based on the recovery model. They also provide ongoing risk assessment and risk management, and are involved in reintegrating these patients into society, which is ultimately our goal here."

Dr. Lenka Zedkova

In addition to the four core rotations outlined above – which are formally referred to as Acute Assessment and Treatment, Forensic Rehabilitation, Forensic Assessment and Community Services (FACS), and the Turning Point Program for young offenders – Residents can also pursue various electives within the curriculum.

These include the Sexual Offenders Assessment and Treatment Program and the Spousal Violence Program, both of which are conducted at the FACS location on 106 Street.

Other electives include Forensic Research, the Centre Point Program, and Civil Forensics, which involves cases from insurance companies, child welfare, professional bodies, law enforcement, institutions, and/or corporations.

Throughout the PGY-6 year, Residents are trained to provide expert testimonies for the Alberta Review Board or the courts, including the newly established Mental Health Court. This is one of the fundamental skills of a forensic psychiatrist.

"The strength of this program is that we can really offer a wide variety of learning experiences. We also have a great group of about 10 educators at AHE and at FACS who are involved in the program. There is a real sense of collegiality and dedication to this field, and I think that provides for a great learning environment," says Dr. Zedkova.

"As for the qualities we look for in assessing candidates for the program, we want to see genuine interest – as demonstrated in the Resident's letter of intent, their reference letters and in the interview. Forensic psychiatry is all about teamwork, so to be flexible and collaborative is also really important, as well as being flexible and open minded toward the forensic population, which can be quite complex."

The capacity for self-reflection, an awareness of one's own strengths and weaknesses, a sense of humility and the willingness to learn from others are also key traits, she says.

"One would hope that at this stage of their careers, Residents would no longer have any rigid, preconceived ideas about the forensic population. When you speak to a patient, no matter how serious their offences are, typically the countertransference is not as strong as during the initial research of the case," she says.

"It's important to understand the complexity of people, their mental illness, life circumstances, and genes that can drive them to commit serious offences. The direct encounters with patients are typically not as intimidating or off-putting as one might initially assume."

In addition to the challenges of working with forensic patients, Dr. Zedkova says the field also offers enormous rewards when very ill patients respond well to treatment and go on to live their lives in the community.

"Clozapine is an antipsychotic drug that's used for treatment-resistant schizophrenia. I've seen what I would call miracles with that particular medication when nothing else really helped. I've seen people improve quite significantly, getting to the rehabilitation unit, then out into the community, and not coming back. So when something like that happens, it's very, very rewarding." **C**

In Focus: Cannabis Research

Study Finds Cannabis Use Has No Positive Effect on Psychosis But is Associated with Lower Pre-Morbid IQ Levels

An archival review of young patients referred to Alberta Hospital Edmonton's Neuropsychology unit shows that cannabis use had no positive impact on cognitive impairment in psychosis, but was associated with lower estimated IQ levels prior to the onset of a primary psychotic disorder.

Those were among the findings of a study by Dr. Scot Purdon, a Clinical Neuropsychologist at AHE, and Dr. Kim Goodard, a Clinical Neuropsychologist at Calgary South Hospital. They examined the records for over a hundred patients referred for assessment between December 2001 and March 2012.

Dr. Purdon, a Clinical Professor in the Department of Psychiatry and Director of the Bebensee Schizophrenia Research Unit, presented highlights of his findings on the Clinical Neuropsychological Effects of Cannabis at a research symposium Oct. 9th.

The sale of recreational cannabis was legalized in Canada by the federal government on Oct. 17th.

The Symposium on Cannabis, Endocannabinoids & Mental Health, sponsored by the Department of Psychiatry's Neurochemical Research Unit and the Neuroscience and Mental Health Institute, was held at the Lister Centre.

Dr. Scot Purdon

Dr. Purdon was one of eight experts in the field of cannabis research and policy from the University of Alberta, the University of Calgary and Alberta Health Services who presented to the symposium.

"The first question I was interested in was really motivated by a meta-analysis suggesting cognitive benefits of cannabis use on cognition in psychosis. The authors came up with a list of pros and cons – good things and bad things about cannabis – and remarkably, psychosis was on both lists, apparently exacerbating symptoms of psychosis but potentially improving cognition," Dr. Purdon told attendees.

"I've been working with Schizophrenia for almost 40 years now and I've not noticed cognitive benefits associated with cannabis use in this population. I'm not so sure that could be true. So I dug into the literature …. and the one thing that jumped out at me was that the studies that were cited did not explicitly separate out people with a substance-induced psychosis from people with a primary psychotic illness, like Schizophrenia."

Although consumption of cannabis produces a temporary "psychotic like" experience, it is fundamentally different from a neurodevelopmental pathology that causes psychosis, he noted.

"The hypothesis we had was, if we separate out a substance-induced psychosis group from a group with a primary psychotic illness, the primary psychotic illness group will perform worse than the substance-induced psychosis group – similar to the published results suggesting cannabis users with psychosis might perform better than non-users with psychosis," he told the symposium.

"The second (hypothesis) was, if we pull out the primary psychosis group, and look at those who use cannabis, they should do worse – not better – than people with a primary psychotic disorder who do not use cannabis – contrary to the published literature," he added.

The researchers found that both the substance-induced psychosis patients and those patients with a primary psychotic disorder showed cognitive impairments, but the impairment was more severe among those with a primary psychotic disorder. They also found that cannabis users with a primary psychotic disorder performed worse than non-cannabis users with a disorder, on measures of memory and verbal learning.

"If you have a psychotic disorder, a primary psychotic disorder and you use cannabis, your cognitive function will not be as good as if you do not use cannabis," he said.

"To sum up, I went looking for the beneficial effect of cannabis in psychosis. I did not find a beneficial effect of cannabis in psychosis. I did find a methodological artifact in the classification of patients with primary psychosis versus substance-induced psychosis that could explain the previous anomalous results," he said.

"It will be very important I think to future research in this area. If you have a psychotic disorder, a primary psychotic disorder and you use cannabis your cognitive function will not be as good as if you do not use cannabis. In fact, earlier use of cannabis seems to be associated with lower pre-morbid IQ." **C**