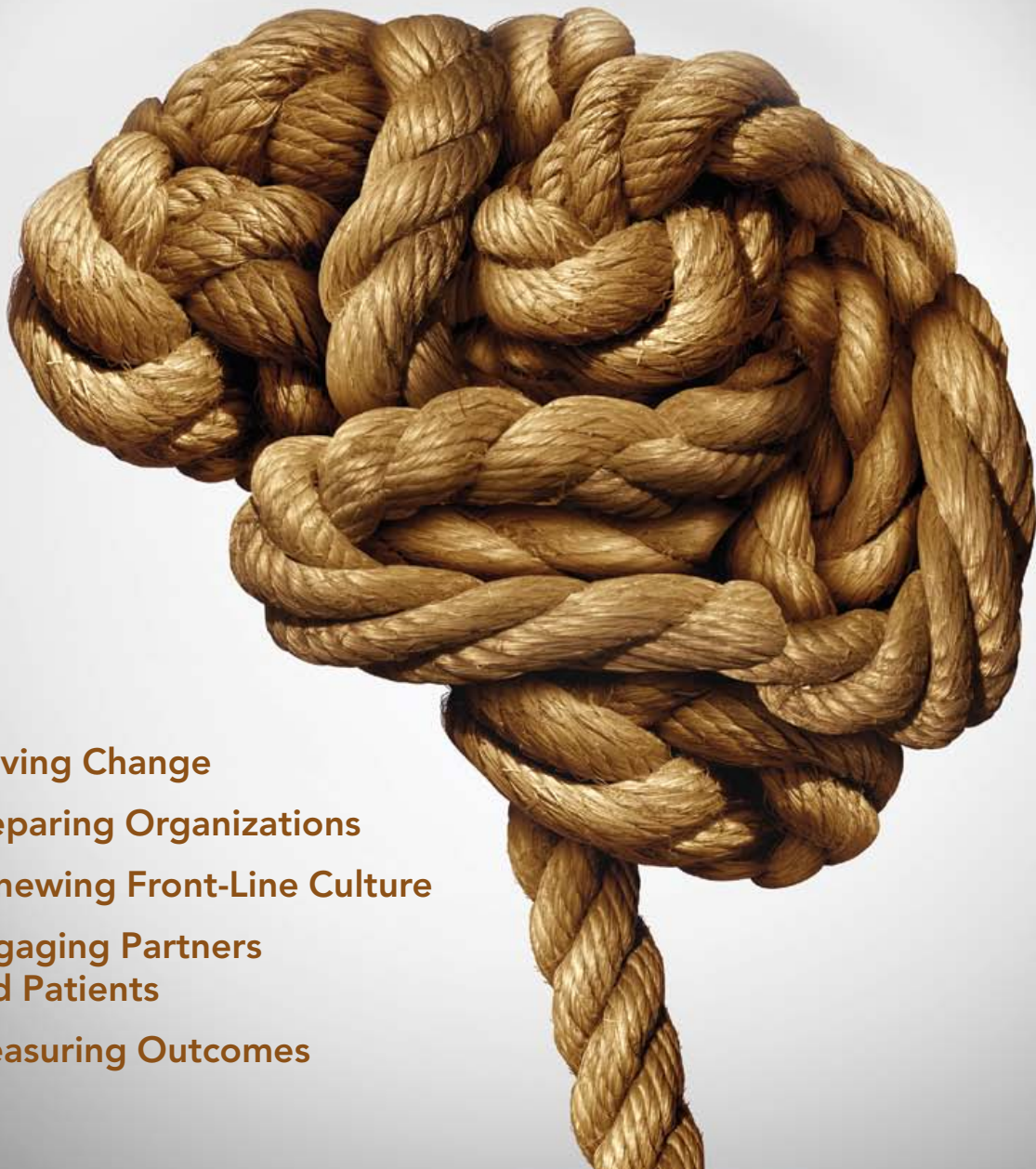


Healthcare Quarterly

TRANSFORMING MENTAL HEALTH SERVICES: LESSONS FROM SOUTH WESTERN ONTARIO



Driving Change

Preparing Organizations

Renewing Front-Line Culture

Engaging Partners
and Patients

Measuring Outcomes

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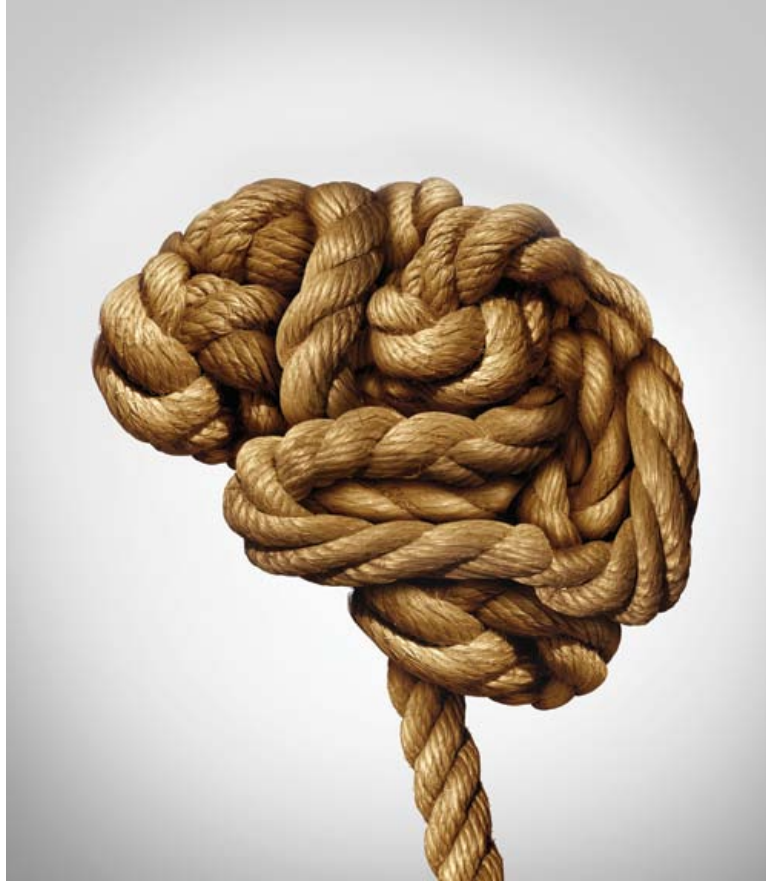
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Valuable Lessons in How to Transform a Mental Health System

As the Chair of the Senate Committee which published Canada's first national report on mental health, and as the Founding Chair of both the Mental Health Commission of Canada and Partners for Mental Health, I am very pleased to have been asked to be the guest editor of this special issue of *Healthcare Quarterly*. This special issue is designed to help organizations and individuals who are involved in transforming a mental health system.

Readers are encouraged to pay particular attention to the Lessons Learned section in the various papers; they provide valuable insights into how to be successful in system reform.

The papers stress the critical importance of detailed planning and strong partnerships. They also illustrate the extraordinary amount of patience, determination and, above all, time required. The resistance to change among those currently working in the mental health system is truly incredible. Unfortunately the people who suffer as a result are people living with a mental illness.

This volume is also valuable for its papers on three issues which are extremely important, yet often overlooked, in mental health system reform. These issues are:

- Peer support
- Social enterprise in which the employees are people living with a mental illness
- Early intervention, particularly for children and youth.

All three of these issues should be a part of any mental health system transformation.

All the organizations and individuals involved in the transformation of the mental health system throughout south western Ontario, and in the London Middlesex area in particular, are to be congratulated for what they have achieved.

Now if only the pace of change could be accelerated elsewhere!

Michael Kirby, OC



Mental Health System Transformation: Drivers for Change, Organizational Preparation, Engaging Partners and Outcomes

Deborah J. Corring, Sandy Whittall, Jill MustinPowell, Sarah Jarman, Patty Chapman and Sam Sussman

Abstract

St. Joseph's Health Care London (hereafter referred to as St. Joseph's) is a publicly funded hospital that has led mental health (MH) service system transformation in south west Ontario following directives from the Health Services Restructuring Commission (HSRC) (Sinclair 2000). This paper documents how provincial policy; HSRC directives; use of change management activities; organizational planning; and partnerships with other hospitals, community agencies and LHINs drove, shaped and accomplished the transformational change.

The transformation included divestment of beds and related ambulatory services to four other hospitals, closure of beds and employment services and the construction of two state-of-the-art facilities. This paper documents the tracking of system performance measures and the outcomes that resulted.

Drivers for Change

The Very Early Days (1850s–1983)

In 1870, the London Asylum (later known as London Psychiatric Hospital) was opened as an independent asylum. Richard Maurice Bucke acted as superintendent of the London Asylum from 1877 to 1902. He is credited with having introduced “moral therapy” to London Psychiatric Hospital. The moral therapy

method employed compassion, leniency and all that was best in the humanitarianism and moral ethics of the Victorian era. It disavowed the use of drugs, physical restraints and bleeding in favour of a psychological approach. Moral therapy, however, was never totally implemented, even by Bucke. By the late 1800s, the institutions throughout Canada bore more of a custodial than a moral therapy stamp. Overcrowding and a lack of resources characterized them all to a greater or lesser extent.

St. Thomas Psychiatric Hospital, a massive institution built to hold 5,000 mental healthcare patients, opened in 1939. Overcrowded and under-resourced, St. Thomas Psychiatric Hospital was similar to the other psychiatric facilities in the province. The patient count when it was opened was 2,400. Then, no sooner had the facility opened when it was closed and served as a training centre for the Royal Canadian Air Force throughout the war years, 1939–1945. It reopened in 1945, and by 1947, there were 1,100 patients.

Provincial Mental Healthcare Reform (1983 to Present)

Mental health reform policy in Ontario has followed a long and winding road and has been attempted more than once. The most recent MH reform initiative has sought to refocus the service delivery system from one with an emphasis on institutionalization of persons with mental illness to a policy reform

that focuses on effective, accessible services, increasingly delivered in the community rather than in a hospital, and oriented to recovery-focused care (CMHA Ontario 2015).

The most recent initiative began in 1983, with a report entitled “Towards a Blueprint for Change: A MH Policy and Program Perspective” (Heseltine 1983), which was followed by the Graham Report (Graham 1988) and the “Putting People First: The Reform of MH Services in Ontario (MOH 1993)” policy statement and implementation guidelines in 1993 and 1995 (MOH 1995) respectively. A review of progress made, published in the “2000 and Beyond: Strengthening Ontario’s MH System” report (Newman 1998), noted that at the 5-year mark, funding had not yet been allocated to implement needed reform.

The HSRC began its work in April 1996. Included in its report was a recommendation for Ontario’s nine provincial psychiatric hospitals to be divested to public hospitals. In addition to specific recommendations in each community regarding closure of beds, transfer of beds to other communities, closure of existing facilities and the building of new facilities, the report also recommended significant transitional funding to build community resources that would offset the eventual closure of beds.

Subsequent policy and implementation guidelines were produced by the Ontario Ministry of Health and Long-Term Care (MOHLTC) in 2000 and 2001. In 2002–2003, MH implementation task forces were formed and, over their 3-year mandate, they provided recommendations to the MOHLTC on how to reform the MH service system in Ontario, specific to several regions.

Their final report, “The Time is Now” (MOHLTC 2002), identified a number of areas of focus to drive reform. They included adopting a recovery philosophy, with the consumer at the centre of the system; creating partnerships with other supporting services in the health, social and justice sectors; implementing regional decision-making; improving local delivery systems; building peer support into the MH system; increasing support to families of people living with mental illness; providing safe and affordable housing; adding an increased emphasis on early intervention and treatment; enhancing employment support; ensuring adequate income support; developing greater system accountability, performance standards and information systems; and appointing a provincial team to keep MH reform on the provincial agenda.

Government policy regarding MH reform remained somewhat silent until 2009, with the release of the “Every Door is the Right Door” report, which outlined the 10-year strategy for MH and addictions service system reform (2009). Finally, Ontario released the “Open Minds, Healthy Minds: Ontario’s Comprehensive MH and Addictions Strategy” document in 2011 (MOHLTC 2011). The strategy is inter-sectorial and interministerial in scope and is intended to align with various other Ontario initiatives, including new strategies arising from

the *Excellent Care for All Act*, the Poverty Reduction Strategy, Early Learning Strategy and the Long-Term Affordable Housing Strategy. Ontario’s new MH and addiction strategy has four guiding goals: 1) improve MH and well-being for all Ontarians; 2) create healthy, resilient, inclusive communities; 3) identify MH and addictions problems early and intervene; and 4) provide timely, high quality, integrated, person-centred health and other human services.

The strategy’s focus in the first three years was on children and youth. Supports for this target population address three key areas: fast access to high-quality services, early identification and intervention and supporting kids with unique needs, and bridging service gaps for remote communities. In the last five years, issues regarding services for the adult population in St. Joseph’s region have focused on emergency room waits; access to beds; funding for a variety of community supports – most particularly case management; peer support; housing; and Tier 2 and 3 activities. Additionally, in 2006, Local Health Integration Networks (LHINs) were established and the MOHLTC published guidelines for the basic principles to be followed for any Tier 3 activities.

The two hospitals in London, Ontario, with the assistance of the South West (SW) LHIN and community partners, have been able to respond to many of the areas of focus noted in the “Time is Now” and the “Open Minds, Healthy Minds: Ontario’s Comprehensive MH and Addictions Strategy” reports, as well as the SW Mental Health Implementation Task Force, while following the HSRC directives. The work done at St. Joseph’s Health Care London in this regard is described below.

MH Transformation at St. Joseph’s Health Care London (2001–2015)

HSRC recommendations directed that the governance and management of London and St. Thomas Psychiatric Hospitals be assumed, as well, by St. Joseph’s in 2001. London and St. Thomas Psychiatric Hospitals were divested to St. Joseph’s Health Care London in 2001. For St. Joseph’s, the directives also included two additional steps. The first was the divestment of beds and related ambulatory services to four other hospitals, closure of beds, and transfer of employment services, assisting in the development of community capacity, and the second was the construction of two new state-of-the-art facilities. The long term goal for St. Joseph’s was to focus on specialized (tertiary) MH care service delivery on an inpatient (IP) and outpatient (OP) basis. Such a large mandate required detailed planning, as outlined below.

Organizational Preparation for Change Within St. Joseph’s and With its Partners (2001–2009)

St. Joseph’s leaders were heavily involved in the SW Mental Health Implementation Task Force (MOHLTC 2002) and

contributed to many of the recommendations made for the region. Although the recommendations were never endorsed by the government, they were used as a guideline by the constituents.

In 2003, discussions took place at the provincial level between the MOHLTC, the Tier 2 partner hospitals and the Ontario Public Services Employees Union (OPSEU), and agreement regarding the first principles of human resources transfers, including the employee rights to follow work and service recognition, were reached. Beginning in 2004 and continuing to 2008, the Tier 2 partner hospitals met to discuss funding transfer methodologies, patient-related planning and other matters of importance. In 2008, the Tier 2 partners endorsed the Program Transfer Methodology (PTM) model, which would divide the funding for MH at St. Joseph's between the partners and the MOHLTC. It was acknowledged from the beginning that the allocations were equitable but not adequate for future service delivery and would be further eroded if there were delays in construction and transfers. As promised, at the five-year mark, following the Tier 1 transfer, the MOHLTC commissioned the consulting company Deloitte to complete a "rightsizing review" as well as a peer review of St. Joseph's mental health care budget. This resulted in a further reduction in the envelope available for the PTM.

In 2003, St. Joseph's submitted the first functional plan to the MOHLTC. In 2005, Infrastructure Ontario (IO) was established and the new IO process introduced, and St. Joseph's was included in the first five-year facility construction plan for the province. In 2007, Tier 2 partners began construction tenders (Grand River Hospital [GRH]), planning (Windsor Regional Hospital), revisions to functional plans (St. Joseph's Healthcare Hamilton and St. Joseph's Health Care London) and costing (St. Thomas Elgin General Hospital). In 2009, St. Joseph's functional plan was approved and St. Joseph's and two other Tier 2 partners moved along the design, build, finance, maintain (DBFM) continuum with IO.

During these years, St. Joseph's also undertook some internal changes. In 2006, it reviewed and realigned its MH clinical programs with an eye to alignment with its provincial and national partners of like mandate, as well as best practices in the literature. The overarching philosophy of care chosen was one of psychosocial rehabilitation (PSR), with a recovery orientation to service provision. Clinical leaders were reduced and realigned at this time, access issues were streamlined with the creation of the coordinated access team (CAT), and consultants were recruited to do a critical review of the programs adoption of PSR and recovery, with a view to recommendations for improvement.

Engaging Partners

The first of the four beds-and-services transfers took place in 2010, when 50 beds were transferred to GRH in Kitchener. In addition, one Assertive Community Treatment (ACT) team

and one transition team, staff and patients were also transferred.

Months of discussions and planning took place prior to the actual transfer. Each patient was reviewed to ascertain his or her ongoing care needs, and a group of community agencies, the sending and receiving hospitals, and representatives of the Waterloo Wellington (WW) LHIN met on a regular basis to minimize the number of patients who needed to be transferred to a bed. As a consequence, several individuals were discharged with appropriate housing and support prior to the transfer of IPs. Families of transferring patients were also engaged and had an opportunity to tour the new space in Kitchener prior to the transfer. Communication from families was positive and reaffirmed one of the underlying principles of MH reform, which suggests that people should be able to access care closer to home.

The husband of a geriatric psychiatry program patient shared his delight in not having to travel from Kitchener to London on a bus every week any longer (something he had done for several years); he was now able to see his wife much more often as she was close to home.

Three issues complicated the transfer. The first was construction delays in the new space in Kitchener, which adjusted the overall timeline. The second was the lack of local capacity in the Kitchener-Waterloo area to provide ongoing tertiary level OP care for patients with a dual diagnosis. Finally, third was the lack of capacity at Cambridge Memorial Hospital (CMH) to take back the acute care overflow work that had been done at St. Joseph's for several years. Clinicians at St. Joseph's set about building capacity in partnership with GRH and the WW LHIN for services for people with dual diagnosis, and the care for these patients was transferred on March 31, 2013. Leaders at both hospitals, both the SW and WW LHIN and the MOHLTC met several times regarding the acute care IP services at CMH, with approval being obtained to increase the number of acute care beds at CMH, and the work was subsequently transferred in May 2012.

In concert with the transfer, 50 beds needed to be decommissioned at the St. Joseph's end and the impact on staff resources managed. Due to the mitigation strategies agreed to by leaders and union executives, a number of opportunities were available to staff – namely transfer with the work, early retirement or voluntary exit, reassignment within the MH programs at St. Joseph's and, as a last resort, notice of layoff. (Overall human resource impacts for all transfers will be noted at the end of this section.) The transfers took approximately one year to plan and execute.

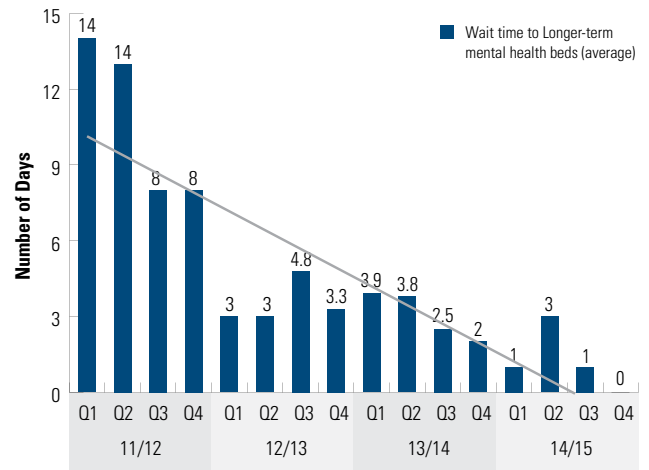
The second transfer to Windsor Regional Hospital occurred in 2011, with 59 beds and three ACT teams being transferred. The third transfer saw 14 beds transfer to St. Joseph's Health Care Hamilton in March 2013, and the final transfer of 15 beds and related ambulatory services to St. Thomas Elgin General

Hospital was in January 2014. Similar patient and family involvement and management of staff impacts occurred on all transfers, with good results. Construction delays also plagued these three transfers. Each transfer again took approximately one year to plan and execute. Details regarding two of the transfers can be found in another article in this issue entitled “Divestment of Beds and Related Ambulatory Services to Other Communities While Maintaining a Patient- and Family-Centred Approach.” In addition, approval was obtained for a three-phase plan for an overall reduction of 70 beds (in addition to the transfers) to ready St. Joseph’s for the number of beds that would be available in the new facility. Phase 1 was completed in December 2010, phase 2 in December 2011 and the final phase in June 2014. A total of 208 beds were transferred or closed over the 4 years. Two employment-related programs were also closed, and considerable attention was paid to working with other hospital and community partners to ensure that St. Joseph’s was engaged in tertiary care work only on an OP basis.

One particularly important system issue was access to the remaining IP beds. In February 2011, with the assistance of the London-Middlesex Community Care Access Centre, the SW LHIN and several community mental healthcare agencies, a review of all long-stay patients was started. Long-stay patients were defined as those who had been in St. Joseph’s beds for more than 365 days. Over the next 4 years, with a consistent focus on discharge of these individuals plus the addition of a transition team for 3 years and involvement in the Council of Academic Hospitals Traditional Discharge Model project (Forchuk 2015), more than 100 long-stay patients were discharged to the community with the right housing and the right supports, with very few readmissions (see Figure 1). As a consequence, the average waiting time for access to remaining beds was

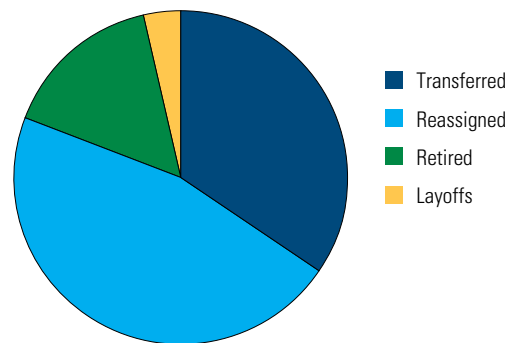
reduced to 1 day in Q3 of 2014/15 and maintained until the end of the transformation period (see Figure 2).

FIGURE 2.
Mental Health Divestment Wait Time Statistics



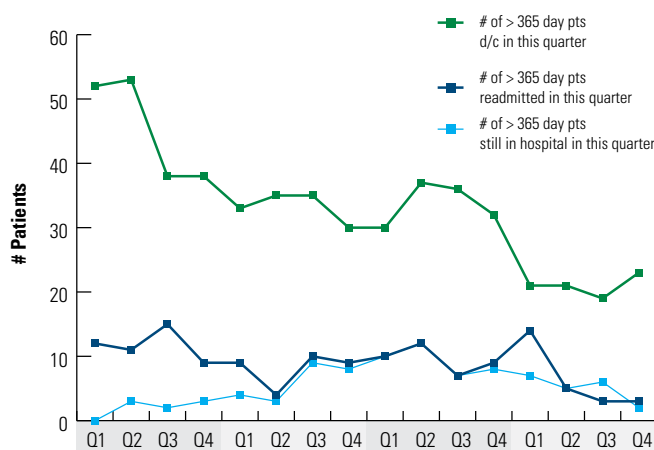
As promised above, the human resources metrics are provided in Figure 3. A shift in care culture was also attended to in this period of tremendous change, and more detail regarding the challenges of that work can be found in another article in this issue entitled “Relentless Incrementalism: Shifting Front-Line Culture From Institutional to Recovery-Oriented Mental Healthcare.”

FIGURE 3.
Human Resources Impact



Last, but certainly not least, was the planning, construction and occupying of two new state-of-the-art facilities that provide the springboard to take us to the next level of clinical and academic excellence.

FIGURE 1.
Mental Health Divestment Discharge Statistics



Lessons Learned

- Understanding the receiving community's array of support services, both hospital and community, and completing a full assessment of individual client needs to match with the available support services was critical to the success with community placements for individuals with complex needs.
- Ensuring a strong relationship base with funders and community providers prior to planning efforts and developing a mutual common vision among partners for desired outcomes is also necessary.
- Advocating for funding assistance to complete and sustain transition and anticipating higher funding and support needs for complex conditions (e.g., dual diagnosis) is necessary.
- Planning well in advance with the MOHLTC to complete necessary documentation and a business case related to changes in facility designation, function, and name can prevent unnecessary delays.

Conclusion

The experiences of the last five years in particular have highlighted the importance of careful planning, attention to change management and fatigue and the invaluable benefits of partnering with service sector partners, staff and physicians, patients, and families of the patients cared for in an organization like St. Joseph's. St. Joseph's organizational roots, values and mission support the needs of a tertiary level mental healthcare service uniquely. Limited space for this paper prevents further details regarding strategies employed on various components, but inquiries are most welcome. **HQ**

References

- Canadian Mental Health Association (CMHA) Ontario. 2015. Retrieved November 11, 2015. <<http://ontario.cmha.ca/public-policy/context/mental-health-reform/chronology-of-reports-recommendations-and-plans/>>
- Forchuk, C. 2015. Implementing the Transitional Discharge Model (TDM) ARTIC Project. Retrieved November 11, 2015. <<http://caho-hospitals.com/partnerships/adopting-research-to-improve-care-artic/tdm/#sthash.FYCSfL1W.dpuf>>.
- Graham, R. 1988. "Building Community Support for People: A Plan for Mental Health in Ontario." Ontario Community Mental Health Committee, Toronto: Ontario Ministry of Health.
- Heseltine, G.F. 1983. "Towards a Blueprint for Change: A Mental Health Policy and Program Perspective: Discussion Paper." Toronto: Ontario Ministry of Health.
- Newman, D. 1998. "2000 and Beyond: Strengthening Ontario's MH System." Toronto: Ontario Ministry of Health.

Ontario Ministry of Health. 1993. "Putting People First: The Reform of the Mental Health Services in Ontario." Toronto: Ontario Ministry of Health.

Ontario Ministry of Health. 1995. "Implementation Planning Guidelines for Mental Health Reform." Toronto: Ontario Ministry of Health.

Ontario Ministry of Health and Long-Term Care. 2001. "Making it Work: The Next Steps: Strengthening Ontario's MH System and Making it Work: Policy Framework for Employment Supports for People with Serious Mental Illness." Toronto: Ontario Ministry of Health and Long-Term Care.

Ontario Ministry of Health and Long-Term Care. 2002. "The Time is Now: Themes and Recommendations for Mental Health Reform in Ontario: Final Report of the Provincial Forum of Mental Health Implementation Task Force Chairs." Toronto: Ontario Ministry of Health and Long-Term Care.

Ontario Ministry of Health and Long-Term Care. 2009. "Every Door is the Right Door: Towards a 10-year strategy MH and Addictions Strategy: A discussion paper." Toronto: Ontario Ministry of Health and Long-Term Care.

Ontario Ministry of Health and Long-Term Care. 2011. "Open Minds, Healthy Minds: Ontario's Comprehensive MH and Addictions Strategy." Toronto: Ontario Ministry of Health.

Sinclair, D. 2000. "Looking Back, Looking Forward: The Ontario Health Services Restructuring Commission, 1996–2000: A Legacy Report." Toronto: The HSRC Commission.

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Divestment of Beds and Related Ambulatory Services to Other Communities While Maintaining a Patient- and Family-Centred Approach

Deborah J. Corring, Deborah Gibson and Jill MustinPowell

Abstract

Individuals living with serious mental illness who require acute and/or tertiary mental healthcare services represent one of the most complex patient groups in the healthcare service delivery system. Provincial mental health policy has been committed to providing services closer to home and in the community rather than an institution wherever possible for some time. This paper articulates the strategies used by one organization to ensure the successful transfer of beds and related ambulatory services to four separate communities. In addition a case study is also provided to describe in more detail the complex changes that took place in order to accomplish the divestments of beds and related ambulatory services to one of the partner hospitals.

Introduction and Context

St. Joseph's Health Care London is a publicly funded hospital that has led mental health service system transformation in southwest Ontario following directives from the Health Services Restructuring Commission (HSRC). The HSRC began its work in April 1996. In its report, one of the recommendations was for Ontario's nine provincial psychiatric hospitals to be divested to public hospitals.

London and St. Thomas Psychiatric Hospitals were divested to St. Joseph's Health Care London in 2001. For St. Joseph's, the directives also included two additional steps. The first was the

divestment of beds and related ambulatory services to four other hospitals, closure of beds, and transfer of employment services, assisting in the development of community capacity, and the second was the construction of two new state-of-the-art facilities.

This paper documents the processes used to ensure successful transfers of beds and services and, using a case study approach, describes the specifics of one of the four transfers of beds and related ambulatory services to another community.

Ontario's first mental health policy document (Heseltine 1983) provided an important guiding principle, namely focusing the primary objective on the achievement of a continuum of service delivery while ensuring that people with mental illness can receive appropriate help in their own communities, more commonly referred to as "receiving care closer to home."

Two of the four transfers involved the transfer of tertiary care beds and related ambulatory services at St. Joseph's to two organizations that were already providing tertiary level care – one that had provided only acute care services before and one that had not had any mental healthcare services previously.

The HSRC directives stipulated that St. Joseph's transfer a total of 138 beds to the four organizations: 59 tertiary care inpatient (IP) beds and related ambulatory services to one organization, 50 tertiary care beds and related services to a second, 14 tertiary care beds and services to a third and finally 15 acute care beds and related services to a fourth.

Recognizing the importance of timing in planning and executing the transfers to four different communities, factoring in the building of new construction or renovation in order to receive the beds and services and focusing on a patient- and family-friendly process, St. Joseph's initiated meetings with the partner hospitals to discuss timing and other issues important to well-planned transfer of services.

One of the principles understood from the beginning is that once the transfer was accomplished, the receiving organizations would then serve the counties aligned with their Local Health Integration Networks (LHIN), and St. Joseph's catchment area would be reduced accordingly. Following a format put in place at the first transfer, and utilizing project management strategies, a steering committee composed of representatives from both hospitals and both LHINs was formed to oversee the details of the transfer and ensure timely and participative communication and decision-making. A kick-off meeting between parties enabled partnership by providing an opportunity for all strategic players to meet each other prior to the start of the work.

The two vice-presidents of mental health at each hospital served as the project sponsors, and senior leaders from finance, human resources, facilities planning, communications and support from both hospitals were named to the committee. In addition, each hospital named a project lead, formed project teams at each site and formed an internal advisory committee to oversee the project internally. A project charter was developed and approved by both project sponsors.

Implementation of Directives at the Patient Care Level

Challenges and Strategies Employed

The primary planning principle agreed upon by all organizations was to ensure that individual patients and their families associated with the transfer were not impacted negatively. A patient transfer committee was formed within St. Joseph's, with a mandate to plan and implement communication and care planning strategies individualized to each patient and family. Their work started several months before the actual transfer and also included providing advice regarding how beds would be decommissioned in preparation for the transfer without unduly impacting access to remaining beds. Beds were to be decommissioned in several of the clinical programs. Each program had patients who were complex and had long lengths of stay.

A discharge planning exercise began, focused on long-stay patients. This strategy is further detailed in another article in this issue – "Mental Health System Transformation: Drivers for Change, Organizational Preparation, Engaging Partners and Outcomes." The exercise involved engaging community mental health agencies, the appropriate Community Care Access Centre (CCAC), Long-Term Care (LTC) home repre-

sentatives and the local LHIN in developing discharge plans for individuals with the right housing and right supports. Given the closure of beds, the CCAC was also able to grant "crisis" status to patients waiting for LTC. The committee recommended that phasing of bed decommissioning occur over 2 to 3 months in order to ensure access to beds in the time before the transfer took place. Using this approach, beds could be taken offline as discharges occurred.

While this work went on, meetings between clinical teams at both hospitals focused on planning for each individual IP transferring. This planning was designed to assist in the preparation of patients, families and clinicians for the transfer. Receiving hospitals included their community mental health agency partners and a representative of their LHIN to also explore possible community alternatives for individuals prior to being transferred to one of their beds. By the end of each process, fewer patients than those identified at the beginning of the process required transfer, with several others discharged to appropriate facilities and support in the local community. This strategy engaged community partners, the LHIN and other sectors early on, thereby preventing the filling and potentially blocking of beds as well as finding patient- and family-friendly alternatives to an IP bed.

Planning for the transfer also required agreement between partners, including any local acute care facilities, that there would be no new admissions or transfers from their area one month before the transfer date. This was meant to minimize patients and their families having to start their care in St. Thomas or London and then have it transferred shortly afterward to the receiving facility. Finally, it was agreed that the actual patient transfers would occur over several days in order to coordinate the movement of St. Joseph's staff who were also transferring with the beds to ensure the delivery of appropriate care at both facilities.

As noted below in the outcomes section, a considerable number of staff from St. Joseph's took advantage of transferring with the work. While this certainly assisted in minimizing the impact on staff, overall, it presented the St. Joseph's clinical programs with the challenge of staffing beds that had not yet been transferred and decommissioned, while the receiving organization oriented the transferring staff over a one-month period while the patients were still in St. Joseph's beds.

It was a little like "building a 727 while in flight," one leader said. In addition, one of the receiving hospitals was experiencing issues with recruitment of additional clinical staff in the local area that were needed to fully staff all of the beds, as they would be negatively impacting staffing at local acute facilities in the process. Agreement was reached at a local level and with St. Joseph's that only a portion of the transferring beds would be opening, with all of them being occupied with the identified IPs from St. Joseph's. The opening of the remaining beds was to be managed by the organization and the LHIN.

The transfer of assertive community teams (ACTs) associated with the geography of the receiving organizations was achieved without difficulty. The transfers were easier because the teams were already physically located in the locality of the transfer, with staff and patients already residing in their communities. One community was also able to accept the transfer of dual diagnosis OPs without difficulty, while another had to build capacity to receive these patients. St. Joseph’s worked with that community for more than a year to help build the capacity by providing education to local providers.

Other administrative issues that were managed included coordinating mitigation strategies to minimize staff impacts (internal transfers, early retirement offers, transfers with the work and voluntary exit packages), and the finalization of the transfer agreement between the two hospitals.

Outcomes

The project outcomes were identified at the beginning of the project and tracked regularly throughout. They are outlined below in Table 1.

Case Study – St. Thomas Elgin General Hospital

Context

The HSRC directives required St. Joseph’s to transfer 15 acute care IP beds and related ambulatory services to St. Thomas Elgin General Hospital (STEGH). After transfer, these services would provide the acute (both IP and OP) and emergency

mental healthcare needs for citizens of Elgin County previously provided by St. Joseph’s. After transfer, St. Joseph’s would continue to provide tertiary IP care when necessary for Elgin county residents and continue to provide ambulatory care in the county through ACTs and other OP services. As noted above, the same project management strategies were put in place.

Challenges and Strategies Employed

As noted above, planning for patients and families impacted by the upcoming transfer took centre stage. A patient transfer team was put in place and meetings arranged with STEGH clinical leaders, community mental health agency partners and representatives of the South West (SW) LHIN to discuss potential discharge planning for patients, which in the end resulted in only four IPs being transferred.

A bigger part of this transfer was the work that needed to be done to ascertain which of the approximately 1,000 OPs should continue receiving tertiary level, OP follow-up with St. Joseph’s, which patients could be transferred back to their family physicians for care, and which were in need of acute care-level follow-up. An extensive review of their clinical needs was completed by their clinical teams and resulted in the transfer of 300 OPs to STEGH.

Further complicating this transfer was the issue of new facilities for STEGH not being scheduled for completion until 2017/18. St. Joseph’s new facility in St. Thomas was due to be opened in June 2013 and the former facility decommissioned in the fall of 2013.

TABLE 1.
Project Outcomes

Project Outcome	How Was This Outcome Met?
Project completed on time and within budget	Local system issues and human resources challenges often delayed opening of the beds at receiving hospitals. Program transfer agreements were adjusted accordingly, extensive discussions were held with all affected and all parties agreed that the project was completed to all parties’ satisfaction.
“Successful” transfer of beds and ambulatory services	Transfer of identified IPs, ACTs and related ambulatory services for persons with dual diagnosis completed on time and within budget.
Preserve financial/budget resources	Decommissioning of units/beds at St. Joseph’s and financial transfer to receiving hospitals completed on time.
Minimize staff impacts	Staff was impacted by delays and lack of information at various points in the process, but in the end, after all transfers and bed reductions, more than 130 staff transferred with the beds, more than 170 were reassigned within St. Joseph’s, more than 60 accepted early retirement offers and voluntary exits, and less than 20 were given layoff notices and exit packages.
Minimize disruption to patient services	Disruption to patient services was minimal. Access to beds was maintained. Quarterly tracking of access to St. Joseph’s beds occurred during the period from 2011 to 2015. Bed access was maintained at an average of 11 days during 2011–2012 and was reduced to an average of 3 days thereafter. See further metrics data in “Mental Health System Transformation: Drivers for Change, Organizational Preparation, Engaging Partners and Outcomes” in this issue.
Minimize disruption to the individual patients impacted by these transfers and their families	Detailed planning by patient transfer team and weekly meetings between St. Joseph’s and receiving clinical teams in the weeks prior to the transfer resulted in minimal impacts to patients and families. Patient and family satisfaction was evaluated through feedback from these parties and was judged to be successful.

In consultation with the SW LHIN and the Ministry of Health and Long-Term Care, the decision was made to renovate existing space at STEGH to accommodate the acute care service as a temporary measure until the new building was completed. The first transfer date chosen was May 30, 2013, to coordinate with the opening of St. Joseph's new facility. Unfortunately, as sometimes happens with renovations of older buildings, unforeseen issues arose that made the May date impossible to achieve, and the transfer date was changed to September 30, 2013. Intensive discussions were held regarding options for delivering care in the interim and included representatives from STEGH mental health and emergency department leaders, local and provincial police, ambulance services, community mental health agencies and the SW LHIN. In the end, the decision was made to relocate the IP services to the St. Joseph's facility in London, relocate the OP services to a community location in the city of St. Thomas and provide clinician and physician support directly to the STEGH emergency department.

Strategies were also put in place to use the wait time to provide orientation to staff for the transfer to their new employer. Staff who had chosen to transfer with the work were assigned to the IP unit where the transferring beds were located and to the OP work that was relocated, and any other staff not transferring were reassigned within St. Joseph's. This strategy allowed for STEGH to plan and deliver the necessary orientation for their new staff while they were waiting for the renovations to be completed. A further delay in the transfer date to January 2014 emphasized the wisdom of relocating the services in preparation for the transfer.

Other administrative issues that were managed included the provision of beds and other furniture to STEGH (which was possible because St. Joseph's would be receiving new beds and furniture with its new facility) and the finalization of the transfer agreement between the two hospitals.

Outcomes

The project outcomes were identified at the beginning of the project and tracked regularly throughout. They are outlined below in Table 2.

Lessons Learned

- Factors such as careful, collaborative planning for patients who were transferring, timing of bed transfers and bed decommissioning, planning for discharge of long-stay patients and maximizing alternatives for staff to minimize impact on them all contributed to the success of the overall effort.
- Wait time for access to the remaining beds at St. Joseph's was reduced over time, thereby minimizing impact on the overall system dependent on those beds. Recognition in each transfer that it was not just the two hospitals impacted but also other hospitals and community partners was critical in completing the transfers. Working with all involved LHINs and Ministry of Health and Long-Term Care (MOHLTC) policy directives for levels of service assisted in sorting

TABLE 2.
STEGH Transfer Project Outcomes

Project Outcome	How Was This Outcome Met?
Project completed on time and within budget	Transfer of four IPs and related ambulatory services (300 OPs). Transfer was delayed twice and required a contingency plan that relocated IP and ambulatory services for 9 months.
"Successful" transfer of beds and service and patient demand to St. Thomas Elgin General Hospital and receiving community	Patient aspects of transfer were successful. Beds and other furniture were also transferred.
Preserve financial/budget resources	Decommissioning of units/beds at St. Joseph's completed on time, 33 staff transferred to STEGH, 9 staff reassigned and no layoff notices needed
Minimize staff impacts	Staff was impacted by delays and lack of information at various points in the process.
Minimize disruption to patient services	There was no disruption to patient services. Access to beds maintained with a weekend hold on admissions at the time of transfer.
Minimize disruption to the individual patients impacted by these transfers and their families	No negative impacts to patients and families were noted. Patient and family satisfaction was evaluated through feedback from these parties and was judged to be successful. STEGH acknowledged that mental healthcare was new to their organization and focused considerable efforts on preparing their staff and their community for the opening of their mental healthcare unit, with an emphasis on addressing stigma. The campaign entitled "Opening Hearts, Opening Minds" sought to build a welcoming environment for patients and families. See comments below.

out what was once thought to be the mandate of provincial hospitals and reaching agreement with partners regarding who was to provide what in the respective communities. In one community, St. Joseph's had for some years accepted acute care IP overflow but knew going forward that this could not continue. Negotiations with the LHIN, MOHLTC and a hospital not part of the transfers eventually resulted in an increase in acute care beds in the region to the satisfaction of all concerned.

- Minimizing staff impacts was also an important objective. St. Joseph's reached early agreement with the involved union locally to use mitigating strategies noted above in Table 1 with good effect. Additionally, for each transfer, meetings were held with receiving and sending unions to facilitate cooperation between unions.
- We learned the importance of ensuring communication with patients and families so that they are adequately informed of plans going forward.

Opening Hearts, Opening Minds

The central message of the campaign was "care closer to home means we now serve all community members in our hospital." St. Thomas is a community where everyone knows everyone. When the first patient arrived, the registration clerk remarked, "She is my best friend." This illustrated how people with mental illness keep the fact that they are receiving care from even their best friends. Later that day, a colleague told the leader that his mother's best friend was receiving mental healthcare and how pleased he was that STEGH had addressed stigma in their culture. **HQ**

References

Heseltine, G.F. 1983. *Towards a Blueprint for Change: A Mental Health Policy and Program Perspective: Discussion Paper*. Toronto: Ontario Ministry of Health.

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Relentless Incrementalism: Shifting Front-Line Culture from Institutional to Recovery-Oriented Mental Healthcare

Deborah J. Corring, Jennifer Speziale, Nina Desjardins, and Abraham Rudnick

Abstract

St. Joseph's Health Care London is a publicly funded hospital that has led mental health service system transformation in south west Ontario following directives from the Health Services Restructuring Commission (HSRC).

This paper documents how provincial policy, HSRC directives, organizational planning, research projects, quality initiatives and change management activities drove, shaped and accomplished a cultural shift at the front line to recovery-focused care.

Simultaneous to these activities, beds and related ambulatory services were divested to four other hospitals, beds and employment services were closed and two new, state-of-the-art facilities were constructed, adding considerable complexities to achieving cultural change. This paper documents the incremental steps that were taken to achieve that change.

Introduction

Until the 1980s, the understanding in the mental healthcare field generally was that a severe mental illness (SMI), particularly a diagnosis of schizophrenia, entailed a deteriorating course. Individuals and families of individuals with such SMIs were counselled to expect that they or their relatives were unlikely to achieve much in life and that the illness they were experiencing would require lifelong treatment and support as well as long periods in hospital. Treatment tended to focus on

psychopathology and symptom control rather than on strategies for rehabilitation related to functional roles and learning to live with mental illness and achieve a desired quality of life (Anthony 2005).

Recovery-oriented care was first formally introduced to the professional field by William Anthony in 1993, although people with lived experience of SMI such as Patricia Deegan had been speaking and publishing about recovery and related care since the 1980s. Anthony suggested that recovery from mental illness involved more than recovery from the illness itself. He noted that “people with mental illness may have to recover from the stigma they have incorporated into their very being: from the iatrogenic effects of treatment settings; from the lack of recent opportunities for self-determination; from the negative side effects of unemployment and from crushed dreams” (Anthony 1993).

Stigma is produced and exacerbated by several sources – society in general, service providers, other persons with mental illness and self-stigma (Corring and Cook 2007). The Mental Health Commission of Canada (MHCC) defines *stigma* as beliefs and attitudes about mental health and mental illness that lead to negative stereotyping of people and prejudice against them and their families (MHCC 2009). This paper will focus on how one Canadian mental healthcare organization tried to address the stigma of its healthcare providers.

Shifting from institutional care to recovery-oriented care

Early Stages

Major reform in service systems, along with significant improvement in treatment and rehabilitation strategies, now makes it possible for people with SMI to live more independently in the community (World Health Organization 2001).

One of the major service system changes is the adoption of recovery-oriented service delivery by mental healthcare facilities. Research has documented improved outcomes of individuals with SMI using this approach to care. In *Toward Recovery and Well-Being: A Framework for a Mental Health Strategy for Canada*, the MHCC noted as its Goal #1 that “people of all ages living with mental health problems and illnesses are actively engaged and supported in their journey of recovery and well-being” (MHCC 2009). Yet, despite the progress noted above, change at the front line of care delivery, particularly in inpatient settings, has been slow.

In Ontario, in 1997, the HSRC tabled a number of significant directives to shift mental healthcare service delivery in south western Ontario. Of particular significance to this paper is the transfer of governance and management of the London and St. Thomas Psychiatric Hospitals as part of a three-tiered process (Corring 2015) to St. Joseph’s Health Care in 2001. The long-term goal established for St. Joseph’s was to focus on becoming a state-of-the-art, specialized (tertiary) mental healthcare facility providing both inpatient and ambulatory services.

From the beginning, St. Joseph’s set about planning for a number of preparatory steps to achieving the next two tiers of restructuring but also knew that attention to the culture of providers at the front line of care was critical to achieving an organization that was fully oriented to recovery.

In the early years, the organizational mission and values would be stated, and various educational activities provided. Despite these efforts, improvement of the attitudes of front-line care providers was slow in regard to the potential for recovery of those being treated in inpatient services, and many institutionalized practices, such as focusing mainly on safety, continued. Something more was needed to achieve change at the front line. It was acknowledged that such fundamental change was an extremely complex process and would require smaller, incremental changes to translate what we saw in the research literature into everyday practice.

Later Stages

Clinical program leadership that believed in, and was committed to, recovery-oriented care was fundamental for change to occur. Therefore, St. Joseph’s realigned the clinical programs and leadership. Prior to the realignment, clinical programs consisted of large general adult programs and small specialty programs.

Realignment strengthened the focus on providing specialty care for individuals with psychotic and mood disorders.

Additionally, a consultation was arranged with acknowledged experts in psychiatric rehabilitation and recovery, with a mandate for a review of current programs and services, noting areas of strength and areas needing improvement.

The consultants provided 27 recommendations focusing on translating St. Joseph’s vision into action, by engaging stakeholder groups in developing an action plan; maintaining momentum without skipping important steps in the implementation process; focusing on building a culture of affirmation, respect and hope; using recovery-oriented language in care planning and documentation; building on identified internal models of excellence; strengthening the patient and family councils; involving community partners in the change and evaluating the implementation of all initiatives attempted for change.

Pilot Projects and Their Evaluation

The Recovery Milieu Project

In an effort to understand what the important elements were to move an inpatient unit with a traditional custodial approach to care to one that is oriented to recovery, a 6-month pilot project was begun on an inpatient unit that was part of a clinical program caring for persons with psychotic disorders.

The unit was an assessment unit with an average length of stay of 3 to 6 months. The aim of the project was to develop a recovery milieu in order to offer each patient an opportunity to maintain, enhance and practice adaptive coping, such as independent living skills and engaging in healthy routines important for safe, successful and satisfying community living.

Several months were spent with a number of front-line providers, planning the project and identifying changes to the unit milieu that would be necessary to support recovery. The changes included, but were not limited to, access to showers when patients wanted to access them rather than at designated times, individualized medication sessions conducted by nurses with patients rather than lineups for meds, the ability to prepare meals on the unit rather than having to receive them from the hospital food services, and the availability of lockers for personal belongings rather than having to store valuables at the care station.

All providers were trained in basic recovery principles using the Illness Management and Recovery approach (Mueser et al. 2012), cognitive behavioural therapy tenets, and rehabilitation readiness strategies. A few providers were already prepared with advance training in these interventions.

As part of an individual recovery/care plan that the patient had access to, he or she determined the need for meal preparation support; home management skills education; relapse-prevention education; peer support; family support; budgeting

skills training; self-care training, including dental hygiene and other physical wellness; medication management; social, vocational, educational, leisure and other meaningful activities; wellness activities; symptom management; substance use management; cognitive remediation and spiritual care support.

This pilot project was evaluated using a focused ethnography framework (Knoblauch 2005). After research ethics board approval, the following methods were used to gather data: focus groups, individual interviews, field journals, document analysis and (pre/post project) Recovery Knowledge Inventory surveys (Bedregal et al. 2006).

Analysis of results was generally positive. Patients spoke of an inviting atmosphere that they had not experienced on other inpatient units. They described the unit as welcoming, quiet and relaxing. One patient described his relationship with a provider as “contact conscious,” with providers addressing his immediate and other needs and goals in an open working relationship. Providers shared how their past, pessimistic assumptions about patients’ capabilities regarding cooking their own meals, managing personal belongings or administering self-medication were challenged and changed as part of the project. An informal check six months later indicated that, despite unrelated change in the organization affecting this unit and others, these gains were sustained.

The Smart Apartment Project

Simultaneous to this pilot project was the creation of a “smart apartment” within the hospital. Building on the knowledge that many people with psychosis also experience cognitive impairments and that smart technology had been used with good effect with other cognitively challenged persons, such as people with dementia (Haig and Yanco 2002), a research project associated with the same unit was established.

A convenience sample of eight inpatients was provided cognitive remediation via smart technology. Each participant lived alone for up to one month in the apartment and engaged in daily living activities such as cooking, cleaning and socializing. They also received care as usual. The technology assisted them in keeping appointments, checking in with providers each day via audio and video communication between the inpatient unit and the apartment to explore well-being and to monitor and prompt for daily living activities such as medication adherence and meal preparation.

Evaluation consisted of baseline and end-of-intervention measures, comprising individual semi-structured interviews with participants and focus groups with providers, as well as quantitative measures such as cognitive testing. Comparative thematic analysis (Boyatzis 1998) was applied to the coding of the individual interview and focus group transcripts.

Qualitative data about the smart apartment revealed three major categories of themes – the apartment experience, the

technology and learning to live on one’s own. Patients reported the apartment as a chance to experience living on their own with the support of the inpatient team. It gave them a sense of privacy that was not possible on the inpatient unit and a place to build confidence in advance of discharge. The technology provided for an interface with providers when the patient felt the need for it and for life skills building. Learning to live on one’s own in a safe setting increased patients’ confidence regarding discharge.

Quantitative data showed moderate improvement in cognitive abilities, but it did not reach statistical significance (Corring et al. 2012). This study is part of a larger, citywide research project that is still in process.

The Vital Behaviours Project

The Mental Health Care (MHC) leadership of the organization was pleased with the success of the two projects and recognized the need for a strategy that would have wider impact across all inpatient units. A small working group of front-line providers, physicians and leaders was formed to plan such a strategy.

An extensive scientific and grey literature review was conducted and revealed a number of strategies used by other facilities. The general conclusion of the planning group was that a preliminary step was necessary. The group identified the need for a project that would identify and reinforce basic vital behaviours (of providers) critical to adopting a recovery orientation to care.

Building on the introduction of the more general Vital Behaviours (Patterson et al. 2008) training that St. Joseph’s was introducing across the organization, the planning group initiated the Vital Behaviours project. It was designed as a quality improvement initiative with formal evaluation and was supported by the MHC leaders and the union’s executive leadership.

A mixed-methods evaluation design with five pilot units and five control units, utilizing focus groups, behavioural observations and quantitative surveys of knowledge and attitudes was used, at baseline, during and after three months of intervention. Communication from leadership emphasized that providers, including physicians of the pilot inpatient units, were expected to demonstrate the vital behaviours on a regular and consistent basis.

Three vital behaviours were addressed: 1) being fully present with patients and families, with an emphasis on being welcoming and using patient and family member names when meeting with them; 2) anticipating care needs and wants through individual conversations with patients on a regular basis and asking how providers and physicians may be of assistance; and 3) engaging patients in purposeful, meaningful conversation and activity to assist them in realizing their goals.

Provider participation in the formal evaluation was limited, probably due in large part to the considerable change occurring in the organization that involved bed and service transfers

to another organization and closure of vocational rehabilitation programs and a parallel human resources process resulting in potential layoffs. Many providers were suspicious of the motivation behind the evaluation and chose not to participate, and other providers vocalized their embarrassment that such basic behaviours needed to be emphasized, although they acknowledged that some of their colleagues did not engage in these behaviours. Providers in the focus groups were able to identify barriers to adoption of these vital behaviours and strategies for wider adoption among providers. The conclusion was that although gains were made, wider impact and adoption of recovery-oriented behaviours had not yet been achieved.

Additional Initiatives to Date

St. Joseph's had also formed the Quality and Recovery Advisory Group during this time, as part of continuing to move this set of initiatives forward. Representatives from all clinical programs and from all disciplines and professions as well as leadership, met monthly to review and advise on program-specific and overall organizational efforts to continue to advance the recovery agenda.

These meetings generated the Enhancing Patient and Family Experience project. This project was based on the work of the Center for Nursing Excellence (International Global Center for Nursing Excellence 2013) that outlined strategies for using patient stories to increase provider appreciation of patient experiences and ultimately to improve patient care.

Mental health research has indicated that hearing directly from persons with mental illness about their experience, i.e., their story, has the greatest impact on reduction of stigma and thus enhances recovery opportunities (Knaak and Patton 2014).

The patient story approach was tested on two inpatient units that the advisory group thought might be the most challenging for implementation; one was a forensic program treatment unit and the other was a dual diagnosis (developmental disability with mental or behavioural disorder) program unit. Providers were asked to meet with their assigned patients and use a set of questions to explore with the patient various aspects of their lives outside the hospital. They were then to do some self-reflection regarding what they had learned and share those reflections with the rest of the treatment team.

Providers on both units adopted the strategy with little effort, incorporating it into everyday activities without too much difficulty and expressing some surprise that it had expanded their view of patients and challenged them to think differently about care plans.

With the relocation of the original mental healthcare building onto a new site neighbouring with physical rehabilitative medicine, the goal of embedding a recovery-orientated philosophy of care has been identified as a priority project within the organization, and a blueprint for design is underway.

Lessons Learned

- The primary lesson learned is that this type of fundamental attitude change of mental healthcare providers takes time, patience and determination.
- Mission statements, educational activities and communication from leadership, although well intentioned, are not sufficient to shift cultures of practice without concrete and persistent reinforcement at the front line of behavioural expectations in delivering such recovery-oriented care.
- The simpler the strategy the more effective it can be. Changes to everyday – seemingly unimportant – routines such as allowing and enabling patients to shower when they feel the need can have important effects.
- Providers who predicted that chaos would result from such a change in routine learned that chaos did not occur and in fact, the change brought unforeseen benefits to them as well as to the inpatients, with time freed up for other duties.
- Time spent with patients learning about their lives before hospitalization reminds providers that they are dealing with human beings who are much more than just someone with an illness.
- The consultants' advice "to maintain momentum without skipping important steps in the implementation process" was wise, even though we may not have fully grasped the implications of that at the time. This work takes incredible amounts of energy and persistence and, when possible, one, or preferably more than one, person should be dedicated to focusing exclusively on this work.
- Finally, this work takes time. The activities described above have taken place over the last nine years. Significant progress has been made, but we are not done yet, and improving the patient experience with a recovery-oriented approach will continue to be a high priority for the hospital's quality improvement plans. Further evaluation as well as research is needed on this matter.

The strategic indicators related to patient experience and restraint and seclusion will be a focus of the council's work during the new strategic plan. Building upon the recent improvement in patient satisfaction scores by implementing initiatives targeted at enhanced provider and patient communication strategies, the design of a new strategy will focus on the creation and implementation of meaningful activities for patients, and we will foster focused quality improvement projects on assessing

the patient experience through experienced-based design methodologies.

In addition, care delivery process improvements, including the standardization of clinical assessment methodologies and tools, reflection and debriefing practices related to the use of restraint and seclusion and the development of enhanced care pathways between inpatient and outpatient services, will occur by applying the principles of recovery-oriented care.

Policy Implications

Adoption of service delivery approaches such as a recovery-oriented approach is complex. The experience outlined above will hopefully inform and make clear for healthcare leaders as well as funders and policy-makers that time, energy and resources are needed to accomplish such fundamental culture change in an organization. The investment is well worth it and will result in improved outcomes for persons living with SMI and other mental illness (and arguably substance use challenges) if we can move beyond the words and address everyday behaviours of healthcare practitioners that reinforce a recovery-oriented approach to care. **HQ**

References

Anthony, W.A. 1993. "Recovery From Mental Illness: A Guiding Vision of the Mental Health Service System in the 1990s." *Psychosocial Rehabilitation Journal* 16(4): 11–23.

Anthony, W.A. 2005. "Forward." In L. Davidson, C. Harding and L. Spaniol, eds. *Recovery From Severe Mental Illnesses: Research Evidence and Implications for Practice*. Boston, MA: Center for Psychiatric Rehabilitation.

Bedregal, L., M.J. O'Connell and L. Davidson. 2006. "The Recovery Knowledge Inventory: Assessment of Mental Health Staff Knowledge and Attitudes About Recovery." *Psychiatric Rehabilitation Journal* 30(2): 96–103.

Boyatzis, R.E. 1998. *Transforming Qualitative Information-Thematic Analysis and Code Development*. Thousand Oaks, CA: Sage Publications.

Corring, D. and J.V. Cook. 2007. "Use of Qualitative Methods to Explore the Quality of Life Construct From a Consumer Perspective." *Psychiatric Services* 58(2): 240–44.

Corring, D., E. Lundberg, R. Campbell and A. Rudnick. 2012. "Using Smart Technology in a Simulated Apartment With Tertiary Care Inpatients: A Feasibility and Exploratory Study." *Psychiatric Services* 63(5): 508.

Corring, D., S. Whittall, J. MustinPowell, S. Jarman, P. Chapman and S. Sussman. 2015. "Mental Health System Transformation: Drivers for Change, Organizational Preparation, Engaging Partners and Outcomes." *Healthcare Quarterly* 18 (Special): 6–11. doi:10.12927/hcq.2016.24441

Haigh, K.Z. and H.A. Yanco. 2002. "Automation as Caregiver: A Survey of Issues and Technologies." In AAAI Workshop on Automation as Caregiver: The Role of Intelligent Technology in Elder Care. Edmonton, AB. 39–53.

International Global Center for Nursing Excellence. 2013. *Elevating the Patient Experience: Advancing Towards Person-Centred Care*. Washington, DC: The Advisory Board Company.

Knaak, S. and S. Patton. 2014. *Building and Delivering Successful Anti-Stigma Programs for Healthcare Providers: Results of a Qualitative Study*. Ottawa, ON: Mental Care Commission of Canada.

Knoblauch, H. 2005. "Focused Ethnography." *Forum: Qualitative Social Research* 6(3): Art. 44.

Mental Health Commission of Canada. 2009. *Toward Recovery and Well-Being: A Framework for a Mental Health Strategy for Canada*. Ottawa, ON: National Library of Canada.

Mueser, K.T, S.J. Bartels, M. Santos, S.I. Pratt and E.G. Riera. 2012. "Integrated Illness Management and Recovery: A Program for Integrating Physical and Psychiatric Illness Self-Management in Older Persons With Severe Mental Illness." *American Journal of Psychiatric Rehabilitation* 15(2): 131–56.

Patterson, K., J. Grenny, D. Maxfield, R. McMillan and A. Switzler. 2008. *Influencer: The Power to Change Anything*. New York, NY: McGraw Hill.

World Health Organization. 2001. *The World Health Report 2001: Mental Health: New Understanding, New Hope*. Geneva, Switzerland: WHO Library.

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Psychiatrist Health Human Resource Planning – An Essential Component of a Hospital-Based Mental Healthcare System Transformation

Sarah Jarmain

Abstract

The World Health Organization (WHO) defines *health human resource planning* as “the process of estimating the number of persons and the kinds of knowledge, skills, and attitudes they need to achieve predetermined health targets and ultimately health status objectives” (OHA 2015). Health human resource planning is a critical component of successful organizational and system transformation, and yet little has been written on how to do this for physicians at the local level. This paper will outline a framework for developing and managing key aspects of physician human resource planning related to both the quantity and quality of work within a hospital setting. Using the example of a complex multiphase hospital-based mental health transformation that involved both the reduction and divestment of beds and services, we will outline how we managed the physician human resource aspects to establish the number of psychiatrists needed and the desired attributes of those psychiatrists, and how we helped an existing workforce transition to meet the new expectations. The paper will describe a process for strategically aligning the selection and management of physicians to meet organizational vision and mandate.

Introduction

Health human resource planning is a critical component of successful organizational and system transformation. It is increasingly recognized that robust human resource manage-

ment practices are a necessary condition for the successful reform of healthcare services (Bach 2001), and these practices need to be developed in conjunction with the desired reforms. To be effective, physician human resource planning should involve consideration of the number of physicians required, the types of roles they need to fulfill, the competencies to fulfill these roles and the attributes of the individual physicians that will support the delivery of evidence-based, high quality, patient-centred care. While there are many frameworks that outline the stages of strategic human resource planning and talent management, they can be summarized as follows:

1. Planning – identify the organization’s human resource needs as determined by a review of organizational need, strategic direction and current and future gaps in numbers or competencies
2. Selection – sourcing, recruiting and selecting individuals with the right knowledge, skills and attitudes
3. Alignment – developing an onboarding process that introduces the candidate to the desired organizational behaviours and performance objectives; subsequent performance development and management to align with organization vision and values
4. Retention – ongoing engagement and empowerment, learning and development, rewards and recognition
5. Succession – career development, transition management and succession planning

This paper will review the relevant literature in physician health human resource planning and describe how one organization (St. Joseph's Health Care London) developed processes to support the planning, selection and alignment of physicians through a period of significant organizational change.

Background

The Mental Health Care Program, part of St. Joseph's Health Care London, is a mid-sized academic mental health program based on two sites that serves a catchment area of approximately 1.5 million people in south western Ontario. It consists of 89 forensic psychiatry beds and 153 non-forensic specialized beds serving individuals from age 14 and up with a range of complex psychiatric disorders. However, it has undergone considerable change over the last 15 years.

In 1997, the Health Services Restructuring Commission (HSRC) in Ontario issued a number of recommendations related to hospital restructuring, including direction for the existing provincial psychiatric hospitals to be divested from the Ontario government and for investment to be made in building new mental health facilities across the province. In the south-west region, these directives resulted in the following:

- 2001: Divestment of London Psychiatric Hospital and St. Thomas Psychiatric Hospital to St. Joseph's Health Care London
- 2006–2007: Restructuring of beds and services to diagnostically based groupings to better align with peer service providers, academic mandate and best practice
- 2010, 2011, 2013, 2014: Divestment of a total of 138 inpatient beds and resources with associated outpatient services to four receiving hospitals
- 2010, 2011, 2014: Reduction in inpatient beds in three phases
- 2013, 2014: Construction of two new facilities for the mental healthcare program and services at St. Joseph's Health Care London – Southwest Centre for Forensic Mental Health Care (completed 2013) and Parkwood Institute Mental Health Care Building (completed 2014)

These structural changes within the region's specialized mental health delivery system required transformational changes of the medical staff in both the number of physicians and their competencies and characteristics. These changes included elimination of psychiatrist positions, transfer of psychiatrists with the divestment of beds and services to other communities and a requirement for increased academic focus and greater specialization. There was a corresponding shift in the philosophy of care from a more traditional, custodial approach to a care model consistent with the principles of recovery and rehabilitation, which similarly required different roles, skills and attitudes

within the psychiatric workforce providing care.

While these structural and cultural transformative changes impacted significantly on the human resource needs of all disciplines, it was particularly essential to attend to these issues within the medical staff, for the following reasons. Whether they hold a position of authority or not, physicians are often looked to as informal leaders by the rest of the interdisciplinary team, and therefore often have a significant impact on the culture of the team. They are also a relatively scarce resource. Lau and colleagues outline a number of studies that suggest that Canada is already experiencing a shortage of psychiatrists and that this problem is projected to worsen significantly over the next 10 years (Lau et al. 2015). Given this shortage, and the fact that it can take from 6 to 18 months from recruitment through to a physician starting with an organization, the need to retain and develop our existing workforce of psychiatrists to be able to continue to serve our region was felt to be essential.

Planning – Determination of Physician Numbers

Traditional approaches to physician health human resource planning have focused on the number of physicians required in a particular region (typically number of physicians per 100,000 population). However, much has been written on the limited utility of this approach because it fails to factor in a variety of contextual factors, including those related to the provider (e.g., stage of career, gender, productivity, degree of subspecialization), the geography (e.g., urban versus rural) and the population being served (e.g., socioeconomic factors, disease burden) (Fooks et al. 2002). Furthermore, this approach has limited utility when applied to the level of the individual organization. Sargeant and colleagues, in their position paper, "Psychiatric Human Resources Planning in Canada," suggest that the judicious application of several approaches, including benchmark, needs-based and demand-based principles, may be more useful than any one alone, as they are suited to different levels of analysis (Sargeant et al. 2010).

In the St. Joseph's Mental Health Care transformation, there was a need to determine the physician full-time equivalents (FTEs) required to support the clinical and academic mandate of the organization through the restructuring process. By identifying the desired service capacity (e.g., number of beds, outpatients served) and relevant workload variables (e.g., patient complexity, desired length of stay, assistance from team members) at each stage of the restructuring, a model was created using previously established workload benchmarks that identified the FTE of physicians needed per service area for each stage. This method allowed for proactive planning to determine the number of physician positions to transfer with divested resources or the number to be reduced to align with the proposed bed reductions. It also provided an opportunity to

explore innovative solutions to retain physicians in the region, for example, partnering with community agencies that needed to recruit psychiatrists to meet their increasing needs.

While estimating the numbers of physicians required and the associated workload is an important underpinning of human resource planning, the area has evolved to include discussions around strategic talent management and high-performance work systems – “a group of separate, but interconnected human resource practices that together recruit, select, develop, motivate and retain employees” (Zacharatos et al. 2005). There is growing evidence that healthcare organizations that have implemented and sustained such evidence-based approaches have documented substantial improvements in operating margins, workforce engagement and performance, faculty promotion rates, and quality of care (Leggat et al. 2011; Fox et al. 2011). A fundamental aspect of these approaches has been to identify the desired behaviours and competencies that will support both the strategic direction of the organization and the desired culture.

There has been a growing recognition that the environment in which physicians practice today is significantly different from that of the past. Recent healthcare reform efforts in the United States and Canada have focused on the “triple aim” of improving healthcare for individuals, improving population health and lowering costs. Physicians, who traditionally have practised with considerable autonomy, are now required to become members of the team-based patient care models that are necessary to support these aims (Mahon et al. 2013; Halpern et al. 2001). The Royal College of Physicians and Surgeons of Canada has recognized this change through its work with the CanMEDS framework, which is in the process of being updated (Frank et al. 2014). In addition to the role of medical expert, physicians are described as having the roles of communicator, collaborator, leader, health advocate and scholar. Updates from prior versions have included an increased focus on quality and patient safety, patient as partner and the role of health information technology.

Development of Physician Human Resource Planning Principles and Selection Criteria

Anticipating the significant impact of the HSRC directives on hospital restructuring, and in turn on physicians and dentists, a guiding document was prepared in 1997 by representatives from the London Hospitals Medical/Dental Staff Organizations, providing a “principled process” to guide medical human resource planning (London Hospitals Task Force on Medical Human Resources, 1997). The intent was to develop plans consistent with “the mission, role and strategic direction for each institution while considering the impact on patient care, academic and research missions.” It formed the basis for the development of a subsequent document in 2010 titled “Human Resource Planning for the Evolving Specialized Mental Health and Forensic Facilities at RMHC/SJHC.” (St. Joseph’s Health

TABLE 1.
Guiding Principles and Physician Selection Criteria

Guiding Principles
<ul style="list-style-type: none"> • Medical/dental resource planning and decision-making will be fair and transparent.
<ul style="list-style-type: none"> • All physicians/dentists will have equal opportunity to apply for positions as these become available.
<ul style="list-style-type: none"> • Hospital, academic (teaching and research) and community needs will be considered in decision-making, together with physician skill and time allotment.
<ul style="list-style-type: none"> • All stakeholders (particularly administrative partners within the hospital but including other departments/programs) will be consulted in the process.
<ul style="list-style-type: none"> • The best person for the position will be selected irrespective of prior hospital attachment or contractual relationship.
<ul style="list-style-type: none"> • An appeals process will be identified.
Physician Selection Criteria
<ul style="list-style-type: none"> • Ability and qualifications to provide evidence-based psychiatric care both in a broad, generalist context and in a range of subspecialty areas, including recovery models of care, evidence-based psychotherapies, psychopharmacology and electroconvulsive therapy (ECT)
<ul style="list-style-type: none"> • Ability for specialized physicians to upgrade where needed, within a reasonable amount of time
<ul style="list-style-type: none"> • Willingness to provide both inpatient and outpatient services
<ul style="list-style-type: none"> • Collegiality (i.e., the ability to work in a professional manner with physician colleagues and other hospital staff)
<ul style="list-style-type: none"> • Contribution (i.e., the degree to which the physician contributes to the program, hospital, university and community)
<ul style="list-style-type: none"> • Physician utilization of resources (e.g., case volumes, lengths of stay, number of separations) are within normative levels
<ul style="list-style-type: none"> • Physicians will be familiar with CanMEDs roles and will practise in this context
<ul style="list-style-type: none"> • Any complaints and concerns expressed by staff/patients regarding the physician that have led to performance management processes may factor into selection process
<ul style="list-style-type: none"> • Strong preference will be given to full-time clinical academics with an adjunct appointment being a minimal requirement
<ul style="list-style-type: none"> • For areas of Royal College subspecialization (child and adolescent, geriatric, and forensic psychiatry), demonstration of defined competencies and affiliations in those specialties will be required
<ul style="list-style-type: none"> • Seniority will not be a consideration unless all other factors between two potential candidates are judged to be equal; in this case, seniority may be the final deciding criterion

Care London Department of Psychiatry, 2010). The physician leaders within the mental healthcare program developed this document with input from key stakeholders, including the medical staff, operational program leaders and the vice-president, medical. The document identified principles and processes and the factors to be considered for physician selection. It also outlined key issues to be considered in the work, such as anticipated decreases in program funding, the need for accessible and effective ambulatory services in the region to support the reduced number of beds, the need for greater collaboration with community partners, changing demographics with an aging population, and the shift in the model of care to a recovery philosophy and emphasis on psychiatric rehabilitation. Table 1 outlines the specific guiding principles and selection criteria that were used.

The above selection criteria were translated into a “physician selection scorecard,” whereby the selection criteria were weighted based on importance to the strategic direction of the organization, and each physician was rated on each of the criteria through a consensus process. Based on these ratings, it was determined whether a physician was a high performer, a solid performer or a low performer and therefore needing improvement. The physicians were provided feedback on where they were perceived to contribute strength to the organization and where they needed improvement. Based on this feedback, a performance development plan was collaboratively created, with targets and timelines for improvement. In some situations, it was clear that the physician would not be able to meet the future requirements of the position (e.g., would not be eligible for an academic appointment with the university) and in this case discussion centred around transition planning options such as retirement or alternative work within the region.

Results and Next Steps

In 2007, St. Joseph’s Mental Health Care program had a total allocation of 64.3 FTE physicians and was staffed with 60 individuals, of which 34 (or 57%) were full-time clinical academics. Through the restructuring process, 10 individuals followed the divested beds and resources, and 5 individuals developed retirement/transition plans to leave the organization. Three physicians undertook part-time work in the community, providing collaborative care to community mental health and addiction agencies. As of 2015, the program’s physician allocation was 42.5 FTEs, with a head count of 45. Of those physicians, 35 (or 78%) were full-time clinical academics, six were adjunct faculty, and four were hospitalists providing medical care. From a qualitative standpoint, the sense is that physician engagement has significantly improved, with increased participation in program planning, medical staff meetings and academic deliverables. Workload remains a challenge due to higher-than-predicted occupancy rates and shorter lengths of stay, but there is an equitable and transparent process to deal

with these issues and plan for future changes in care delivery.

In regard to next steps, the organization is embarking on an initiative to further improve physician engagement through a focus on shared leadership practices, increased emphasis on performance measurement and ongoing quality and process improvement. Discussions are underway with a peer tertiary mental healthcare program to share elements of the physician human resource planning framework and evaluate the spreadability of the approach. There is a need to evaluate these approaches in a more formalized way and look at how they might be adapted for different settings and contexts. **HQ**

Lessons Learned

- **Physician engagement** – A key success factor in our work was the engagement of our front-line physicians in the selection of principles to guide our transformation work. This involvement facilitated the later implementation of the principles and contributed to the development of a culture of transparency and equity.
- **Communication** – We initially underestimated the need for repeated and varied communication to the physicians, given the speed at which rumours and misinformation can spread. We addressed this concern by providing monthly updates at our medical staff meetings, even if there wasn’t new information to share, along with the rollout of key information through our physician leaders and one-on-one meetings with the physicians. This was in addition to the monthly staff and physician forums that are co-led by the vice-president, mental health and the site chief.
- **Planning approaches** – A challenge in the physician planning process was the significant lead time required for making any change to physician staffing for the organization. This longer lead time was due to a combination of long notice periods for salaried physicians (approximately 12 months), the need to demonstrate a robust performance management process for those physicians who weren’t meeting the future requirements of the organization, and the typical time to recruit a new psychiatrist, which could range from 6 to 12 months. In addition to these factors, it was important to have mitigation strategies in place when physicians left the organization, well before their position was reduced. We dealt with this problem by identifying who might be willing to take on additional work on a temporary basis and ensuring we compensated individuals for this increased workload.

References

- Bach, S. 2001. "HR and New Approaches to Public Sector Management: Improving HRM Capacity." *Workshop on Global Health Workforce Strategy*, Anney France, December 9–12, 2000.
- Fooks, C., K. Duvalco, P. Baranek, L. Lamothe and K. Rondeau. 2002. "Health Human Resource Planning in Canada: Physician and Nursing Workforce Issues; Appendix A - Literature Review." *Commission on the Future of Health Care in Canada*. Retrieved November 11, 2015. <http://cprn.org/documents/14944_en.pdf>
- Fox, S., S.A. Bunton and V. Dandar. 2011. *The Case for Strategic Talent Management in Academic Medicine*. Washington, DC: Association of American Medical Colleges.
- Frank, J.R., L. Snell and J. Sherbino. 2014. *The Draft CanMEDS 2015 Physician Competency Framework — Series III*. Ottawa, ON: The Royal College of Physicians and Surgeons of Canada.
- Halpern, R., Lee, M.Y., Boulter, P.R., Phillips, R.R. 2001. "A Synthesis of Nine Major Reports on Physicians' Competencies for the Emerging Practice Environment." *Academic Medicine* 76(6):606-15.
- Lau, T., D. Zamani, E.K. Lee, K.D. Asli, J. Gill, N. Brager, R. Hawa, W. Song, E. Gill, R. Fitzpatrick, N.M. Menezes, V.H. Pham, A.B. Douglass, S. Allain, G.B. Meterissian, N. Gagnon, H. Toeg and C. Murphy. 2015. "Factors Affecting Recruitment Into Psychiatry: A Canadian Experience." *Acad Psychiatry* 39(3): 246–52.
- Leggat, S.G., T. Bartram, and P. Stanton. 2011. "High Performance Work Systems: The Gap Between Policy and Practice in Health Care Reform." *J Health Organ Manag* 25(3): 281–97. doi:10.1108/14777261111143536
- London Hospitals Task Force on Medical Human Resources. 1997.. "The Path of Development: City-Wide Medical and Dental Staff Human Resources Planning." Unpublished document. St. Joseph's Health Care London, London Canada.
- Mahon, K.E., M.K. Henderson and D.G. Kirch. 2013. "Selecting Tomorrow's Physicians: The Key to the Future Health Care Workforce." *Acad Med* 88(12): 1806–11. doi:10.1097/ACM.0000000000000023
- Ontario Hospital Association (OHA). 2015. "Physician Leadership Resource Manual." Retrieved November 11, 2015. <<https://www.oha.com/CurrentIssues/keyinitiatives/PhysicianandProfessionalIssues/QPSGT/Pages/PhysicianLeadershipResourceManual.aspx>>.
- Sargeant, J. K., T. Adey, F. McGregor, P. Pearce, D. Quinn, R. Milev and N. Dada. 2010. "Psychiatric Human Resources Planning in Canada." *Canadian Journal of Psychiatry* 55(9): 1–20.
- St. Joseph's Health Care London - Department of Psychiatry. 2010. "Human Resource Planning for the Evolving Specialized Mental Health and Forensic Facilities at RMHC/SJHC." Unpublished document. St. Joseph's Health Care London, London Canada.
- Zacharatos, A., J. Barling, and R.D. Iverson. 2005. "High-Performance Work Systems and Occupational Safety." *J Appl Psychol* 90(1): 77–93. doi:10.1037/0021-9010.90.1.77

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Social Determinants of Health: Housing and Income

Cheryl Forchuk, Kevin Dickins and Deborah J. Corring

Abstract

Social determinants of health such as housing and income have a large impact on mental health. Community-based initiatives have worked to address access to housing, prevent homelessness and assist people who are homeless with mental health problems. There have been several large research projects to tease out multiple subgroups such as youth and veterans and other individuals experiencing long-term homelessness. The issue of poverty has been addressed by exploring issues related to employment. The use of social enterprises is a promising practice to address issues around poverty, social inclusion and employment. Similarly, the community has worked to move hospital-based employment programs to the community.

Social Determinants of Health

The term *social determinants of health* refers to those “economic and social conditions that shape the health of individuals, communities and jurisdictions as a whole” (Raphael 2009: 2). Raphael gives examples of economic and social conditions as gender, education, income and its distribution in society, housing, employment and job security, access to food, access to healthcare, living with a chronic disability and membership in a minority racial group. These aspects, alone or in combination, have been shown to have a stronger association with ill health than the effects of an individual’s behaviour related to diet, smoking, physical activity or alcohol consumption (Raphael 2009).

The determinants of health were integral to the drawing up of the Ottawa Charter for Health Promotion in 1986 and were also considered central to achieving “Health for All” by the year 2000 and beyond. The concept of health promotion includes people’s capacity to actively participate in control of their health with the proviso that certain prerequisites need to be met. These provisos link back to the social determinants of health and include peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity (World Health Organization [WHO] 1986). In regard to the promotion and maintenance of mental health, these determinants are particularly significant.

Within the London-Middlesex area, we have had a number of projects examining two specific social determinants – housing/homelessness and income/poverty. There have been two Community and University Research Alliance (CURA) initiatives over the past decade to enhance capacity building in these areas using a participatory action research (PAR) approach through the active engagement of community agencies, people with lived experience and researchers.

Housing

From 2002 to 2006, the Social Sciences and Humanities Research Council (SSHRC) funded a five-year CURA project on housing and mental health. This programmatic funding enabled the development of research capacity within multiple community agencies and further understanding of how these complex

issues occur in the context of a mid-sized city surrounded by small towns and rural communities. One priority was to better understand the reason for homelessness increasing as a mental health issue and to develop strategies to address this trend. The impact of deinstitutionalization of psychiatric survivors from long-stay hospitals to community-based mental health-care, along with changing housing policy (from the federal to provincial and then municipal levels), placed some individuals at increased risk of homelessness throughout Ontario and Canada. The deinstitutionalization process happened during a period when affordable housing was limited, particularly the public housing stock. Despite the dramatic decrease of available beds within psychiatric hospitals during the early 1990s, a concurrent increase in community-based housing did not occur. The disconnect between housing policy, income support policy, and mental health policy at the provincial level in this period resulted in a situation where many people with mental health problems found themselves homeless (Forchuk et al. 2007). For example, the Toronto shelter system found that approximately two-thirds of its population had a previously diagnosed addiction and an additional two-thirds were diagnosed with other psychiatric conditions (Goering et al. 2002). In London, specific diagnoses are not tracked at the shelter level.

The provision of stable housing and having a place to call home is a basic human need (WHO 1986). A number of strategies have been developed and implemented in London that address such concerns as preventing discharge from psychiatric hospital wards to homelessness (Forchuk, Vann et al. 2011; Forchuk, Godin et al. 2013a and 2013b), addressing the specific needs of homeless youth (Forchuk, Richardson et al. 2013) and homeless veterans (Forchuk et al. in press).

To prevent discharge to homelessness, a baseline study was conducted to determine the extent of this issue. Using data from London shelters and hospitals, this phenomenon occurred, conservatively, almost 200 times per year (Forchuk et al. 2006). An intervention was then developed to more quickly provide in-hospital access to housing stability income support through a partnership with the local offices of Ontario Works and Ontario Disability Support Program, as well as providing available housing support through the local Canadian Mental Health Association (CMHA). This intervention, after pilot testing (Forchuk et al. 2008), was further refined with online support from the wards, including access to the Ontario Works database, as well as a database of accessible housing in the London area. Following this intervention, the shelter data showed a 90% drop, from an original 200 cases to just 15 direct discharges to their emergency services (Forchuk et al. 2013b; Forchuk, Richardson et al. 2013).

Another example of a collaborative project is London Community Addiction Response Strategy (CAREs), a non-profit organization that aims to improve the health and

housing outcomes of individuals experiencing homelessness who live with the complex and co-occurring challenges associated with addiction, mental health and poverty. A recent study explored outcomes in health and housing, as well as participants' healthcare utilization and emergency shelter use before and after enrollment in London CAREs. The study identified reductions in emergency room visits, resulting in decreased strain on the healthcare system while supporting individuals in the community (Forchuk et al. in press).

The work of the CURA on mental health and housing/homelessness was cumulated into a 2011 book (Forchuk, Csiernik et al. 2011) that contains two dozen chapters of published works emerging from collaborative efforts.

Income/Poverty

The London community was unprecedented in receiving a second CURA from SSHRC. The second CURA initiative focuses on poverty and social inclusion among psychiatric survivors.

The relationship between poverty and mental illness is both straightforward and complex (CMHA 2007). People with mental illness often live in chronic poverty, and conversely, poverty is a significant risk factor for poor physical and mental health (CMHA 2007). Understanding this broader context is key to addressing poverty, through the promotion of mental health and in supporting the recovery of persons with mental illness. Having a stable income, either from employment or through financial support and benefits, is directly related to other determinants of health, namely affordable housing and rent, food and transportation to access healthcare (Raphael 2009). Social inclusion, or the ability to engage fully in the community, is also somewhat dependent on available finances (Mikkonen and Raphael 2010). A community-based solution is the development of social enterprises to provide competitive quality employment for people who have experienced a mental illness. Our CURA on poverty and social inclusion has partnered with community agencies to evaluate these new approaches to employment. Examples include IMPACT Junk Solutions (IMPACT), as well as a variety of employment strategies, to replace the previously closed hospital-based employment programs at St. Joseph's Health Care London's Regional Mental Health Care Program in London and St. Thomas.

Transitioning Employment Programs From Hospital to Community

Vocationally related activities have been a part of the care for patients in St. Joseph's mental health programs throughout its history. Over the years, vocational activities have included farm work, work placements within the hospital departments and programs, greenhouse work, and light industrial packaging and assembly. As the field of vocational rehabilitation progressed, greater emphasis was placed on preparation for employ-

ment, such as upgrading education and work opportunities outside of these institutions. Sheltered workshops at both sites preceded supported employment. Sheltered workshops provide revenue-generating alternatives to the general labour market for individuals with disabilities, including psychiatric disabilities, while supported employment programs equip individuals with necessary supports and services to be successful in competitive employment (Canadian Association for Community Living 2011). Feedback from participants of the sheltered workshop programs over the years has been positive. They reported the importance of being productive, being accepted, not feeling pressured, and having opportunities for socialization. Unfortunately, a move from this type of sheltered “employment” to competitive employment was achieved by only a few.

The 1997 directives from the Health Services Restructuring Commission (HSRC) of Ontario resulted in a number of changes to the delivery of mental healthcare services in southwestern Ontario. The governance and management of the two psychiatric hospitals was transferred to St. Joseph’s Health Care London in 2001, during the initial phase. Subsequent phases in 2011 resulted in the transfer of beds and related services to four other communities, leading to a shift of resources to the community, the closure of the two vocational programs attached to the hospitals and the construction of two new mental healthcare facilities. Functional planning for the two new facilities did not involve continuing the two vocational programs. In keeping with provincial mental health reform philosophy, vocational and other rehabilitation services were to be provided in the community, rather than at an institution, in order to better assist individuals with mental illness in their reintegration into everyday life (Ontario Ministry of Health and Long-Term Care 2011).

The two programs were situated on the grounds of each hospital site and were committed to providing client-centred vocational services. The primary focus was to assist individuals to develop employment skills and provide vocational training and education opportunities. The predominant work that was available consisted of light assembly and packaging from local industry. Individuals could work a few hours or several hours per week, depending on their wish to work and their work tolerance. The limitations of what they could earn placed on them by the Ontario Disability Support Benefits and/or by other disability pension also impacted the number of hours worked, as did the availability of work available to individuals.

Clients accessing these services had a wide range of abilities and potential for competitive employment. When the closure of the two sheltered employment programs was announced, service users expressed a significant sense of loss and anxiety regarding their future. Reassurances were provided with alternative work spaces in the community, but these were met with a fair degree of pessimism.

Preparation for the closure of these services with transition to more evidence-informed vocational rehabilitation services, such as supported and transitional employment, began in earnest when partnerships across sectors were formed with the local South West (SW) LHIN: Goodwill Industries, CMHA Elgin, and the previous Western Ontario Therapeutic Community Hostel (WOTCH) organization, which later became part of CMHA London-Middlesex. In order to track what happened to individuals after these services closed and to assess the impact on them, a formal evaluation was planned and the CURA Vocational Transitions project became part of a larger CURA social enterprise initiative.

The St. Thomas sheltered workshop program closed its doors in June 2013. Goodwill developed new services in St. Thomas, based on a light industrial contract platform. Goodwill Pivotal was launched in July 2013, with some initial one-time funding from the SW LHIN. It was premised on the “choose, get and keep” model of psychiatric rehabilitation, established in the last few decades by researchers at Boston University (Danley et al. 1992). Goodwill Pivotal provides a social enterprise environment with a focus on productivity and assistance for individuals who face barriers to competitive employment. An additional service element was added that focused on transitional employment with wraparound supports, including job coaching, job-seeking support and a job development specialist. CMHA Elgin received annual funding from the SW LHIN and developed services designed to provide vocational preparation and experiences for individuals.

With London closing its sheltered workshop in March 2014, Goodwill expanded its London operation to accommodate persons who were interested in pursuing employment with them, and similar to St. Thomas, added a transitional employment element to its overall services. CMHA London-Middlesex welcomed referrals to its individualized (particularly, placement and support) vocational services, which were primarily based on a place-then-support model, for those interested in the opportunities they provided. The CURA Vocational Transitions research project has tracked individuals affected by these closures and is nearing the end of the evaluation period, with results to be reported in 2016.

IMPACT Junk Solutions

Designed to be an innovative solution to the high unemployment rate amongst individuals diagnosed with a mental illness, IMPACT was launched in the spring of 2012 as a self-sustaining social enterprise of CMHA London-Middlesex. IMPACT provides professional junk removal and commercial cleaning services to the London area. As a revenue-generating enterprise that does not receive any direct funding from CMHA or any other government source, this model poses significant operational challenges. However, these challenges

are outweighed by the benefits created through the development of a competitive employment opportunity, rather than being yet another funded program.

Having started with only 3 employees, IMPACT has quickly grown to accommodate over 25 staff in its brief 3-year existence. With each employee living with a mental health diagnosis, the perception from the community, at times, is that the quality of work will be inferior to that of a traditional provider. Contrary to these perceptions, IMPACT has been the recipient of multiple awards and nominations and has received recognition as the Ontario Government's first ever Social Enterprise Strategy. The employees of IMPACT were privileged in both 2013 and 2015 with the *London Free Press* Best of London award for the best junk removal/recycler. This recognition signified the community's embracing of the social enterprise and the abilities of those working within it.

Honoured by the Social Enterprise Strategy of Ontario, IMPACT has established a unique business model, not only for a social enterprise but unique for any revenue-generating company. IMPACT operates its junk removal service with a triple bottom line philosophy that ensures social, environmental and financial sustainability; "Focusing on People, Planet, and Profit" allows IMPACT to be successful while creating new working and learning opportunities for employees.

When IMPACT employees remove items from a customer's home or property at a cost, they transport the items back to their warehouse. They then carefully sort items that can and will be kept in the warehouse and those that can be recycled, either by another social enterprise or through other recycling avenues, as is done with electronics and metals. The items that are kept in the warehouse are instrumental to creating an ecosystem of community building. Furniture and household items are repurposed by donation to individuals and families in need, often three to four times a week. This act of social beneficence allows the employees of IMPACT to be in the position of service providers, not service recipients, a responsibility they cherish and excel in.

To date, IMPACT has diverted over 52 tons of material from landfills, either through its recycling efforts or by donations. This environmental stewardship has resonated with customers, who now call upon IMPACT as opposed to other competitors, knowing that their items can be repurposed.

In addition to junk removal services, IMPACT operates a residential and commercial cleaning service that makes up roughly 70% of its workforce. The cleaning contracts provide steady, routine employment for the cleaning employees. The cleaning contracts take place in the evening, a schedule that employees find works well with their living habits and sleep patterns. The cleaning staff fulfill several responsibilities beyond cleaning the contracted properties; they also ensure that buildings are locked each evening and alarm systems are activated

upon the completion of their shifts. Their relationships with customers have been instrumental in combatting the stigma associated with mental illness.

IMPACT has benefitted from having a workforce comprised entirely of individuals with lived experience, as none of their previous concerns with staff turnover, absenteeism and human resources management have been realized. The dedication and commitment to work demonstrated by the employees of IMPACT illustrate the advantage that competitive employment has on the well-being and recovery of individuals living with a

Lessons Learned

- It is believed that the transition of vocational support services from an institution base to that of a community agency such as was undertaken by St. Joseph's is relatively unique in the group of former provincial psychiatric hospitals.
- Although discussions began several months before the first closure, it took considerable time to put alternatives in place as they had to be built from the ground up. Although time was spent with individuals to plan for the change, the resulting down time for clients proved difficult for them. Over time, many have resumed participation in one of the alternatives but some have not done so.
- It became apparent that some of the clients were unable to make the transition due to a lack of ability to transition from a sheltered environment to one that was supportive but more demanding than the institution-based program they had been involved with in the past. If other organizations were to consider such an initiative, a planning period of at least one year is recommended to ensure smooth transitions for clients.
- The promise provided by social enterprises is worth further exploring in mental health. While there are many examples of successful social enterprises, they tend to be grassroots organizations and community-specific. Developing a social enterprise often requires different skill sets than those typically needed within organizations that provide mental healthcare. It requires an entrepreneurial approach, marketing and a strong business case to be developed.
- Linking with and learning from other social enterprises is an important strategy for success. The Social Enterprise Council of Canada can be a useful resource. However, there does not appear to be any specific list of social enterprises specifically addressing the needs of people with mental illnesses.

mental health diagnosis. Growth of this social enterprise and the awards and recognition it has already received speak to the gains made in reducing the stigma surrounding mental illness. The employees of IMPACT continue to develop themselves while strengthening their communities, one junk removal call at a time.

Implications/Conclusion

In order to address the social determinants of health, particularly as they are manifested in people with mental illness and addiction issues, it is important to foster partnerships that cross all sectors of social care and healthcare. Those who advocate for this specific subpopulation of society must think beyond solutions that predominantly focus on the mental health sector. In London, there has been a great deal of work to not only address social determinants of health, but also to evaluate the effectiveness of such approaches. **HQ**

References

- Canadian Association for Community Living. 2011. *Achieving Social and Economic Inclusion: From Segregation to "Employment First."* Toronto, ON: Canadian Association for Community Living.
- Canadian Mental Health Association, Ontario. 2007. *Poverty and Mental Illness*. Retrieved November 11, 2015. <http://ontario.cmha.ca/public_policy/poverty-and-mental-illness/#.VbjR0bXwDhk>
- Danley, K.S., K. Sciarappa, and K. MacDonald-Wilson. 1992. "Choose-Get-Keep: A Psychiatric Rehabilitation Approach to Supported Employment." *New Directions for Mental Health Services* 53, 87–96.
- Forchuk, C., R. Csiernik and E. Jensen. 2011. *Homelessness, Housing, and Mental Health: Finding Truths, Creating Change*. Toronto, ON: Canadian Scholars' Press Inc.
- Forchuk, C., M. Godin, J.S. Hoch, S. Kingston-MacClure, M.S. Jeng, L. Puddy and E. Jensen. 2013a. "Preventing Homelessness After Discharge From Psychiatric Wards: Perspectives of Consumers and Staff." *Journal of Psychosocial Nursing and Mental Health Services* 51(3): 24–31.
- Forchuk, C., M. Godin, J.S. Hoch, S. Kingston-MacClure, M.S. Jeng, L. Puddy and E. Jensen. 2013b. "Preventing Psychiatric Discharge to Homelessness." *Canadian Journal of Community Mental Health* 32(3): 17–28.
- Forchuk, C., L. Joplin, R. Schofield, R. Csiernik, C. Gorlick, and K. Turner. 2007. "Housing, Income Support and Mental Health: Points of Disconnection." *Health Research Policy and Systems* 5: 14.
- Forchuk, C., S.K. MacClure, M. Van Beers, C. Smith, R. Csiernik, J. Hoch and E. Jensen. 2008. "Developing and Testing an Intervention to Prevent Homelessness Among Individuals Discharged From Psychiatric Wards to Shelters and 'No Fixed Address.'" *Journal of Psychiatric and Mental Health Nursing* 15(7): 569–75.
- Forchuk, C., J. Richardson, and H. Atyeo. In press. "Addressing Homelessness Among Canadian Veterans." In Canadian Observatory on Homelessness, eds., *Exploring Effective Systems Responses to Homelessness*. Toronto, ON: The Homeless Hub.

Forchuk, C., J. Richardson, K. Laverty, M. Byrant, A. Rudnick, R. Csiernik, ... and C. Kelly. 2013. "Service Preferences of Homeless Youth With Mental Illness: Housing First, Treatment First, or Both Together." In S. Gaetz, B.O'Grady, K. Bucciari, J. Karabanow and A. Marsolais eds., *Youth Homelessness in Canada: Implications for Policy and Practice*. 95–110. Toronto, ON: Canadian Homelessness Research Network Press.

Forchuk, C., G. Russell, S. Kingston-MacClure, K. Turner and S. Dill. 2006. From Psychiatric Ward to the Streets and Shelters. *Journal of Psychiatric and Mental Health Nursing* 13(3): 301–08.

Forchuk, C., R. Vann, E. Wilura, J. Hoch, M. Jeng, S. Kingston-MacClure and E. Jensen. 2011. "Reducing Psychiatric Discharges to Homelessness." *European Psychiatry* 26(1): 1717.

Goering, P., G. Tolomiczenko, T. Sheldon, K. Boydell and D. Wasylenki. 2002. "Characteristics of Persons Who Are Homeless for the First Time." *Psychiatric Services*, 53(11): 1472–74.

Mikkonen, J. and D. Raphael. 2010. *Social Determinants of Health: The Canadian Facts*. Toronto, ON: York University School of Health Policy and Management.

Ontario Ministry of Health and Long-Term Care. 2011. *Open Minds, Healthy Minds: Ontario's Comprehensive Mental Health and Addictions Strategy*. Ontario: Queen's Printer for Ontario.

Raphael, D. 2009. *Social Determinants of Health: Canadian Perspectives* (2nd ed.). Toronto, ON: Canadian Scholars' Press Inc.

World Health Organization. 1986. *The Ottawa Charter for Health Promotion*. Retrieved from <http://www.who.int/healthpromotion/conferences/previous/ottawa/en/WHO>.

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Peer Support

Cheryl Forchuk, Michelle Solomon and Tazim Virani

Abstract

The Mental Health Commission of Canada defines peer support as “a supportive relationship between people who have a lived experience in common ... in relation to a mental health challenge or illness ... related to their own mental health or that of a loved one” (Sunderland et al. 2013: 11). In Ontario, a key resource for peer support is the Ontario Peer Development Initiative (OPDI), which is an umbrella organization of mental health Consumer/Survivor Initiatives (CSIs) and peer support organizations across the province of Ontario. Member organizations are run by and for people with lived experience of a mental health or addiction issue and provide a wide range of services and activities within their communities. The central tenet of member organizations is the common understanding that people can and do recover with the proper supports in place and that peer support is integral to successful recovery. Nationally, Peer Support Accreditation and Certification Canada has recently been established. The relatively new national organization focuses on training and accrediting peer support workers. This paper focuses on a range of diverse peer support groups and CSIs that operate in London and surrounding areas.

Peer Support in Region

A review of peer support programs in the South West Local Health Integration Network (LHIN) identified eight programs

that were publically funded through the South West LHIN and operated by a CSI. The programs were assessed against promising practice criteria for peer support identified in the literature. The majority of South West LHIN *peer support* models used by CSIs were based on an informal peer support model or a walk-in centre. In addition, some of the programs also used a formal/intentional peer support model. However, since intentional peer support was often reported in the absence of formal matching (i.e., formal matching being a key element of formal peer support), it may be possible that the identification to a formal/intentional peer support model was used more broadly than intended. Table 1 below (Sunderland et al. 2013) denotes a spectrum of peer support models that range from friendship to clinical care. Peer support models used in the South West LHIN were more aligned to the friendship end of the spectrum of models (see Table 2) (Mings and Cramp 2014). The eight programs are identified by number only within the chart. In addition, most of the beneficiaries of peer support were identified through word of mouth, outreach and community referrals. In some instances, referrals were made by mental health professionals where some linkages were established, the majority of which were not formalized. The Transitional Discharge Model (TDM) research study implemented in the London area provided interactions between some of the CSIs and mental healthcare professionals and service organizations.

TABLE 1.
Spectrum of Peer Support Models

	Friendship	Informal Peer Support – naturally occurring, voluntary, reciprocal relationships with peers, one-on-one or possibly in a community
		Clubhouse/Walk-in Centre – mainly psychosocial and social recreational focus with peer support naturally occurring among participants
		Self-Help, Mutual Peer Support – consumer-operated/run organization and activities, voluntary, naturally occurring, reciprocal relationships with peers in community settings
		Formalized/Intentional Peer Support – consumer-run peer support services within community settings, group or one-on-one, focusing on issues such as education, employment, MH systems navigation, systemic/ individual advocacy, housing, food security, Internet, transportation, recovery education, anti-discrimination work, etc.
		Workplace Peer Support – workplace-based programs where employees with lived experience are selected and prepared to provide peer support to other employees within their workplace
	Clinical Care	Community Clinical Setting Peer Support – peer supporters selected to provide support to patients/clients that utilize clinical services, e.g., outpatient, ACT teams, case management, counselling
		Clinical/Conventional MH System-Based Peer Support – clinical setting, inpatient/outpatient, institutional peer support, multidisciplinary groups, recovery centres, or rehabilitation centre crisis response, crisis management, emergency rooms, acute wards

TABLE 2.
Peer Support Programs in the SW LHIN and Types of Models Employed

Peer Support Program	Informal Model	Walk- In Centre/ Activity Centre	Clubhouse Model	Self-Help, Mutual	Formalized/ Intentional PEER SUPPORT	Workplace Model	Family Model	Community Clinical Setting Model	Clinical / Conventional MH System-Based Model
1	Yes	No	No	No	Yes	No	Yes	No	No
2	Yes	Yes	Somewhat	Somewhat	Somewhat	Yes	No	No	No
3	Yes	Yes	Yes	Yes	No	Yes	No	No	No
4	Yes	Yes	No	Somewhat	Somewhat	No	No	No	No
5	Yes	Yes	No	Yes	Yes	No	Yes	Yes	Yes
6	Yes	Yes	Yes	Yes	Yes	No	No	Somewhat	No
7	Yes	No	No	No	Yes	No	No	No	No
8	No	No	No	No	Yes	No	No	No	No

The major gap in the South West LHIN was the relative absence of peer support programs in workplace and clinical settings (e.g., community or hospital), although, with the introduction of the TDM studies, several partnerships had resulted between CSIs and professional services in hospitals. Once the two-year study grant (funded through the Council of Academic Hospitals of Ontario [CAHO]) came to an end, there were concerns that this type of model would not be sustained, despite positive health and system outcomes.

CONNECT for Mental Health

One example of a group providing peer support is CONNECT for Mental Health Inc. CONNECT is a non-profit peer support organization run by and for individuals who have been

affected by mental illness. It was founded in 2007 by Michelle Solomon, who was driven by her own experiences with mental health issues and her own need for peer support. As a student nurse, Michelle started a group at the Fanshawe College Student Union, sharing her story and letting others know they were not alone. Her strong vision was to create a peer support organization in London. This was supported by other consumer/survivors, and in 2011, CONNECT became an official non-profit organization.

CONNECT’s vision is to promote sustainable systems of support that enable individuals affected by mental illness to thrive and maintain wellness in the community. To do this, CONNECT embarks on a three-fold mission: 1) supporting individuals affected by mental illness, 2) educating a wide

audience on relevant mental health topics, and 3) providing outreach to the community to help decrease stigma and promote early intervention of mental health disorders.

CONNECT focuses on engaging youth and young adult populations and maintaining face-to-face contact with individuals in the community. Meetings occur at the local library or coffee shop and in community spaces. There is an emphasis on “getting into action for mental health,” where individuals are encouraged to be active participants and experts in their own recovery. Volunteers offer emotional support, support that encourages positive coping and self-management of mental illness. To date, CONNECT has more than 50 volunteers who offer both group and one-to-one peer support services. Volunteers are recruited through venues such as Kijiji and social media websites and are then trained in peer support through CONNECT and OPDI’s peer support core essentials program.

Support

CONNECT provides peer support in group settings. The longest-running program is the weekly coffee “socials,” where individuals drop in to gain emotional support from others who have “been there.” There is also an eight-week recovery group, started in 2012, that addresses topics that promote self-management and the exploration of tools to help prevent crises and maintain wellness. This group occurs at the local Canadian Mental Health Association (CMHA). In 2013, CONNECT started a student support group at Western University for students in need of support with mental health and school.

CONNECT partnered with Lawson Health Research Institute, London Health Sciences Centre, and OPDI in 2013 to provide transitional support to individuals being discharged from the hospital. The TDM, funded by CAHO, expanded CONNECT’s provision of peer support in the community. In this program, peer coordinators have a presence on the hospital ward, offering peer support to clients and also matching clients with volunteers who further support peers in the community after their discharge. Furthermore, in 2014, St. Joseph’s Health Care’s Parkwood Institute invited CONNECT to offer peer support to their clients, allowing CONNECT to provide support to individuals who are in hospital for longer periods of time.

Education

As a consumer/survivor voice, CONNECT works with organizations in the community to provide education to the public on topics concerning mental illness and recovery. From 2008 to 2012, CONNECT partnered with the London Public Library (central branch) to provide workshops on various mental disorders and mental health and to raise awareness about supports. To date, CONNECT partners with organizations who want to provide information and raise public awareness on mental health.

Outreach

In addition to working with community organizations to facilitate educational events, CONNECT has an outreach team, whose purpose is to connect with the community, particularly with youth, to decrease stigma associated with mental illness, promote early intervention and connect individuals to peer support. Volunteers share their personal experience with mental illness and recovery through public speeches. Venues include Western University and other public forums in the community.

In a community that is in need of various types of support for mental health struggles, CONNECT has seen an amazing response from its residents. People are likely to open up to individuals who have “been there,” and in turn, gain emotional support, which places people with lived experience in an opportune situation to help. With the proper training, mentorship and financial support, peer support can be used to help people maintain wellness. The key to starting a peer support group is to listen to the needs of individuals, work with people who share the same vision for the group and foster leadership from people who are passionate about helping others. With a dedicated team and support from the community, anything is possible.

Tips for Starting a Peer Support Group from CONNECT

Vision: Create a vision for the group. What is the group trying to achieve?

Audience: Who is the audience?

Goals: What are the needs of the group and how will you meet those needs?

Guidelines/Contract: How will people share? Is everyone expected to share? What topics will not be discussed?

Facilitation: Are the facilitators trained in peer support? Is this training evidence based?

Topics/Discussion: Will there be specific topics? Are topics evidence based? Is discussion random or structured?

Crisis Management: How will adverse events be handled to maintain the safety of the group?

Boundaries: Participants are experts on their experience and don’t give advice. Use “I” language. It’s social support, not clinical support.

Local Innovation and Consumer/Survivor Groups Involvement in Research

CSIs have a long involvement in research generally. This is illustrated with the involvement in the TDM. The TDM is an evidence-based approach that includes both peer support and continued involvement of inpatient staff until a therapeutic relationship has been established with the community care provider (Forchuk et al. 2013; Forchuk et al. 2007a and b). It was originally developed through a participatory action research project, including front-line hospital and community

staff, consumers who were currently hospitalized as well as ones who had successfully made the transition to the community, and researchers. The pilot ward was a long-term schizophrenia program, where length of stay was typically many years. The concept of providing a safety net of relationships, both professional and through a peer friendship model, was the cornerstone of what people said they needed to make a successful transition out of hospital. All 38 inpatients on the pilot ward were successfully transitioned to community care (Forchuk, Chan et al. 1998; Forchuk, Jewell et al. 1998; Forchuk, Schofield et al. 1998; Schofield et al. 1997). TDM has since been tested in a number of wards. For example, in a randomized cluster study with 26 tertiary care wards (13 implementing TDM and 13 with usual care) across four hospital sites, the length of stay on the TDM wards dropped by 116 days per person (Forchuk et al. 2005). The TDM has been replicated in many places. For instance, after a successful randomized trial on acute care wards in Scotland (Reynolds et al. 2004; Sharkey et al. 2005), where the control group was more than twice as likely to be readmitted, the Scottish parliament declared TDM a best practice. More recently, TDM was identified as a best practice by CAHO (n.d.). CAHO supported an implementation project to extend the model. Two London hospitals (London Health Sciences Centre and St. Joseph's Health Care London), OPDI and local peer support organizations were recently involved, with the Lawson Research Institute as the lead site.

TDM was implemented in collaboration with OPDI on 14 wards (eight tertiary, six acute) in nine hospitals across Ontario. Peer support coordinators and volunteers/workers based out of CSIs partnered with participating hospital wards to offer the peer support component of the TDM. The average length of stay on the participating wards dropped by an average of 9.8 days, which freed up the equivalent of approximately \$33 million. As well, consumers being discharged reported feeling better supported and less anxious in making the transition to the community.

Recent Regionwide Work

The South West LHIN has sponsored the development of a regional peer support strategy focusing on strengthening existing peer support models that promise practices while addressing identified gaps. This strategy is in alignment with Ontario's 10-year mental health and addictions strategy, which states, "An Ontario where all people have the opportunity to thrive, enjoying good mental health and well-being throughout their lifetime – an Ontario where people with mental illness or addictions can recover and participate in welcoming, supportive communities" (Ontario Ministry of Health and Long-Term Care 2011: 4).

A key South West LHIN peer support strategy is the development of partnerships between CSIs and mental healthcare

programs in the community and in hospital. A stakeholder engagement process was used to identify the following hopes, aspirations and outcomes that stakeholders wished to achieve:

- Regionwide acceptance of peer support as a valid and effective intervention
- Availability of peer support wherever individuals are in their recovery journey – community, hospital, outpatient, work and school, as well as wherever they live in the region – urban, rural or remote locations
- Appropriate and sustainable funding to support implementation of models based on promising practices
- CSIs and mental health providers working in a true partnership – as true partners, peer supporters are part of the planning and ongoing oversight of mental health and addiction programs
- Standards for peer support practices linked with accountability
- Continuous support and improvement of existing peer support programs, while filling the gaps with new models where these are needed, such as models that include partnership with clinical agencies. Expand mandates of existing programs, where appropriate and feasible, to address gaps
- Peer support programs – no matter where they exist – in CSI or on mental healthcare teams – are part of a peer support network of sharing and learning

Areas of Focus and Goals

Stakeholders reflected on a set of promising practices identified through the literature and assessed their own peer support programs against these practices. The findings from the self-reflections, or self-assessments, of these programs were presented at an in-person stakeholder meeting. Through discussions and an exercise to rank priorities, the following four areas of focus were identified for the peer support strategy:

- Models of peer support
- Standards in training and investments in people
- Linkages and integrated processes with the mental health-care system
- Governance and infrastructure support

The South West LHIN will be sharing the peer support strategy with our board in October 2015 to receive a motion to accept the report, recommendations and suggested next steps. Some readiness activities are already underway.

Conclusion

Peer support has a long and valued role within the London area as well as across the entire South West LHIN. The groups in the area have a strong history and are continuing to evolve to

address the needs of people who experience mental health and addiction challenges. Many of the groups began as grassroots organizations. They tend to offer more informal forms of peer support. A major area of potential growth is with more formal arrangements with clinical services. An example of where this does occur is with the TDM, which encourages partnerships between psychiatric wards and consumer organizations. Some groups also have formal arrangements with the local CMHA offices, but these are often informal systems. Using evidence-based approaches, CSIs and peer support organizations in London, Ontario, as well as throughout the LHIN, are working together in partnership with others to provide strong support to individuals with mental health and addiction issues. The strong partnerships with CSIs and research have supported the evidence base, demonstrating the benefits of peer support. **HQ**

Lessons Learned

- Consumer organizations that provide peer support often start as grassroots, volunteer organizations. As they grow and experience success, the need to look at funding increases. Start looking at diverse sources of funding as early as possible.
- Linkages and communication with the formal mental health system ensures that the consumer's voice is heard, provides support and increases referrals.
- Peer support organizations need to work together and provide peer support for each other. They have a unique role within the healthcare system and can provide concrete learning and assistance to each other.

References

- Council of Academic Hospitals of Ontario (CAHO). (n.d.). *The Transitional Discharge Model: People-Centred, Peer-Supported Project Impactful for Both System and Clients*. Retrieved 20 July 2015. <<http://caho-hospitals.com/the-transitional-discharge-model-people-centred-peer-supported-project-impactful-for-both-system-and-clients/>>.
- Forchuk, C., Y.L. Chan, R. Schofield, M.-L. Martin, M. Sircelj, V. Woodcox, and B. Overby. 1998. "Bridging the Discharge Process." *The Canadian Nurse* 94(3): 22–26.
- Forchuk, C., J. Jewell, R. Schofield, M. Sircelj and T. Valledor. 1998. "From Hospital to Community: Bridging Therapeutic Relationships." *Journal of Psychiatric and Mental Health Nursing* 5(3): 197–202.
- Forchuk, C., M.-L. Martin, Y.L. Chan and E. Jensen. 2005. "Therapeutic Relationships: From Psychiatric Hospital to Community." *Journal of Psychiatric and Mental Health Nursing* 12(5): 556–64.
- Forchuk, C., M.-L. Martin, E. Jensen, S. Ouseley, P. Sealy, G. Beal, ... and S. Sharkey. 2013. "Integrating an Evidence-Based Intervention Into Clinical Practice: "Transitional Relationship Model." *Journal of Psychiatric and Mental Health Nursing* 20(7): 584–94.

Forchuk, C., W. Reynolds, S. Sharkey, M.-L. Martin, E. and Jensen. 2007a. "The Transitional Discharge Model: Comparing Implementation in Canada and Scotland." *Journal of Psychosocial Nursing and Mental Health Services* 45(11): 31–38.

Forchuk, C., W. Reynolds, S. Sharkey, M.-L. Martin and E. Jensen. 2007b. "Transitional Discharge Based on Therapeutic Relationships: State of the Art." *Archives of Psychiatric Nursing* 21(2): 80–86.

Forchuk, C., R. Schofield, M.-L. Martin, M. Sircelj, V. Woodcox, J. Jewell and L. Chan. 1998. "Bridging the Discharge Process: Staff and Client Experiences Over Time." *Journal of the American Psychiatric Nurses Association* 4(4): 128–33.

Mings, E., and J. Cramp. 2014. *Best Practices in Peer Support: 2014 Final Report*. Retrieved July 15, 2015. <<http://eenet.ca/wp-content/uploads/2014/08/Best-Practices-PeerSupport-Final-Report-2014.pdf>>.

Ontario Ministry of Health and Long-Term Care. 2011. *Open Minds, Healthy Minds: Ontario's Comprehensive Mental Health and Addictions Strategy*. Ontario: Queen's Printer for Ontario.

Reynolds, W., W. Lauder, S. Sharkey, S. Maciver, T. Veitch and D. Cameron. 2004. "The Effects of a Transitional Discharge Model for Psychiatric Patients." *Journal of Psychiatric and Mental Health Nursing* 11(1): 82–88.

Schofield, R., T. Valledor, M. Sircelj, C. Forchuk, J. Jewell and V. Woodcox. 1997. "Evaluation of Bridging Institution and Housing – A Joint Consumer-Care Provider Initiative." *Journal of Psychosocial Nursing and Mental Health Services* 35(10): 9–14.

Sharkey, S., S. Maciver, D. Cameron, W. Reynolds, W. Lauder and T. Veitch. 2005. "An Exploration of Factors Affecting the Implementation of a Randomized Controlled Trial of a Transitional Discharge Model for People With a Serious Mental Illness." *Journal of Psychiatric and Mental Health Nursing* 12(1): 51–56.

Sunderland, K., W. Mishkin, Peer Leadership Group and Mental Health Commission of Canada. 2013. *Guidelines for the Practice and Training of Peer Support*. Calgary, AB: Mental Health Commission of Canada. Retrieved from: <http://www.mentalhealthcommission.ca>.

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Prevention and Early Intervention Program for Psychoses (PEPP)

Ross M.G. Norman and Rahul Manchanda

Abstract

The Prevention and Early Intervention Program for Psychoses (PEPP) was established in 1997 for individuals with first-episode non-affective psychotic disorder. The objectives of PEPP are to improve outcomes for clients by providing a prompt, comprehensive, coordinated and effective treatment program as well as to advance research concerning early intervention for psychotic disorders. This article describes the clinical and research program and the lessons learned.

Introduction

Psychotic disorders, such as schizophrenia, are amongst the most personally disruptive and costly of psychiatric conditions. Although medical interventions have proven effective in reducing positive symptoms such as hallucinations and delusions, their impacts on negative symptoms, including reduced motivation and expressiveness, and other characteristics associated with the illness, are less robust (Miyamoto et al. 2012). Psychosocial interventions also have proven benefits on symptoms, functioning and quality of life (Turner et al. 2014) but are not always readily available in effective form (Lehman and Steinwachs 1998).

Symptoms of psychosis typically have their onset in late adolescence or early adulthood. If they are not successfully treated, psychotic illnesses can have a very deleterious impact on the

long-term prospects of affected young people as exemplified by repeated hospitalizations, high rates of unemployment, poor quality of life and high rates of suicide. It is important, therefore, to promptly provide the best possible treatment to those who develop a psychotic disorder.

Over the past 20 years, there has been considerable enthusiasm for reforming mental health services in order to provide excellent care more quickly, particularly for young people (Coughlan et al. 2013). Much of this work has been spearheaded in the field of early intervention for psychotic disorders (McGorry 2015). The Prevention and Early Intervention Program for Psychoses (PEPP), in London, Ontario, was one of the first developed within North America for the purpose of providing better services more quickly to improve outcomes for young people with psychotic disorders. From its inception in 1997, PEPP has been an integrated clinical and research program devoted to not only developing and providing improved clinical care but also evaluating outcomes for patients, developing a research base for improving service delivery and better understanding the nature of psychotic disorders and determinants of outcome (www.PEPP.ca).

Clinical Program

The core features of the PEPP clinical program include the following:

- a) Initiatives for case detection and rapid assessment of previously untreated individuals showing possible symptoms of psychosis; prompt initiation of treatment of those found to have a non-affective psychotic disorder. To facilitate case identification, PEPP has carried out education programs with schools, community service agencies and healthcare providers concerning the symptoms of psychosis and the importance of early intervention. In addition, PEPP has an open referral policy, responding to enquiries from anywhere in the community — including families and potential clients — without the need for physician referral. Initial screening is carried out by a psychiatric nurse or social worker within 24 hours and, if indicated, this is followed by an appointment for a full assessment with a psychiatrist, offered within one week. Individuals between the ages of 16 and 40 with a previously untreated psychotic disorder who live in the defined catchment area are immediately accepted into the program — there is no waiting list. Those who present with other mental health problems are referred to alternative services.
- b) Following admission to PEPP, a treatment plan is developed in collaboration with the client and, when feasible, family. Using standardized scales, assessments of symptoms, functioning and living circumstances are carried out on a regular basis during the individual's treatment to assess progress and identify needs, and treatment plans are updated as indicated.
- c) Flexibility in assessment and treatment approaches in order to facilitate engagement. There can be significant barriers to an individual's willingness to accept treatment, even when a psychotic disorder is clearly present. These barriers include an ill person's poor insight about the presence of a disorder (Amador and David 2004) and the perceived stigma of having a serious psychiatric illness (Corrigan 2004). It is sometimes necessary to show considerable flexibility and creativity to facilitate and maintain engagement. Assessments and clinical interventions are, when necessary, undertaken outside of the clinic, including in the home. While pharmacological interventions can be essential, we do not insist that clients take medications in order to be provided with support and education. In order to encourage engagement and reduce disruptions, hospital admission or compulsory treatment is used only when absolutely required. Considerable efforts are made to negotiate a shared understanding of what is wrong and what is required between clinicians and families.
- d) Provision of comprehensive and coordinated pharmacological and psychosocial interventions to quickly address the acute symptoms of psychosis and bring about recovery. Given evidence of fragmented and poorly coordinated delivery of services for individuals with psychotic disorders

in the past (Bachrach 1986), an assertive case management model (Mueser et al. 1998) is central to PEPP. The case manager is responsible for ongoing assessment of the client's needs, coordinating interventions and advocating for the client's needs.

- e) Provision of interventions designed to achieve several outcomes. Often, the first priority is reduction of the disruptive and bizarre symptoms of psychosis, which can include hallucinations and delusional thinking. Pharmacological interventions are usually an essential factor in addressing such symptoms. The rationale for choice of antipsychotic medication is explained, and treatment is generally initiated with as low a dose as possible and gradually increased as needed. Symptom response and side effects are closely monitored. When adherence to oral medications is problematic, longstanding injectable preparations can be used. Often, particularly over the first months of treatment, adjustments in type and dosage of medication are required.

Experiencing a psychotic disorder is very disruptive to a young person's life, often accompanied or preceded by difficulties in school or work, disruptions in interpersonal relations and social support, substance abuse, anxiety and/or depression and the so-called negative symptoms of social withdrawal, decreased motivation, emotional expression and social engagement. These phenomena (often exacerbated by the stigma of having a serious mental illness) can present major barriers to an individual's full personal, social and functional recovery. PEPP provides both individual and group interventions to address these concerns.

All clients receive supportive therapy from their case managers. Specific psychological interventions, such as cognitive behavioural therapy, are provided through the Program's clinical psychologist to address problems with anxiety, depression and substance use. Interventions are also delivered through several group formats, including the Recovery through Activity and Participation (RAP) group, which provides low-stress activities to enhance daily functioning; the Youth Education Support (YES) group, which is designed to assist clients in the process of recovery by preventing relapse and encouraging resumption of important roles; and Cognitively Oriented Skills Training (COST) group, which addresses any challenges in cognitive functioning in order to facilitate clients' return to school or work.

- f) Involvement of families. Psychotic disorders have implications for the families of those afflicted, and families often play an important role in identifying the psychosis and facilitating engagement in treatment and recovery. From the time of initial contact with PEPP, strong efforts are made to involve families in the assessment process, in

Lessons Learned

Our experience in developing the program, our research, and findings from other centres, support the following conclusions relevant to delivering early intervention services for individuals with psychotic disorders.

- Earlier intervention (shorter treatment delay) is associated with better treatment outcomes (Marshall et al. 2005; Norman et al. 2007).
- Reducing treatment delay is challenging (Cassidy et al. 2008; Lloyd-Evans et al. 2011) and needs to include educating both the public and healthcare professionals about the symptoms of psychosis and the need for early intervention.
- Specialized early intervention services for psychosis, which are designed to specifically address barriers to service engagement and the needs of young people experiencing psychotic illness, bring about better outcomes than standard mental health services (Craig et al. 2004; Petersen et al. 2005). Continuing to provide less intense specialized services increases the likelihood that benefits will persist (Norman et al. 2011). There is evidence that early intervention programs can also lead to healthcare cost savings (Goldberg et al. 2006; McCrone et al. 2010).
- Recovering from a psychotic disorder requires more than the reduction of acute symptoms through medication and includes psychological, functional and social dimensions (Norman et al. 2013; Windell et al. 2012). Addressing psychological and social influences, as well as substance use, are important in bringing about broader recovery (Carr et al. 2009; Norman et al. 2012b; Windell and Norman 2013).
- Ideally, there should be ongoing monitoring and measurement of the services being provided to clients and families and of their outcomes. It is important to keep examining the logic and effectiveness of the program. This would help in the identification of areas needing improvement and lead to necessary adjustments in the program model and service delivery (Rossi et al. 2004). Although the rationale for such an approach seems impeccable, there are considerable difficulties in obtaining reliable and relevant information in the context of a busy clinical service and regularly providing feedback to the program. Ideally, there would be personnel whose time could be devoted to facilitating such a process, but few programs can support such a resource. Even with such supports, obtaining the necessary information from busy clinicians who are already struggling to meet broader institutional reporting requirements is challenging.
- The symptoms of an acute psychotic episode are often very distressing and disruptive and can require hospitalization. Dedicated beds for specialized early psychosis care, and close coordination between the services provided by an early intervention program such as PEPP and inpatient services, are essential (IEPA Working Group 2005). In addition, physical proximity to an inpatient service allows prompt and effective response to situations where there is urgent need for hospitalization and also facilitates the engagement of first-episode inpatients into PEPP. On the other hand, it is also desirable that early intervention programs be located in non-stigmatizing community settings. Balancing these needs and protecting the required inpatient resources has proven difficult.
- As noted earlier, there are several psychological, social and economic aspects to recovery. Given the young age at which psychotic disorders usually occur, issues related to employment are very important. Employment can provide financial benefits and may also yield benefits for symptoms and psychological well-being (Burns et al. 2009; Priebe et al. 1998). The addition of an employment counsellor to our staff has been helpful in beginning to address clients' employment needs, but much remains to be done. The development of a supported employment program (Mueser and McGurk 2014) and possibly the development of social enterprises (Gilbert et al. 2013) would be of considerable assistance in increasing actual employment rates among our clients, but these require additional resources.
- Early intervention services are by definition time-limited (IEPA Working Group 2005). For those clients requiring continuing specialized care, it is important that appropriate long-term services be available (Kam et al. 2015). There have been significant difficulties in accessing such services within the London region, resulting in many clients continuing to receive follow-up services from clinicians within PEPP. This situation results in the diversion of resources and threatens the program's capacity to continue to provide ready access to services for individuals and families dealing with a recent-onset psychotic disorder.

supporting engagement and treatment and in facilitating recovery. Families themselves usually need help and PEPP endeavours to provide this help through education about the illnesses and treatments, as well as practical advice and support for coping with the challenges families face. These have been provided through educational workshops, which include information on the nature of psychosis, treatment and psychosocial issues related to outcome; individual family interventions; and a parent support group. In addition, video materials were developed to help educate and support families. Families can provide important mutual support for one another and can be strong advocates for those with psychotic disorders and provision of required services (Norman et al. 2008a).

Intensive treatment within PEPP usually occurs for a minimum period of two years, with additional follow-up for up to a total of five years.

Research

From its inception, PEPP has functioned as an integrated clinical and research program, focusing on pathways to care (Norman and Malla 2009), treatment outcomes for our clients (Norman et al. 2011), the influence of treatment delay on recovery (Norman et al. 2007; Norman et al. 2012a), the stigma associated with psychotic disorders (Norman et al. 2008b), the nature and determinants of recovery from psychosis (Windell et al. 2012), as well as furthering understanding of the basic pathology of schizophrenia and related psychotic disorders (Manchanda et al. 2005; Manchanda et al. 2014).

Conclusions

Although we and our colleagues at PEPP feel some satisfaction in what has been accomplished, we are very aware of the continuing challenges in developing and evaluating an early intervention program for psychosis. Even though PEPP has now been in existence for almost 20 years, we must always consider it a program under development. Its ongoing evolution has to respond to new knowledge generated in the field (e.g., Bird et al. 2010; Wunderink et al. 2013); the evolving standards of care (Addington et al. 2009) and our own recognition of our clients' current needs and weaknesses of the program. These challenges have to be addressed while dealing with constraints posed by the local mental health service delivery system. **HQ**

References

Addington, D., R. Norman, C.E. Adair, R. Manchanda, E. McKenzie, B. Mitchell and C. Pryce. 2009. "A Comparison of Early Psychosis Treatment Services Using Consensus and Evidence-Based Performance Measures: Moving Towards Setting Standards." *Early Intervention in Psychiatry* 3(4): 274–81. doi:10.1111/j.1751-7893.2009.00143.x

Amador, X.F. and A.S. David. 2004. *Insight and Psychosis: Awareness of Illness in Schizophrenia and Related Disorders*. New York, NY: Oxford University Press.

Bachrach, L.L. 1986. "The Challenge of Service Planning for Chronic Mental Patients." *Community Ment Health J* 22(3): 170–74.

Bird, V., P. Premkumar, T. Kendall, C. Whittington, J. Mitchell and E. Kuipers. 2010. "Early Intervention Services, Cognitive-Behavioural Therapy and Family Intervention in Early Psychosis: Systematic Review." *British Journal of Psychiatry* 197(5) 350–56. doi:197/5/350 [pii] 10.1192/bjp.bp.109.074526

Burns, T., J. Catty, S. White, T. Becker, M. Koletsi, A. Fioritti, W. Rossler, T. Tomov, J. van Busschbach, D. Wiersma and C. Lauber. 2009. "The Impact of Supported Employment and Working on Clinical and Social Functioning: Results of an International Study of Individual Placement and Support." *Schizophrenia Bulletin*. 35(5): 949–58. doi:10.1093/schbul/sbn024sbn024 [pii]

Carr, J. A., R.M. Norman and R. Manchanda. 2009. "Substance Misuse Over the First 18 Months of Specialized Intervention for First Episode Psychosis." *Early Intervention in Psychiatry* 3(3): 221–25. doi:10.1111/j.1751-7893.2009.00136.x

Cassidy, C. M., N. Schmitz, R. Norman, R. Manchanda and A. Malla. 2008. "Long-term Effects of a Community Intervention for Early Identification of First-Episode Psychosis." *Acta Psychiatrica Scandinavica* 117(6): 440–8. doi:ACP1188 [pii] 10.1111/j.1600-0447.2008.01188.x

Corrigan, P.W. 2004. "How Stigma Interferes With Mental Health Care." *American Psychologist* 59(7): 614–25.

Coughlan, H., M. Cannon, D. Shiers, P. Power, C. Barry, T. Bates, M. Birchwood, S. Buckley, D. Chambers, S. Davidson, M. Duffy, B. Gavin, C. Healy, H. Keeley, M. Maher, C. Tanti and P. McGorry. 2013. "Towards a New Paradigm of Care: The International Declaration on Youth Mental Health." *Early Intervention in Psychiatry* 7(2): 103–08. doi:10.1111/eip.12048

Craig, T. K., P. Garety, P. Power, N. Rahaman, S. Colbert, M. Fornells-Ambrojo and G. Dunn. 2004. "The Lambeth Early Onset (LEO) Team: Randomized Controlled Trial of the Effectiveness of Specialized Care for Early Psychosis." *British Medical Journal* 329(7474): 1067.

Gilbert, E., S. Marwaha, A. Milton, S. Johnson, N. Morant, N. Parsons, A. Fisher, S. Singh and D. Cunliffe. 2013. "Social Firms' Provision of Employment Opportunities for People With Mental Ill Health: A UK Survey." *Mental Health Today* 24–27.

Goldberg, K., R. Norman, J.S. Hoch, N. Schmitz, D. Windell, N. Brown and A. Malla. 2006. "Impact of a Specialized Early Intervention Service for Psychotic Disorders on Patient Characteristics, Service Use, and Hospital Costs in a Defined Catchment Area." *Canadian Journal of Psychiatry* 51(14): 895–903.

IEPA Working Group. 2005. "International Clinical Practice Guidelines for Early Psychosis." *British Journal of Psychiatry Suppl* 48(s120–24). doi:187/48/s120 [pii]10.1192/bjp.187.48.s120

Kam, S.M., S.P. Singh and R. Uptegrove. 2015. "What Needs to Follow Early Intervention? Predictors of Relapse and Functional Recovery Following First-Episode Psychosis." *Early Intervention in Psychiatry* 9(4): 279–83. doi:10.1111/eip.12099

Lehman, A.F. and D.M. Steinwachs. 1998. "Patterns of Usual Care for Schizophrenia: Initial Results From the Schizophrenia Patient Outcomes Research Team (PORT) Client Survey." *Schizophrenia Bulletin*. 24(1): 11–20; discussion 20–32.

Lloyd-Evans, B., M. Crosby, S. Stockton, S. Pilling, L. Hobbs, M. Hinton and S. Johnson. 2011. "Initiatives to Shorten Duration of Untreated Psychosis: Systematic Review." *British Journal of Psychiatry* 198(4): 256–63.

- Manchanda, R., R.M. Norman, A.K. Malla, R. Harricharan and S. Northcott. 2005. "Persistent Psychoses in First Episode Patients." *Schizophrenia Research* 80(1): 113–16.
- Manchanda, R., R.M.G. Norman, A. Malla, R. Harricharan, S. Northcott and J. Richard. 2014. "EEG Abnormalities and Five Year Outcome in First Episode Psychosis." *Canadian Journal of Psychiatry* 59(5): 285–88.
- Marshall, M., S. Lewis, A. Lockwood, R. Drake, P. Jones and T. Croudace. 2005. "Association Between Duration of Untreated Psychosis and Outcome in Cohorts of First-Episode Patients: A Systematic Review." *Archives of General Psychiatry* 62(9): 975–83. doi:62/9/975 [pii]10.1001/archpsyc.62.9.975
- McCrone, P., T.K. Craig, P. Power and P.A. Garety. 2010. "Cost-Effectiveness of an Early Intervention Service for People With Psychosis." *British Journal of Psychiatry* 196(5): 377–82. doi:10.1192/bjp.bp.109.065896196/51377 [pii]
- McGorry, P.D. 2015. "Early Intervention in Psychosis: Obvious, Effective, Overdue." *Journal of Nervous and Mental Disease* 203(5): 310–18. doi:10.1097/NMD.00000000000028400005053-201505000-00002 [pii]
- Miyamoto, S., N. Miyake, L.F. Jarskog, W.W. Fleischhacker and J. A. Lieberman. 2012. "Pharmacological Treatment of Schizophrenia: A Critical Review of the Pharmacology and Clinical Effects of Current and Future Therapeutic Agents." *Molecular Psychiatry* 17(12): 1206–27. doi:10.1038/mp.2012.47mp201247 [pii]
- Mueser, K.T., G.R. Bond, R.E. Drake and S G. Resnick. 1998. "Models of Community Care for Severe Mental Illness: A Review of Research on Case Management." *Schizophr Bull* 24(1): 37–74.
- Mueser, K.T. and S.R. McGurk. 2014. "Supported Employment for Persons With Serious Mental Illness: Current Status and Future Directions." *Encephale* 40 Suppl 2 (S45-56). doi:10.1016/j.encep.2014.04.008S0013-7006(14)00113-4 [pii]
- Norman, R.M.G., L. Hassall, S. Scott Mulder, B. Wentzell and R. Manchanda. 2008a. "Families Dealing With Psychosis: Working Together to Make Things Get Better." In J.F.M. Gleeson, E. Killackey and H. Krstev eds., *Psychotherapies for the Psychoses: Theoretical, Cultural, and Clinical Integration*. New York, NY: Routledge.
- Norman, R. and A. Malla. 2009. "Pathways to Care and Reducing Treatment Delay in Early Psychosis." In H.J. Jackson and P.D. McGorry eds., *The Recognition and Management of Early Psychosis: A Preventive Approach*. Cambridge, MA: Cambridge University Press.
- Norman, R.M., A.K. Malla, R. Manchanda, D. Windell, R. Harricharan, J. Takhar and S. Northcott. 2007. "Does Treatment Delay Predict Occupational Functioning in First-Episode Psychosis?" *Schizophrenia Research* 91(1–3): 259–62. doi:S0920-9964(07)00037-0 [pii]10.1016/j.schres.2006.12.024
- Norman, R.M., R. Manchanda, A.K. Malla, D. Windell, R. Harricharan and S. Northcott. 2011. "Symptom and Functional Outcomes for a 5 Year Early Intervention Program for Psychoses." *Schizophrenia Research* 129(2–3): 111–15. doi:10.1016/j.schres.2011.04.006S0920-9964(11)00212-X [pii]
- Norman, R.M., R. Manchanda, D. Windell, R. Harricharan, S. Northcott and L. Hassall. 2012a. "The Role of Treatment Delay in Predicting 5-Year Outcomes in an Early Intervention Program." *Psychological Medicine* 42(2): 223–33. doi:10.1017/S0033291711001140S0033291711001140 [pii]
- Norman, R.M.G., R.M. Sorrentino, D. Windell and R. Manchanda. 2008b. "Are Personal Values of Importance in the Stigmatization of the Mentally Ill?" *Canadian Journal of Psychiatry* 53(12): 75–83.
- Norman, R.M.G., D. Windell, J. Lynch and R. Manchanda. 2013. "Correlates of Subjective Recovery in an Early Intervention Program for Psychoses." *Early Intervention in Psychiatry* 7(3): 278–84.
- Norman, R.M.G., D. Windell, R. Manchanda, R. Harricharan and S. Northcott. 2012b. "Social Support and Five Year Functional Outcomes in an Early Intervention Program." *Schizophrenia Research* 140(1–3): 37–40.
- Petersen, L., P. Jeppesen, A. Thorup, M.B. Abel, J. Ohlenschlaeger, T.O. Christensen, G. Krarup, P. Jorgensen and M. Nordentoft. 2005. "A Randomised Multicentre Trial of Integrated Versus Standard Treatment for Patients With a First Episode of Psychotic Illness." *British Medical Journal* 331(7517): 602.
- Priebe, S., R. Warner, T. Hubschmid and I. Eckle. 1998. "Employment, Attitudes Toward Work, and Quality of Life Among People With Schizophrenia in Three Countries." *Schizophrenia Bulletin*. 24(3): 469–77.
- Rossi, P.H., M.W. Lipsey and H.E. Freeman. 2004. *Evaluation: A Systemic Approach* (7th ed). Thousand Oaks, CA: Sage.
- Turner, D.T., M. van der Gaag, E. Karyotaki and P. Cuijpers. 2014. "Psychological Interventions for Psychosis: A Meta-Analysis of Comparative Outcome Studies." *American Journal of Psychiatry* 171(5): 523–38. doi:10.1176/appi.ajp.2013.130811591831621 [pii]
- Windell, D. and R.M. Norman. 2013. "A Qualitative Analysis of Influences on Recovery Following a First Episode of Psychosis." *International Journal of Social Psychiatry* 59(5): 493–500. doi:10.1177/00207640124437510020764012443751 [pii]
- Windell, D., R. Norman and A.K. Malla. 2012. "The Personal Meaning of Recovery Among Individuals Treated for a First Episode of Psychosis." *Psychiatric Services* 63(6): 548–53. doi:10.1176/appi.ps.201100424
- Wunderink, L., R.M. Nieboer, D. Wiersma, S. Sytema and F.J. Nienhuis. 2013. "Recovery in Remitted First-Episode Psychosis at 7 Years of Follow-Up of an Early Dose Reduction/Discontinuation or Maintenance Treatment Strategy: Long-Term Follow-Up of a 2-Year Randomized Clinical Trial." *JAMA Psychiatry* 70(9): 913–20. doi:10.1001/jamapsychiatry.2013.191707650 [pii].

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Early Intervention in Mood and Anxiety Disorders: The First Episode Mood and Anxiety Program (FEMAP)

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Abstract

The First Episode Mood and Anxiety Program (FEMAP) was developed for youth with mood and/or anxiety concerns in London, Ontario, to provide early intervention for these disorders, similar to the first-episode psychosis programs across Ontario and Canada. The logic and causal models of the pathway to and through FEMAP are described and inclusion/exclusion criteria are delineated. Results of the process evaluation of the model and preliminary data from a treatment-effectiveness evaluation and ongoing cost-comparison evaluation are provided. Several characteristic quotes from youth utilizing the service are included, as is an overview of utilization statistics. Challenges and lessons learned are conveyed.

Background

Many facts support early intervention. First, 75% of all mental illnesses start before the age of 25 (Kessler et al. 2007). Second, early intervention is the medical standard for chronic and/or episodic illnesses, including diabetes (Nathan et al. 2007), chronic pain (MTUS 2009), heart disease (Grady et al. 2000), arthritis (Emery 2002), multiple sclerosis (Jacobs et al. 2000) and cancer (Smith et al. 2006). Third, provincial and national initiatives for early identification and intervention of psychosis have been standard for over a decade (Ehmann et al. 2004). Finally, mood and anxiety disorders respond well to treatment,

particularly if treated early (Perry et al. 1999; Kennard et al. 2009; Rapee et al. 2009; Berk et al. 2011; Otte 2011).

Given these facts, it is remarkable that, in 2006, no services were available for psychiatric help for teenagers with a mood or anxiety problem in London, Ontario, with a wait time of less than 18 to 24 months. Moreover, accessible psychiatric care was ridiculously brief – one to two visits to the hospital's urgent consultation service, usually accessed through the emergency room (ER) or other physician referral. The expense to the system determined by this care pathway, almost necessitating a visit to the ER, was equally untenable. And this situation was not unique to London, Ontario (EAO, personal communication).

The negative economic consequences of non-treatment of mental illnesses far exceed the direct costs of treatment (Hu 2006). For mood and anxiety disorders, the hidden cost of non-treatment may include youth dropping out of school, thereby not achieving their academic potential, which in turn leads to underemployment and the need for social assistance. Disturbed family and friend relationships are also common and, without intervention, there is further deterioration of youth's social supports. Some youth resort to substance abuse to manage their symptoms. Suicide, the second leading cause of death in 15- to 24-year-olds in Canada (Langlois and Morrison 2002), can be the final conclusion to untreated mood and anxiety disorders.

The Rea Chair of Affective and Anxiety Disorders was created through a generous donation from the Rea Family Foundation. Filled in late 2005, the position established a commitment to furthering research excellence in the understanding and treatment of mood and anxiety disorders. The incoming psychiatrist (EAO) was interested in brain imaging and the neurocircuitry of reward processing in major depressive disorder in the early stages, before patients have lived through years of debilitating illness. This led to the emphasis on identifying late teens and young adults with depression in 2006. What was not a surprise was that depression in youth was prevalent. What was a surprise was that after completing research protocols investigating brain pathophysiology there was nowhere to send these youth for treatment. That was the inspiration for the First Episode Mood and Anxiety Program (FEMAP).

Local Innovation

FEMAP started as one psychiatrist (EAO) with the ardent support of the then department chair (SF). FEMAP was modelled on the early psychosis program in London – the Psychosis and Early Intervention Program for Psychoses (PEPP) (Norman and Manchanda 2015). PEPP includes the ability to self-refer, emphasis on ambulatory services, short wait times, no artificial discharge dates and focus on first episode. In addition, the integration of clinical care and clinical research is standard.

With that backdrop, FEMAP took shape. Mood and anxiety disorders caught early are treatable with psychotherapy and psychopharmacology, even though they often recur (Perry et al. 1999; Morriss et al. 2007; March et al. 2009; Rapee et al. 2009). By 2011, funded by the department of psychiatry, charitable donations and research project funding, FEMAP had 1.6 full-time equivalents of psychiatrist, a full-time intake assessment clinical social worker, a one-day-per-week addictions therapist, a one-day-per-week family therapist and a receptionist. By 2013, charitable donations had supported hiring a psychologist two days per week.

In early 2009, with the help of the department chair (SF) and support of the St. Joseph's Health Care Hospital board, FEMAP moved from limited hospital space to a renovated house in the community. This provided a much friendlier, welcoming and less stigmatizing environment for youth. With guidance from our health systems evaluation expert (EV), we set about to fully describe and evaluate FEMAP.

FEMAP's goal is to catch mood/anxiety disorders early, identify youth and treat them effectively before they veer off their normal developmental trajectory. The causal and logic models, updated from previous versions (Ross et al. 2012; Osuch et al. 2015), are illustrated in Figure 1. The upper diagram reflects experiences/changes expected in youth with mood/anxiety problems on their pathway to and through care; the logic model presents program activities to effect the expected

changes. The logic model includes outputs (program activities) and short-, medium- and long-term outcomes, such as a reduction in ER and inpatient psychiatric service utilization, school dropouts and suicide attempts.

Programmatic activities of Phase I involve community outreach, in-person and in-depth assessment and the establishment and communication of recommendations to youth. The recommendations include acceptance into FEMAP for treatment versus the decision that the youth would be better served in another program or, in rare cases, reassured that no specialty mental healthcare is needed. If youth are referred elsewhere, facilitation of that transition is attempted.

Phase II involves full psychiatric or psychological evaluation, treatment and recovery from illness. Two possible long-term outcomes are: 1) sustained recovery from illness or 2) eventual recurrence of illness requiring episodic care or lack of remission and the need for prolonged care. Due to the natural course of mood and anxiety disorders, some youth will have sustained recovery while others will experience repeated episodes of illness or chronic illness.

Adherence to strict inclusion/exclusion criteria has been essential to optimize scarce resource utilization. These criteria for FEMAP are as follows: mood or anxiety symptoms as the primary problem; age 16–25 (previously 16–26); no developmental delay or severe learning disability; no primary substance use that preceded the onset of mood/anxiety symptoms; no major medical problems; no ongoing legal charges; and less than 18 months of prior psychiatric medication treatment. These criteria were designed for one primary purpose – maximizing the probability that youth admitted into FEMAP could recover with the level of treatment available, given the lack of resources. Youth were screened by using a brief telephone interview.

Results of Innovation

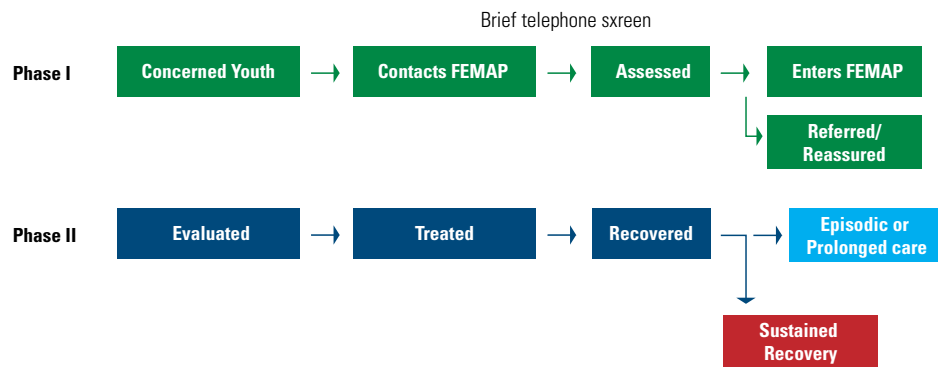
Pathway to Care

Phase I has undergone a process evaluation to determine whether it has been meeting its goals as a pathway to care; the results indicate that the outreach was effective and the model was attracting youth in need of specialty psychiatric care, as indicated by their severity of symptoms and level of functional impairment (Ross et al. 2012; Osuch et al. 2015). Given the ability of youth to access FEMAP without a physician referral, careful screening according to FEMAP inclusion/exclusion criteria and a full in-person assessment by a skilled clinician have been important in reducing over-inclusion of inappropriate patients, a potential negative unintended consequence of open access.

In the early evaluation, approximately 73% of 548 youth who contacted FEMAP were appropriate and were accepted into the program after screening and assessment (Osuch et al.

FIGURE 1. Pathway through care and Logic model of the First Episode Mood and Anxiety Program (FEMAP).

A. Pathway through care of FEMAP, including two phases that support youth on their trajectory through care. Phase I consists of outreach, intake and assessment of youth with mood/anxiety concerns. Phase II involves full psychiatric/psychological evaluation, and then treatment and, ideally, recovery to baseline functioning.



B. Logic model indicates outputs (activities and participation) as well as outcomes or impact, including short-, medium- and long-term impacts. Potential unintended consequences are listed as well. FMD = family medical doctor.

Outputs		Outcomes – Impact		
Activities	Participation	Short-term	Medium-term	Long-term
<p>Phase I: Intake process allows for self-referral</p> <p>Assess and identify: level of symptom severity; symptom clusters; level of functional impairment</p> <p>Direct youth to needed services: FEMAP or other</p>	<p>Youth age 16-25 with concerns related to mood and/or anxiety with or without substance use</p> <p>FEMAP staff provide assessment of youth with mental health and substance use concerns</p> <p>Psychiatric, psychological, addictions and family therapy specialty treatment services in one location</p>	<p>Direct access of youth with significant mood/ anxiety concerns to mental health services, when they're ready</p> <p>Less usage of Emergency Services as first point of contact for psychiatric care by youth</p>	<p>Reduction in functional impairment of youth with mood/anxiety concerns</p> <p>Recovery from mood/ anxiety and substance use disorder(s)</p>	<p>Fewer untreated youth with mental illness</p> <p>Reduced youth school drop-out and unemployment</p> <p>Reduced youth suicide</p> <p>Reduced inpatient psychiatric service use</p> <p>Reduced stigma; faster recovery</p>
<p>Phase II: Provide treatment, as clinically indicated</p>		<p>Potential Unintended Consequences: Excessive use of psychiatric specialty services by youth who are not ill enough to warrant such services—cost implications</p> <p>With no FMD referral, psychiatrist is left doing long-term care</p>		

2015). Recent, newer data indicate that this proportion has increased to 85% in a sample of 607 youth calling for services or referred by a physician, suggesting that the community is getting better at self- (and physician-) screening. Of 897 youth recently assessed, less than 5% were not accepted but only reassured that no specialty services were needed. This indicated that over-inclusion was minimal (Osuch et al. 2015) and the FEMAP telephone screening criteria were highly effective at minimizing clinician time spent with youth not needing specialty care.

The pathway evaluation also revealed that the term first episode is a misnomer in that between 60 and 70% of youth

assessed at FEMAP had received prior treatment for mood and/or anxiety concerns (Osuch et al. 2015). This was also evident based on the clinical history of many youth who had not sought prior professional help, but first episode was retained in the program title to encourage youth to connect even when they are unsure if they are “sick enough” to justify reaching out for help.

Referral sources for accessing the program varied. Between 2009 and 2015, a majority of youth (63% of 1332) who came to FEMAP did so from non-physician referrals. In recent years, non-physician referrals included those from post-secondary school services such as university or college guidance (11%) and secondary school services (5%).

Treatment Effectiveness and Cost Comparison

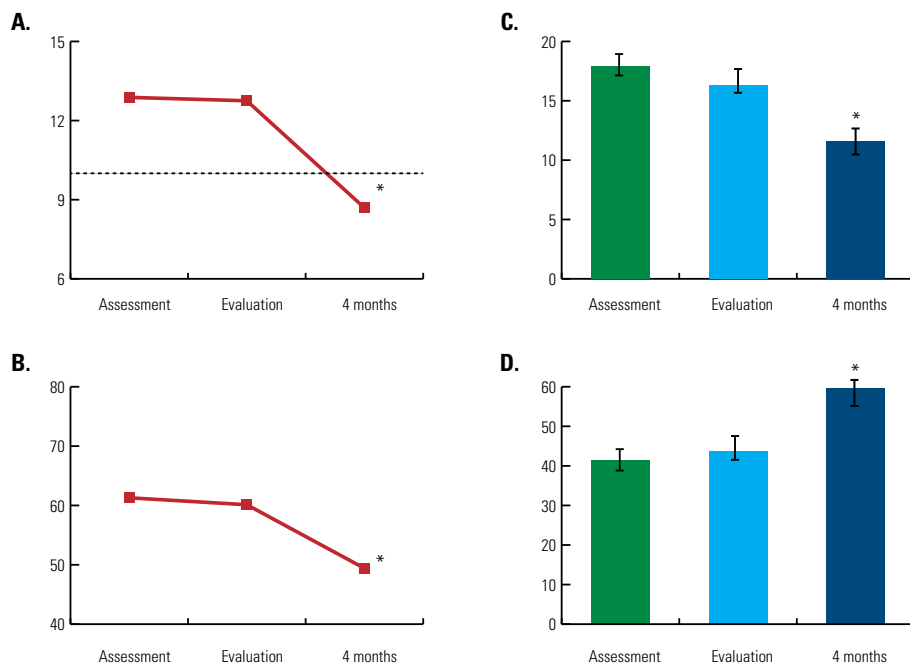
Phase II involves full psychiatric/psychological evaluation, treatment and recovery back to baseline functioning (Figure 1A). The goal of treatment is full recovery with no artificial termination of treatment based on time. Treatment goals include stabilization so that specialty mental healthcare is no longer required; medication administration can be taken over by a family doctor (FMD), if necessary and available.

Figure 2 illustrates the course of symptom severity for depression and anxiety in the first 88 FEMAP patients to be evaluated in our ongoing longitudinal, prospective treatment-effectiveness study. It also illustrates functional improvement and life satisfaction for the same time period. Each clinical measure indicated highly statistically significant improvement over the course of treatment. Further results are pending completion of this effectiveness study. The measure shown in Figure 2A is the Montgomery-Asberg Depression Rating Scale (MADRS) self-report version, which has 9 questions, and possible scores range from 0 to 27; high score indicates low mood/higher depression and scores greater than 10 indicate probable or undoubted need for treatment (shown by the horizontal line in Figure 2A). MADRS scores were highly significantly better at 4-month follow-up, and fell below the threshold score for need

for treatment. The Reiss-Epstein-Gursky Anxiety Sensitivity Index (ASI) (Figure 2B) has 16 questions with possible scores ranging from 0 to 64; high score indicates greater anxiety. The Sheehan Disability Scale (SDS) (Figure 2C) has three Likert-scale questions resulting in a total score ranging from 0 to 30. A score of 5 on any one of the subscales indicates clinically significant functional impairment. The bar graph illustrates mean total scores at the three time points shown; there was highly significant improvement in functioning at the 4-month follow-up. The Quality of Life Enjoyment and Satisfaction Questionnaire – Short Form (QLESQ) (Figure 2D) has 14-item scale ranging from 14 to 70. Again, the bar graph shows that the youth in treatment at FEMAP experienced a highly significant improvement in their life enjoyment and satisfaction scores.

In spite of high rates of remission in youth with mood/anxiety disorders, there are several possible long-term outcomes. Recovery can be sustained over time or the course of illness can be marked by recurrent episodes, or, for the most ill patients, by the need for prolonged care and incomplete recovery. The probability of subsequent depressive episodes is significantly higher after one depressive episode, even when treatment is optimal (Melartin et al. 2004; Vittengl et al. 2007). Anxiety disorders also can recur (Nay et al. 2013). Thus, as with other episodic illnesses,

FIGURE 2. Treatment effectiveness of the FEMAP model for the first 88 patients evaluated in phase II of the pathway through care



* indicates clinically significant changes of $p < .001$ at time points indicated, as assessed with repeated measures ANOVA.

establishing a positive working relationship with care providers is important so that repeat episodes will be captured early and long-term problems prevented. Often, the only difference between a mild-to-moderate mental illness and a chronic and persistent one is the passage of time and the absence of adequate treatment. A long-term, one-plus year follow-up study of the therapeutic effectiveness and cost-effectiveness of FEMAP is underway.

FEMAP allows youth to return to treatment for subsequent episodes of care, provided they have not drastically aged out of the program. When a youth has been highly engaged with the program, gotten better and been discharged, only to have a recurrence several years later, it is clearly most clinically and economically efficient to have FEMAP treat that individual again.

Formal cost effectiveness studies of FEMAP are pending, but data using several relevant cost comparisons have proven illustrative. In the United Kingdom, the London School of Economics found that paying for non-physician mental healthcare providers (social workers, psychologists) to conduct treatment through the National Health Service provided an overwhelming savings compared with the cost of social assistance (Layard 2006). To conduct a similar but simpler analysis, we compared the cost of 4 months of treatment at FEMAP to several other common mental healthcare-related costs.

The average cost of 4 months of treatment at FEMAP for the first 63 patients in our study was determined by chart review. These costs included all clinician sessions (psychiatrist, psychologist, addictions worker; all group or individual therapy sessions), laboratory tests ordered, and medications prescribed by FEMAP clinicians. This averaged \$1634 per patient. In contrast, the cost of compelling an individual to a psychiatric evaluation in an ER using Form 1 of the *Mental Health Act* in Ontario, plus the cost of the ER visit, was approximately \$2188 per patient, based on 330 such cases at the London Health Sciences Centre in fiscal year 2013–2014. Further, the cost of being on the Ontario Disability Support Program for 4 months, based on the pay-out costs to the provincial budget as of September/October of 2014, was \$4392 per patient. From these estimated cost comparisons, it is reasonable to suspect that effective, early, outpatient treatment of youth with mood/anxiety disorders may be a much wiser investment of social dollars than failing to treat these illnesses in the early stages and paying the longer-term consequences.

Patient Experience

In the context of a research project, we interviewed patients about their past experiences with mental healthcare in general and with FEMAP in particular. Responses revealed how youth experienced the mental healthcare system and the path to receiving care within it. Illustrative quotes are below.

Comparing previous mental healthcare services to FEMAP, one young man stated:

...outside of FEMAP, trying to find an appointment with a psychiatrist was freaking ludicrous, like it was unreal, and I can't even begin to imagine the situation I would have been in if I wasn't supported by my parents. Like I don't even know, man, what people must be going through. It was insane. So that like blew my mind, especially when we talk about how this is Canada and universal healthcare and all that, and it's completely inaccessible. (male, age 25)

About getting help at FEMAP: *"It has gotten easier. The first couple of times ... it's the hardest thing in the world trying to open up to a complete stranger, [to tell them] something you've never told another living soul."*

About his treatment provider at FEMAP this individual stated:

She really does seem to care, and uh, [is] talking a lot more than any other doctor I've had. Like I was afraid of it at first, but I've really started to – I don't think 'enjoy' is the right word – but it's good.... This is the first place I've come to where I've actually felt a proper patient–doctor dynamic. I'm more than just a chart. They actually want to find out what's wrong and deal with that.

In contrast, regarding prior treatment in other settings, he stated: *"And, yeah, just the in and out, the in and out like, 'Just take these pills,' just doesn't work."* (male, age 26)

There is an expectation that FMDs will be the major providers of mental healthcare for youth with mood and anxiety concerns. However, some youth had strong opinions about that model:

I was uncomfortable especially because a family doctor to me doesn't ... like you go there for physical things. That's what was in my mind and I was like, 'How am I supposed to tell him what's going on? Like, he's probably going to judge me and stuff like that, because I'll have to go back to him later to talk about physical things and it might be awkward' It was very awkward, yeah. Umm, he is definitely more of, like, a medical kind of guy and I didn't feel comfortable telling him my feelings at all and umm, I just wanted to get out of there as soon as possible. (female, age 18)

The need to have an empathic treatment provider who cared emerged repeatedly.

Well, I was treated like a person, not a ... just some experiment or study. I sort of expected having [the treatment providers at FEMAP] just be there to help me get better, but I didn't think that they would necessarily invest all the

time and emotion that they did into me.... But they still did because they genuinely cared about me, and I wasn't expecting that. (female, age 17)

Challenges and Ongoing Need

There have been challenges along the way. FEMAP has assumed care for several patient groups that it was not specifically designed for. This was done to provide care for youth who would have otherwise gone untreated. This has included youth with posttraumatic stress disorder; youth with eating disorders (ED) not ready to accept specialized ED treatment but who had substantial mood/anxiety symptomatology; and youth with substance use disorders, mostly isolated to cannabis and/or alcohol use. Secondary substance use is quite common in youth presenting with mood/anxiety symptoms and we have found cannabis use to be associated with lower functioning in this population (Osuch et al. 2013).

Conversely, a feature that FEMAP intended to maintain but has not been able to is rapid response. There was a 65% increase in requests for service between March 2013 and May 2015, with over 35 new contacts per month, over 80% of whom are appropriate for the service. With no resources forthcoming for stable clinical salaries and no way to hire new clinical staff, this has led to long wait times. The wait for entry into FEMAP has gone from 2 weeks to over five months – a wait that is truly unacceptable for an early intervention program. This should be rectified without compromising the quality of service delivered by the program, and the most effective way to do so would be to add psychiatric support.

The complementary challenge is the discharge of youth from the program, as specified as an unintended consequence in the logic model (Figure 1B). While the average youth is substantially improved in only 4 months of treatment or less, some need more. Generally, this is not a matter of determining who will prescribe stable doses of medications to youth who are doing well. Even without a FMD, such youth are not a substantial expenditure to the system because renewing a prescription once or twice per year is not an onerous cost. The problem arises when youth do not get better quickly with treatment.

While some mental healthcare systems address the challenge of treatment refractoriness by placing limits on duration of treatment, such an approach is not consistent with the medical model or best practice (McIntyre and O'Donovan 2004). It would not be considered acceptable for the treatment of other episodic/chronic medical illnesses to terminate treatment based on a certain number of sessions. Consider a clinic for diabetes where people with unstable diabetes are discharged to no care after 10 sessions even when their blood sugar is poorly controlled. Oddly, mental healthcare appears to be unique within the medical model in deciding on end of treatment based on factors other than the patient's condition.

Lessons Learned

- FEMAP provides an example of a well-characterized healthcare delivery model for early intervention for mood and anxiety disorders in transition-aged youth. The model's pathway to care, treatment effectiveness and cost-effectiveness have all been studied or are under research investigation.
- The program has been able to engage the population it aims to help – youth in the early stages of dysfunction from mood and/or anxiety disorders, with or without secondary addiction issues. Symptom severity and level of function of the youth studied were highly significantly improved with treatment. Youth appear to have a positive experience with the service and feel comfortable with the clinicians they receive care from.
- Self-referral did not result in the over-inclusion of inappropriate patients and appeared to make little difference when discharging youth who no longer needed psychiatric expertise.
- Some youth with other related mental health challenges found help at FEMAP, where alternatives were not otherwise accessible in the community.
- A preliminary cost comparison of FEMAP appeared excellent — the cost of treating mood/anxiety disorders effectively in their early stages is far less than the cost of waiting until youth require ER visits, hospitalization or social assistance. Mood and anxiety disorders with or without comorbid addiction issues account for a large component of mental illnesses with their onset in youth and are highly treatable, making programs such as FEMAP a clear benefit to the overall mental healthcare system design. We conclude that this is an appropriate use of specialty psychiatric resources.
- Provincial commitment to fund programs like FEMAP is imperative. With a wait time now growing from two weeks several years ago to over five months currently, FEMAP is destined to collapse as it fails to meet the rapid response needed for an early intervention strategy, even while the need/demand for its services increases.
- Next steps could include incorporation of this model into a test site of province-wide hubs to provide comprehensive care to transition-aged youth, as inspired by the Boeckh Foundation and related advocates for youth mental healthcare (Snowdon 2014).

On the contrary, as long as a young person is continuing to make even small progress and there is no better, alternative place for the youth to get treatment, she or he can continue at FEMAP. Therefore, FEMAP clinicians have had to become sensitive to when youth are not motivated to change and create incentives for them to do so or abandon efforts at treatment and discharge them until such motivation is forthcoming. **HQ**

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References

Berk, M., A. Brnabic, S. Dodd, K. Kelin, M. Tohen, G.S. Malhi, L. Berk, P. Conus and P.D. McGorry. 2011. "Does Stage of Illness Impact Treatment Response in Bipolar Disorder? Empirical Treatment Data and Their Implication for the Staging Model and Early Intervention." *Bipolar Disord* 13(1): 87–98.

Ehmann, T., M. Gilbert and L. Hanson. 2004. *Early Psychosis Intervention: A Framework for Strategic Planning*. Vancouver, B.C.: Canadian Mental Health Association.

Emery, P. 2002. "Evidence Supporting the Benefit of Early Intervention in Rheumatoid Arthritis." *J Rheumatol Suppl* 66: 3–8.

Grady, K.L., K. Dracup, G. Kennedy, D.K. Moser, M. Piano, L.W. Stevenson and J.B. Young. 2000. "Team Management of Patients With Heart Failure: A Statement for Healthcare Professionals From The Cardiovascular Nursing Council of the American Heart Association." *Circulation* 102(19): 2443–56.

Hu, T.W. 2006. "Perspectives: An International Review of the National Cost Estimates of Mental Illness, 1990–2003." *J Ment Health Policy Econ* 9(1): 3–13.

Jacobs, L.D., R.W. Beck, J.H. Simon, R.P. Kinkel, C.M. Brownschidle, T.J. Murray, N.A. Simonian, P.J. Slasor and A.W. Sandroek. 2000. "Intramuscular Interferon Beta-1a Therapy Initiated During a First Demyelinating Event in Multiple Sclerosis. CHAMPS Study Group." *N Engl J Med* 343(13): 898–904.

Kennard, B.D., S.G. Silva, S. Tonev, P. Rohde, J.L. Hughes, B. Vitiello, C.J. Kratochvil, J.F. Curry, G.J. Emslie, M. Reinecke and J. March. 2009. "Remission and Recovery in the Treatment for Adolescents with Depression Study (TADS): Acute and Long-Term Outcomes." *J Am Acad Child Adolesc Psychiatry* 48(2): 186–95.

Kessler, R.C., G.P. Amminger, S. Aguilar-Gaxiola, J. Alonso, S. Lee and T.B. Ustun. 2007. "Age of Onset of Mental Disorders: A Review of Recent Literature." *Curr Opin Psychiatry* 20(4): 359–64.

Langlois, S. and P. Morrison. 2002. "Suicide Deaths and Suicide Attempts." *Health Rep* 13(2): 9–22.

Layard, R. 2006. "The Case for Psychological Treatment Centres." *Bmj* 332(7548): 1030–32.

March, J., S. Silva, J. Curry, K. Wells, J. Fairbank, B. Burns et al. 2009. "The Treatment for Adolescents With Depression Study (TADS): Outcomes Over 1 Year of Naturalistic Follow-Up." *Am J Psychiatry* 166(10): 1141–49.

McIntyre, R.S. and C. O'Donovan. 2004. "The Human Cost of Not Achieving Full Remission in Depression." *Can J Psychiatry* 49(3 Suppl 1): 10S–16S.

Melartin, T.K., H.J. Rytsala, U.S. Leskela, P.S. Lestela-Mielonen, T.P. Sokero and E.T. Isometsa. 2004. "Severity and Comorbidity Predict Episode Duration and Recurrence of DSM-IV Major Depressive Disorder." *J Clin Psychiatry* 65(6): 810–19.

Morriss, R.K., M.A. Faizal, A.P. Jones, P.R. Williamson, C. Bolton and J.P. McCarthy. 2007. "Interventions for Helping People Recognise Early Signs of Recurrence in Bipolar Disorder." *Cochrane Database Syst Rev*(1): CD004854.

MTUS. 2009. "Chronic Pain Medical Treatment Guidelines." Retrieved November 11, 2015. <http://www.dir.ca.gov/dwc/DWCPropRegs/MTUS_Regulations/MTUS_ChronicPainMedicalTreatmentGuidelines.pdf>.

Nathan, D.M., M.B. Davidson, R.A. DeFronzo, R.J. Heine, R.R. Henry, R. Pratlley and B. Zinman. 2007. "Impaired Fasting glucose and Impaired Glucose Tolerance: Implications for Care." *Diabetes Care* 30(3): 753–59.

Nay, W., R. Brown and R. Roberson-Nay. 2013. "Longitudinal Course of Panic Disorder With and Without Agoraphobia Using the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC)." *Psychiatry Res* 208(1): 54–61.

Norman, R.M.G. and R. Manchanda. 2016. "Prevention and Early Intervention Program for Psychoses (PEPP)." *Healthcare Quarterly* 18 (Special): 37–41. doi:10.12927/hcq.2016.24442

Osuch, E., E. Vingilis, E. Ross, C. Forster and C. Summerhurst. 2013. "Cannabis Use, Addiction Risk and Functional Impairment in Youth Seeking Treatment for Primary Mood or Anxiety Concerns." *International Journal of Adolescent Medicine and Health* 25(3).

Osuch, E.A., E. Vingilis, C. Summerhurst, C.I. Forster, E.E. Ross and A.J. Wrath. 2015. "Process Evaluation of an Early-Intervention Program for Mood and Anxiety Disorders Among Older Adolescents and Young Adults." *Psychiatr Serv* 66(10): 1113–7 doi: 10.1176/appi.ps201400256

Otte, C. 2011. "Cognitive Behavioral Therapy in Anxiety Disorders: Current State of the Evidence." *Dialogues Clin Neurosci* 13(4): 413–21.

Perry, A., N. Tarrier, R. Morriss, E. McCarthy and K. Limb. 1999. "Randomised Controlled Trial of Efficacy of Teaching Patients With Bipolar Disorder to Identify Early Symptoms of Relapse and Obtain Treatment." *BMJ* 318(7177): 149–53.

Rapee, R.M., C.A. Schniering and J.L. Hudson. 2009. "Anxiety Disorders During Childhood and Adolescence: Origins and Treatment." *Annu Rev Clin Psychol* 5: 311–41.

Ross, E., E. Vingilis and E. Osuch. 2012. "An Engagement and Access Model for Healthcare Delivery to Adolescents With Mood and Anxiety Concerns." *Early Interv Psychiatry* 6(1): 97–105.

Smith, R.A., V. Cokkinides and H.J. Eyre. 2006. "American Cancer Society Guidelines for the Early Detection of Cancer, 2006." *CA Cancer J Clin* 56(1): 11–25; Quiz 49–50.

Snowdon, A. 2014. *Graham Boeckh Foundation: Headspace Business Case*. London, ON: International Centre for Health Innovation.

Vittengl, J.R., L.A. Clark, T.W. Dunn and R.B. Jarrett. 2007. "Reducing Relapse and Recurrence in Unipolar Depression: A Comparative Meta-Analysis of Cognitive-Behavioral Therapy's Effects." *J Consult Clin Psychol* 75(3): 475–88.

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The South West Local Health Integration Network Behavioural Supports Ontario Experience

Iris Gutmanis, Jennifer Speziale, Lisa Van Bussel, Julie Girard, Loretta M. Hillier and Kelly Simpson

Abstract

Creating a seamless system of care with improved system and patient outcomes is imperative to the estimated 35,000 older adults living with mental health problems and addictions in the South West Local Health Integration Network. Building on existing investments and those offered through the Behavioural Supports Ontario program, strategies to improve system coordination were put in place, cross-sectoral partnerships were fostered, interdisciplinary teams from across the care continuum were linked, and educational opportunities were promoted. This evolving, co-created system has resulted in a decrease in alternate level of care cases among those with behavioural specialized needs and improved client/family perceptions of care. Also, in fiscal year 2014/15, it provided more than 7,000 care providers with learning opportunities.

Background

Increasing numbers of older adults are living with behavioural and psychological symptoms associated with cognitive impairment due to mental health problems, dementia, addictions and other neurological conditions (Brookmeyer et al. 2007; Mathillas et al. 2011; Smetanin et al. 2009). Referred to as *responsive behaviours*, behavioural and psychological symptoms can include aggression, disruptive behaviours, disinhibition, apathy, depression, anxiety and agitation (Cerejeira et al. 2012;

Patterson et al. 1999; Savva et al. 2009). These behaviours are a means of communication and reflect a response to something in the person's environment (Cohen-Mansfield 2000; Kunik et al. 2010). Responsive behaviours can threaten the safety and well-being of the people experiencing them as well as their care providers (Rodney 2000) and others within the care environment (Rosen et al. 2008). Responsive behaviours are associated with increased care costs (Beeri et al. 2002; Herrmann et al. 2006), increased risk for hospitalization (Toot et al. 2013), early institutionalization (Chan et al. 2003), and mortality (Russ et al. 2012). In response to this growing problem, in 2010, the Ontario government created the Behavioural Supports Ontario (BSO) program, a pan-provincial, regionally implemented quality improvement (QI) initiative that utilizes evidence-informed change strategies and knowledge translation best practices aimed at improving the system of care of older persons experiencing responsive behaviours (Gutmanis et al. 2015).

An estimated 16,904 people in the South West Local Health Integration Network (LHIN) are living with dementia (Hopkins 2010). As well, an estimated 26,077 to 46,019 older adults are living with a mental health problem that could lead to responsive behaviours, dependent on the specific diagnoses (based on prevalence estimates of 17%–30%; Ontario Seniors' Secretariat 2009). To meet service needs, multi-sectoral health service providers came together to co-create a system of care for those

living with responsive behaviours. Planning accounted for many factors, including the broad geography of the South West LHIN (size: 21,639 square kilometres), current and future population need and the multiple service provider agencies involved.

This paper outlines the change strategies, executed in stages, that were implemented in the South West LHIN and that led to system redesign. It also describes the impact of those changes both on health system transformation and on those living with responsive behaviours and their family members. Funding was provided by the South West LHIN.

Methods

Health system partners focused on co-creating a system of care that was person-centred, would maximize the skills of staff in a variety of healthcare settings and would provide equitable access to services. St. Joseph's Health Care London was identified as the organization responsible for LHIN-wide BSO coordination. In 2010, a South West LHIN BSO steering committee was struck, comprised of members from many agencies/services to ensure that multi-sectoral, diverse perspectives were at the table. Described below and organized by the three BSO pillars ((1) system coordination and management, (2) intersectoral and interdisciplinary service delivery and (3) knowledgeable care teams and capacity development (Gutmanis et al. 2015); operational and clinical structures were developed, implemented and evaluated to support the BSO system of care.

System Coordination and Management

Many agencies/services were tasked with improving the coordination of services offered across the care continuum, including six Schedule 1 hospitals (i.e., psychiatric facilities designated under the *Mental Health Act*), 79 long-term care (LTC) homes, six Alzheimer Societies, 10 adult day programs (ADPs) offering overnight respite, St. Joseph's Health Care London (a tertiary-care hospital that offers both specialized geriatric mental health services and specialized geriatric services) and the South West Community Care Access Centre. The development of a common agenda and regional QI plans was facilitated by the BSO operational team (including a project, evaluation and QI lead) and at LHIN and local levels through Kaizen events (Grabau and Swartz 2012) that frequently included value stream mapping (Martin and Osterling 2013). Findings informed the South West LHIN BSO action plan (South West Local Health Integration Network 2012). These events assisted with the articulation of a BSO client value statement, vision, mission and values (Table 1).

To ensure coordinated, system-wide change at a local level, Geriatric Cooperatives were created in five sub-LHIN areas. Co-led by a local hospital director and a community agency lead, representatives from regional mental health services were asked to identify system gaps and develop local work plans

TABLE 1.
BSO Vision, Mission and Values

BSO Client Value Statement: "I am a unique individual who wants to live my life with dignity."

BSO Vision: Enabling older adults to achieve positive emotional and behavioural health and to live with dignity, value and meaning

BSO Mission: Through partnership, collaboration, innovation and evidence-informed practice, to build a quality-driven, sustainable behavioural support system of person/family-centred care for older adults living with or at risk of developing responsive behaviours

BSO Values:

- Person-centred/family driven
- Support for caregivers, both informal and formal
- Collaboration
- Innovation
- Compassion
- Evidence-informed
- Integrity
- Trust
- Respect
- Cultural competency
- Courage to act beyond the status quo

that leveraged existing capacity. In addition, Cooperatives were mandated to coordinate, leverage and improve linkages among agencies/services.

In the summer of 2012 and 2015, Geriatric Cooperative members completed the Partnership Self-Assessment Tool (PSAT; <http://www.lmgforhealth.org>), a standardized tool that identifies effectiveness related to synergy, leadership, efficiency and sufficiency of resources (Lasker et al. 2001; Wiess et al. 2002). In addition, experience-based design (EBD) (Bate and Robert 2006) methodology was used to gather personal stories from individuals with responsive behaviours, their caregivers and staff that described the emotional touch points associated with healthcare journeys. This information was used to identify QI opportunities.

Intersectoral and Interdisciplinary Service Delivery

Multiple strategies were used to ensure interdisciplinary service delivery. One such strategy was the creation and/or enhancement of Geriatric Mental Health Outreach Teams (GMHOTs). Based out of local Schedule 1 hospitals, GMHOT members provide assessment, consultation and short-term follow-up, as well as timely education and support to staff working in LTC homes, hospitals and community organizations, in addition to families and other care partners. GMHOT members come from many disciplines, including recreation therapy, social work and occupational therapy. Teams are led by enhanced psychogeriatric resource consultants (EPRCs), who provide "in the moment," case-based training opportunities, link team members with local

services and specialized geriatric psychiatry expertise when more intensive services are needed, and act as a liaison between the EPRC Network and the Geriatric Cooperatives. EPRCs can be from multiple professional backgrounds, including social work and nursing.

Further service enhancements included embedded BSO LTC home staff. Registered nurses, registered practical nurses, and/or personal support workers collaborate with all LTC home staff to improve the care experience of residents and their families and offer staff education regarding responsive behaviours. They are the point of contact within the LTC home for other community-based services and specialized geriatric psychiatry resources. As well, additional social work/social support staff were added to local Alzheimer Societies, and more spaces were funded for ADPs offering overnight respite.

Knowledgeable Care Teams and Capacity Development

Existing provincial resources were leveraged to support the development of LTC home and community service provider QI skills, including the *Health Quality Ontario Residents First Initiative* (<http://www.hqontario.ca/quality-improvement/long-term-care>), which provided QI training and coaching within LTC homes. The BETSI tool (Behavioural Supports Ontario 2012a), a framework that helps organizations identify staff readiness and need for education as well as appropriate programs to meet these needs, was administered across all sectors involved with BSO in the South West LHIN. Subsequently, in collaboration with local, regional and provincial experts, the local EPRCs and the BSO operational team coordinated education delivery, providing both in-kind informal coaching and formal teaching. As well, the *Capacity Building Roadmap* (Behavioural Supports Ontario 2012b), a tool that describes the core competencies required to manage responsive behaviours, was used to develop job descriptions.

The EPRC Network continues to coordinate education initiatives across the LHIN. As well, technology (e.g., Ontario Telemedicine Network, OTN) is used to support clinical and educational activities. HealthChat, an online forum for health professionals to share information, communicate and collaborate (www.healthchat.ca), is used as a central repository for BSO-related information and tools (e.g., assessment and QI tools, protocols, data collection tools) as well as a communication venue for educational opportunities.

Results

System Coordination and Management

EBD (Bate and Robert 2006) data showed that consumers felt that they were “assessed to death,” were not sure what was happening with pending referrals to services, were confused by medical jargon, lacked knowledge of available services and

supports and how to access them and needed greater access to crisis-oriented services. Communication strategies were implemented that minimized assessment duplication and let clients know when referrals were received and what crisis services were available. These strategies continue to be tweaked using QI methods. As well, plans are in place to train EBD champions across the region.

In 2012, 54 Geriatric Cooperative members (a 64% response rate), and the PSAT findings indicated that the Cooperatives were functioning fairly well in all areas (Gutmanis and Hillier 2012). However, mean scores were in the “work zone” for all dimensions, suggesting that more effort was needed to maximize the partnership’s collaborative potential (Table 2). Subsequently, strengths-based Cooperative work plans were generated in an effort to maximize local partnerships.

When the tool was re-administered in 2015 (Gutmanis and Hillier 2015), only 43 members (a 38% response rate) completed the survey. However, similar results were obtained. Across both administrations, the majority of respondents (>74%) reported that the benefits of Cooperative partnership “exceeded” the drawbacks. The majority of respondents provided ratings of “mostly” or “completely” satisfied (ranging from 63% to 74%)

TABLE 2.
Geriatric Cooperative Evaluation: Partnership Self-Assessment Tool (PSAT) Results by Year

Dimension	2012 (N = 54) Mean (range)	2015 (N = 43) Mean (range)
Synergy	3.5 (3.2–3.7)	3.4 (3.1–3.7)
Leadership	3.4 (3.0–3.9)	3.4 (3.3–3.6)
Partnership Efficiency	3.3 (3.1–3.8)	3.6 (3.5–3.7)
Administration and Management Effectiveness	3.2 (2.7–3.7)	3.2 (3.1–3.4)
Sufficiency of Non-Financial Resources	3.7 (3.3–3.9)	3.7 (3.7–3.8)
Sufficiency of Financial and Other Capital Resources	3.8 (3.4–4.0)	3.7 (3.6–3.9)
Benefits Exceeding Drawbacks (% Positive)	74.1% (69.3%–100%)	74.5% (55.5%–87.5%)

Note: Scores from 1.0 to 2.9 are in the Danger Zone, which means that this area needs a lot of improvement. Scores from 3.0 to 3.9 are in the Work Zone, which means that more effort is needed in this area to maximize the partnership’s collaborative potential. Scores from 4.0 to 4.5 are in the Headway Zone, which means that although the partnership is doing pretty well in this area, it has the potential to progress even further. Scores from 4.6 to 5.0 are in the Target Zone, which means that the partnership currently excels in this area and needs to focus attention on maintaining its high score.

with the way people/organizations worked together, their role in the partnership, plans for achieving goals and the way the partnership implemented its plans (Gutmanis and Hillier 2012; Gutmanis and Hillier 2015). Administration and management effectiveness (e.g., coordinating communication among people/organizations outside of the partnership, providing orientation to new partners) remains an area that needs further work. When asked to identify barriers, respondents indicated that time constraints, high membership turnover and maintaining/improving partner engagement posed challenges.

Qualitative data (i.e., patient and caregiver stories) demonstrate some of the impacts of improved system coordination. One caregiver whose spouse used the overnight respite program on an ongoing basis wrote, “You certainly have relieved a lot of pressure off me, because being the caregiver 24/7 was extremely hard on me.”

Client impacts were also observed. For example, one LTC home was struggling to find the best approach with a resident who was refusing to take his medications and was experiencing suicidal ideation. In collaboration with the local Community Stroke Rehabilitation team, the GMHOT was able to gain a better understanding of the resident’s personal situation and adapt the approach to care used by the LTC home staff. One of the LTC home staff said,

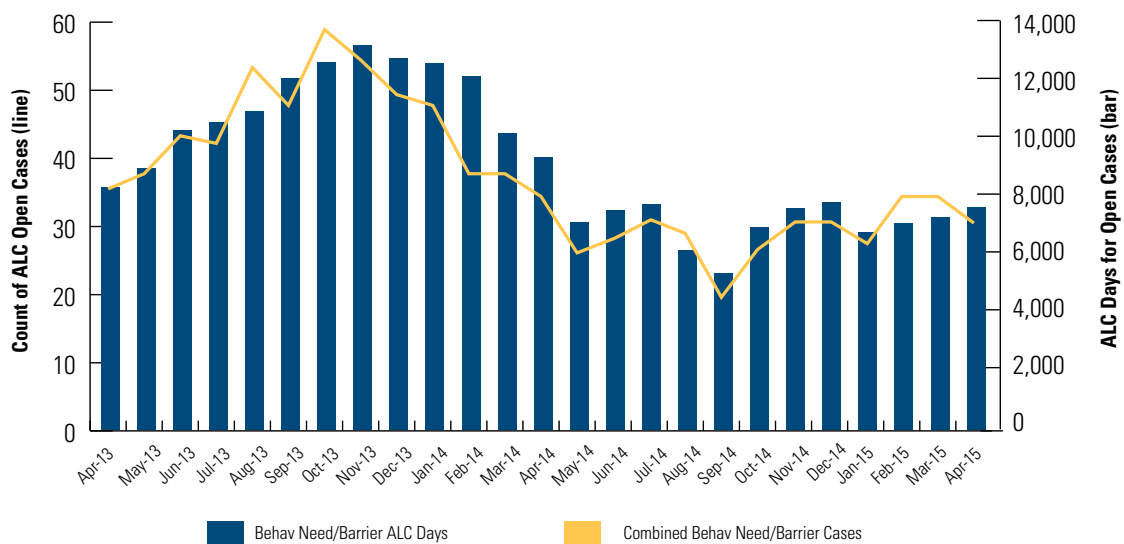
One month after we started this initiative, we saw a completely different individual!...While it may take a lot of effort on our part, our home has learned to really listen to what the resident is trying to tell you.

Intersectoral and Interdisciplinary Service Delivery

As predicted, need continues to increase. The number of clients served by the BSO program has increased from 2,294 in the third quarter of 2013/14 to almost 3,560 in the fourth quarter of 2014/15. More than 6% of the population aged 65 or older are now being seen through BSO.

Both system and individual-level impacts have been noted. Between October 2013 and April 2015 there were fewer open alternate level of care (ALC) cases among those with behavioural specialized needs in the South West LHIN, as well as fewer ALC days (South West Local Health Integration Network 2015). As seen in Figure 1, the number of open ALC cases among those with behavioural specialized needs has varied from a high of 58 in October 2013 to a low of 24 in September 2014. From November 2013 to April 2014, the number fell from 55 cases to 36 cases (average: 49.8 cases). Over the same six-month period in 2014/15, the mean number of open ALC cases was 36% lower (mean: 31.8 cases). A similar decrease in the number of ALC days for open cases

FIGURE 1.
Number of Open ALC Days and Cases With Behavioural Specialized Needs by Month: South West Local Health Integration Network



ALC = alternate level of care; Behav = behavioural; Source: South West Local Health Integration Network 2015; Data source: iPort, Cancer Care Ontario

is observed between November 2013 and April 2014, with a similar levelling off between November 2014 and April 2015.

Qualitative data further demonstrate the impact of interdisciplinary care on clients and their families. A LTC home resident who had exhibited inappropriate behaviour toward other residents was referred to a local hospital for assessment and recommendations. As reported by the LTC home;

The BSO staff, inpatient mental health team, hospital psychiatrist, LTC home Director of Care and Alzheimer Society met together with [Resident]’s family to review his history, challenges and possible treatment approaches. [Resident] was successfully returned to his LTC home within a week of admission to the hospital ... Other residents’ safety has increased. No incident reports have been recorded since the client’s return to the facility and no responsive behaviours have been exhibited.... There was no one individual more responsible for [Resident]’s care than another. The team was truly interdisciplinary in its approach to client-centred care.

Knowledgeable Care Teams and Capacity Development

Opportunities for capacity development have increased. In 2012/2013, at the onset of the BSO initiative, 34 education events/presentations related to the care of those with responsive behaviours were scheduled. This increased to 325 in 2013/2014, and then to 410 in 2014/2015. In 2013/14, more than 1,100 people attended these events. This number increased dramatically in 2014/15, to 7,025 people.

Demonstrating effective outcomes, one caregiver wrote to the then Ontario Minister of Health and Long-Term Care, Deb Matthews, and related the story of her husband who had frontotemporal dementia. Amongst several comments about the high quality of care he received, she wrote of the LTC home in which her husband was living, “All of the services are provided by well trained, caring and cheerful professionals, who make every possible effort to ensure those under their care feel secure, comfortable and content.”

Discussion

With the implementation of BSO, system coordination has improved and cross-sectoral communication has been enhanced. Partnerships facilitated by the Geriatric Cooperatives have changed the way agencies/services collaborate. As evidenced by client and family stories, interdisciplinary service delivery has improved client perceptions of care and increased the time clients spend in the right place, accessing the right services. The observed reduction in ALC days, though likely attributable to the combined efforts of several LHIN-wide initiatives,

Lessons Learned

Broad system change is not without its challenges and risks.

- Developing a common language proved more difficult and confusing than expected (e.g., some mobile teams were called behavioural response teams while others were called BSO outreach teams, confusing some referral sources).
- Sustainability has been challenging, particularly in regard to staff recruitment and retention, ensuring capacity development in light of staff turnover and maintaining partner engagement, as recently evidenced by some flagging engagement in the Geriatric Cooperatives. Static funding can potentially result in staffing erosion, as hospitals, LTC homes and community services will not be able to compensate for the anticipated rise in program and salary costs.
- Measuring BSO impacts/outcomes has been challenging, as there is currently no valid method of accessing BSO-specific data from existing large databases. Process and QI measures continue to be collected and used to understand system evolution.

Although these factors may be considered barriers, they also serve as opportunities for creative problem-solving; these issues are frequent agenda items at BSO meetings at provincial, regional and local levels.

suggests improved client flow. And, when services are provided by well trained, qualified staff, clients feel safe.

Although in place for several years, this new way of working together requires nurturing, and, as evidenced by the PSAT results, more effort is needed to maximize collaborative efforts. Moving forward, with stable, appropriate, and consistent membership, the Cooperatives will likely be in a better position to excel in all areas of their partnership.

BSO has been a catalyst for change. It builds on existing local and system resources and strengths and provides an approach to capacity and care model development that has the potential for replication in other jurisdictions seeking sustainable system change. A renewed culture of QI and a fully developed health-care force that keeps asking, “How can we make this better?” will result in a system of care that can adapt and rectify future service gaps.

Next Steps

As BSO evolves, ongoing local and system change will focus on continuing support to primary care, the establishment

of behavioural support units and alignment with existing provincial and local addictions, dementia, and HealthLink strategies (http://www.health.gov.on.ca/en/pro/programs/transformation/com_healthlinks.aspx). Additional investments to build on OTN technology and other mobile devices and electronic patient systems across the South West LHIN will further support clinical and educational initiatives.

Recently, a provincial operations team and BSO secretariat were created with the aim of linking BSO initiatives across Ontario to promote best practices in assessment, capacity development and measurement. The “Ontario Best Practice Exchange & Beyond” event was held on September 25, 2015. In his concluding remarks, Dr. Ken LeClair (Queen’s University, Professor and Chair, Division of Geriatric Psychiatry) supported the philosophy of moving forward together for better health and healthcare for older persons with responsive behaviours, mental health and addictions, dementia, and families and caregivers. By honouring people, honouring partners and honouring possibilities, person- and family-centred care is and will continue to be the foundation on which we build a better system of care for those living with responsive behaviours. **HQ**

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References

Bate, P. and G. Robert. 2006. “Experience-Based Design: From Redesigning the System Around the Patient to Co-designing Services with the Patient.” *Quality and Safety in Health Care* 15: 307–10. doi:10.1136/qshc.2005.016527

Beeri, M.S., P. Werner, M. Davidson and S. Noy. 2002. “The Cost of Behavioral and Psychological Symptoms of Dementia (BPSD) in Community Dwelling Alzheimer’s Disease Patients.” *International Journal of Geriatric Psychiatry* 17(5): 403–08. doi:10.1002/gps.490

Behavioural Supports Ontario. 2012a. “Behavioural Education and Training Supports Inventory (BETSI).” Toronto, ON: Author. Retrieved July 8, 2015. <<http://brainxchange.ca/Public/Resource-Centre-Topics-A-to-Z/Behavioural-Education-and-Training-Supports-Invent.aspx>>.

Behavioural Supports Ontario. 2012b. *Capacity Building Roadmap*. Toronto, ON: Author. Retrieved July 8, 2015. <<http://brainxchange.ca/Public/Files/BSO-Resources/BSO-capacity-building-roadmap.aspx>>.

Brookmeyer, R., E. Johnson, K. Ziegler-Graham and H.M. Arrighi. 2007. “Forecasting the Global Burden of Alzheimer’s Disease.” *Alzheimer’s and Dementia* 3: 186–91. doi:10.1016/j.jalz.2007.04.381

Cerejeira, J., L. Lagarto and E.B. Mukaetova-Ladinska. 2012. “Behavioural and Psychological Symptoms of Dementia.” *Frontiers in Neurology* 3: 73. doi:10.3389/fneur.2012.00073

Chan, D.C., J.D. Kasper, B.S. Black and P.V. Rabins. 2003. “Presence of Behavioral and Psychological Symptoms Predicts Nursing Home Placement in Community-Dwelling Elders With Cognitive Impairment in Univariate but Not Multivariate Analysis.” *Journal of Gerontology Series A, Biological Sciences and Medical Sciences* 58(6): 548–54.

Cohen-Mansfield, J. 2000. “Theoretical Frameworks for Behavioral Problems in Dementia.” *Alzheimer’s Care Quarterly* 1: 8–21.

Graban, M. and J. Swartz. 2012. *Healthcare Kaizen: Engaging Front-line Staff in Sustainable Continuous Improvement*. New York, NY: Productivity Press.

Gutmanis, I. and L.M. Hillier. 2012. “Behavioral Support System for Older Persons With Behavioral Challenges: Evaluation of Geriatric Cooperatives in Southwestern Ontario.” London, ON: South West Local Health Integration Network.

Gutmanis, I., and L.M. Hillier. 2015. “Behavioural Supports Ontario – South West: Elevation of Geriatric Cooperatives in Southwestern Ontario: 2015.” London, ON: St. Joesph’s Health Care London.

Gutmanis, I., M. Snyder, D. Harvey, L.M. Hillier and J.K. LeClair. 2015. “Health Care Redesign for Responsive Behaviours – the Behavioural Supports Ontario Experience: Lessons Learned and Keys to Success.” *Canadian Journal of Community Mental Health* 34: 45–63. doi:10.7870/cjcmh-2015-001

Herrmann, N., K.L. Lancot, R. Sambrook, N. Lesnikova, R. Hebert, P. McCracken, A. Robillard and E. Nguyen. 2006. “The Contribution of Neuropsychiatric Symptoms to the Cost of Dementia Care.” *International Journal of Geriatric Psychiatry* 21(10): 972–76. doi:10.1002/gps.1594

Hopkins, R.W. 2010. “Dementia Projections for the Counties, Regional Municipalities and Census Divisions of Ontario. Kingston, ON, PCCC Mental Health Services.” *Geriatric Psychiatry Program Clinical/ Research Bulletin* Number 16. 7-7-2015.

Kunik, M.E., A.L. Snow, J.A. Davila, A.B. Steele, V. Balasubramanyam, R.S. Doody, P.E. Schulz, J.S. Kalavar and R.O. Morgan. 2010. “Causes of Aggressive Behavior in Patients With Dementia.” *Journal of Clinical Psychiatry* 71: 1145–52. doi:10.4088/JCP.08m04703oli

Lasker, R.D., E.S. Wiess and R. Miller. 2001. “Partnership Synergy: A Practical Framework for Studying and Strengthening the Collaborative Advantage.” *Milbank Quarterly* 79: 179–205.

Martin, K. and M. Osterling. 2013. *Value Stream Mapping: How to Visualize Work and Align Leadership for Organizational Transformation*. New Hill, NY: McGraw Hill.

Mathillas, J., H. Lovheim and Y. Gustafson. 2011. “Increasing Prevalence of Dementia Among Very Old People.” *Age and Ageing* 40: 243–49. doi:10.1093/ageing/afq173

Ontario Seniors’ Secretariat. June 3, 2009. Presentation to the Select Committee on Mental Health and Addictions.

Patterson, C.J., S. Gauthier, H. Bergman, C.A. Cohen, J.W. Feightner, H. Feldman and D.B. Hogan. 1999. "The Recognition, Assessment, and Management of Dementing Disorders: Conclusions From the Canadian Consensus Conference on Dementia." *Canadian Medical Association Journal* 160: S1–S15.

Rodney, V. 2000. "Nurse Stress Associated With Aggression in People With Dementia: Its Relationship to Hardiness, Cognitive Appraisal and Coping." *Journal of Advanced Nursing* 31(1): 172–80.

Rosen, T., K. Pillemer and M. Lachs. 2008. "Resident-to-Resident Aggression in Long-Term Care Facilities: An Understudied Problem." *Aggression and Violent Behavior* 13: 77–87. doi:10.1016/j.avb.2007.12.001

Russ, T.C., G.D. Batty and J.M. Starr. 2012. "Cognitive and Behavioural Predictors of Survival in Alzheimer Disease: Results From a Sample of Treated Patients in a Tertiary-Referral Memory Clinic." *International Journal of Geriatric Psychiatry* 27(8): 844–53. doi:10.1002/gps.2795

Savva, G.M., J. Zaccai, F.E. Matthews, J.E. Davidson, I. McKeith and C. Brayne. 2009. "Prevalence, Correlates and Course of Behavioural and Psychological Symptoms of Dementia in the Population." *British Journal of Psychiatry* 194(3): 212–19. doi:10.1192/bjp.bp.108.049619

Smetanin, P., P. Kobak, C. Briante, D. Stiff, G. Sherman and S. Ahmad. 2009. "Rising Tide: The Impact of Dementia in Canada in 2008 to 2038." Toronto, ON, Risk Analytica.

South West Local Health Integration Network. 2012. "Developing a Behavioural Support System for Older Persons With Responsive Behaviours in the South West LHIN Action Plan: Part A." Retrieved July 7, 2015. <www.southwestlhin.on.ca/.../SW_ActionPlan%20A%205Apr12%20Final>.

South West Local Health Integration Network. 2015. "South West LHIN Seniors Portfolio Internal Dashboard." London, ON: South West Local Health Integration Network.

Toot, S., M. Devine, A. Akporobaro and M. Orrell. 2013. "Causes of Hospital Admission for People With Dementia: A Systematic Review and Meta-Analysis." *Journal of the American Medical Directors Association* 14(7): 463–70. doi:10.1016/j.jamda.2013.01.011

Wiess, E.S., R. Miller Anderson and R.D. Lasker. 2002. "Making the Most of Collaboration: Exploring the Relationship Between Partnership Synergy and Partnership Functioning." *Health Education and Behavior* 29: 683–98. doi:10.1177/109019802237938

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Mental Healthcare Delivery in London-Middlesex Ontario – The Next Frontier

Karima Velji and Paul Links

The next frontier for mental healthcare delivery will be focused on three facets of innovation, namely structure, process and outcome. The structure innovation will seek to develop new models of care delivery between the two hospitals and with the community. The process innovation will focus on embedding strategies to adopt a recovery and rehabilitation approach to care delivery. Lastly, the outcome innovation will use system wide quality improvement methods to drive breakthrough performance in mental healthcare.

Background

The mental health services in the London-Middlesex area of Ontario have undergone a significant amount of transformation over the past two decades. This transformation has been focused on the development of innovative models of care within the hospital-based and community-based mental health programs.

In 2014, St. Joseph's Health Care (St. Joseph's) completed a 17-year journey to transform its tertiary mental healthcare service delivery following directives made by Ontario's Health Services Restructuring Commission (HSRC) in 1997. The HSRC provided direction for three tiers of change. Tier 1 called for the transfer of governance and management of the then London and St. Thomas Provincial Psychiatric Hospitals to St. Joseph's Health Care London; Tier 2 called for the transfer of

138 beds and related ambulatory services to four partner hospitals in the region as well as the closure of 70 beds; and Tier 3 recommended investment in building community capacity to enable persons living with serious mental illnesses to achieve successful community living. Finally, the HSRC also directed the building of two purpose-built facilities to replace aging hospital infrastructure.

Mental health services at the London Health Sciences Centre (LHSC) have also undergone significant changes. Prior to 1995, there were four independent acute care departments of psychiatry. In 1995, University Hospital and Victoria Hospital amalgamated to become LHSC, with a single mental health program.

There has been significant growth and expansion in the capacity and capability of community mental health and addictions services in London and across the South West Local Health Integration Network (LHIN) over the last two years. The South West LHIN has made funding investments over the last two years to strengthen community-based mental health and addictions services (\$7.8 million, representing 90 new community-based staffing positions).

We are well poised to build the next frontier of mental healthcare delivery, by leveraging the transformation that has taken place and addressing the structure, process and outcome of mental healthcare delivery within the hospital-based programs we lead, while continuing to build strong linkages and integration with the community.

The Next Frontier – Structure

Amalgamation of Hospital Programs

We have embarked on a feasibility study to explore amalgamation of mental health programs at LHSC and St. Joseph's while we continue to strengthen integration efforts with the community.

LHSC provides Schedule 1 psychiatric services, including acute inpatient and ambulatory care services, to the residents of London and Middlesex and a larger catchment area for selective programs. St. Joseph's offers specialized inpatient and ambulatory mental healthcare services to all residents of the South West LHIN and receives referrals from all six Schedule 1 hospitals in the LHIN. A significant number of patients transfer from LHSC to Parkwood Institute Mental Health Care. In fiscal year 2014–15, 50% of all admissions to Parkwood Institute Mental Health Care came from LHSC.

Access and wait times issues continue to be a challenge for hospital-based mental health services. LHSC's acute care mental healthcare unit has been operating at 110% occupancy for over one year, and mental health volumes presenting to the emergency room have increased by 30% over the last year. Also, more than 50% of the registered outpatients of St. Joseph's who require inpatient admission still end up in the emergency room as the point of entry into the system. LHSC and St. Joseph's have made great strides with successful discharge of long-stay patients; however, numbers of patients requiring alternate level of care continue to be an issue, at about 10% of the bedded volumes.

The voluntary integration of hospital-based mental health programs is seen as a foundational step to achieve the following objectives:

- Develop a single, comprehensive, cohesive and strategic approach to the delivery of all hospital-based mental health services and associated teaching/research programs
- Improve the patient experience, coordination and continuity of care and clinical outcomes
- Synchronize patient populations and models of care within the integrated program and enhance integration with the community
- Optimize allocation of resources and alignment with funding reform

There is a further opportunity to define patient populations served across the continuum of care and develop care pathways and integrated outcomes for these populations.

Integration With Community

The feasibility study will also examine opportunities to further strengthen partnerships and integration with the community. There are existing strong partnerships between the hospitals and the community mental health and addiction programs of the Canadian Mental Health Association (CMHA) Middlesex and Addictions Services of Thames Valley (ADSTV). Under formal agreements between these entities, addictions transitional case managers (ATCMs), transitional case managers (TCMs) and nurse practitioners (NPs) hired by the community sector work at LHSC to support the transition of patients with mental health and addictions issues to community services. LHSC, CMHA Middlesex and ADSTV have worked in partnership to create a new crisis centre, including residential supports, in the city of London. LHSC, St. Joseph's, Hotel Dieu Grace Hospital in Windsor and Western University's Division of Child and Adolescent Psychiatry have partnered to support the Ontario Child and Youth Telepsychiatry Program – Western Hub to increase access to psychiatric consultation for professionals and for children and youth living in rural, remote and underserved communities. Since 2010, St. Joseph's geriatric psychiatry program has been responsible for the regional coordination of a Behavioural Supports Ontario (BSO) program. The aim of BSO is to improve the lives of caregivers and older adults with responsive behaviours due to dementia, mental health and addictions issues and other neurological disorders.

Building on these strong linkages, we are also increasing our collaborations with primary care providers. Over the past two decades, some of the greatest advances in the field of mental healthcare have been new evidence-based practices that are shown to improve the outcomes of individuals with mental illness. For those with severe mental illness, these evidence-based practices have included Assertive Community Treatment and Illness Management and Recovery models of care (Mueser et al. 2003). Collaborative care interventions for depression for patients with primary care providers have demonstrated a twofold increase in treatment adherence, improvement in depressive outcomes lasting up to five years, increased patient satisfaction with care and improved primary care satisfaction with treating depression (Katon and Seelig 2008). The mental healthcare program at LHSC and St. Joseph's Health Care have been leaders in practice innovations including our Mental Health Consultation and Evaluation in Primary Care (MHCEP) and Transition into Primary-Care Psychiatry (TIPP) services, which provide a spectrum of linkages between mental healthcare and family physicians to improve care and access. In addition, our programs are evaluating the use of SMART technologies to improve the care of patients with severe mental illness and patients with multiple comorbid medical and psychiatric disorders.

The future of our community collaboration involves 1) extending our collaborative practice innovations to new community partners; 2) developing team-based patient care, targeting multiple disease states in conjunction with other medical care providers and 3) implementing and evaluating these models of care using the latest technologies. Our plans include establishing a Practice Innovation Centre that will develop and deliver the latest service innovation models to our integrated mental health service, developing self-management approaches for patients with multiple comorbid conditions and using SMART technologies to provide decision support, patient-based feedback and program evaluation.

The Next Frontier – Process

Recovery and Rehabilitation

The tertiary mental health program of St. Joseph's is located in a new building on the campus of the Parkwood Institute, which was established in November 2014. The patient and resident populations served at this one purposeful geographic location include rehabilitation, specialized geriatrics, complex care, palliative care, veterans care and specialized mental healthcare. Bringing these teams together presents us with the potential to leverage and create new synergies to achieve breakthroughs in care, recovery and rehabilitation. We are at an important crossroads, where we can fully embrace and renew the ageless knowledge that care of the body, mind and spirit go hand in hand (Anthony et al. 1990; Anthony and Liberman 1986; Mental Health Commission of Canada 2015).

St. Joseph's strategic plan for 2015–2018 has identified three areas of clinical, academic and educational focus. One of these three areas is recovery and rehabilitation, which the Parkwood Institute will play a critical role in advancing.

The Lawson Health Research Institute has also recently led the development of a research strategic plan aligned with Parkwood Institute and the focus on recovery and rehabilitation. The St. Joseph's Health Care Foundation is also well aligned and supporting the priorities within this plan.

Under the umbrella of recovery and rehabilitation has been the development of cognitive vitality and brain health, which has enabled us to bring together clinical and research leaders in the areas of rehabilitation, geriatrics, dementia care, acquired brain injury and mental healthcare – many already nationally and internationally recognized leaders in their individual fields – to explore new ground in advancing collaborative, interdisciplinary research, education and clinical care. Their work continues as they offer interdisciplinary-team-learning opportunities and identify a set of collaborative research and care projects to further together.

As our new future emerges, St. Joseph's regional and provincial role as a leader in recovery and rehabilitation models will

grow. This priority will now come alive through the development of a comprehensive blueprint, in addition to articulating the overall care, teaching and research priorities, to achieve the vision of Parkwood Institute. By 2018, Parkwood Institute will be regarded as the provincial leader in integrated recovery and rehabilitation models of care, built on leveraging knowledge and synergies across programs and through interdisciplinary teaching and research.

Within the context of our strategic plan, the development of a blueprint for recovery and rehabilitation is envisioned, inclusive of our tripartite mission of care, education and research. This blueprint will leverage the current strengths to scale up quick-win opportunities while developing the infrastructure for a long-term centre of excellence for recovery and rehabilitation – body, mind and spirit. In addition, the recalibration of a research chair to encompass a recovery and rehabilitation focus at Parkwood Institute is regarded as a key enabler for this work.

The Next Frontier – Outcome

Our program is dedicated to the relentless pursuit of safety for our patients, family and staff. In addition to our day-to-day work to support quality and safety for our patients, we will focus on bold and audacious goals for safety. For example, one of our future focuses on safety will be directed to the prevention of suicide in patients under our care. A broad, multi-level approach is required to prevent suicide.

First, we understand that our services must address the risk of suicide behaviour over and above interventions that are directed to treat and manage the individual's mental illness.

Second, certain psychotherapies for patients at risk for recurrent suicide behaviour have led experts to extract a limited number of psychotherapy principles that may be effective in reducing the risk of future suicide behaviour. These basic principles of management include the following (Links 2011):

- Adopting a theoretical model of understanding suicide behaviour to promote the confidence and understanding to work with patients who are suicidal
- Providing a stable treatment framework by increased activity of the therapist
- Conveying empathic validation plus the need for the patient to control destructive behaviours
- Fostering a greater sense of self-agency through the therapeutic relationship
- Establishing a connection between destructive behaviours and current feelings
- Developing methods with the patient to differentiate nonlethal from true suicidal intention
- Setting a low threshold for seeking consultation or supervision

Third, managing transitions in care, for example after discharge from hospital, can be an effective way to prevent suicides. Knesper and colleagues (2010) summarized the evidence for rapid follow-up after discharge from emergency departments or inpatient settings and concluded that early contact after discharge led to significant reductions in suicide reattempts versus usual care. Attempts to improve community linkages after hospitalization appear to be simple but effective ways of preventing repeated suicide behaviour and, perhaps, suicides.

Finally, the prevention of suicide may be advanced by striving for perfection rather than incremental goals, and the zero-suicide approach promoted by the Suicide Prevention Resource Center provides a toolkit to health and mental health programs to follow and implement (<http://zerosuicide.sprc.org/about>). Our approach will be to adopt and adapt these various novel strategies to our own integrated mental health program.

Our program is also engaged in quality assurance projects targeting certain diagnostic patient groups; for example, one project being launched aims to increase engagement in mental health treatment for patients with schizophrenia to improve outcomes (Kreyenbuhl et al. 2009). Three outcomes will be evaluated as part of the quality assurance project: readmission to our psychiatric services, compliance with follow-up appointments and compliance with mental health treatment (including medications). The quality assurance project will measure the outcomes pre- and post-initiating low-intensity interventions across the integrated mental health program. The low-intensity interventions include minimizing wait time to first appointment, reaching-out techniques prior to first appointment and enhancing our community reintegration curriculum during hospitalization (Boyer et al. 2000).

The goal of the project is to improve by 50% our readmission rates in 30 days or less after discharge, which is currently approximately 13% overall across the integrated mental health program.

Conclusion

The next frontier of mental healthcare delivery will leverage the transformation that has taken place within our region by addressing the structure, process and outcome of mental healthcare delivery within the hospital-based programs, while we continue to build strong linkages and integration with the community. **HQ**

References

- Anthony, W.A., M.R. Cohen and M.D. Farkas. 1990. *Psychiatric Rehabilitation*. Boston: Boston University, Center for Psychiatric Rehabilitation.
- Anthony, W.A. and R.P. Liberman. 1986. "The Practice of Psychiatric Rehabilitation: Historical, Conceptual and Research Base." *Schizophrenia Bulletin* 12: 542–59.

Boyer, C.A., D.D. McAlpine, K.J. Pottick and M. Olfson. 2000. "Identifying risk factors and key strategies in linkage to outpatient psychiatric care." *American Journal of Psychiatry* 157:1592–1598

Katon, W.J. and M. Seelig. 2008. "Population-Based Care of Depression: Team Approaches to Improving Outcome." *Journal of Occupational and Environmental Medicine* 50:459–67.

Knesper, D.J. 2010. *Continuity of Care for Suicide Prevention and Research: Suicide Attempts and Suicide Deaths Subsequent to Discharge From an Emergency Department or an Inpatient Psychiatry Unit*. American Association of Suicidology and Suicide Prevention Resource Center. Newton, MA: Education Development Center, Inc.

Kreyenbuhl, J., I.R. Nossel and L.B. Dixon. 2000. "Disengagement from Mental Health Treatment among Individuals with Schizophrenia and Strategies for Facilitating Connections to Care: Review of the Literature." *Schizophrenia Bulletin* 35 (4):696–703.

Links, P.S. 2011. "The Role of Physicians in Advocating for a National Strategy for Suicide Prevention." *CMAJ* 183(17): 1987–90. doi:10.1503/cmaj.111008

Mental Health Commission of Canada. 2015. *Guidelines for Recovery-Oriented Practice*. Mental Health Commission of Canada.

Mueser, K.T., W.C. Torrey, D. Lynde, P. Singer and R.E. Drake. 2003. "Implementing Evidence-Based Practices for People With Severe Mental Illness." *Behavior Modification* 27(3):387–411.

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