

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

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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.

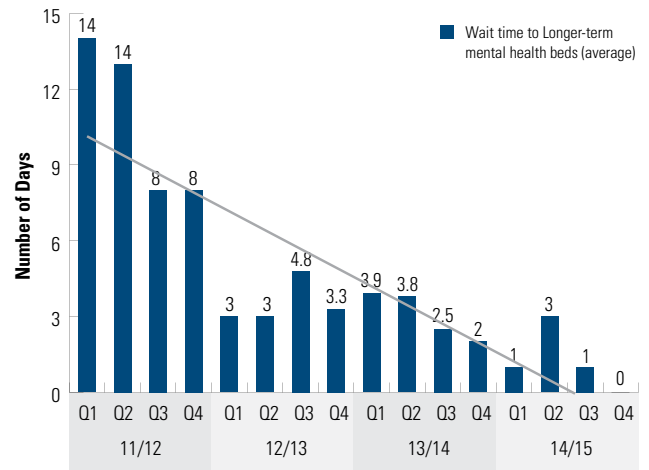
The second transfer to Windsor Regional Hospital occurred in 2011, with 59 beds and three ACT teams being transferred. The third transfer saw 14 beds transfer to St. Joseph's Health Care Hamilton in March 2013, and the final transfer of 15 beds and related ambulatory services to St. Thomas Elgin General

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

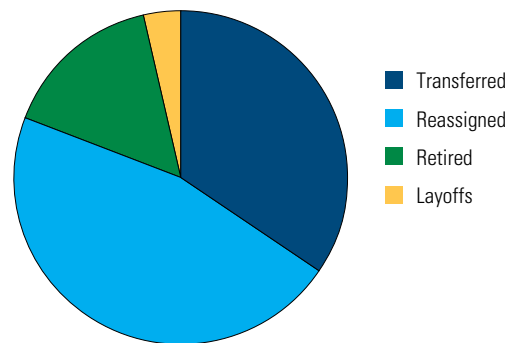
reduced to 1 day in Q3 of 2014/15 and maintained until the end of the transformation period (see Figure 2).

FIGURE 2.
Mental Health Divestment Wait Time Statistics



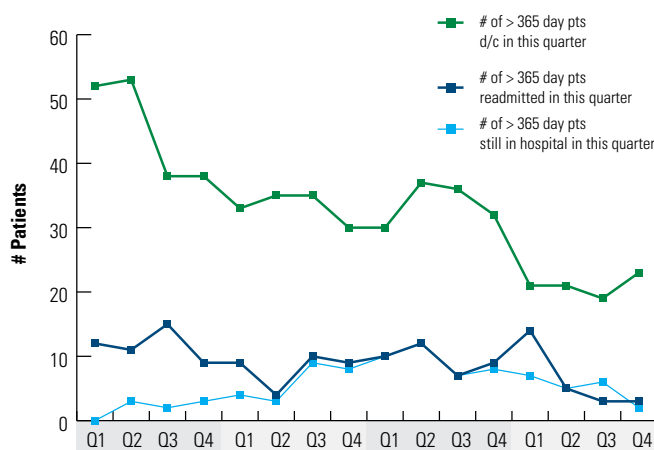
As promised above, the human resources metrics are provided in Figure 3. A shift in care culture was also attended to in this period of tremendous change, and more detail regarding the challenges of that work can be found in another article in this issue entitled “Relentless Incrementalism: Shifting 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**

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