

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

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## 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 (Knobloch 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**

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