

Confidence and Accuracy in Short-Term Assessments of Risk: Implications for Training and Implementation

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*Province-wide solutions.
Better health.*

Introduction

Confidence & Accuracy

- Relationship varies widely across domains.
 - Overall, research suggests positive (weak to moderate) relationship (e.g., Sporer et al., 1995).
 - In clinical decision-making → minimally related (e.g., Goldberg, 1959; Nadler et al., 1994; Wedding, 1983).



Introduction (cont.)

Accuracy & Decision Making

- Much research on factors affecting accuracy of clinical decision making (e.g., Ægisdóttir, 2006).
 - Factors influencing accuracy of *violence* risk assessments (e.g., rater confidence):

Study	Sample	Outcome	Finding
Douglas & Ogloff (2003)	Forensic	Community violence	+
McNiel et al. (1998)	Civil	Inpatient violence	+
Rabinowitz & Garelik-Wyler (1999)	Civil	Inpatient violence	None.



Introduction (cont.)

The Present Study

- Explored generalizability of past findings.
 - Examined predictive accuracy & rater confidence in assessments across broader risk domains:
 - violence to others
 - suicide
 - self-harm
 - unauthorized leave



Method

Sample

- 9 psychiatrists, 8 senior nurses, & 6 social workers
- 331 START forms for 137 forensic psychiatric patients (122 men, 15 women)
 - Included nonduplicated patients only
 - 0 - 3 forms returned/patient ($M = 1.98$; $SD = 0.70$)



Method (cont.)

Measures

Short-Term Assessment of Risk and Treatability (START)

- Risk assessments
- At time of study, START used 6-point item scales
 - total scores = sum of 20 item scores
 - 4 risk domains [self-harm, suicide, unauthorized leave (UL), & others]

Revised Overt Aggression Scale (OAS)

- Outcome data
- Modified version of Yudofsky et al.'s OAS (1986)
 - Observable aggressive behavior.
 - Rated least (1) to most severe (4) → presence vs. absence
 - Expanded to include suicide & unauthorized absence.



Method (cont.)

Procedure

- Assessments
 - Brief training workshop
 - Completed individually following prep. for Review Board.
- Outcome data
 - 1-year period
 - Hospital & community clinical-legal files
 - *Note.* 129 patients available for follow-up.



Method (cont.)

Confidence Ratings

- Raters also indicated agreement with “*I am confident in the accuracy of my assessment*” from:
 - 1 (*strongly disagree*) to 5 (*strongly agree*)
- For the purposes of analyses, START assessments divided into two confidence groups (e.g., Douglas & Ogloff, 2003; McNiel et al., 1998):
 1. moderate ($<$ median)
 2. high (\geq median)



Results

- Overall, mean confidence = 3.84 / 5 ($SD = 0.46$).
 - Median & Mode = 4.00 (“agree”)
- No sig. diff. in confidence by rater profession.
- Trend for *higher* total START scores/risk estimates in *high* confidence group:

Ratings	Confidence Groups	
	< Mdn <i>M (SD)</i>	≥ Mdn <i>M (SD)</i>
START Total Scores	68.78 (15.04)	70.10 (17.05)
Risk to Others	1.46 (0.68)	1.60 (0.66)
Risk of Self-Harm	1.08 (0.27)	1.13 (0.35)
Risk of Suicide	1.05 (0.22)	1.10 (0.30)
Risk of UL	1.18 (0.39)	1.35 (0.62)



Results (cont.)

Predictive Validity Comparisons

1. Point biserial correlations

- Test associations between *continuous* predictor (START total score) & *dichotomous* outcomes (OAS behaviours).

2. Areas under the curves (AUCs) of Receiver Operating Characteristic curves

- Higher AUC = better discrimination.
- Z statistics to compare (see Delong et al., 1988).



Results (cont.)

Point Biserial Correlations

Modified OAS	r_{pb}		Comparison (Z)
	< Mdn (N = 45)	\geq Mdn (N = 192)	
Any Aggression	.49***	.30***	1.33
Verbal Aggression – Others	.55***	.25***	2.13*
Physical Aggression – Objects	.45**	.25***	1.34
Physical Aggression – Others	.39**	.19*	1.29
Self-Harm	.40**	.10	1.90
Unauthorized Leave/Attempt	.06	.11	-0.30
Suicide	n/a	n/a	n/a

Note. * $p \leq .05$. ** $p \leq .01$. *** $p \leq .001$.

Results (cont.)

Receiver Operating Characteristics

Modified OAS	AUC		Comparison (Z)
	< Mdn (N = 45)	≥ Mdn (N = 192)	
Any Aggression	.79***	.68***	1.32
Verbal Aggression – Others	.83***	.66***	2.08*
Physical Aggression – Objects	.78**	.69***	0.93
Physical Aggression – Others	.63**	.73**	1.06
Self-Harm	.87*	.61	2.63**
Unauthorized Leave/Attempt	.58	.58	0.08
Suicide	n/a	n/a	n/a

Note. * $p \leq .05$. ** $p \leq .01$. *** $p \leq .001$.

Results: Inpatients Only

- Overall, mean confidence = 3.83 / 5 ($SD = 0.46$).
 - Median & Mode = 4.00 (“agree”)
- No sig. diff. in confidence by rater profession.
- Trend for *higher* total START scores/risk estimates in *high* confidence group:

Ratings	Confidence Groups	
	< Mdn <i>M (SD)</i>	≥ Mdn <i>M (SD)</i>
START Total Scores	77.27 (15.72)	78.98 (12.24)
Risk to Others	1.64 (0.84)	1.88 (0.68)
Risk of Self-Harm	1.21 (0.43)	1.21 (0.41)
Risk of Suicide	1.14 (0.36)	1.19 (0.39)
Risk of UL	1.15 (0.38)	1.47 (0.65)



Results (cont.)

Point Biserial Correlations – Inpatients

Modified OAS	r_{pb}		Comparison (Z)
	< Mdn (N = 16)	\geq Mdn (N = 73)	
Any Aggression	.16*	.20	-0.14
Verbal Aggression – Others	.71**	.21	2.23*
Physical Aggression – Objects	.54*	.16	1.47
Physical Aggression – Others	.55*	.24*	1.24
Self-Harm	.45	.16	1.11
Unauthorized Leave/Attempt	n/a	.14	n/a
Suicide	n/a	n/a	n/a

Note. * $p \leq .05$. ** $p \leq .01$.

Results (cont.)

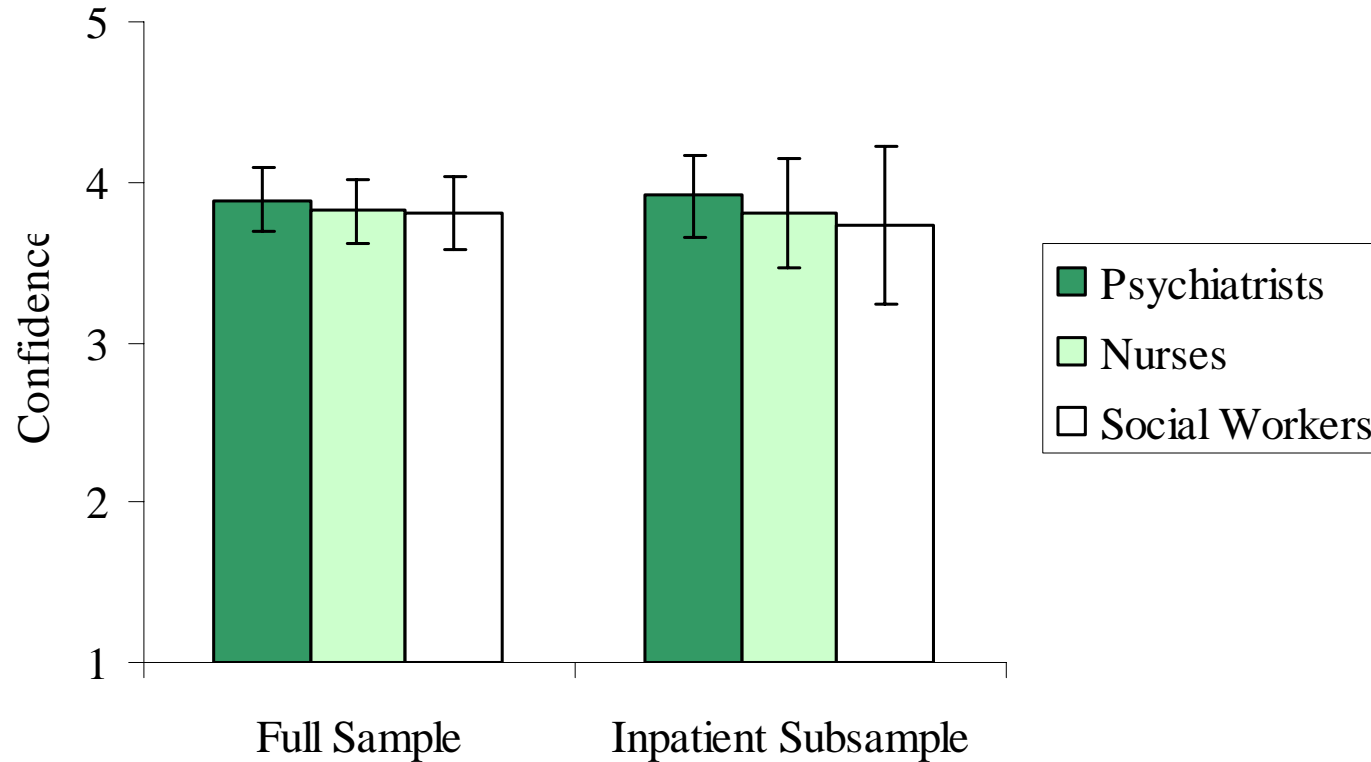
Receiver Operating Characteristics – Inpatients

Modified OAS	AUC		Comparison (Z)
	< Mdn (N = 16)	≥ Mdn (N = 73)	
Any Aggression	.87*	.61	2.23*
Verbal Aggression – Others	.90**	.62	2.59**
Physical Aggression – Objects	.81*	.60	1.57
Physical Aggression – Others	.83**	.64	1.45
Self-Harm	.82	.62	1.38
Unauthorized Leave/Attempt	.58	.38	n/a
Suicide	n/a	n/a	n/a

Note. * $p \leq .05$. ** $p \leq .01$.

Discussion Summary

- Generally, raters confident in accuracy.
- Confidence *not* function of rater profession:



Discussion (cont.)

Summary (cont.)

- Confidence *inversely* related to accuracy.
 - Exception: physical aggression - others
 - However, accuracy high across groups & few *significant* differences.



Discussion (cont.)

Implications

- Mental health professionals must have 'appropriate' confidence in assessments (e.g., Ruscio, 2000; Smith & Dumont, 1997).
 - Poor calibration → serious risk (patient & public)
- How to improve calibration?
 - Training & Implementation (see Smith & Dumont, 1997)
 - Cautions re: overconfidence
 - Feedback (i.e., no feedback → no learning)



Discussion (cont.)

Limitations

- Relatively small number of raters
- Low variability in confidence
- Limited training
- Previous version of START



Discussion (cont.)

Conclusions

- Strengths of study:
 - Multiple raters from diverse professions
 - In vivo assessments (interview + file review)
 - Prospective design
- Future research → factors ↑ ↓ confidence:
 - Individual differences (raters/patients)?
 - Nature of assessment?
 - Information available?



Thank you.

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Coding Short-Term Assessments of Risk Based on File Review: Practical Implications

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Abstract

Comparing assessments completed by research assistants to those previously completed by treatment team members, the present study investigated the practical implications of coding START through file review (i.e., in the absence of interviews).

Introduction

The Short-Term Assessment of Risk and Treatability (START; Webster et al., 2004) provides mental health professionals with guidelines for evaluating and managing psychiatric patients' risk of violence to others, suicide, self-harm, self-neglect, unauthorized absence, substance use, and victimization. To date, most risk assessment literature has relied on studies in which independent researchers, not practicing clinicians, completed risk assessments. The ecological validity of these studies may be questionable (de Vogel & de Ruiter, 2004) as leave decisions and assessments are made by treatment team members in practice (Webster et al., 1997). The present study investigated the practical implications of having research assistants code START through file review.

Method

Using information available in hospital files, two research assistants completed START assessments for 51 forensic inpatients included in a pilot study in which treatment team members (9 psychiatrists, 8 senior nurses, 6 social workers) completed STARTs. Assessors also provided ratings of user-friendliness, including an estimate of the length of time (in minutes) required to complete the assessment, as well indicating agreement on a scale from 1 (strongly disagree) to 5 (strongly agree) with nine user satisfaction statements. For analyses, ratings were collapsed into two groups: *disagree* (strongly disagree + disagree) and *agree* (strongly agree + agree). Midpoint ratings (3 = neither agree nor disagree) were excluded.

Analyses

We evaluated the practicality of coding START based on file review by comparing completion time, number of omitted items, START total scores, risk estimates, and ratings of user-friendliness of file-based assessments to those previously completed by treatment team members. One patient was excluded from all analyses due to missing file data.



Figure 1. The information required for completing this instrument was readily available.

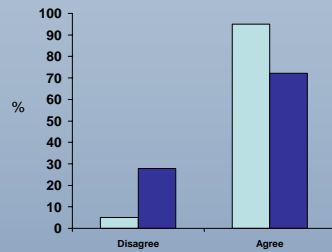


Figure 3. It was easy to make the finer distinctions (i.e., deciding between + vs ++).

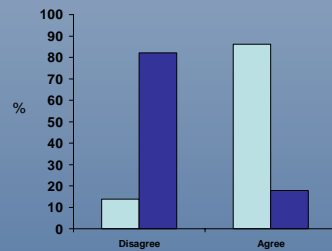
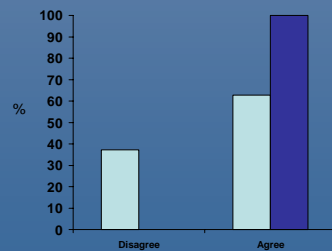


Figure 5. The inclusion of 'Specific Risk Estimates' was useful for this patient.



Acknowledgements:

This research was funded by a Riverview Hospital and Forensic Psychiatric Services Commission Research Grant. The first author also wishes to acknowledge the support of the Social Sciences and Humanities Research Council of Canada.

Figure 2. It was easy to make the fundamental +/- decision.

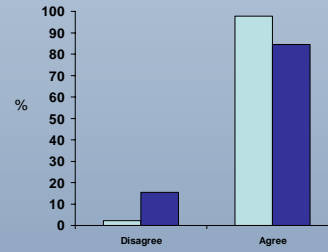


Figure 4. The inclusion of 'Signature Risk Signs' was useful for this particular patient.

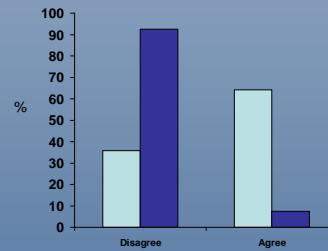
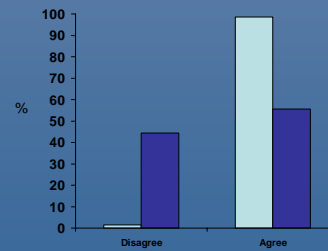


Figure 6. I am confident in the accuracy of my assessment.



Results

Administration & Scoring

The number of items omitted was significantly higher on average for file review ($M = 2.04$; $SD = 1.63$; $Range = 0 - 6$) than in vivo ($M = 0.47$; $SD = 1.37$; $Range = 0 - 12$) assessments, $t(157) = 6.34$, $p < .001$.

Pairwise comparisons demonstrated that overall, START total scores and estimates of risk for self-harm and unauthorized leave did not differ significantly across file-based and in vivo assessments, but estimates of risk to others and risk for suicide were significantly different. Specifically, as may be seen in the table below, estimates made based on in vivo assessments were significantly lower than those made based on file review for those two risk domains.

Table 1. START Scores and Specific Risk Estimates

	In Vivo M (SD)	File Review M (SD)	Comparisons t
START Total Scores	77.01 (13.64)	73.71 (16.30)	1.32
START Risk Estimates			
Risk to Others	1.84 (0.69)	2.80 (0.46)	8.80***
Self-Harm	1.20 (0.41)	1.20 (0.50)	0.00
Suicide	1.16 (0.36)	1.39 (0.61)	2.94**
Unauthorized Leave	1.46 (0.66)	1.39 (0.76)	0.61

** $p < .01$. *** $p < .001$

User-Friendliness

Shown in Figures 1 – 6, in vivo and file-based assessments differed significantly across six 'user friendliness' domains, with raters generally more likely to endorse the user-friendliness of in vivo assessments (with one exception – see Figure 5), χ^2 s (1) ≥ 7.87 , p 's $< .01$. Agreement rates for the remaining three 'user friendliness' domains (i.e., 1 - there was sufficient time to score the instrument; 2 - the items were easily applied to the circumstances of the patient; and 3 - the instrument provided a comprehensive risk summary) were equally high across assessments (87 – 100%).

Discussion

The challenge of collecting data from files is widely acknowledged (Långström et al., 1999). Results suggest that this may be particularly true for START as there may be less information on file to code strengths and dynamic items in the short term. Further, it might be that treatment team members, having intimate knowledge of the patient, may alone have the level of information detail necessary to perform these risk evaluations. Findings contribute to a better understanding of the nature of the similarities and differences between such file-based and interview-informed assessments.

Addiction Services in BC & Alberta: Comparisons Along the Continuum of Care

Deborah Ross, MSc, Derek Lefebvre, BSSc, Gerald Thomas, PhD,
& Patrick Smith PhD

Introduction

In recent years, and in line with other nations, Canada's provincial healthcare systems have largely been regionalized. While there are benefits to regional service delivery structures, there are also risks related to regional variations in availability and access to a comprehensive continuum of care.

Background

The project on which this poster is based was carried out under the National Treatment Indicators Working Group of the Canadian Centre on Substance Abuse (CCSA) and the Canadian Executive Council on Addictions (CECA). It aimed to characterize addiction services in each province and territory and the extent to which they form a continuum of care. Methods included: web-based research, phone interviews with key contacts in government and and service provision organizations, and data collection on organization, funding, services, and clients. This poster describes and compares the structure and scope of the addiction services continuum in Canada's two westernmost provinces

Service Systems

While the BC and Alberta (AB) healthcare systems are both regionalized, they differ with respect to the involvement of provincial versus regional structures in the delivery of addiction services.

The AB Mental Health Board (AMHB) has since 2004 been responsible for provincially mandated mental health services. Most other mental health services are provided by the 9 regional health authorities (RHAs). The primary provider of problem substance use and gambling services is the Alberta Alcohol and Drug Abuse Commission (AADAC). Accountable to the Minister of Health and Wellness, AADAC offers services in 49 communities through rural area offices, urban clinics, and residential facilities. AADAC also contracts with about 30 community-based agencies for additional services.

In 2002, the BC Ministry of Health (MOH) combined mental health and addictions (MH&A) under one portfolio. The MOH provides funding to 1 provincial (PHSA) and 5 RHAs, the latter of which are divided into 16 Health Service Delivery Areas (HSDAs). The RHAs are responsible for governing, planning, and coordinating core MH&A services within their regions. The PHSA provides province-wide specialized MH&A services. Services may be provided directly or contracted out to other service providers.

Continuum of Services

The continuum of care concept implies that a range of accessible services responding to the acuity, chronicity and complexity of addictions problems should be available. Core services provided by AADAC fall under: prevention, withdrawal management services (WMS), outpatient (OP) services, and inpatient (IP) treatment. The BC MOH promotes a continuum that spans similar service categories, although the RHAs vary as to the extent to which these services are offered (see below). In addition to core services, each province offers targeted (e.g., to youth) and specialized (e.g., for concurrent disorders) services to address the unique needs of their population. Harm reduction services – such as needle exchange – are offered in the large urban centres, but tend to fall under public health rather than addiction services.

	Alberta			British Columbia		
	Service	Available	Locations	Service	Available	HAs
SA		Embedded within other services			Embedded within other services	
WMS	Shelter	√	5	Sobering Beds	√	VCH VIHA
	Home Detox	√	2	Home Detox	√	FHA VCH
	Daytox	√	2	Daytox	√	VCH PHSA
	Residential	√	10	Residential	√	All
OP	Problem Gambling	√	1			
	Prevention/ Education	√	60	Prevention/ Education	√	All
	OP Tx	√	58	OP Tx	√	All
	Day	√	9	Day	√	All
IP	MMT	√	5	MMT	√	All
	Residential Intensive (S-T)	√	12	Residential Tx	√	All but NHA
	Residential (L-T)	√	8	Supportive Recovery	√	All but PHSA

N.b. - Types of detox offered within community or residential settings include: social, medically supported, and medical. Methadone maintenance therapy (MMT) services are provided by dedicated programs as well as by community-based GPs in both AB and BC.

Challenges & Limitations

- Definitions and operationalization of service data are neither standardized nor consistent
- Information systems differ according to structural aspects of systems and corresponding accountability frameworks
- Less information is available from contracted agencies
- Integration of MH&A services in BC
- A description of the scope of services does not reflect the use, capacity, or integration of such services
- Services and supports not captured include those provided outside the specialized service system (e.g., public health)
- Ongoing regionalization-related changes

Observations

- AB and BC offer a similar range of core services along a broad continuum of care
- Both provinces are evolving towards increased prevention and health promotion activities, improved capacity for and access to community-based services, and decreased reliance on residential treatments
- There is greater overall cohesion of services and information within AB's centralized addiction service system
- Certain BC RHAs offer a strong, well-coordinated continuum of care, while others remain less well served
- Innovative services have evolved in response to perceived gaps in care, e.g., bus to health services in BC's north; mobile youth outreach teams in AB's north.
- In each province there is progress towards minimum reporting standards and outcome measurements

Conclusion

Without denying the need for region- and population-specific service planning, funding, and delivery, provincial bodies should work with regional structures to ensure consistent and equitable access across regions to services along a full continuum of care.

“Regionalization...lags behind in information technology and innovation, and its performance will be limited unless this gap is closed”

Lewis & Kouri, 2004

THE SHORT-TERM ASSESSMENT OF RISK AND TREATABILITY: IMPLEMENTATION OF A NEW RISK ASSESSMENT INSTRUMENT

Devon Harabalja \pm ∇ , Johann Brink \pm ∇ , Tonia L. Nicholls \pm $*$, & Sarah L. Desmarais \pm $*$

\pm BC Mental Health & Addiction Services, ∇ University of British Columbia, $*$ Simon Fraser University

Description of Organizations

Forensic Psychiatric Services Commission (FPSC)

- A multi-site health organization providing specialized hospital and community-based assessment, treatment and clinical case management services for adults with mental illness who are in conflict with the law.

Forensic Psychiatric Hospital (FPH)

- A secure, 190-bed facility that serves individuals referred by the Courts for treatment and assessment.
- The Forensic Psychiatric Hospital is a designated mental health facility under the Mental Health Act, which provides for involuntary admissions for treatment purposes.
- The facility consists of nine clinical units (five secure, three closed, and one open).

Background

- The Short-Term Assessment of Risk and Treatability (START; Webster et al., 2004) is a new evidence-based measure intended to inform multiple risk domains, and to assist decision makers regarding client-centered risk reduction and management strategies.

Importance of the Problem

- Assessment guides that consider risk factors as well as specific client strengths, and relate directly to day-to-day patient management, are clearly needed (APA, 2006; Verdun-Jones, Brink, Lussier, & Nicholls, 2006).

Description of the Initiatives

- In response to the above challenge, START, a 20-item multidisciplinary instrument, was developed by FPSC in collaboration with colleagues from St. Joseph's Healthcare, ON

Pilot User-Satisfaction Study

(Brink & Livingston, 2004)

Overall high acceptance rates by FPH clinicians of START

Results:	%
• information to complete form available	93
• easy to make the strength/risk distinction	84
• items were easily applied each client	82
• provided a comprehensive risk summary	66
• confidence in accuracy	82
• sufficient time to code the form	88
• completion time: 7.8 minutes	

Clinical Implementation of START

Location	Organization	Application	Status	
			In progress	In place
Montreal, CN	Douglas Hospital	Md Secure Risk Ass Unit		✓
Calgary, CN	Peter Lougheed Centre	Jail Diversion		✓
Liverpool, UK	Ashworth Hospital	Forensic Inpt		✓
London, UK	Blenheim Healthcare	Forensic Inpt		✓
Ireland	Dundrum Mental Health Hospital	Corrections reception	✓	
Norway	St. Olav's Hospital	Forensic inpt	✓	
Australia	Justice Health	Transition in/out		✓
Richmond, BC	Richmond Health Services	Community		✓
Port Coquitlam, BC	Forensic Psychiatric Services	Forensic Patients	✓	

Validation Study (Nicholls et al., 2006)

- FPH treatment team members completed the 20-item, dynamically-focused START for all forensic patients before the review panel ($N = 138$) over a six month period.
- File reviews and official records were used to track post-risk assessment outcomes.
- Results revealed:
 - High rates of generally low-level adverse events.
 - Item Homogeneity = .48
 - Internal consistency (Cronbach's alpha) $\alpha = .87$
 - Interrater reliability, ICC2 = .87, $p < .001$.

START Implementation Committee Members

Dr. Johann Brink (chair)	John Charles
Michelle Collins	Sarah Desmarais
Krista Field	April Furlong
Susan Gressel	Karin Jackson
Tess Kroeker	Dr. LeeAnne Meldrum
Angus Monaghan	Dr. Tonia Nicholls
Clement Poquiz	Allan Solk
Dr. Rakesh Lamba	Dr. Karen Whittemore

START Implementation Project

Strategy:

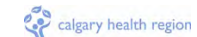
- The START initiative will be implemented in a gradual and incremental manner across the entire Forensic Psychiatric Service, starting with one maximum security unit at FPH (A2) in September 2006 and then to the other units in the hospital, before implementation in the regional Clinics.
- Staff will be trained in how to work within a multidisciplinary team to complete START assessments on patients

Training at FPH:

- Full START training: Psychiatrists, Case Managers, Social Workers, Primary Nurses, Psychologist
- Awareness Training: Health Care Workers, Rehabilitation Staff, Managers, Others
- Training will be done by Dr. Johann Brink, Dr. Tonia Nicholls, & Sarah Desmarais, Ph.D. Candidate
- START assessments will be completed every three months and at transition points by the interdisciplinary treatment team
- Completed START summary sheets will be signed off by all team members



Improving Primary Care Professionals' Knowledge of Children's Mental Health



Monitoring the progress of my clients when they are on medication. I will communicate more with the doctors who have children and adolescents. I will definitely take the additional ideas I could offer in treatment and also continue the strategies/treatment goals that I was currently using....all the mentioned

Registrant feedback from a module evaluation

Recipient feedback from a telehealth consultation

Harold Lipton, MA, RPsych & Ellen Perrault, MSW, RSW
Healthy Minds/Healthy Children Outreach Service, Calgary, AB

Background

- 1 in 4 Canadian children have a mental health concern
- 50% of adult mental health issues have roots in childhood or adolescence
- More than 75% of children do not receive needed services
- The most common mental health service provider is the primary care practitioner
- Practitioners often need support to provide these services, especially those who are isolated
- Practitioners are challenged to find the time to keep up-to-date with new knowledge and resources
- In 2002, SACYHN began a project to build the capacity of primary care in children's mental health and improve coordination and integration of inter-regional efforts

Service Objectives

- Improve the capacity of primary care providers in Southern Alberta to meet children's mental health needs
 - Provide services "closer to home"
 - Increase the knowledge base of practitioners
- Improve inter-regional coordination of services by facilitating knowledge transfer and supporting referrals/

Service Model

- Telephone, video, and Internet-based technologies are accessible and flexible alternatives to more traditional platforms for learning and clinical consultation
- Consultation in-office or via telehealth/telephone, maintaining involvement of practitioner & using local resources wherever possible
- Theme based inservicing, e.g. understanding psychological testing in primary care
- Professional Resource Development
 - Information Prescriptions
 - Desk Reference
- Online Professional Development

Consultations

- More than 200 consults involving 92 unique cases
 - 57 ♀ 35 ♂
- Consultations involving 17 family physicians, paediatricians and mental health clinicians
- Vast majority did not require referral to specialized service
- Focus on capacity building: practitioner present in virtually all consults, and patients in a minority

Telehealth

- "Virtual team" – multi-site, including children's clinicians from all over Southern Alberta
- Support for diagnosis, treatment planning, referral to specialized services

Information Prescriptions

- 5 information prescriptions developed
- Over 30,000 in circulation around the province
- Short listings of current books, websites, videos on mental health topics designed for primary care distribution to patients on:



Desk Reference

- 1st edition published – hard copy and CD
- Screens, diagnostic aids, treatment strategies
- Living document: to be updated
- 800 in circulation

Online Professional Development

- Began 2005 and covers all of Alberta
- Partnership of SACYHN, Alberta Mental Health Board, Capital Health Region, & Calgary Health Region
- Delivered in collaboration with the Faculty of Social Work, U of C, with assistance of the Faculty of Medicine (U of C) Office of Continuing Medical Education
- Guided by interprofessional advisory group including: AMHB, Family Medicine, Paediatrics, Psychiatry, Psychology, Social Work, and U of C Faculty of Medicine, Office of Continuing Medical Education
- 100% web based
- Accredited (RCPS, CFPC & ACSW)
- Modules on current children's mental health topics - Currently on 3rd round
 - 17 different modules
 - Registration of 130+
 - Every health region in Alberta represented
 - Diverse audience with cross section of rural/urban and multiple professions
- Instructive modules: PowerPoint slides with narrative
- Asynchronous discussion facilitated among presenters and registrants
- Option for synchronous dialogue
- Ongoing discussion support
- Interprofessional presenters from various regions, programs and educational institutions
- Interest growing in other provinces

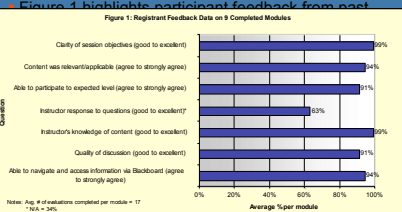


Figure 1: Registrant feedback on the modules, the presenters and the technology

Conclusion

- The service has resulted in enhanced access to consultation and increased professional knowledge, relationships, and expertise for providers.
- Practitioners have preferred the education focus to capacity building, and are seeking consultation less than expected. Possible reasons include: compensation issues, scheduling pressures.
- Participant evaluation data from the continuing professional development sessions indicates high levels of satisfaction with the practical focus and the opportunity to dialogue with other participants. Self report data indicate participants' learning from the experiences of their colleagues and presenters.
- Evaluation of the service will continue as the Healthy Minds/Healthy Children service is formulating an upcoming evaluation project to research practice change.

For more information please contact:
Harold Lipton

Website

Program information

Links to other sites

Contains entire resources of project

www.healthymindshealthychildren.ca



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