MEETING THE INPATIENT MENTAL HEALTH & ADDICTIONS CARE NEEDS OF ISLANDERS

A PROPOSED FUTURE ROLE FOR HILLSBOROUGH HOSPITAL

Final Report

Submitted to HPEI Mental Health & Addictions Steering Committee

Issued: July 3, 2014

CSI Consultancy

TABLE OF CONTENTS

EXECUTIVE SUMMARY

Health PEI is the operational entity responsible for planning, delivering and evaluating healthcare services/programs to meet the needs of residents of PEI. Health PEI works closely with the Department of Health and Wellness, which has responsibilities for policy development, standards setting and perhaps most importantly, allocating public resources to fund the mandate of Health PEI.

Mental Health and Addiction (MH&A) services are organized under a province-wide programmatic structure that encompasses the full spectrum of MH&A services. As a provincial program spanning the continuum of care, the MH&A program is uniquely positioned to integrate services, allocate resources to support the highest need areas and address system-level quality/safety concerns by ensuring the involvement of various experts in mental health and addictions care delivery.

Over the last number of years, the specialty focus of Hillsborough Hospital has become unclear and the ability to address the needs of defined 'specialty populations' has been limited by a number of issues, resulting in concerns about its focus and care delivery models. Given this, Health PEI contracted CSI Consultancy to work with the MH&A program to confirm the future role of Hillsborough Hospital (HH) as a provincial resource delivering specialty inpatient mental health services within an integrated continuum of care. Accordingly, while the report focuses on the role of HH, it also comments on services delivered at the Prince County Hospital (PCH) and at the Queen Elizabeth Hospital (QEH).

In completing the assessment, the literature was reviewed and interviews were held with over 100 people including patients and families, providers from all disciplines and administration. The perspectives gleaned from the parallel work regarding engagement of psychiatrists also inform this project, where appropriate. Some of the overarching issues that help frame the context for this review include:

1. Across Canada, the deinstitutionalization of clients previously cared for in psychiatric facilities has been problematic for a subset of clients who have experienced difficulty integrating into community-based care settings and are re-admitted to the provincial facility, reflecting a "safety-net" role described, by some, as "re-institutionalization by popular demand." The Hillsborough Hospital has had a similar 'deinstitutionalization' experience. ***The CSI Team see this as a critical issue that needs to be resolved as Hillsborough has, by default, fulfilled the "safety net" role and is now criticized for failing to provide access to specialty services because beds are "blocked" by people who need housing***.

2. The MH&A program has been the subject of numerous reviews over the past decade, with most identifying similar issues and themes. This suggests that the various levels of decision-makers throughout the system have been unable (or unwilling) to reach consensus regarding the policy changes they are willing to enact and/or the strategic and operational changes they are willing to pursue to implement the recommendations. ***The CSI Team notes that the inability to achieve consensus regarding the recommendations outlined in this report cannot be an option as the citizens who depend on the provision of MH&A services deserve better.***

3. The MH&A Program was the first clinical area to be formally organized under a program management model (2008). The transition to program management was intended to improve care for Islanders by enabling better coordination and integration of care within a province-wide service delivery model. The literature on program management tells us that this shift (regardless of jurisdiction or program area) commonly leads to unintended consequences as providers, organizations, and patients alike, struggle with new structures, processes, models and roles designed to ensure connectivity across the continuum. ***The CSI Team concluded that the transition to program management has failed to create an integrated mental health continuum because providers/facilities have continued to operate autonomously without consequences or repercussions.***

The above system-level issues are largely beyond the control of MH&A leaders, clinicians and staff, and yet, they impact program planning and care delivery every day. In addition, parts of the physical facility at HH are seriously outdated and not well suited to the needs of a specialty provider within a

contemporary and integrated model of care. Despite this, Patients/Families are very appreciative of the compassionate care provided by the staff at HH, and this represents a strength that can be leveraged as the MH&A program moves forward with the recommendations outlined in this report.

Recommendations contained in this work include:

- ***Recommendation #1: Health PEI to confirm that Inpatient Care will be managed under a One Island System model, whereby the MH&A Program defines the specific roles and mandates (Levels of Care) for all three inpatient sites (Hillsborough, PCH and QEH) as well as the expectations of the community hospitals with regard to providing care to MH&A patients.***
- ***Recommendation #2: Health PEI to confirm that Levels of Care as outlined above and to direct the MH&A Program to develop specific admission and discharge criteria for each Level/Site as well as the required transfer criteria and protocols to be used when a patient requires care at a higher Level of Care facility. Where possible, direct admission to the required service at the higher level of care facility should be available.***
- ***Recommendation #3: Health PEI clearly identify behavioural and process expectations for its internal leaders, clinicians and staff regarding the need to transition to a fully integrated delivery model that defines clear decision-making roles and responsibilities to enhance collaboration and optimize care transitions.***
- ***Recommendation #4: Health PEI needs to differentiate the various levels of accountability that impact MH&A services including the operational mandate that is vested with the MH&A Program, the professional practice mandate for the recommended Department of Psychiatry and other professional practice structures (e.g. Provincial Chief Nursing Officer).***
- ***Recommendation #5: MH&A Program establish a working group with Primary Care providers, Community-based MH&A staff, and Hillsborough Hospital staff to define and prioritize key operational processes that should be redesigned to enable smoother transitions of care and better communication between sectors that fall within Health PEI's operational mandate. The program should implement "pilots" and evaluate to enable adoption across populations.***
  Note: The MH&A Program's plan includes initiatives reflective of the above recommendation. Re-stating it here is intended to reinforce its importance as a priority to be pursued in the near-term.
- ***Recommendation #6: MH&A Program offer to work with the Chief Mental Health & Addictions Officer to establish a working group to fast-track proposals to resolve the housing issues that are currently being served by Hillsborough under the safety net role.***
  Note: The above is not intended to usurp the work of the Chief Mental Health Officer, but rather to suggest that Health PEI, and more specifically, the MH&A Program might want to present this to her as an opportunity to pursue a shared goal in this area in advance of her final report being completed.
- ***Recommendation #7: MH&A Program establish a working group with two OOP providers (East Coast Forensics and Homewood) to determine how joint care planning can be enhanced so that Islanders are better served across the continuum of pre-transfer, care during their stay off-Island and post-transfer / follow-up care on Island. Implement "pilots" and evaluate to enable adoption across populations.***
  Note: any work with OOP providers must involve Medical Affairs because OOP treatment is referred by physicians and the budget falls under the responsibility of Medical Affairs. A clear deliverable should be to enable better coordination pre and post transfer; as well as addressing accountability to ensure 'value for money' for services provided by others.

1.0 SETTING CONTEXT & BACKGROUND

Why the Project Was Undertaken

Health PEI is a single entity responsible for planning, implementing and evaluating operational aspects of healthcare in PEI. Health PEI works closely with the Department of Health and Wellness in the government which has responsibilities for planning, setting standards and allocating the budget to Health PEI as well as some operational oversight as taken from the Department website[1]:

- Provide leadership in maintaining and improving the health and well-being of citizens;
- Provide leadership in innovation and continuous improvement and to provide specific high quality administration and regulatory services to the health system and Islanders;
- Provide policy, program and operational leadership respecting the Island health care system; and
- Provide horizontal leadership and coordination in the implementation of Government's Healthy Living Strategy

Multiple studies of Mental Health and Addiction (MH&A) services were completed over the last few years[2,3,4,5,6,7], and while the MH&A Program leaders were working diligently to plan and implement the many recommendations, several recent media reports have raised concerns amongst politicians, residents and bureaucrats that services were not being provided in an optimal manner, and that Hillsborough Hospital specifically was not delivering care in accordance with its perceived mandate.

Given these pressures, Health PEI engaged CSI Consultancy to assist with the program planning process by addressing two major challenges they perceived in the provision of MH&A services: (1) the mandate of Hillsborough Hospital as a provincial resource; and (2) the engagement and accountability of the psychiatrists in planning and operation of the MH&A program. This report deals with the first project.

CSI interpreted all of the above to mean that Health PEI was seeking to develop a role for Hillsborough Hospital, using a system-wide perspective for Mental Health and Addictions that would further strengthen the connections to acute inpatient mental health and addictions services and the community mental health services in the province.

This system wide perspective underscores both the Strategic Directions of Health PEI for 2013-2016 that calls for a *renewed model of home-based services; renewed model of community-based primary health care; health system enablers; and the integration of acute and facility based care* as well as the stated Vision for the Mental Health and Addictions Program to deliver "**quality services and supports which are person-centered, recovery-oriented and integrated to assist Islanders in achieving their optimal level of mental health and participation in community life "**(2009)**.**

Methodology

In November of 2013, CSI Consultancy was engaged to conduct an assessment and deliver on the objectives and goals outlined above. The project was ably supported by HPEI staff - Bobbi Jo and Billie-Jean Flynn, Autumn Getson and Stacey O'Connor. To meet the stated objectives and produce the deliverables, in the required timeframe, CSI proposed a four-phase work-plan:

- **Phase 1: Project Mobilization** to confirm the leadership structure, priorities and terms of reference for the project, verify project management roles, obtain all relevant background

[1] http://www.gov.pe.ca/health/index.php3?number=1037417&lang=E referenced on Feb 19, 2014.
[2] PEI Auditor General's report, 2012.
[3] Accreditation report, Health PEI, Oct. 11, 2013.
[4] Mental Health Facilities Review: comparable Canadian examples.
[5] Mental Health Facilities Review: funding.
[6] Transforming Methadone maintenance treatment to meet the growing need of Islanders. August 2012.
[7] Developing a provincial bed map. June 2013.

information, conduct leadership interviews, confirm the planning development approach, develop a strategy for engaging internal and external partners, reviewing communications strategy and developing the detailed work-plan.

- **Phase 2: Understanding Your Current Reality** through engaging key stakeholders through interviews, completing research and a literature review, and developing a framework to guide the management and development of programs and services, responsive to both the population and Health PEI.
- **Phase 3: Building A New and Exciting Future** by bringing stakeholders together to review findings, reconfirm the overall vision for Hillsborough Hospital in the context of the Mental Health and Addictions system in PEI through a 'think tank' session.
- **Phase 4: Developing a Roadmap for Moving Forward** to deliver a clear and comprehensive plan that provides evidence informed recommendations to guide the future development and management of the Hillsborough Hospital.

Documentation Review and Data Analysis

A number of reviews have been conducted on aspects of the Mental Health and Addictions Programs over the past ten years, and these were made available to the CSI team including, but not limited to:

- *The Mental Health and Addictions Review, commissioned by the Department of Health and Wellness in 2012 and released in 2013*;
- *The Auditor General's Report on Community Mental Health Services*;
- *The Provincial Bed Mapping Review and Recommendations, conducted by the Hay Group in 2013;*
- *Strategic Plan for Mental Health and Addictions Services developed in 2009*; and
- *Numerous internal documents related to the MH & A program, including a project summary of initiatives/projects in various stages of implementation.*

In addition to reviewing all of the above, CSI submitted a separate data request to obtain information related to utilization and length of stay (LOS) at the Hillsborough Hospital so that we could understand service and operational profiles of the units to complete the deliverables requested by Health PEI. Rates for Out of Province referrals to the East Coast Forensic Unit, in Halifax and to other facilities in New Brunswick and Ontario were requested and provided.

Unfortunately there were some challenges with the data request as appropriate coding of patients in Hillsborough Hospital has only recently started which made multi-year comparisons challenging and data findings inconclusive. As such, the experiential observations and conclusions of stakeholders were weighted more heavily as a result.

The following analysis was completed and is included in the appropriate sections in this report:

- Percent of total ALC cases at one point in time in Hillsborough Hospital;
- Critical mass requirements to sustain specific programs, such as forensics; and
- Other indicators that support the need and role of a 'speciality' facility for complex patients experiencing a mental health and/or addictions health problem; and.
- Previous reports that outlined future projections of mental health and addictions health problems in the population that would be best served by in-patient psychiatric beds.

Literature Review& Leading Practices

The extensive background material provided by Health PEI was complimented by a literature/jurisdictional review that focused on three areas:

1. The emergence of a **population health mandate** as the driving force in health system reforms throughout the developed world, all of which are anchored in a renewed emphasis on delivering more care in the community, supported by a robust primary health care system and contemporary

community supports including housing. These models assume reducing the reliance on hospitals for in-patient mental health care that can, and should, be delivered in the community.

2. The characteristics of **fully integrated programs that span the continuum of mental health and addictions services** and include multiple partners delivering different **levels of care** using clear **criteria that enable effective transitions of care**.
3. The focus on the role and contributions of a **provincial psychiatric facility** in responding to the population needs for 'speciality services' within the continuum of mental health and addictions services.

Stakeholder Engagement

Initial engagement with program leaders took place on January 9th and 10th, 2014, with the goal of confirming the overall approach in mobilization. A steering committee was created to lead and provide direction to both projects. In parallel, and in response to Health PEI's renewed strategic plan (2013-2016), the leadership restructuring of mental health and addictions with acute and facility based care was communicated in late December, 2013.

In collaboration with the Steering Committee and Health PEI project leads, key internal and external partners were identified and invited to participate in either individual or group interviews during the second week of February, 2014. Acknowledging the numerous attempts of engaging providers for input into previous reviews/ reports, the CSI Team was struck by the continued interest, commitment and passion, held by providers, for clients/patients and families with mental health and/or addiction health problems.

In addition to the broad stakeholder engagement with providers of mental health and addiction services on the Island, three patient/family focus groups were held to ensure their perspectives were heard and included in the process. The number of patients and families who participated in the focus groups as well as their willingness to share their experiences/stories with the MH and A's system in Health PEI was particularly heart wrenching and further confirms the need to fully engage patients and families in the development and evaluation of programs/services for this population, if the vision for the program is to be realized.

The planned Hillsborough Think Tank, described in the methodology section above, was held on March 12, 2014 and brought over 40 providers, managers and partners together to discuss and validate the findings and proposed future vision for Hillsborough Hospital within the larger system context. Three facilitated discussion groups explored solution-focused opportunities aimed at addressing key population groups: acute inpatient; forensics; and the complex psycho-geriatric. Strong consensus emerged regarding what needs to happen to improve services amongst all groups and these ideas and recommendations have been integrated into the roadmap, discussed in the final sections of this report.

Outline of this Report

This report presents its findings recommendations as follows:

- The "Overall Landscape" within which services at Hillsborough are delivered (Section 2)
- A "Current State Assessment" that summarizes where things stand today and how we got here (Section 3)
- A "Proposed Future State" that outlines a potential vision/mandate for Hillsborough (as well as some key consideration regarding an effective Operating Model through which the vision can be mobilized) within the context of a revitalized MH&A program continuum in PEI (Section 4), and
- The importance of change management research re: Implementation Planning (Section 5).

2.0 THE LANDSCAPE WITHIN WHICH HILLSBOROUGH FUNCTIONS

PEI has a population of 145,000 people and a growth rate of 0.05% between 2012 and 2013 compared to a growth rate of 1.16% in all of Canada over the same period of time.[8]The comparatively low population has several effects: the tax base is low and hence government spending must be very cautious; there are comparatively fewer skilled and experienced individuals in the work force needed to perform many of the bureaucratic and professional services that the province provides either through the public or private sector; and, as often mentioned in the interviews – "everyone knows or is related to everyone".

Health PEI has instituted several important changes over the recent years, all of which are grounded in the organization's overall vision, mission, values and strategic goals and objectives:

Vision	***One Island health system supporting improved health for Islanders.***
Mission	***Working in partnership with Islanders to support and promote health through the delivery of safe and quality health care.***
Values	***Caring - We treat everyone with compassion, respect, fairness, and dignity.*** ***Integrity - We collaborate in an environment of trust, communicate with openness and honesty, and are accountable through responsible decision-making.*** ***Excellence - We pursue continuous quality improvement through innovation, integration, and the adoption of evidence-based practices.***
Goals & Objectives	***Quality - We will provide safe, quality, and person-centered care and services.*** ***Access - We will provide access to appropriate care by the right provider in the right setting.*** ***Efficiency - We will optimize resources and processes to sustain a viable health care system.***

Health PEI's Program Management Model

The MH&A Program was the first Island-wide comprehensive clinical program to be organized under as Program Management model in 2009. The goal at that time was to improve the quality, efficiency and integration of the multiple services relevant to ~12,000 adults and children served each year. The Mental Health Services Strategy defined at that time outlined three strategic directions: *Clarify Accountability in the Mental Health System; Enhance Service Delivery; and Address Human Resource Challenges.* Key principles identified as guiding the current mental health system's culture and priorities include:

- Person-centred
- Accessibility (in all its dimensions)
- Collaboration across providers and between providers and clients
- Accountability (who is responsible for what and to whom)
- Respect for all stakeholders
- Excellence, evidence-based practices and ongoing quality improvement
- Comprehensive continuum of support
- Recovery-oriented
- The unique role of families and others is supported, as appropriate

Reducing wait times and improving access to mental health services was identified as the priority focus in 2013-2014.

The Program is responsible for services across the province and spanning the continuum from inpatient to outpatient, to community and has developed various strategies to enhance the delivery of these services. Inpatient services are provided in three hospitals – Hillsborough Hospital (HH), Queen Elizabeth Hospital (QEH) and Prince County Hospital (PCH) – plus the inpatient addiction unit at the

[8]http://www.gov.pe.ca/photos/original/pt_pop_rep.pdf

Mount Herbert. The budget for services within the MH&A program is approximately $36-37 million not including costs for psychiatrists, addiction physicians and out of province cases (which reside within Medical Affairs).

A single Operations Director was appointed in 2011, and she oversees the continuum of care delivery services (e.g. inpatient, outpatient, and community services). A new Medical Director was formally named in the fall of 2013 and he oversees the physicians involved in MH&A services.[9] The Program Management model is meant to be a co-director model whereby both directors collaborate to plan, solve problems and implement changes for the improvement of services. In December 2013, a restructuring of Health PEI aligned the MH&A program with the acute care system under the direction of a single Executive Director for Acute Care, Mental Health & Addictions Services.

This planning process did not investigate Health PEI's program management model extensively, but given the need to link observations and recommendations made below in a program setting, it is important to recognize not only the program's existence but also its challenges. Accordingly, suggestions that affect the MH&A Program are based on the experience of CSI's team in program management models and not on a comprehensive review of the current PEI model.

Recently, an individual was appointed as an interdepartmental lead for mental health and addictions services whose responsibility includes, among others, addressing policy issues between various government departments with mandates that impact mental health including Departments responsible for health, wellness, justice, social services, housing, children and youth.

What the Literature Tells Us About Program Management

Nohria (1995) stated that[10], "Organizations exist to enable a group of people to effectively co-ordinate their efforts to get things done. The structure of an organization is the pattern of its organizational roles, relationships and procedures that enable such coordinated action by its members." In other words, **organizational design allows the work of the organization to get done by defining the structures, processes and roles within which people work** to deliver the services required by the people they individually and collectively serve.

Dr. Bryce Taylor, writing in his book *Effective Medical Leadership,* identifies some of the complexities of these structures and the organizational transitions that take place as they are introduced:

- Physician structures have typically been developed under a **Departmental Model** that is defined by the MD specialty (e.g. Medicine) and may be sub-divided into Divisions by sub-specialty (e.g. Haematology). These structures formally report to the Medical Advisory Committee and are largely focused on professional practice issues. They typically have a limited role in, or control over, resource management decisions (even though they often exert considerable informal influence over decision-making and resource allocation planning processes).
- Hospital operations have traditionally been organized under a **Functional Model** reflecting professional groupings (e.g. Nursing, Social Work, and Physiotherapy) and/or operational/service functions (e.g. Housekeeping, Food Services). In the traditional model, departments managed their own budgets and reported to a senior executive who was accountable to the CEO. Resource planning involving multiple departments required cooperation between managers and decisions could be stalled because of a lack of agreement on priorities and collective ownership of initiatives.
- Most hospitals have now shifted their managerial structures to some form of **Program Management** that reflects more of a patient orientation, rather than the more provider-centric models that existed in the functional structures. Under these models, services and staff are clustered around the common characteristics of the patient population being served, with resources deployed to the program. These models are then incorporated into some form of **Matrix Management** that creates a truly inter-professional team focused on patient populations while continuing to connect and align staff with some of the traditional structures.

[9] http://www.healthpei.ca/index.php3?number=1040534&lang=E

[10] Glickman, S.W. et al (2007). *Promoting quality: the health-care organization from a management perspective,* International Journal for Quality in Health Care 2007 19(6):341-348

Taylor notes that the transition to these new structures is not always an easy process, as all the players have to get used to new models, processes, relationships and expectations, and it is often easy to "fall back" into old models as resistance to the new concepts builds. To overcome this, a deliberate and consistent focus is required to reinforce the intent and expectations. Leadership development support to the program leaders is also an essential enabler as they take on new roles and responsibilities. **The importance of these enablers cannot be overstated when one considers the current state of affairs with regard to Hillsborough Hospital.**

The History of Deinstitutionalization in Mental Health

Morrow et al, writing in the Journal of Ethics in Mental Health in November 2008[11], provide an excellent summary of the history of deinstitutionalization in Canada, an excerpt of which is provided below.

Psychiatric deinstitutionalization began in Canada in the 1950s with a shift of care from public mental hospitals to community mental health services. Deinstitutionalization was, and continues to be, driven by a number of interconnected forces including developments in psychopharmacology, new psychosocial rehabilitation practices, studies of the negative impact of institutional life, concerns about the civil rights of people with mental illnesses and cost-containment. Some of the early assessments of psychiatric deinstitutionalization produced in the 1960s, 1970s and 1980s reported on the negative aspects of the process, particularly the deterioration of people leaving institutions. Critics argued that governments had failed to fund adequate community supports for people with mental illnesses trying to reintegrate into communities.

Deinstitutionalization made people with mental illness more visible as the closing of large hospitals made the sources of a person's care less visible. In some instances, deinstitutionalization has meant the shift of beds from large psychiatric institutions to the backwards of hospitals and/or the application of institutional treatment models characterized by paternalism and coercion in community settings; that is, one could argue that the institution has not disappeared but rather changed location. Trans-institutionalization has been further observed in research that documents the criminalization of people with mental illnesses after leaving institutional psychiatric care, such that people with mental health problems are institutionalized in corrections facilities rather than being treated in hospitals.

Historical accounts of institutionalization and deinstitutionalization typically describe these processes as linear and progressive yet the evidence is that the processes are cyclical rather than continuous, with various phases occurring over the past 40 years. Psychiatric hospitals serve both manifest and latent functions. Manifest functions of psychiatric hospitals include, for example, the provision of treatment for both short to intermediate stay patients, custody for long-term patients, the desire to protect people who are vulnerable, respite for family caregivers and secure provision for involuntary and assaultive patients. Latent functions, in contrast, may include job security for professional staff, segregation from society of people who are understood as 'deviant' or dangerous and political solutions to problems with the visibility of people who are mentally ill and homeless.

How society cares for people with mental illness reflects its social and economic tensions and highlights that care occurs, not only in a medical, but also a political context. Thus, there have consistently been ebbs and flows regarding society's tolerance for deinstitutionalization and the visibility of people with mental illnesses. Calls to re-institutionalize people are rarely based on research evidence and instead garner support through editorials and sensationalized media reports of people with mental illnesses as violent and unpredictable. Missing from the public dialogue is a discussion how best to meet the comprehensive needs of people with mental illnesses, needs which include housing, income security, access to meaningful activities and other social rights.

Hillsborough Hospital draws a number of parallels with the deinstitutionalization history as well as *re-institutionalization by popular demand phenomenon* described above.

[11]Morrow et al, *Is Deinstitutionalization a 'Failed Experiment'? The Ethics of Re-institutionalization*, Journal of Ethics in Mental Health, November 2008

Mental Health in PEI – A Myriad of Reviews

As noted in Section 1, numerous mental health and addiction reviews have been conducted in PEI since 2002, generating numerous reports and multiple recommendations and strategies to improve the provincial system or address a specific program/service issues and challenges. At the request of CSI, these reviews/reports were shared to provide history and context for our work. A summary of some of these are provided below:

- **A Model for Mental Health Service Delivery for PEI** (2002) outlined recommendations to move mental health services from individual community/facility responses to a provincial system response; enhance follow up for those clients with serious and persistent mental illness; balance community and hospital based resources; and connects initial, intensive and specialty treatment interventions.
- **One Island Community; One Island Health System** (2008) was authored by CSI following a system-wide review of all health services on the Island. The recommendations envisioned a future state model whereby services would be delivered to the population "through a single, integrated system of care, one grounded in evidence-based decision making and focused on improving health, enhancing access and refocusing the emphasis of the care delivery system on primary health care and services that can appropriately and safely be provided locally". This work established the context for developing integrated mental health programming within an integrated health system.
- The **Review of Mental Health and Addictions Services and Supports in Prince Edward Island** (2013) was commissioned by the Department of Health and Wellness to further improve efforts and to increase awareness of the broad scope of interventions across the life course that are needed to achieve better health and fewer mental health and addictions issues in the long term by identifying six priority areas that would require the coordination and collaboration of all government departments.
- The **Auditor General's Report** (2012) sought to determine if a comprehensive long-term plan was developed that would set direction for community mental health on the Island and whether residents had timely access to CMH programs and services. The review resulted in twelve recommendations related to the need to develop a long term plan; formalize agreements with partners (NGO's); standardizing screening and triage processes; improving communication and responsiveness between hospitals and CMHC; improving data management for reliability, consistency and wait time reports; and the need to conduct periodic supervisory case reviews.
- The **Methadone Management Treatment Program (MMTP)** review (2012) focused on developing strategies to improve access for methadone treatment.

In addition to the external reviews/reports completed, and noted above, other internal evaluations/reviews/reports have been done. Some have been in response to the reports noted above and others have been initiated by internal processes within Health PEI. For example, an evaluation of the Mental Health and Addictions operational framework was completed in January 2013 and presented to the Executive Leadership team recently. Key recommendations from that review include:

- Development of strategies to further engage psychiatrists and improve access to their services;
- The need to further clarify roles and responsibilities of providers and services;
- Developing more equitable administrative on call processes;
- Addressing wait times for core services more effectively; and
- The need to engage all providers in a supportive way to enable the change agenda to be realized.

Many of these issues are addressed in the mandates for the two planning projects completed by CSI.

In addition to these external and internal reviews, there are 29 initiatives/projects, at various stages of implementation, currently in play within the MH&A program including projects identified as priority to those focused on early intervention prevention and education activities.

Other related and connected initiatives, outside of the MH&A mandate, include work being done for children with special needs and seniors mental health strategy within Long Term Care.

Conclusions Regarding the Landscape Within Which Hillsborough Operates

An extraordinary amount of energy and work has been expended in response to the multiple, often repetitive, mental health & addictions reviews that have been undertaken over the past decade. Hillsborough Hospital has attempted to respond to the many competing demands in order to improve services for Islanders. However, two important points must be acknowledged about the prior studies. The first is that the resultant reports, strategies and workplans identified consistent needs/gaps/issues. The second is that Program leaders have struggled to gain traction in key areas resulting in some level of open criticism by others.

The CSI team has concluded that the vast majority of these criticisms are not wholly justified, largely, because of two realities that have not been acknowledged and are not well understood:

1. **Resistance to Change Due to a Local Focus as Opposed to a Solution Imperative.** The MH&A Program was one of the first (if not only) clinical area to be formally organized under a Program Management construct. The literature regarding program management clearly tells us that the shift to Program Management is fraught with challenges as people often resist (sometimes passively but usually openly) new strategies, structures and processes that changes formal and informal power bases and/or threatens the perceived "independence" or "autonomy" that were part of the previous models. The CSI team heard, and believes, that this the case in PEI where hospitals, providers and in some cases entire communities, have pushed back and resisted changes that they believed would impact local services, reduce the perception of local control or require changes in how they engage and interact with others.

   Any work that flows from this planning process MUST address the leadership gap(s) that exist OUTSIDE of the MH&A program to shift the culture of blame to one of support and ensuring success, as the program leaders attempt to mobilize and address the program challenges and issues.

2. **Hillsborough Hospital Has Assumed a Larger System Role Without Formalized Supports and Assistance.** For some MH&A clients, the process of deinstitutionalization has been problematic with the result being that Hillsborough Hospital has been forced to play the safety net role for the entire system by readmitting people who have not transitioned well and/or cannot continue to be supported safely and effectively in the community. This safety net role is not part of the formal Program mandate, but it does siphon resources away from the intended mandate. This safety net role has been assumed by Hillsborough, without recognition and support by others of both the need for such a role, and the reality that Hillsborough has by default, taken it on.

   In the absence of alternative solutions being developed, it is likely that the safety net role will continue to be part of what Hillsborough delivers for the foreseeable future. Given this, one can only hope that people outside of the Program will be more open to acknowledging the failure of the system as a whole to address the issue and reduce the criticism of the Health PEI and the MH&A Program Leaders, for failing to deliver the full range of specialty services that they expect to be delivered through the Hospital.

3.0 FINDINGS OF THE CURRENT MH&A SYSTEM

Preamble

Planning to confirm the future role of Hillsborough Hospital is ultimately about choices and making decisions about key issues facing the organization. To support the MH&A Program and Health PEI in making choices, the consultants have undertaken an extensive stakeholder engagement process to help inform the process by identifying key issues and opportunities. The consultation process has also been augmented by a thorough review of materials, those that were provided by the client and those that were researched by the team from our own resources. All of this leads to a series of themes that will ultimately be translated into a set of directions, goals and action plans.

In this section, we present the outputs of the engagement and documentation review process. It has to be stated however that the focus may come across as negative because it is the negative aspects that need to be resolved. The negative focus is not meant to imply that there is nothing good happening – there definitely is – but identifying major issues to be resolved is required.

History of Hillsborough Hospital: One Piece of the Puzzle

The current Hillsborough Hospital was officially opened in 1957, albeit with parts of the prior aged facilities of the former Hillsborough Hospital and Riverside Special Care Home still in place. The Special Care Home consisted of what was left of Falconwood Hospital that was destroyed by fire in 1931.

In 1957 the population of the hospital was between 350-400 patients. Over the years these numbers dwindled as the process of deinstitutionalization was deployed. By 1982 with the opening of the Queen Elizabeth Hospital's Unit 9 and the general move of patients to the community the population was down to 192 patients.

Starting in 1992 there was a gradual movement of patients out of the hospital with people being transferred either into other facilities, community settings or back to their private residences, as part of a concerted effort to deinstitutionalize care.

At the same time, Unit 6 - the adolescent unit, moved from Hillsborough Hospital to a separate facility, and the staff and resources were also transferred to the Provincial Group Home as part of Child and Family Services.

Approximately a year later, a number of staff (2 RN's, 4 LPN's and 3 Resident Care Workers) were moved administratively to the McGill Centre to manage the Community Options program. They had previously worked out of Hillsborough in the old Adolescent Unit, although they had always been managed by McGill and hence, the resources were already in the McGill budget.

The downsizing process at Hillsborough Hospital continued over a period of some fifteen years, ultimately shrinking the total bed base at Hillsborough from 191 to the 69 beds that are in operation today. With the shift of numerous patients back to the community and the change in the overall service model, there is now an increasing need for respite care.

The age of the facility has required upgrading over the last number of years. The following provides a highlight of some of the work that has been done:

- Unit's 5 and 7 have been completely re-modeled and expanded, with Unit 5 now able to serve all clients in private rooms. Unit 7 was, and still is, very cramped but renovations have provided large common areas with new flooring.
- Changes were made to Unit 8 so that patients can go to the cafeteria without going outside. Previously patients had to go outside the building to access the cafeteria for meals (rain or shine).
- All of the furniture for patients in the common areas has been replaced/upgraded.

Current Mandate for Hillsborough

Currently, Hillsborough's stated role and mandate is that of a provincial resource centre intended to provide specialized acute and rehabilitative mental health care to Islanders who are experiencing serious and persistent mental illness, co-occurring developmental and psychiatric conditions, and complex psycho geriatric conditions. The following outlines the specific units, capacity and focus at Hillsborough:

- **Acute Care, Unit 3:** A 17 bed specialized acute care unit which also serves as an admission unit for the hospital, providing assessment, diagnosis, treatment, planning and condition stabilization. The unit serves a wide range of patients such as: assessments for criminally responsible and fitness to stand trial, court ordered treatment or detainment, serious and persistent mental illness, concurrent disorders and increasingly, psycho geriatric conditions.
- **Psychogeriatric Care, Unit 5:** A 17 bed psycho geriatric unit that provides assessment, diagnosis, treatment planning for complex conditions typically to geriatric populations, or those who are experiencing conditions commonly experienced by geriatric populations. The purpose of the unit is to treat illness and stabilize behaviour problems associated with psychiatric conditions, allowing the person to return home or a supported living arrangement.
- **Co-Occurring Conditions, Unit 7:** A 17 bed unit that provides care to individuals experiencing complex co-occurring developmental and psychiatric conditions, often for which no alternate supported housing exists, or where the receiving community setting feels unable to provide the necessary supports.
- **Rehabilitation, Unit 8:** An 18 bed unit which provides psychosocial rehabilitative care to those whose treatment plan requires a more protracted period of care and range of service that can currently be provided in the community. The unit provides individual and unit programming to assist with the psycho social rehabilitative goals of patients with complex, serious and persistent mental illness.
- **Neuro Trauma Unit**: 1 bed unit, which provides care to one individual with severe brain injury. This unit is funded by the WCB.

Admission to Hillsborough Hospital may occur on either a voluntary or involuntary basis with involuntary admissions being governed under the statutes contained in the Mental Health Act, under the Criminal Code Review Board or through an Adult Protection Order. It must be noted that an increasing number of people are being ordered by the criminal court for detention to the Hospital.

What the Data Tells Us

As outlined previously, the lack of robust information regarding current activity at Hillsborough prevents any definitive conclusions from being drawn.

That said, the information we do have provides some baseline insights about both Hillsborough and the larger system in terms of demand. For example community mental health referrals increased to 5,394 in 2012/13 as compared to 4,725 in 2010/11. This represents a 14% increase in just 2 years.

Stakeholders consistently expressed concern about the ability to transfer appropriate patients to HH in a timely way. This is partially explained by the reality that ~50% of the current beds are occupied by Alternate Level of Care (ALC) clients, meaning that 50% of clients do not reflect the defined specialty mandates of Hillsborough, but cannot be transitioned to an alternate setting for a variety of reasons.

What We Heard From You

Mental Health and Addiction Services represent a complex continuum of programs/services delivered by providers in a variety of settings and locations ranging from primary care through in-home care and community service settings to specialty-level care that includes ambulatory/day treatment, short- and long-term inpatient care, specialty consultation support to other levels of care and population/program-specific housing in residential care environments.

Universally, stakeholders acknowledge the current MH&A system in PEI has the potential for multiple "breakdowns" in the continuum, including gaps in care (i.e. services not available in PEI) as well as challenges related to a lack of coordination, communication and consistency related to hand-offs/transitions of care between sectors/settings.

Despite numerous reviews/reports, projects and initiatives, not to mention organizational restructuring intended to enable integration; providers continue to report that they feel 'isolated' and work independently. This is compounded by an apparent inability for providers and leaders to reach consensus for the creation of integrated solutions capable of overcoming existing barriers related to access and flow. As a result, there is a risk that services to patients and families are less than optimal.

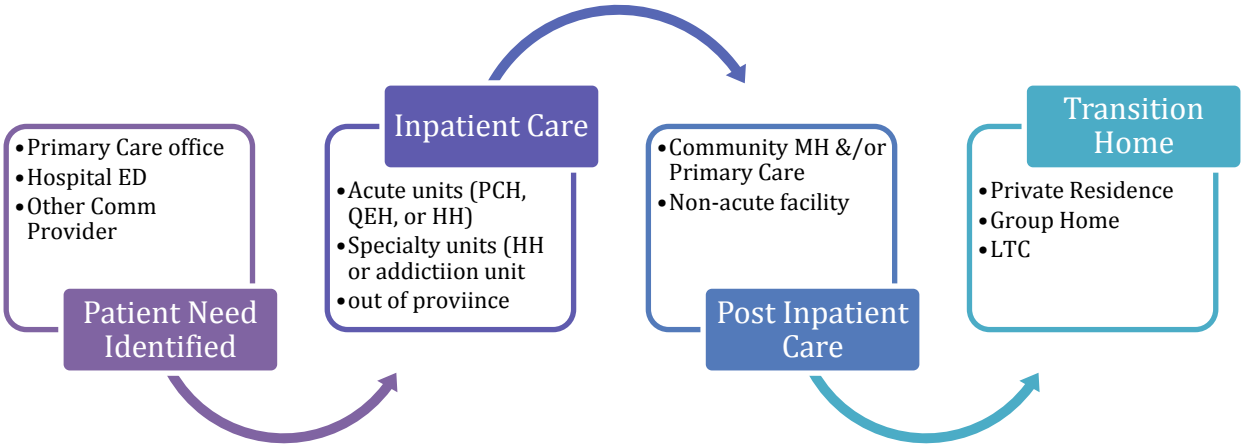
As it relates to Hillsborough, three key themes came up in all interviews:

1. There is a clear acknowledgment of the compassionate care currently provided by staff;
2. There is an overwhelming lack of clarity in roles and accountabilities regarding the role that Hillsborough should play and its relationship to other facilities and services; and
3. The limitations of the current physical plant represent serious barriers to advancing the role in the immediate term.

As noted above, the past two decades has seen a number of changes at Hillsborough Hospital, all of which are consistent with the 'deinstitutionalization' of care that has occurred across the country. The reduction of 120 beds to 69 beds reflects the strategy to transition patients to the community and reflects the evidenced informed practice of incorporating a 'recovery model approach'.

Unfortunately, the intended community supports have not always been fully deployed or realized and **re-institutionalization by popular demand** has occurred for some clients. As a result, approximately half of the current 69 beds are occupied by patients that require services under the safety net role. As the safety net role has neither been formalized nor financially supported, this activity siphons valuable resources away the system creating gaps in services that limit the ability to serve the most vulnerable islanders.

In an ideal world, MH&A patients could enter the continuum of care through a variety of routes and seamlessly move between providers and sectors as needed when their care needs change. A conceptual outline of the intended flow when an inpatient admission is required is shown below



Listening to Clients and Families

The CSI team had the privilege to meet with clients and families (28), identified by the CMHA, in the East and West of the Island. A client/family focus group was also held at Hillsborough, which included

current patients/families of Hillsborough. The clients and their families interviewed included perspectives of mothers, fathers, sisters, brothers, wives and husbands. We were particularly struck by their openness and willingness to share their stories and experiences with the MH & A system in PEI in the hope of improving overall services for other Islanders.

We heard an overwhelming message of support for staff at Hillsborough, who are described as caring, compassionate and supportive. Feedback on Psychiatrists was mixed with examples of consistent care, compassionate and praise for physicians who "listen" to stories of inconsistency, "not listening" and a perceived lack of coordination.

We also heard that clients and families feel that Psychiatrists are not accountable to anyone and it gives the client a sense of helplessness. People also note that Psychiatrists appear to be able to make their own schedule and decide who they see and when they see them. The inconsistencies create confusion for clients as they leave Hillsborough, often with no clear plans for follow-up.

For many, Hillsborough was the last hope for their loved one, with Hillsborough stepping in to meet a need for people who either suffer from illness from which one simply does not "recover" (e.g. severe dementia) or represent housing issues because no suitable housing option has been identified. In both cases, the families raved about the care they received and receive at Hillsborough.

Clients and families, in active treatment and/or recovery care models, reported a sense of "uncertainty about their treatment plan" and unmet expectations for full and active treatment programming. Client's and families were often unclear as to why they were admitted to Hillsborough, as opposed to other hospitals, and many did not feel there was a clear treatment or discharge plan.

The biggest confusion expressed by patients/families related to the purpose of Unit 3. The other units appear to have a clear purpose that is understood by the client's and their families and were less clear for the reason for admission to unit 3.

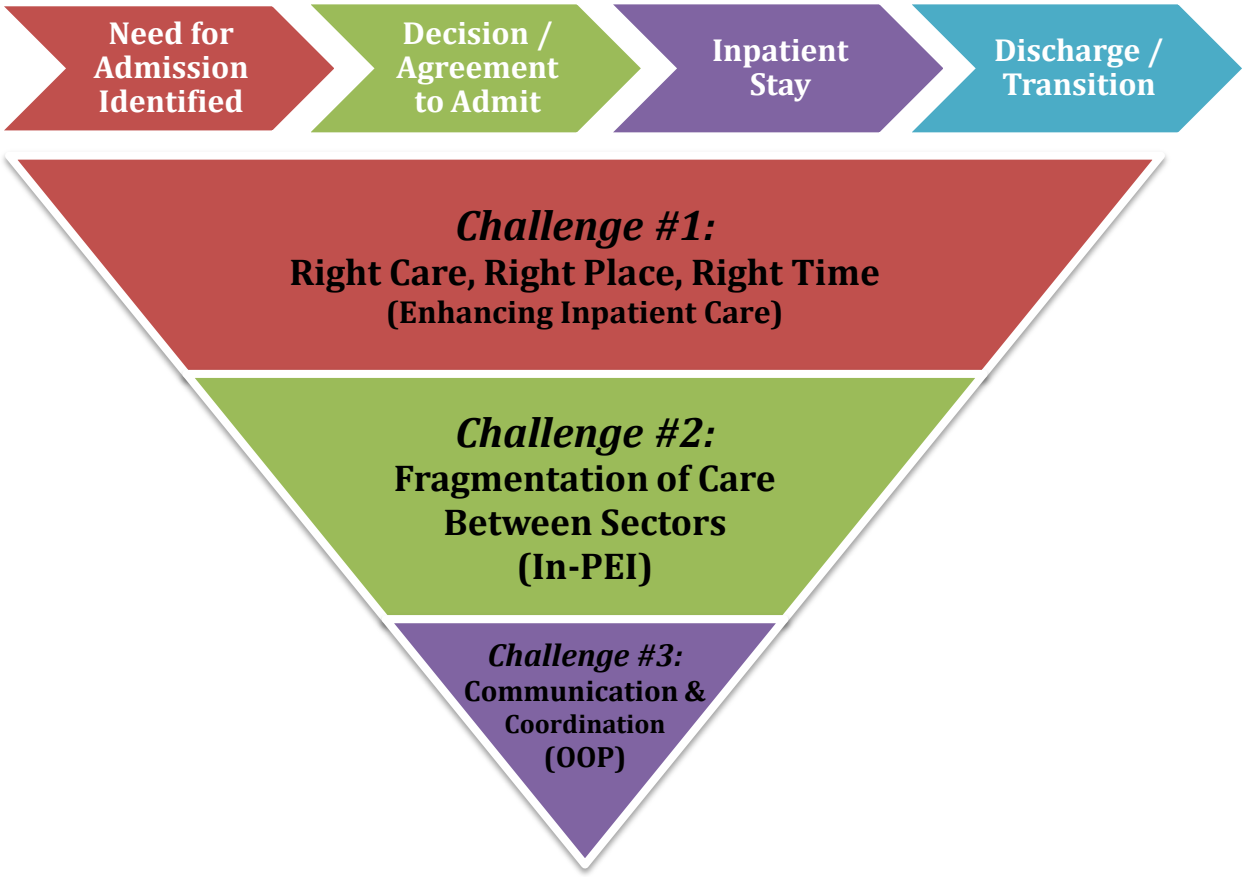
Listening to Staff

We met with over 100 direct providers, managers and select partners associated with the MH&A programs in Health PEI. The concerns, issues and improvement suggestions were consistent amongst all and included gaps related to:

- Clarity in the roles, responsibilities and relationships between inpatient acute mental health and addictions care
- Accountability at all system levels (system, program and client)
- Identification of clear priorities
- Progress in the achievement of identified goals
- Understanding of the program and services
- Integration and buy in from all care providers
- Clear clinical/care pathways.
- Role clarity for members of the clinical team.
- Clear accountability of Psychiatrists
- Clear communication between all parts of the MHA and system in PEI (Outreach, outpatient, inpatient, various hospitals) and lack of communication within Hillsborough.
- Family's clarity and understanding on the process to express concerns or to provide feedback.
- Appropriate housing
- Clear definition and shared understanding of the purpose of each unit
- Appropriate location to serve children and youth
- A patient navigator to assist working through the system

- Admission and discharge criteria
- Consistent availability of Psychiatrists as they are often pulled form outpatient clinics to cover inpatient care

Unfortunately, transitioning across the spectrum of inpatient care is not always a smooth process, and breakdowns occur in three main areas.



Challenge #1: Right Care, Right Place, Right Time

A consistent message shared by all stakeholders and partners throughout the process is that the general concept of *One Island Health System* continues to be an elusive goal when it comes to an integrated inpatient mental health continuum of care. This is directly related to the lack of a unifying vision that ensures that all patients requiring inpatient care can consistently get the care they need, when and where they need it.

Within the formal continuum of inpatient care available on PEI, there are three "acute" units (one each at PCH, QEH and Hillsborough) and four specialty care units (3 at Hillsborough and an addictions unit at Mount Herbert). Smaller community hospitals also serve some of the inpatient care needs (e.g. for patients admitted to medical units who have co-morbidities or complications related to mental health and addiction issues).

Acute Inpatient Care

Dealing first with inpatient acute care in the three formal units at PCH, QEH and Hillsborough, there are many challenges to pursuing this vision, all grounded in a variety of perspectives that often reflect an individual's "bias" based on where they work, but likely the biggest issue is the lack of clarity or consensus regarding the need for *differentiated* roles at each site. The following highlights the concerns expressed by stakeholders regarding each of the acute units:

QEH Unit 9(adult) and 9A (youth)

- Lack of clarity between the role and function of unit 9 and unit 3 at HH
- Appropriate programming for patients/families
- Appropriate placement of longer stay patients
- Complex co-morbidities among clients entering unit
- Lack of widely accepted criteria for admittance to the unit
- Inappropriate long admissions of clients for whom placement issues are primary
- Ethical issues arising in the care of extended stay clients (not resourced to meet the longer-term developmental needs of extended stay adolescent clients (not getting appropriate exercise, outdoor time, social/play opportunities and educational programming.
- Backup into other QEH medical services
- Lack of staff commitments to unit 9A (inadequate dedicated trained staff and limited allied health resources)
- Lack of ongoing opportunities to easily network and plan with other pediatric services
- Very poor physical environment for unit 9A
- Overburdened community based services for adolescents with an identified need to implement an intermediate day program between the inpatient unit and community outpatient services.

PCH

- Since Health PEI has moved to an East/West model for delivery of health care, leaders at PCH consistently state that it would be appropriate and beneficial if PCH and West have their own Psychiatry service in this region.
- Data used to support this perspective includes the fact that the top 4 reasons for admission from ED department in 12/13 for patients aged 8-17 were related to Mental Health. In the 18-59 age groups, 3 out of the top 10 reasons for admission were related to mental health.
- There is a clear belief that the current model cannot be sustained at PCH with these numbers. Significant pressure on PCH by QEH patients for form 1A patients, particularly after 5 pm.
- Access to Hillsborough is viewed as "impenetrable"
- Wait times for a patient to be seen is extremely lengthy; follow-up care requirements from these appointments, is unclear and not transparent
- Barriers between Community Mental Health and the Hospitals are seen to be significant with perceived confidentiality issues related to data exchange being flagged as a problem.
- QEH psychiatrists do not appear to accept PCH Psychiatrists' assessments
- Perceived solution is that West PEI should have its own Crisis Response Centre with additional psychiatrists and appropriate resources.

Hillsborough (unit 3)

- Staff feel that their skill sets are not being fully utilized because they are not receiving the right patients in the overall facility.
- Much work needs to be done to bridge gaps in the community with community care facilities. QCRS (Queens County Residential Services) and LTC Centers. Better coping strategies are required within these organizations to manage behaviour and prevent crisis rather than having to use a reactive approach.
- Work is also required to bridge gaps with other Government Departments such as income support, justice, legal aid, and others who have a role to play in the management of mental health clients.
- Forensics patients on the unit are an issue, because they are mixed with elderly patients with dementia, and very mentally ill patients. Tailoring programming to meet the varied needs is difficult.
- Hillsborough is perceived by the government and community to be a long-term care facility. Our interviews with stakeholders confirmed this belief.

The discussions outlined above clearly show that the three units do not function as an integrated, effective and optimal "system of inpatient care". This issue is made more acute by varying levels of understanding by patients, families and providers for how the system of care works, which creates the need for greater levels of duplication and redundancy. While the CSI Team understands the frustrations that lead to these positions, we also note that maintaining/building a high level of duplicative services across these sites is likely not affordable or sustainable. One obvious barrier is the cap on the number of psychiatrists on the Island and the already fragility of the model related to coverage for current core services, let alone an expanded service profile at PCH. Another unintended consequence is the perception that another provider organization cannot meet the needs of clients creating unnecessary and non-productive competition.

Specialty Inpatient Care

Complementing the care delivered in the three "acute" units at PCH, QEH and Hillsborough, a range of specialty needs related to inpatient care exist, including:

- **Crisis Admission/Management/Stabilization**: This could be either short-term (possibly delivered in acute care initially), as well longer-term admissions to address ongoing issues of risk, stabilization and chronic management on a long-stay unit prior to discharge home or to the right community housing provider.
- **Rehab/recovery unit**: Admission focuses on goals of changing treatment and developing skills to return to life in the community.
- **Concurrent Disorder:** Treatment and stabilization for persons experiencing both mental health and addictions issues concurrently. There are clear standards that could support PEI in establishing its role in servicing persons with concurrent disorders.
- **Dual Disorder:** Provides short-term stabilization in order to return to community living through cooperative efforts with community housing providers (e.g., Queens County Residential Services). QCRS is a community not-for-profit organization that is governed by a volunteer board. It provides a range of residential supports to persons with intellectual disabilities through various group homes in the community. The organization also provides a range of day program services with the goal of supporting the client to participate and thrive in their community. In Prince County, Community Connections (PCCC) provides a similar role and service.
- **Psycho-Geriatric**: Services for older clients with complex behaviour issues
- **Forensics**: Forensic clients need to clearly fit the mandate of "Forensic" and we heard of many patients described as Forensic but may not meet the criteria. Typically, a Forensic Patient would:
    - Have committed illegal offenses, and
    - Have been diagnosed as having mental illness or an intellectual disability
    - Have been assessed as unfit to stand trial and/or be deemed not criminally responsible for the offence, and
    - Been determined, through their connection with the CCRB, to require a parallel path to those available through the 'regular justice system'.

    The focus of forensic care is toward *accountability* for their actions, *public safety*, and *rehabilitation*. In the current model, Hillsborough plays more of an outpatient assessment role, although some forensics patients are reportedly maintained on some units at Hillsborough. Others are transferred to East Coast Forensics.

The *re-institutionalization by popular demand phenomena* described previously has compromised the facility's ability to consistently deliver its intended mandate as it has been forced to play a 'safety net' role that meet the needs of clients requiring specialized acute and rehabilitative mental health care for people who experience serious and persistent mental illness, experience co-occurring developmental and psychiatric conditions, and/or present with complex psycho-geriatric conditions.

As a result, approximately half of the current 69 beds are occupied by patients that require services under the safety net role, and this creates confusion and conflict, resulting in gaps in service that have the potential to reduce the ability of the overall system to meet the needs of the most vulnerable Islanders.

Challenge #2: Reducing Fragmentation Across Sectors

Whereas the above section summarized current state findings regarding inpatient care, this section focuses more on meetings care needs across the continuum regardless of sector or care delivery setting. Discussions are grounded in four realities:

1. Health systems around the world are recognizing that a focus on a **population health mandate** is essential, requiring a shift from hospital-centric models to community based solutions.
2. The emerging **importance of quality/safety** demands that organizations "raise the bar" along multiple dimensions and in all care settings.
3. Publically funded systems are struggling to address the **increasing cost burden** associated with providing health services to an aging, and increasingly complex, population
4. Nationally, the Mental Health Commission is calling for a **truly transformative agenda**, one grounded in a strong community/primary care sector that serves an increasingly complex population, and is supported by specialty care when needed.

The current state of affairs in Health PEI represent a complex continuum of services delivered by providers in a variety of settings. There is a real opportunity to bring providers together in a more system-based model to eliminate inherent breakdowns that create gaps in services for patients and families, and frustration for provider organizations and staff. There is also a real need to capitalize on the numerous reviews completed to reduce providers' perceptions related to isolation and fragmented delivery models.

Some of the reasons for this ongoing situation is attitudinal, meaning that the value and benefit of operating as one program/one system has not yet been fully accepted. . Building a plan that garners buy-in across the multiple constituencies will not be easy, but it must be done if there is to be any hope of resolving issues that have existed for decades and have become almost entrenched and accepted as "unfixable factors."

Challenge #3: The Increasing Cost of Out of Province Care

One of the key challenges facing PEI is the lack of critical mass to develop certain specialty programs locally such as Forensics and Addiction treatment for complex clients. The volume of services accessed through out of province providers, and the resulting costs, are summarized below:

East Coast Forensic:

- 2010/11: less than 4 clients with a 25 day length of stay @ a cost of $138,000
- 2011/12: 7 clients with a total of 236 days of care (ALOS = 33.7) @ a cost of $130,272
- 2012/13: 6 clients with a total of 525days of care525 (ALOS = 87.5) @ a cost of $300,956

The disturbing trend shown above is the significant increases in Average Length of Stay (ALOS) and the increasing cost burden to the Provincial Treasury. Even with the increasing ALOS, the total use in 2012/13 was still less than 1.5 beds over the course of the year, meaning that a service could not be cost effectively established to deliver that care locally. That said, it is not clear if there are unmet needs, or needs that are being managed locally, that may provide increased critical mass to enable a local model to be developed.

Other out of province facilities commonly referred to include Homewood, Ontario where patients are usually referred from the inpatient MH units in PEI; Bellwood, Ontario and Portage, NB for addiction treatment and Peel, Ontario for children and family services.:

- 2011/12: **Total Costs to PEI = $917,474**

- 19 clients to Portage @ a cost of $300,900
- 19 clients to Homewood @ a cost of $455,424

Less than 4 clients to Bellwood @ a cost of $161,150

- 2012/13**: Total Costs to PEI = $1,361,945**
  - 16 clients to Portage @ a cost of $297,923
  - 36 clients to Homewood @ a cost of $997,802
  - Less than 4 clients to Bellwood @ a cost of $66,220
- 2013/14 (YTD): **Total Costs to PEI =$1,034,060**
  - Less than 4 clients to Peel Children's services @ a cost of $243,535
  - 12 clients to Portage @ a cost of $192,400
  - 20 clients to Homewood @ a cost of $574,340
  - Less than 4 clients to Bellwood @ a cost of $23,785

While conclusions should never be drawn with less than three years of data, out-of-province referrals increased 41% in 2012/13 (39 cases in 11/12 to 55 in 12/13) resulting in an overall cost increase of almost $450,000.

Staff note that there are currently reviewing the out-of-province referral processes, but if this trend continues, serious consideration should be given to reviewing a business case for expanded service capacity on PEI. Given anecdotal comments that a number of clients relapse, additional local capacity and expertise may enable more people to maintain sobriety after their initial treatment is completed. Considering the increasing costs for out of province referrals, the development of an evaluation framework to assess the quality of service delivered and the value for money would be an important strategy to implement.

What the Literature Tells Us About Differentiating Levels of Care

The development of mental health services for people with severe mental illness in Canada has paralleled approaches found in other countries around the world. Increased knowledge and understanding of the needs of individuals and families experiencing a mental health and/or an addiction health problem have demonstrated that less emphasis on a traditional illness model of care to a recovery model enables more positive clinical outcomes. Key features of the model include: recovery oriented, client-centered principles, and meaningful activity, including community involvement and up to daily access to skills training and structured group treatment (Trainor & Ilves, 1999). Individualized supports and supportive counselling are emphasized as important elements, along with psychosocial rehabilitation and psychiatric treatment. It is noted that the integration of existing community mental health services to promote independence and self- sufficiency is important (Trainor & Ilves, 1999; Holley, et al., 1997) As a result; reliance on inpatient psychiatric care has decreased significantly over the last forty years, evidenced by the reduction in acute psychiatric beds throughout Canada. A wide range of community supports have been developed, reflecting the variety of program models and philosophies found in many other countries (Sealy & Whitehead, 2004; Latimer, 2005).

Mental Health Commission of Canada

Founded in 2007, the Mental Health Commission of Canada (MHCC) is intended to serve as a catalyst for improving the mental health system by changing the attitudes and behaviours of Canadians around mental health issues. Through its unique mandate from Health Canada, the MHCC brings together leaders and organizations from across the country to accelerate these changes.[12]

A first phase of the MHCC's body of work was completed in 2009 with the release of *Toward Recovery and Well-Being: A Framework for a Mental Health Strategy for Canad*a, which put forward a vision and broad goals for transforming the mental health system. The Strategy translates this vision into 26 priorities and 109 recommendations for action, grouped under the following 6 Strategic Directions:

[12]http://www.mentalhealthcommission.ca

1. **Promotion and Prevention:** Promote mental health across the lifespan in homes, schools, and workplaces, and prevent mental illness and suicide wherever possible.
2. **Recovery and Rights:** Foster recovery and well-being for people of all ages living with mental health problems and illnesses, and uphold their rights.
3. **Access to Services:** Provide access to the right combination of services, treatments and supports, when and where people need them.
4. **Disparities and Diversity:** Reduce disparities in risk factors and access to mental health services, and strengthen the response to the needs of diverse communities and Northerners.
5. **First Nations, Inuit and Métis:** Work with First Nations, Inuit, and Métis to address their mental health needs, acknowledging their distinct circumstances, rights and cultures.
6. **Leadership and Collaboration:** Mobilize leadership, improve knowledge, and foster collaboration at all levels.

A follow-up report from the MHCC – *Towards Recovering and Well-Being: A Framework for a Mental Health Strategy for Canada* – reiterated the six Strategic Directions above, proposing seven linked goals for a transformed mental health system:

1. People of all ages living with mental health problems and illnesses are actively engaged and supported in their journey of recovery and well-being.
2. Mental health is promoted, and mental health problems and illnesses are prevented wherever possible.
3. The mental health system responds to the diverse needs of all people living in Canada.
4. The role of families in promoting well-being and providing care is recognized and supported.
5. People have equitable and timely access to appropriate and effective programs, treatments, services and supports that are seamlessly integrated around their needs.
6. Actions are informed by the best evidence based on multiple sources of knowledge, outcomes are measured, and research is advanced.
7. People living with mental health problems/illnesses are fully included as valued members of society.

In shaping the future state vision and specific recommendations in Section 4 of this report, we have attempted to ensure that the 6 Directions and 7 Goals from the MHCC are reflected and reinforced.

Learnings from Other Provinces

While the Mental Health Commission has established a national platform for Mental Health services, individual provinces have also developed guidelines to assist with planning and delivery of mental services, particularly as it relates to specialty populations such as seniors, children and youth as well as people suffering from dual diagnoses or being managed in the forensic system.

In BC, a major focus within the mental health system has been targeted at building better community capacity by focusing on support primary care providers to manage more complex cases. Similarly, recent developments Ontario have demonstrated the benefits of instituting intensive case management approaches for complex patients, focusing on strategies to coordinate services and provide more specialty care through community-based models to better support the 1% and 5% of people who contribute to upwards of 50% of all hospital costs.

In addition to the recent initiatives in the community, Ontario launched its *Comprehensive Mental Health and Addictions Strategy* in 2011, focusing on children and youth in the first three years. The Strategy has helped 50,000 more kids and their families access the supports they need, when and where they need it. As part of the Strategy, the province has hired more than 770 new mental health workers in schools and communities. These workers provide timely and high quality services that have already helped 35,000 kids and their families.

The new workers include:

- 260 new workers in community child and youth mental health agencies to provide kids access to services closer to home
- 144 nurses working with district school boards and local schools to support the early identification and treatment of students with potential mental health and/or addiction issues
- 72 Mental Health Leaders in school boards to provide leadership and coordination in effective school mental health
- 21 new workers in the court system to keep youth out of the justice system and refer them instead to community-based services
- 19 new full-time Nurse Practitioner positions for pediatric and adult eating disorders treatment services
- 175 additional new mental health workers in schools, who will provide kids support to address their mental health needs
- More than 80 new Aboriginal mental health and addictions workers in high-needs communities

While many of these types of initiatives extend beyond the mandate of Health PEI, they are noted here as they could serve as ideas to be considered in PEI as Youth are a specialty population that fits within Hillsborough's mandate and focus. Clearly any work in this area would have to align with the current planning being completed by the newly appointed Chief Mental Health & Addictions Officer.

In addition, a new **Tele-Mental Health Service** is expanding access to specialized mental health consults to children and youth in rural, remote and underserved communities, providing more than 800 additional psychiatric consults this year for a total of 2,040 this year. This could be another potential role for Hillsborough as the hospital seeks to identify solutions to enable enhanced access to services within the context of its specialty mandate.

The Ontario government has joined with mental health leaders and other community partners to create the **Medical Psychiatry Alliance**. The Alliance includes the Centre for Addiction and Mental Health (the former Provincial Psychiatric Hospital in Toronto that could be compared to Hillsborough, albeit on a larger scale), the Hospital for Sick Children, Trillium Health Partners (two large community hospitals in Mississauga), and the University of Toronto as well as a private donor who has contributed a substantial philanthropic investment. This new initiative will help people who are at risk of both physical and mental illnesses — or currently living with these illnesses — get the care and treatment they need.

Australian Guidelines

Building on the Canadian research, the CSI Team also looked to Australia to determine what work has been done there on frameworks for care delivery. We chose Australia because the country is often cited as the world leader regarding Mental Health & Addictions services and the resultant frameworks are seen as examples of best practice around the world. The Government of Queensland published its *Clinical Services Capability Framework for Public and Licensed Private Health Facilities* in 2012 to "provide a standard set of minimum capability criteria for service delivery and planning." The framework includes multiple modules, one of which focuses on Mental Health. Some of the key excerpts from that document include:

Mental health services are concerned with the assessment, diagnosis, monitoring and treatment of people who have a mental illness or disorder characterized by a clinically significant disturbance of thought, mood, perception, memory and/or behavior.

Mental health services address the needs of a broad mix of patient types across the entire age spectrum (children, adolescents, adults and older persons). A person's need for mental health services can be short, medium, long term or intermittent, and often spans various levels of care and service areas across the health continuum. The delivery of mental health services routinely considers and responds to the special needs that may be associated with the mental health of:

- *Aboriginal and Torres Strait Islander peoples*
- *People of culturally and linguistically diverse backgrounds*
- *People living in rural and remote areas*
- *People with a comorbidity or complex needs—this may include, but is not restricted to, patients with a mental health diagnosis as well as:*

- *an intellectual disability*
- *a substance-use disorder*
- *a dementing illness or other brain disorder/s*
- *severe or complex medical problems*
- *a sensory impairment*
- *a forensic history.*

The Australian framework includes four levels of service (Child/Youth Services, Adult Services, Older Persons Services, and Statewide / Other Targeted Services), encompassing Ambulatory, Inpatient Acute and Inpatient Non-Acute programming. The graphics/tables below summarize the comprehensive of the service framework.

Service section	Service subsections	Service subsection notes
1. Child and Youth Services	1.1 Ambulatory Services	Levels 1–6
	1.2 Acute Inpatient Services	Levels 2–6
	1.3 Non-Acute Inpatient Services	Levels 5–6, including criteria for the Adolescent Drug and Alcohol Withdrawal Service and the Adolescent Extended Treatment Centre
2. Adult Services	2.1 Ambulatory Services	Levels 1–6, including services delivered by Continuing Care Teams, Mobile Intensive Treatment Teams and community-based Acute Care Teams
	2.2 Acute Inpatient Services	Levels 2–6. Private sector commences at Level 3 for psychosurgery only, otherwise commences at Level 4
	2.3 Non-Acute Inpatient Services	Levels 4–6, including criteria for Community Care Units, Medium Secure Services, and Acquired Brain Injury and Mental Health Units
3. Older Persons Services	3.1 Ambulatory Services	Levels 1–6
	3.2 Acute Inpatient Services	Levels 2–6
	Non-Acute Inpatient Services	To allow for further statewide strategic planning and development for this service area, this section will be held over until the next review of the Framework

The services identified above could be delivered in a variety of settings, including PCH, QEH and Hillsborough, residential care facilities, and community based service settings.The balance of services tend to be more specialty and nature and likely reflect the services more consistent with the mandate of Hillsborough Hospital.

Based on the above, the following is a breakdown of how Hillsborough could be developed as separate units with varying levels of care

- Crisis Admission/Stabilization- **Level 6 Acute Inpatient Service**
- Rehab/recovery unit**-. Level 5 Acute Inpatient Service**
- Forensic- pre/post East Coast Forensic **Level 6 Acute Inpatient Service**
- Concurrent Disorder**- Level 4 Non-Acute Inpatient Service**
- Dual Disorder- **Level 4 Acute Inpatient Service**
- Geriatric Mental Health **Level 5 Acute Inpatient Service**

- Dementia – **this could be a Long Term Care unit not designated as Psychiatric but for behaviour challenges**

Service section	Service subsections	Service subsection notes
4. Statewide and Other Targeted Services	4.1 Child and Youth Forensic Services	Level 5 (relevant to public sector mental health services only)
	4.2 Adult Forensic Services	Level 6 (relevant to public sector mental health services only)
	4.3 Perinatal and Infant Services	Levels 3–6
	4.4 Emergency Services	Levels 4–5, including services delivered by hospital-based Acute Care Teams (relevant to public sector mental health services only)
	4.5 Evolve Therapeutic Services	Levels 4–5 (relevant to public sector mental health services only)
	4.6 Eating Disorders Services	Level 6
	4.7 Homeless Health Outreach Services	Level 5 (relevant to public sector mental health services only)
	4.8 Deafness and Mental Health Services	Level 6 (relevant to public sector mental health services only)
	4.9 Transcultural Services	Level 6 (relevant to public sector mental health services only)
	Intellectual Disability and Mental Health Services	To allow for further statewide strategic planning and development for this service area, this section will be held over until the next review of the Framework
	Consultation-Liaison Mental Health Services	To allow for further statewide strategic planning and development for this service area, this section will be held over until the next review of the Framework
	Early Psychosis Services	To allow for further statewide strategic planning and development for this service area, this section will be held over until the next review of the Framework

What the Literature Tells Us About the Need for Client/Family Voices to be Heard

Underlying any change that flows from this work must be an enhanced focus and deliberate strategy to better engage patients and family in all aspects of care planning and operational decision-making.

Susan Edgman-Levitan, Executive Director of the Stoeckle Center for Primary Care Innovation at Massachusetts General Hospital and Chair of the Patient Engagement Forum notes that "Patient engagement will be the "blockbuster drug of the 21st century" that will help countries [and organizations] to "shepherd resources". She goes on to state that "Professionals need to get off their pedestals and patients need to get off their knees."[13]The report of the Patient and Family Engagement Working Group goes on to state that:

The solutions to the health challenges of today and tomorrow won't come from doing business as usual; they will come from building effective partnerships and harnessing the untapped global power of ordinary people who care about improving their health. That is what the UN and World Health Organization have recognized in their development of the post-2015 agenda: they have sought public advice, through a series of consultations and an online global survey. More than one million people, representing 194 countries, participated in the survey, and in their responses, they confirmed the primacy of two goals: "a good education" and "better healthcare". These goals are world priorities, for governments and for their people.

Building on this general overview of the importance of engagement, the Centre for Addiction & Mental Health in Toronto launched an initiative through the Canadian Foundation for Healthcare Improvement (CFHI)[14] in 2012. The goal was to understand how patients and providers could collaborate more effectively in an innovative approach to care, focusing on the need to improve staff members' uptake of recovery-oriented care values and practices in Schizophrenia. The key challenge is summarized as:

Staff working with people living with schizophrenia see them at their most unwell. Few, if any, see what happens after discharge, when their former clients are recovering and getting on with their lives. This reality makes it difficult for some staff to take a recovery-focused approach to care as opposed to a custodial approach. Toronto's Centre for Addiction and Mental Health (CAMH) was challenged to shift staff attitudes and beliefs about their clients.

The key goal was to train trains former clients to speak about their experiences with small groups of inpatient unit staff, recognizing that "if you give inpatient staff a chance to have that kind of human connection and see where people's lives go, then it might change their perspectives on care… It can carry forward into care being more recovery oriented" **Initial results published in May 2013 demonstrated very early positive outcomes.** The work continues.

Summary of the Key Opportunities for Improvement

1. Increased role for Patients and Families in the overall planning, potentially expressed through formal Patient & Family Advisory Committees
2. Creation of Patient/Client non-clinical navigator role in MH&A
3. Introduction of clear clinical pathways from outreach to admission to discharge
4. Development of a contemporary accountability framework for all
5. Introduction of a Collaborative Committee with Hillsborough and Housing Providers (e.g., QCRS, PCCC, CMHA, LTC, Community Care)
6. Confirm how to best address issues of child and youth access to beds and services
7. Clarify specific mandate for each unit at Hillsborough and, by extension, PCH and QEH

[13] Susan Edgman-Levitan et al., *Partnering with Patients, Families, and Communities for Health: A Global Imperative,* Report of the Patient and Family Engagement Working Group, 2013.

[14] http://www.cfhi-fcass.ca/sf-docs/default-source/impact-stories/IS-Patients-Staff-Collaborate-E.pdf?sfvrsn=0

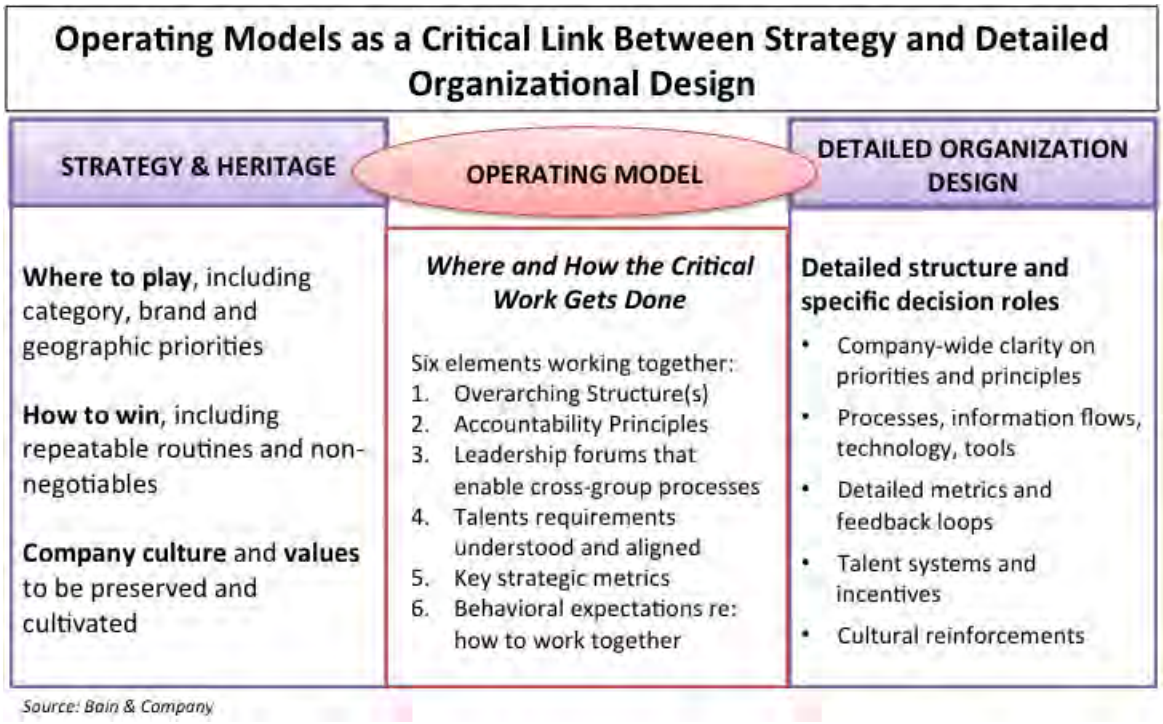
4.0 DEFINING A PROPOSED FUTURE STATE

Operating Model Framework

The issues summarized in the previous section have some commonalities and overlap with respect to impact as well as resolution strategies/recommendations. Accordingly, this section transitions away from the specific issues and presents a series of inter-connected "big picture" strategies that the Review Team believes should be pursued to enable the program to pursue its desired future state.

In considering how to best frame the proposed recommendations/solutions, the Review Team decided that the overarching issue is the absence of an effective *Operating Model* within the MH&A Program. *Operating Models* are emerging as a formal tool that organizations are increasingly using to define structures, accountability frameworks/principles and organizational processes that will be consistently used to enable effective operational management and ensure success.

Bain and Company (2012), in their white paper *Winning Operating Models* note that an *operating model* "dictates where and how the critical work gets done, serving as the vital link between strategy and the detailed organization design that it puts in place to deliver on the strategy." The figure below is adapted from Bain's paper:



Whereas recommendations in the companion report to this work (the Report dealing with Psychiatrists issues) focused solely on the *Operating* Model, this project must deal with some of the issues noted in the left side of the graphic above – ***Strategy & Heritage***.

Roger Martin, former Dean of the Rotman School of Business, stresses that any organization that is moving forward with defining Strategic Directions intended to address long-standing issues must be prepared to *discuss the undiscussables*, that is, to openly talk about the things that are normally avoided in the course of normal day-to-day interactions. Some of the issues surrounding the role of Hillsborough will require us to discuss the undiscussables.

"Where to Play" and "How to Win"

In preparing for the Think Tank where the themes from this review were presented and key issues related to future role of Hillsborough Hospital was debated, CSI proposed a draft vision for Hillsborough. That Vision was grounded in the need for a **population based approach** that more **specifically defines the MH&A health problems** and complexities that would be **best served in Hillsborough** versus those that can **best be served in other facilities** in the province.

With this overarching context in mind, CSI recommends the following:

1. Health PEI reconfirm the regional role of HH as the tertiary/specialty centre for mental health supporting key populations under two models:
   a. Deliver the full continuum of specialty care (inclusive of inpatient beds, ambulatory/day programming and specialty consultation support services to other levels of care) for those populations where the critical mass exists to do so, and
   b. Deliver ambulatory, consultation and care coordination support for populations that receive inpatient care outside of PEI.
2. The populations that require Specialty Services at HH should be able to leverage the full continuum of inpatient, ambulatory and specialty consultation supports, which requires:
   a. Clarity in roles, responsibilities and relationships between all acute inpatient units (PCH, QEH & HH) must be clarified. For example, Australian framework/standards, a leading practice, may be helpful can be applied to achieve needed clarity along the acute care continuum.
   b. Services should be centered on Rehab/Recovery, focusing on goals of changing treatment and developing skills to return to life in the community. This could include caring for people with persistent and chronic mental illness that may require the standards and care usually associated and provided by a regional referral MH facility (HH).
   c. Services that supports clients presenting with addiction issues and those with Concurrent Disorders provide care and treatment no matter where in the MH&A program they present.
   d. Supports for Seniors Mental Health clients, in collaboration with LTC, (e.g. Psycho-geriatric population) including the potential for a secure or locked unit for people with advanced dementia and at risk to wander off the unit and harm themselves. This focus will require collaboration with LTC to avoid limiting the possibilities and the ability to ensure other areas of the system are accountable for the services they are mandated to provide. If the decision is to keep the psycho-geriatric unit as part of HH, clarify in the role for the unit to support transition to LTC and provide (medium/long stay, 6 months to 1 year as per MHCC system guidelines).
   e. MH&A should confirm the role of HH, in relation to clients with dual disorders, as a short term treatment approach with the goal and focus of a return to the community.
3. Populations that require Specialty Services, within the MH&A continuum, yet require some services in partnership outside of PEI, will also require coordination of care when they return to PEI,
   a. Treatment for clients, involved in the legal system, with a forensic status and require rehabilitation and treatment and support into the community when they return to PEI from the East Coast Forensic Centre, and involve the CCRB directives.
   b. Addiction clients and clients with concurrent disorders in coordination with PEI Addiction Services who receive addiction support in facilities in Ontario or elsewhere, and
   c. Care for Youth clients (16-18 years of age) who need MH & A support.
4. The safety net role is also responding to a legitimate patient need. This role has been assumed by Hillsborough Hospital by default and would need to be addressed to enable HH to fulfill the current and future mandate. However, if these patients' ongoing requirement is actually long term care, then Health PEI must determine which segment of their programs and services are best positioned to provide high quality long term care for these patients and which other programs or services are necessary partners to address the issues of complex cases.

The above "vision" was **fully endorsed by the participants at the Think Tank.**

Restating the page long descriptive statements immediately above, the future vision for inpatient MH&A care in PEI can be summarized as follows:

Recommendation #1: Health PEI to confirm that Inpatient Care will be managed under a One Island System model, whereby the MH&A Program defines the specific roles and mandates (Levels of Care)for all three inpatient sites (Hillsborough, PCH and QEH) as well as the expectations of the community hospitals with regard to providing care to MH&A patients.

In pursuing this recommendation, Levels of Care for the three primary inpatient sites will need to be confirmed. This should be done leveraging the extensive work outlined in the Australian framework as a guide. As the Australian framework is a 132-page document, it will not be re-stated here but it can be accessed at http://www.health.qld.gov.au/cscf/docs/30_mentalhealth.pdf.

In summary, the Australian framework indicates the following:

Hillsborough to be designated as a Level 5 facility: The Level 5 Service Description is as follows:

- *A Level 5 service is capable of providing short- to medium-term and intermittent inpatient mental health care to low-, moderate- and high-risk/complexity **voluntary and involuntary adult mental health patients**. Adolescent patients older than 14 years and older persons (aged 65 and older) may access this service where clinically and developmentally appropriate, and in line with policy and procedural documentation of the adult service. This service **provides mental health care 24 hours a day**.*
- *This level **service is delivered predominantly by a comprehensive, multidisciplinary team of mental health professionals** (psychiatrist, nurses, allied health professionals) within a **dedicated mental health hospital** or a general hospital that has a dedicated mental health acute inpatient unit.*
- *Service provision typically includes: multidisciplinary assessment and targeted interventions by mental health professionals; patient and carer education and information; documented weekly case review; group programs; extensive primary and secondary prevention programs; consultation-liaison with higher and lower level mental health services; and referral, where appropriate.*

In some cases, **Hillsborough will also deliver care equivalent to a Level 6 facility**: The primary difference between Level 5 and Level 6 is the level of risk and complexity of the care required (e.g. forensics). The Level 6 Service Description is as follows:

- *A Level 6 service is capable of providing short- to medium-term and intermittent inpatient mental health care to voluntary and involuntary adult mental health patients who **present with the highest level of risk and complexity**. The patient group accessing this level of service maybe a **targeted population with special care needs**. They may **demonstrate the most extreme comorbidities and/or indicators of treatment resistance**.*
- *This service is a highly specialised and/or statewide inpatient service that is delivered from a large general hospital that incorporates a dedicated mental health unit. Alternatively, this service may be delivered from a purpose-designed and -built mental health facility. This service demonstrates specialist expertise in the delivery of mental health services to **a patient group that cannot be safely and effectively cared for in any other level of acute inpatient mental health service**. This service provides mental health care 24 hours a day.*

Alternatively, the MH&A Program could decide to manage QEH and HH as a single program that spans 5 units and 2 buildings, for the purposes of patient management. If this approach is selected, QEH/HH would be jointly designated as Level 5 with some Level 6 capacity.

If QEH and HH are not designated jointly, **Queen Elizabeth Hospital should be designated as a Level 4 facility.** The Level 4 Service Description is as follows:

- *A Level 4 service is capable of providing short- to medium-term and intermittent inpatient mental health care to low- and moderate-risk/complexity voluntary adult mental health patients, and, **if authorised to do so, involuntary mental health patients**. Adolescent patients older than 14*

years and older persons (aged 65 and older) may access this service where clinically and developmentally appropriate, and in line with policy and procedural documentation of the adult service. This service provides mental health care 24 hours a day.

- *This level of service is delivered predominantly by mental health professionals within a dedicated mental health hospital or a general hospital that has a dedicated acute inpatient mental health unit.*
- *Service provision typically includes: multidisciplinary assessment and targeted interventions by mental health professionals; patient and carer education and information; documented weekly case review; some group programs; primary and secondary prevention programs; consultation-liaison with higher level mental health services; and referral, where appropriate.*

Prince County Hospital be designated at a Level 3 facility. This is recommended because PCH does not currently admit involuntary patients, and in the opinion of the CSI team, the scope **should not be** expanded to allow for involuntary admissions because the current staffing models would not adequately accommodate this patient population. By avoiding the additional investments needed to enhance staffing would serve to duplicate services at the lower levels of care, any resources that might be available for service expansion can be strategically deployed to address gaps in the specialty continuum. The Level 3 Service Description is as follows:

- *A Level 3 service is capable of providing short- to medium-term or intermittent inpatient mental health care to low-risk/complexity voluntary adult mental health patients. This service provides general healthcare and mental health care 24 hours a day.*
- *This level service is delivered predominantly by general and mental health professionals (onsite) within a general medical facility that has a limited number of dedicated mental health beds or may operate as a mental health special care suite/area.*
- *Service provision typically includes: assessment and targeted interventions by general and mental health professionals; patient and carer education and information; documented case review; primary and limited secondary prevention programs; consultation-liaison with higher level mental health services; and referral, where appropriate.*
- *If providing psychosurgery, an agreement with a public or suitable licensed private health facility that provide a higher level of mental health service for the transfer of the patient following the post-surgical recovery period.*

Community Hospitals (e.g. Alberton and Montague) would be Level 2 facilities, which means they are capable of *providing limited short-term or intermittent inpatient mental health care to low-risk/complexity voluntary adult mental health patients. This service provides general healthcare and some limited mental health care 24 hours a day. This level of service is delivered predominantly by a team of general health clinicians within a facility that does not have dedicated mental health staff (on-site) or beds. Medical services are provided on-site or in close proximity to provide a rapid response at all times. Service provision typically includes: assessment, brief interventions and monitoring; patient and caregiver education and information; documented case review; consultation-liaison with higher level mental health services; and referral, where appropriate.*

The issue of **Medical Psychiatry** should also be reviewed to determine how models such as this might be deployed to better support the delivery acute care to patients admitted to other services but who have mental health challenges as a complicating factor impacting their care.

Recommendation #2: Health PEI to confirm that Levels of Care as outlined above and to direct the MH&A Program to develop specific admission and discharge criteria for each Level/Site as well as the required transfer criteria and protocols to be used when a patient requires care at a higher Level of Care facility. Where possible, direct admission to the required service at the higher level of care facility should be available.

Focusing back on the Operating Model framework to the issues outlined in this report, solutions are clustered under six thematic areas:

1. Overarching Structures and Leadership Processes

2. Accountability Principles/Frameworks
3. Cross-Group Processes
4. Quality Metrics
5. Patient and Family Engagement
6. Change Management Support

Overarching Structures and Leadership Processes

All of the above assumes that all stakeholders will rally behind the vision and goal to enhance the level of integration and coordination between sites by providing enough clarity regarding roles as well as admission, discharge and transfer criteria that people know when and where to refer a patient.

Recommendation #3: Health PEI clearly identify behavioral and process expectations for its internal leaders, clinicians and staff regarding the need to transition to a fully integrated delivery model that defines clear decision-making roles and responsibilities to enhance collaboration and optimize care transitions.

Accountability Principles/Frameworks

Much of this work was addressed in the companion project related to Psychiatrists. The one piece possibly worth noting here is the need to reaffirm the accountability structures for operations, professional practice and physician contract management under the various senior leaders at Health PEI. The responsibilities of other senior leaders to help support and enable the changes needed to enhance MH&A services should also be clearly articulated.

Recommendation #4: Health PEI needs to differentiate the various levels of accountability that impact MH&A services including the operational mandate that is vested with the MH&A Program, the professional practice mandate for the recommended Department of Psychiatry and other professional practice structures (e.g., Provincial Chief Nursing Officer).

Cross Group Processes

Leveraging the work to clarify levels of care and admission/discharge/transfer criteria for each inpatient facility, similar work is required to ensure that services that align along the continuum of care as defined by patient population (e.g. youth, adults and seniors) as well as by programming need or service type (e.g. crisis, rehab/recovery, dual diagnosis) should be undertaken.

The Australian framework can assist with this work as well, but the key focus will be on confirming the gap analysis and addressing communication barriers that prevent seamless transitions of care between sectors. This has both a "within PEI" focus as well as a "between PEI and off-Island providers" focus.

Some examples of internal barriers presented previously include:

- Fragmented/inconsistent care planning processes that lead to incomplete care plans or care plans that are not shared between care teams and sectors.
- IT system and/or internally imposed policy issues that inhibit the effective sharing of patient information between community mental health and hospitals.
- Sub-optimal communication processes and/or a lack of effective forums to support information sharing and joint planning (e.g. between Hillsborough and community housing providers as well as between MH&A staff and primary care providers).
- Inconsistent data collection processes that do not support or are not used to effectively to enable planning.

Recommendation #5: MH&A Program establish a working group with Primary Care providers, Community-based MH&A staff, and Hillsborough Hospital staff to define and prioritize key operational processes that should be redesigned to enable smoother transitions of care and better communication between sectors that fall within Health PEI's operational mandate. The Program should implement "pilots" and evaluate to enable adoption across populations.

Note: The MH&A Program's plan includes initiatives reflective of the above recommendation. Re-stating it here is intended to reinforce its importance as a priority to be pursued in the near-term.

Recommendation #6: MH&A Program offer to work with the Chief Mental Health & Addictions Officer to establish a working group to fast-track proposals to resolve the housing issues that are currently being served by Hillsborough under the safety net role.

Note: The above is not intended to usurp the work of the Chief Mental Health Officer, but rather to suggest that Health PEI, and more specifically, the MH&A Program might want to present this to her as an opportunity to pursue a shared goal in this area in advance of her final report being completed.

Some examples of issues related to care for Islanders when a portion of the care is delivered out-of-province (OOP) include:

- Inconsistent criteria regarding the appropriateness of referrals to OOP providers for care.
- Poor communication with the OOP providers during the care process as well as with regard to discharge planning.
- Sub-optimal processes for repatriation with a defined plan of care for the patient upon their return to PEI.

Recommendation #7: MH&A Program establish a working group with two OOP providers – East Coast Forensics and Homewood) to determine how joint care planning can be enhanced so that Islanders are better served across the continuum of pre-transfer, care during their stay off-Island and post-transfer / follow-up care on Island. The Program should implement "pilots" and evaluate to enable adoption across populations.

Note: any work with OOP providers must involve Medical Affairs because OOP treatment is referred by physicians and the budget falls under the responsibility of Medical Affairs. A clear deliverable should be to enable better coordination pre and post transfer; as well as addressing accountability to ensure 'value for money' for services provided by others.

Note: there are numerous ideas presented in the Think Tanks that can help to provide concrete options for inclusion as Recommendations 4, 5 and 6 are pursued and implemented

5.0 PLANNING FOR IMPLEMENTATION

A key issue moving forward will be a Change Management framework. Change is difficult in most environments but it is reportedly more difficult in PEI. Once a culture of resistance to change develops, it can be very difficult to move forward. There are many reasons why change efforts fail, and some of the best-known work in this area was completed by Harvard Professor Dr. John Kotter several years ago. Kotter's work[15] is too detailed to fully present here, but the 8 key stages or attributes of effective change processes he identifies are presented in the table below, along with a general summary of the actions required and pitfalls that must be avoided at each stage.

Stage	Action Needed	Pitfalls
Establish a sense of urgency	Examine organizational and system-level realities for potential crises and untapped opportunities. Convince at least 75% of your managers that the status quo is more dangerous than the unknown.	Underestimating the difficulty of driving people from their comfort zones Becoming paralyzed by risks
Form a powerful guiding coalition	Assemble a group with shared commitment and enough power to lead the change effort. Encourage the coalition to function as a team outside the normal hierarchy.	No prior experience in teamwork at the top Relegating team leadership to an HR, quality, or strategic-planning executive rather than a senior line manager
Create a vision	Create a vision to direct the change effort. Develop strategies for realizing that vision.	Presenting a vision that's too complicated or vague to be communicated in five minutes
Communicate the vision	Use every vehicle possible to communicate the new vision and strategies for achieving it. Teach new behaviors by the example of the guiding coalition.	Under-communicating the vision Behaving in ways antithetical to the vision
Empower others to act on the vision	Remove or alter systems or structures undermining the vision. Encourage risk taking and nontraditional ideas, activities, and actions.	Failing to remove powerful individuals who resist the change effort
Plan for and create short-term wins	Define and engineer visible performance improvements. Recognize and reward employees contributing to those improvements.	Leaving short-term successes up to chance Failing to score successes early enough (12 months into the change effort)
Consolidate improvements and produce more change	Use increased credibility from early wins to change systems, structures, and policies undermining the vision. Hire, promote, and develop employees who can implement the vision. Reinvigorate the change process with new projects and change agents.	Declaring victory too soon — with the first performance improvement Allowing resistors to convince "troops" that the war has been won
Institutionalize new approaches	Articulate connections between new behaviors and corporate success. Create leadership development and succession plans consistent with the new approach.	Not creating new social norms and shared values consistent with changes Promoting people into leadership positions who don't personify the new approach

As the leadership team prepares to undertake more detailed implementation planning, use of the Operating Model Framework presented previously, and a change management framework such as the one above should be used to guide the work.

[15] Leading Change: Why Transformation Efforts Fail. Kotter,JP. Harvard Business Rev, March/April 1995, pg. 59.