

RECOVERY:
FROM NEIGHBOURHOOD TO NEURON



Hôpital
Douglas
Hospital

2006-2010 Strategic Plan

STRATEGIC PLANNING PROCESS

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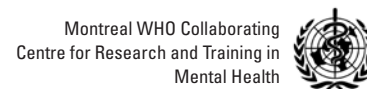
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FOREWORD

On behalf of the Douglas Hospital, the Douglas Hospital Research Centre, the Douglas Hospital Foundation, the boards of directors, the staff, professionals, scientists, patients and everyone working at the Douglas, we are proud to present the 2006-2010 Strategic Plan. This Plan announces the values and commitment of the Douglas Hospital community. It clarifies the vision and identifies the strategic directions that will guide our actions throughout the next few years.

Our vision “Recovery Through the Integration of Care, Teaching and Research – From Neighbourhood to Neuron” is ambitious. It is based on solid collaboration within the organization, as well as with our external partners. It proposes a new philosophy of care, which calls for all parties to be involved in improving the quality of life of people suffering from mental illness and in promoting their autonomy and full potential. The vision also requires fighting against stigmatization – through improved knowledge resulting from research and public education projects – in the hope that people suffering from mental illness will ask for help more quickly, thereby increasing the potential for recovery. It will then be possible for them to reintegrate into their own environment and assume more productive roles in the community.

The 2006-2010 Strategic Plan clarifies the reasons behind the anticipated changes, which are essential in the context of the current chaotic healthcare network. We note, in particular, the healthcare reform and the Mental Health Action Plan of the Ministry of Health and Social Services, the Kirby Report on national strategies, as well as economic, scientific and academic concerns. The Plan also describes the following overall directions that will guide these changes:

- 1. Require excellence and the integration of clinical, teaching and research activities:** This integrative approach is in line with the learning organization, interdisciplinary, and continued improvement philosophy. It calls for a renewed synergy.
- 2. Improve knowledge and influence directions in mental health:** Destigmatization and partnerships within Quebec and Canada, and with international partners, underlie this strategic direction, which is based on the leadership of members within our organization.
- 3. Consolidate a result-based culture:** This strategic direction calls for excellence and rigour to achieve identified goals within a context of resource rationalization.

The challenges ahead call for difficult choices, but the calibre of our resources, and our values of excellence and innovation, based on commitment, collaboration and education, are our assurance of future success. With these underlying values, a clear vision, and solid partnerships, we will be able to face these challenges and concentrate all our energies on improving the quality of life of people suffering from mental illness.

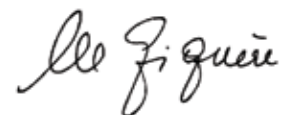
On behalf of the boards of directors of the three organizations, we wish to thank Nicole Germain, Assistant to the Director General, and Jocelyne Lahoud, Administrative Director of the Research Centre, for their masterful management of this project. This Strategic Plan is the result of a wide consultation and of sustained collaboration between the Hospital, Research Centre and Foundation. We wish to thank everyone who took part in this process, which is essential for the future development of the Douglas Hospital.



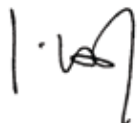
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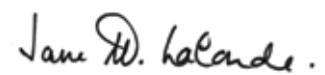
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The background is a textured, mottled orange color. Overlaid on this is a network of white dashed lines that intersect and cross each other. Many of these lines terminate in small white arrowheads, pointing in various directions across the page. The overall effect is that of a complex, abstract path or a network diagram.

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.01 INTRODUCTION

VISION Recovery Through the Integration of Care, Teaching and Research – From Neighbourhood to Neuron.

VALUES The Douglas values **excellence** and **innovation**, based on **commitment, collaboration** and **education**.

COMMITMENTS The Douglas is committed to:

- ▶ Be a learning organization that inspires pride and a sense of belonging;
- ▶ Be passionate in seeking excellence and quality;
- ▶ Focus on outcomes in moving towards evidence-based practices;
- ▶ Inspire new ideas and innovation to improve care and services;
- ▶ Be an interdisciplinary environment that stimulates partnership and knowledge exchange;
- ▶ Improve the mental health of populations through developing international projects;
- ▶ Fight discrimination against people suffering from mental illness.

For the first time in its history, the Douglas Hospital gives itself an integrated strategic plan, consolidating the strategic directions of its three entities, namely, the Hospital, the Research Centre and the Foundation. This integration is even more significant, as each of the three components of its mandate falls under the aegis of a different ministry:

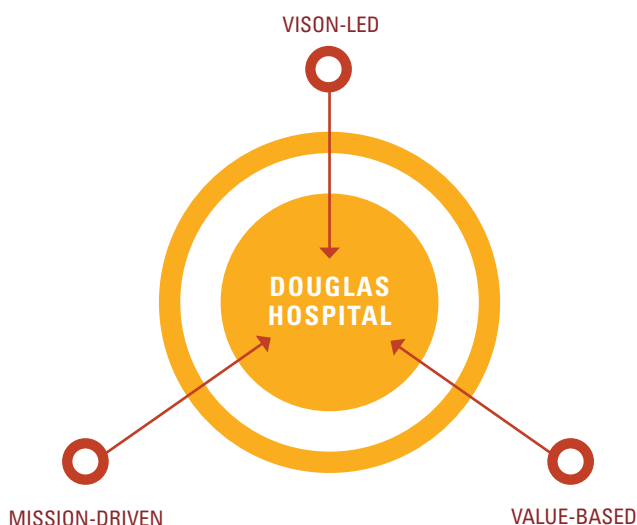
- ▶ Care and Services: Ministry of Health and Social Services;
- ▶ Research: Ministry of Economic Development, Innovation and Exportation; and
- ▶ Teaching: Ministry of Education, Leisure and Sport.

The Douglas Hospital evolves within a complex environment in the midst of structural turmoil. Prudent and clear planning is essential within such a context. The integrated 2006-2010 Strategic Plan therefore describes the vision and values that will guide our decisions over the next few years. The Plan clarifies the organizational environment and addresses the turbulence in the external environment that prompts the needed changes announced in the Plan for the next four years. It states, at a strategic level, the directions and objectives that will allow us to achieve a vision of **Recovery Through the Integration of Care, Teaching and Research – From Neighbourhood to Neuron**. This vision calls to action every component of society, the healthcare system, and the scientific and academic networks, and requires collaboration by all stakeholders.

As a University Institute in mental health member of the McGill University Integrated Health Network (RUIS¹ McGill), our plan is aligned with the University's White Paper on the Future of McGill University. The WHO² Collaborating Centre for Research and Training in Mental Health fully supports our mission statement, vision and values, as well as our strategic directions and objectives, and is a partner committed to our success.

The Strategic Plan is the result of sustained collaboration and wide consultation with patients and their families, clinicians, researchers, managers, partners of the health, education and research networks, and regional and ministerial authorities. Their

full cooperation made it possible for us to better evaluate the stakes in our external environment, as well as strengths and challenges in our internal environment. The Plan is therefore well aligned with the MHAP and the health system reform implemented by the Ministry of Health and Social Services. This concerted consultation allowed us to clarify our role in the hierarchical healthcare system and focus our vision and underlying strategic directions for the next four years. The Strategic Plan will guide the drafting of operational action plans to be developed on an annual basis and will also allow us to identify development, reorganization and resource allocation priorities throughout this period.



As our vision announces, all our actions are aimed at improving the mental health and quality of life of those we serve and of the general population.

Our ticket to success: A clear vision, solid values and an unshakable commitment.

1 Réseau universitaire intégré de services.

2 WHO: World Health Organization.

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.02

THE DOUGLAS - AN OVERVIEW

HISTORICAL BACKGROUND – YOU MUST KNOW *WHERE YOU ARE FROM TO KNOW WHERE YOU ARE GOING*

Founded in 1881 by Alfred Perry, the Protestant Hospital for the Insane, renamed Douglas Hospital in 1965, was built on the 150-acre site it still occupies to this day. The first patient was admitted in July 1890 and the Hospital has continued to devote itself to improving knowledge and treatment of mental illness ever since.

From the time of its founding to this day, the Hospital has had to constantly depend on the community's support in order to secure its development. Since it was not administered by a religious organization, as was the case for most French hospitals, it had to depend even more on the generosity of the public and on volunteerism. These traditions still hold true today and they account for one of the Hospital's fundamental values of openness to the community, which led to the creation of the Auxiliary in 1959, and of the Douglas Hospital Foundation in 1971. This openness continues to develop to this day and has allowed us to successfully implement several community reintegration initiatives.

Recognized as a center of excellence, the Hospital was affiliated with McGill University in 1946. Its training programs are recognized and continue to welcome an increasing number of students in all disciplines related to mental health. The Hospital has always been at the forefront of modern psychiatry. It was the Douglas who, in 1953, introduced the pharmacological treatment of psychoses to North America; this gave rise to the development of novel and decreasingly restrictive approaches and triggered deinstitutionalization in the mid-60's. Around that time, the Hospital became increasingly committed to understanding the brain's biological mechanisms, in order to improve understanding of the causes of major mental illnesses. A leader in the field of mental health research, the Douglas Hospital Research Centre was officially created in 1979 and developed an outstanding international reputation. It became a WHO collaborating centre in 1982.

Wishing to provide cutting-edge treatments that would be less intrusive and as normalizing as possible, the Douglas pioneered the implementation of post-treatment clinics in the community, as well as the creation of a halfway house for the social rehabilitation of patients. In 1967, the Douglas Hospital was named the first psychiatric hospital to be accredited by the Canadian Council on Health Services Accreditation — a testament to the importance it places on quality.

In order to ensure success in achieving this goal, the Hospital also invested in the community by providing seed money to different organizations involved in alleviating the plight of the mentally ill. These organizations have evolved and still continue to play an important part in the success of the social reintegration of patients into their own environment. Accompanied by a significant increase in out-patient services and rehabilitation services, the hospitalized population continues to decrease: although it reached a peak of more than 1,840 hospitalized patients in 1966, there are now only 254 in-patients, while there are 8,944 external patients. These successes would not have been possible without our expert, devoted and committed human resources.

The pace of change in the network has continued to increase in the last few years. The difficult economic context, lack of resources and increasing demand for services put more and more pressure on the Hospital. In fact, in the course of the last ten years, the Hospital catchment population increased by 47%, budgets were cut by approximately \$10M, while the Hospital was investing \$4M in external services. This reorganization involved 20% of our resources, while maintaining a balanced budget. This success was even more significant because it was accompanied by major changes in our human resources following massive retirements, and the transfers and reassignments they generated.

All these changes and a turbulent external environment caused the Douglas to review its organizational model. In 1999, the Hospital opted for a new structure and several changes were implemented, which caused major adjustments in our ways of doing things. Two major changes were the implementation of a program management structure and of shared management at the different hierarchical

levels, in order to support the chosen structural model. Recognizing our leadership, the MHSS³ designated us as a University Institute in mental health in the spring of 2006.

The Douglas Hospital's history has been sculpted from values that highlight excellence in clinical practices, innovation in teaching and training programs, and the significant contribution of research to the advancement and sharing of knowledge in mental health. It also bears witness to the participation of patients and their families, and to the contribution of caregivers and community partners in struggling with mental illness. These shared values constitute the fabric of the Hospital, the basis of its organizational culture. They guide our strategic directions and our actions.

ORGANIZATIONAL ENVIRONMENT

The organizational structure is reflective of the strategies adopted to achieve the vision and mission. It also constitutes the impetus to put values into practice and to implement the management philosophy. The Hospital opted for a **program management** structure, which puts an emphasis on the development of care processes aimed at achieving set outcomes that are based on five specific principles:

- ▶ **Client-centered approach:** places the patient at the centre of our concerns. Each program is not based on a particular therapeutic act, but on a specific type of clientele.
- ▶ **Results-based initiatives:** aims to identify clear result indicators linked to desirable outcomes for the clientele under care.
- ▶ **Decentralization of power and resources:** makes teams accountable and promotes management autonomy, as well as a more cautious use of available resources to achieve desirable outcomes.
- ▶ **Interdisciplinarity:** implies an explicit recognition of the complementary nature of the different fields of

expertise involved in reaching targeted results because interdisciplinary teams are responsible for processes and ensuring outcomes. It is therefore important that performance evaluation take into account the team's results, rather than only individual performance.

- ▶ **Continued improvement:** implies that results obtained form the basis for continued adjustments in practices applied to reach these results, and that the team is in a constant search for improved standards of excellence.

As for the Research Centre, it opted for a structure based on research themes organized around specific disease groupings, in order to maximize synergies, focus on research outcomes and the potential for discovery.

To ensure adequate clinical and research management, the Douglas opted for a **shared management** approach. Program management implies mastering both the therapeutic/scientific process and a capacity to manage several professional and technical resources contributing to this process. These qualities are rarely found simultaneously in one person. Hence the overall responsibilities, roles and tasks are shared between two individuals, with the goal being to reach objectives.

Finally, the key concept that underlies management philosophy at the Douglas Hospital and the Research Centre is that of a **learning organization**. This is defined as an organization able to systematically solve its problems, experiment with new models, learn from its history and past experiences, learn from proven practices and the experiences of others and, finally, to transfer knowledge efficiently and promptly throughout the organization. This means seizing available opportunities to implement mechanisms that will allow the organization to learn.

Convinced that structure influences behaviour, we have therefore implemented a structure that is conducive to strengthening the learning organization philosophy and achieving our vision and mission.

3 MHSS: Ministry of Health and Social Services

A DAY AT THE DOUGLAS

Each day:

- 12 people show up in the Emergency Room;
- 233 patients occupy beds;
- 63 caregivers visit patients in their homes;
- 271 patients take part in rehabilitation activities;
- 63 patients are cared for in our day hospitals;
- 340 people are seen in our external clinics;
- 215 students or trainees learn from our experts or scientists;
- 861 clients live in residential resources affiliated with the Hospital;
- 129 requests for expertise/consultation are dealt with by our clinicians;
- 778 people visit our web site;
- 8,214 e-mails are sent to people using our network;
- 45 people submit an application to join our workforce;
- 84 payments are made to suppliers;
- 300 lab tests are performed;
- 2,500 medications are distributed;
- 685 meals are prepared.

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.03

WHY CHANGE?

ENVIRONMENT, STAKES, CHALLENGES

1ST, 2ND AND 3RD LINE SERVICES:

1ST LINE: universally accessible, it is mandated to promote health and prevent illness. It is the gateway to services, as well as a site for diagnosis, treatment and rehabilitation for the entire population. It responds to 70% of the demand for services and constitutes a hub for the integration of services provided to an individual. These services are provided by the CSSSs, community organizations, physicians and other caregivers in private clinics, etc.

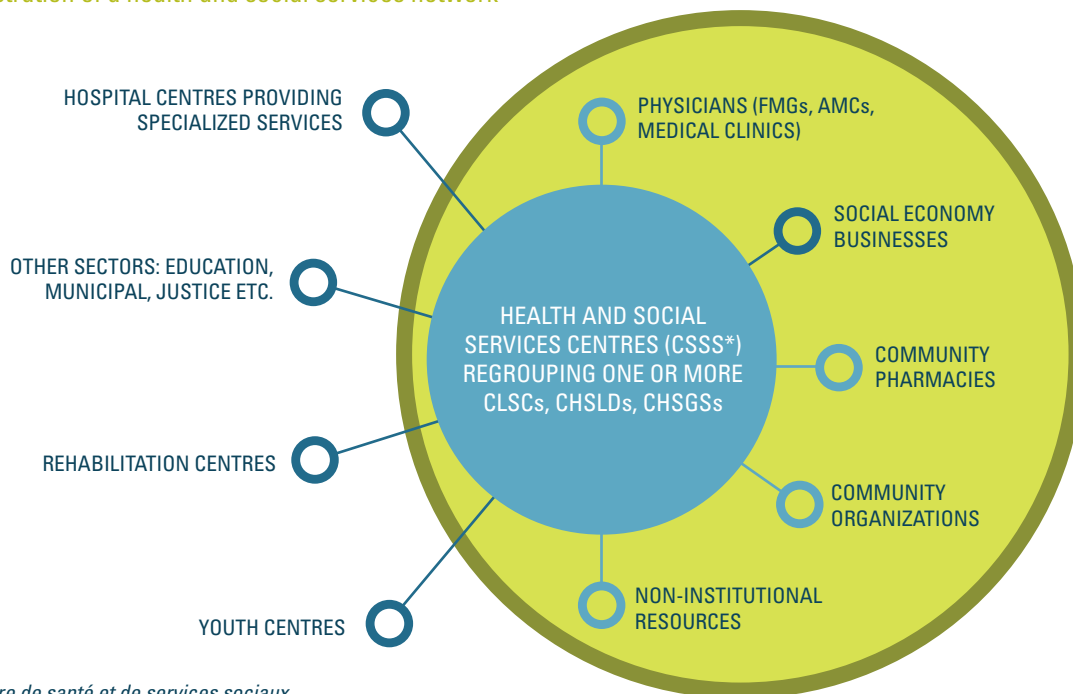
2ND LINE: supports 1st line services. Mainly accessible upon referral, 2nd line services are provided by CSSSs, certain community organizations and all hospital centres providing psychiatric services. 2nd line services are: specialized evaluation and treatment, hospitalization and intensive follow-up. They also include specialized support for children and youth. They serve to solve complex problems in response to 29% of the demand for services.

3RD LINE: supports 1st and 2nd line services. They are only accessible upon referral. They are geared to address very complex disorders, with a low prevalence rate and which are so complex that they require an expertise not available in 2nd line. This represents approximately 1% of the demand for services. These services are identified by the RUIS, approved by the MHSS and are provided by university network affiliated hospital centres.

TO CONSOLIDATE PARTNERSHIPS AND ENSURE ALIGNMENT WITH THE HEALTH SYSTEM REFORM AND THE 2005-2010 MENTAL HEALTH ACTION PLAN (MHAP)

In 2003, the Quebec government instituted a new structure for health and social services, based on **populational responsibility** and on a **hierarchical health system**. In accordance with these principles, sectorization in mental health was abolished and new local health networks were implemented, each with a Health and Social Services Centre (CSSS for *Centre de santé et de services sociaux*). Figure 1 shows how these networks are organized, and the interaction between the CSSS and the other components of the network. The CSSSs have a collective responsibility for their respective catchment population and therefore are the gateway to the system.

Figure 1: Illustration of a health and social services network



* CSSS for *Centre de santé et de services sociaux*

The reform also announced the implementation of university integrated health networks (RUIS), responsible for providing superspecialized 3rd line services. The Douglas Hospital, as a University Institute in mental health affiliated with the McGill RUIS, is not integrated with a CSSS, but is one of its partners.

► **Populational responsibility:** As opposed to the conventional model, based on illness and on response to the needs illness creates, populational responsibility is founded on the belief that health is a collective valuable asset that must be maintained and developed. This approach places more emphasis on the determinants of health and prevention. To this end, it aims to coordinate service delivery based on a given population, rather than

on the basis of the individuals using the services. In short, it concludes that regional and local authorities have a responsibility regarding the health of individuals in their regions, particularly in relation to accessibility to appropriate services and the effectiveness of treatment and action in their environment.

► **Hierarchical health system:** This concept is intended to guarantee better complementarity between services, and facilitate the process a person must follow between 1st, 2nd and 3rd line services. In other words, the objective of the hierarchy is to ensure that the right service is offered to the right person, at the right place, at the right time and by the right service provider.

Mental Health, a Priority

With its **2005-2010 Mental Health Action Plan (MHAP)**, the government declared its intention of making mental health a priority. It made significant commitments to that end. The MHAP defines how care and services are to be organized within the framework of the reform. Changes we are making to the organization of services will allow us to improve our response to the needs of those, young and old, living with mental health problems. The MHAP was conceived to focus the energies of all mental health caregivers and to promote acceptance and openness towards people suffering from mental illness.

All actions taken in mental health are aimed at recovery and empowerment. The MHAP responds to the need to adapt services based on the specific needs of each one. It proposes a vision that includes prevention and health promotion considerations. Partnerships among the various caregivers, based on a respect for each other's values and approaches, constitute a key success factor throughout the MHAP. The mental healthcare system is supported by research, follow-up, evaluation, training and information activities.

Path followed in the hierarchical system: Figure 2 illustrates the path a child or an adult may follow to access mental health services, starting at the community level. Collaboration and partnerships form the basis of the model.

Shared care and 1st-2nd line partnership: The Douglas is called to work in close collaboration with the LaSalle and Old Lachine CSSS and the South-West-Verdun CSSS through its shared care program. The goal is to provide needed support to 1st line services in order that they may fully play their role, while making sure that there is a continuous link with our 2nd line services. Our capacity to work as a team and be open to others will ensure the success of this major transformation.

Role of university institutes in mental health and 3rd line partnerships: Each of the four RUIS is formed around one of Quebec's faculties of medicine. The RUIS are responsible for providing specialized services to their respective catchment

regions. As a nationally-recognized centre of excellence, a university institute in mental health, such as the Douglas, must be able to support the development of best practice models. In the context of the MHAP and the present Strategic Plan, we have a key role in innovating and developing practices.

Where teaching is concerned, innovative services, and the changes that they bring about in professional practices, as well as the intensification of interdisciplinarity, will guide university curriculum, as well as training programs and settings. As for research, a critical mass of researchers and highly expert clinical workers in our organization will promote the development and transfer of knowledge across all training, teaching and research activities. Research, particularly evaluative research, and knowledge exchange stemming from research, are all elements needed to successfully implement the MHAP.

TO IMPROVE THE QUALITY OF LIFE OF PEOPLE WE SERVE

Scientific progress shows that mental disorders, like other physical illnesses, are the result of a complex interaction of biological, psychological and social factors (Figure 3). It proves

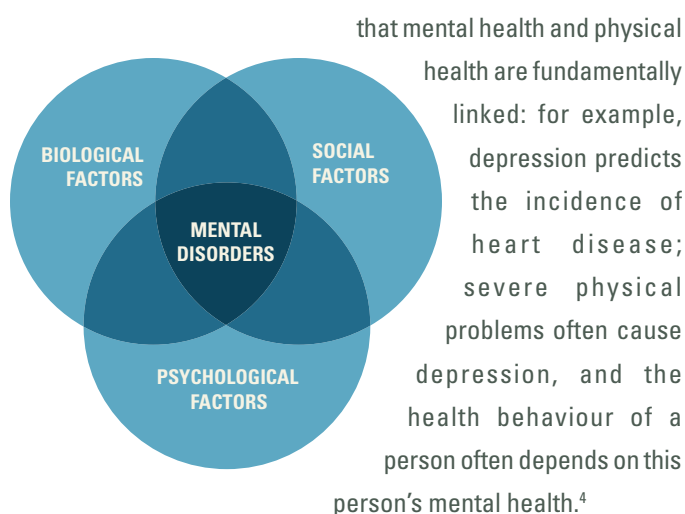
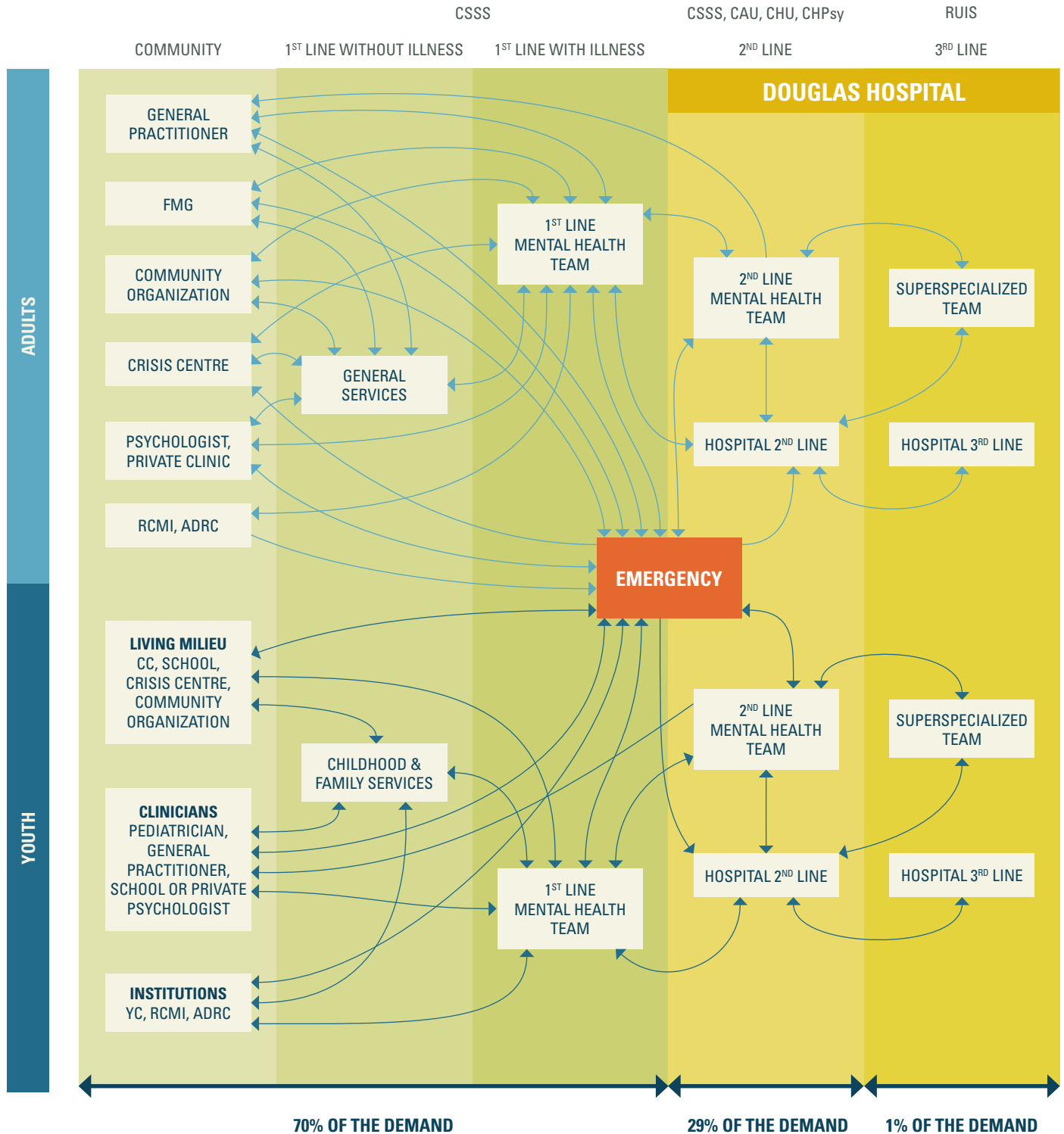


Figure 3: Interaction of biopsychosocial factors

4 The World Health Report 2001 – Mental Health: New Understanding, New Hope.

Figure 2: Path followed in the mental health-care system



ADRC: Alcohol and Drug Rehabilitation Centre
 CAU: Centre affili  universitaire (translated as University Affiliated Centre)
 CC: Childcare Centre
 CHPsy: Centre hospitalier de soins psychiatriques (translated as Psychiatric Care Hospital Centre)

CHU: Centre hospitalier universitaire (translated as University Hospital Centre)
 FMG: Family Medicine Group
 RCMi: Rehabilitation Centre for Mentally Impaired
 YC: Youth Centre

Prevalence of Mental Illnesses

Assessments of mental disorder prevalence vary from one study to another, based on the types of illnesses considered as well as on methodological factors, but all report a high prevalence. The WHO⁵, for example, reported in 2001 that more than 25% of the world population suffered from mental health problems at one time or another. A recent study conducted in the United States by Kessler et al. (June 2005)⁶, which measured the prevalence of a large number of non-psychotic disorders (anxiety and mood disorders, impulsivity disorders, alcohol and drug use), shows a much higher prevalence for the population under study: 46.4% lifetime prevalence and 26.2% for a 12-month period. The Study on the Mental Health of Montrealers (2003)⁷, conducted by the Montreal Public Health Department, which measures the prevalence of a smaller number of disorders than in the Kessler study, proposes that Montrealers have a 29% prevalence of mental disorders over their lifetime, while it is less than 11% for a 12-month period. The MHAP is based on an estimate of 15% for a 12-month period.

In accordance with the *National Comorbidity Survey* conducted in the United States in the early 90s, severe mental illnesses⁸ are found in approximately 2.6% of the population.⁹ The MHAP

uses this estimate when stating that between 2 and 3% of the population suffer from severe mental disorders.

Other than genetics and the conditions under which childhood took place, various factors influence the prevalence, onset and evolution of mental disorders such as poverty, age as well as sex, particularly in the case of suicide.

Poverty: People who perceive themselves as poor are particularly inclined to present disorders. Poverty and associated conditions (unemployment, low education, deprivation and homelessness) affect a sizeable segment of our society. A review of 15 studies¹⁰ found the median ratio for overall prevalence of mental disorders between the lowest and the highest socioeconomic categories was 2.1:1 for 12 months and 1.4:1 for lifetime prevalence (Kohn et al., 1998). Various studies conducted throughout the world (including North America) show similar results.¹¹ The number of homeless people suffering from mental illness is constantly increasing. A study conducted in Quebec in 1999¹² on this population showed a 12-month prevalence of 43.3% and a lifetime prevalence of 61% of Axis I¹³ disorders not linked to substance abuse.

Age: Kessler et al.¹⁴ (June 2005) showed that first onset of mental disorders occur before the age of 14 in 50% of cases and before the age of 24 in 75% of cases. The Study on the Mental Health

5 The World Health Report 2001 – Mental Health: New Understanding, New Hope.

6 Kessler, Ronald C, PhD; Wai Tat Chiu, AM; Olga Demler, MA, MS; Ellen E. Walters, MS (2005) - Prevalence, Severity, and Comorbidity of 12-Month DSM-IV Disorders in the National Comorbidity Survey Replication, *Arch Gen Psychiatry*/Vol 62, June 2005, pp. 617-627.

7 *Enquête sur la santé mentale des montréalais*, Département de santé publique de Montréal, 2003.

8 Schizophrenia; bipolar disorders; severe depression, obsessive-compulsive disorders and panic disorders; autism.

9 Kessler RC, Berglund PA, Zhao S et al. (1996), The 12-month prevalence and correlates of serious mental illness (SMI). In: *Mental Health, United States, 1996*, Manderscheid RW, Sonnenschein MA, eds. DHHS publication No. 96-3098. Washington, D.C.: U.S. Government Printing Office; cited in Torrey EF (2002), "Severe Psychiatric Disorders May Be Increasing", *Psychiatric Times*, April, XIX:4, <http://www.psychiatrytimes.com/p020401b.html>, Date of access: February 24, 2006.

10 The World Health Report 2001 – Mental Health: New Understanding, New Hope.

11 WHO International Consortium of Psychiatric Epidemiology 2000.

12 *L'Enquête auprès de la clientèle des ressources pour personnes itinérantes des régions de Montréal-Centre et de Québec, 1998-1999*, produced by l'Institut de la statistique du Québec.

13 DSM-IV (Diagnostic and Statistical Manual - Revision 4) is used to classify mental disorders. It is composed of five dimensions: Axis I: clinical syndromes; Axis II: developmental and personality disorders; Axis III: physical health; Axis IV: psychosocial and environmental stressors; Axis V: global functioning.

14 Kessler, Ronald C, PhD; Patricia Berglund, MBA; Olga Demler, MA, MS; Robert Jin, MA; Kathleen R. Merikangas, PhD; Ellen E. Walters, MS (2005) - Lifetime Prevalence and Age-of-Onset Distributions of DSM-IV Disorders in the National Comorbidity Survey Replication, *Arch Gen Psychiatry*/Vol 62, June 2005, pp. 593-602.

of Montrealers states that people between the age of 15 and 24 show the highest rates of people who perceive themselves to have average or poor mental health, while they are the ones least inclined to use services for their problems.¹⁵ People between the ages of 30 and 39 show the highest rate of people actually consulting for their mental health problems. We will come back later to the effects of delays or failure to seek help.

Sex: In Montreal, like Canada, the prevalence of mental illnesses is approximately the same for women as for men. However, women suffer more from affective and anxiety disorders while men suffer more from problems related to addiction. This is consistent with WHO data. However, the Study on the Mental Health of Montrealers shows that women are much more likely to seek help (11.3%) than men (6.6%), while, on the other hand, suicide is much higher in men than in women, with a ratio of 3.5:1.

Severity and Comorbidity: Approximately half of people suffering from a severe mental illness (schizophrenia, bipolar disorders) also suffer from addiction.¹⁶ Not only is comorbidity linked to severity of disorders, it also often jeopardizes compliance to treatment as well as successful outcome.

Failure or delay to seek help: A study by Wang et al.¹⁷ published in June 2005, concluded that failure to make prompt initial treatment contact is a pervasive aspect of unmet needs for mental health care in the United States. Further, the study states that interventions to speed initial treatment contact are likely to reduce the burdens and hazards of untreated mental

disorders. The authors have evaluated that the delay between first onset and initial treatment contact ranges from 6 to 8 years for mood disorders and 9 to 23 years for anxiety disorders. An evaluation performed by Statistics Canada¹⁸ reveals that only 32% of people suffering from mental illness or addiction have consulted a healthcare professional, while the MHAP proposes a rate of 50%. The Montreal Public Health Department data reveals that 15% of Montrealers reported having consulted during the past year. According to the evaluation of clinicians, 13% of Montrealers have a severe functional impairment and 7% are at risk. Overall, 18% of the population needs clinical intervention. However, only half seek treatment, whatever the nature of the disorder. We believe that various factors influence delays or failure to seek help as soon as possible after first onset, such as a lack of knowledge of what mental illness is and, of a more pernicious nature, discrimination, which persists in regards to mental illnesses and those who suffer from such problems.

Suicide: Montreal has the lowest suicide rate of the 18 health regions in Quebec (14.6 for 100,000 population), but the highest among all urban regions of Canada. Quebec has the highest suicide rate of Canada (19.9 for 100,000 population). The suicide mortality rate of Montrealers has increased over recent years. While approximately the same number of women and men have reported having had suicidal thoughts, the increase in the suicide rate mostly affects men, whose rate is 3.5 times higher than that of women. Men aged between 20 and 24 years of age and between 35 and 54 are most at risk.

Significant variations between the different study results stated above serve to confirm one very important requirement: to better evaluate our clientele and its needs. This is a priority of the MHAP, and a team grant, which should greatly contribute to improved knowledge, has recently been awarded to our researchers by the Canadian Institutes for Health Research. An objective of the present Strategic Plan deals with this specific issue.

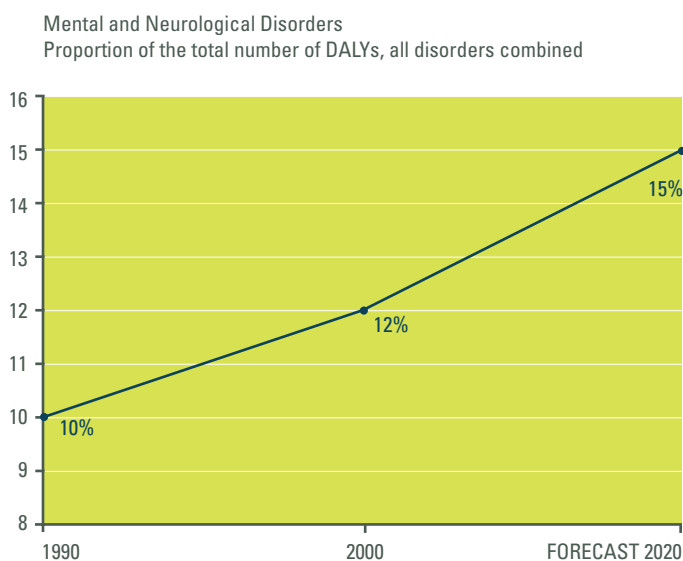
15 Canadian Community Health Survey 2003 (CCHS 2003) – Cycle 1.2 – Mental Health and Welfare – Statistics Canada.

16 Regier, D., et al., Comorbidity of mental disorders with alcohol and other drug abuse: Results from the Epidemiological Catchment Area (ECA) study. *Journal of the American Medical Association*, 1990. **264**: p. 2511-2518.

17 Wang, Philip S. MD, DrPH; Patricia Berglund, MBA; Mark Olsson, MD, MPH; Harold A. Pincus, MD; Kenneth B. Wells, MD, MPH; Ronald C. Kessler, PhD (2005) - Failure and Delay in Initial Treatment Contact After First Onset of Mental Disorders in the National Comorbidity Survey Replication, *Arch Gen Psychiatry*/Vol 62, June 2005, pp. 603-613.

18 Canadian Community Health Survey 2003 (CCHS 2003) – Cycle 1.2 – Mental Health and Welfare – Statistics Canada.

Chart 1: Evolution of burden



Burden of mental health on the individual and the family

Health burden has traditionally been measured only in terms of incidence/prevalence and mortality.¹⁹ While these indices are well suited to acute diseases, they are not suited to chronic and disabling diseases like most mental illnesses. This is the reason why two new indices have been used to evaluate the burden of these disorders: DALYs (disability adjusted life years) and YLDs (years of life lived with disability).^{20,21}

Chart 1 shows the extent of the mental health burden in the world. According to a recent study by Thornicroft and Tansella²², this

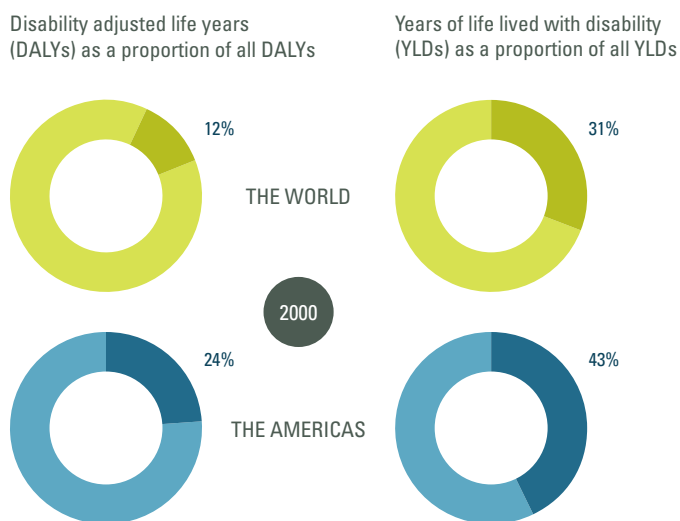
19 The World Health Report 2001 – Mental Health: New Understanding, New Hope.

20 DALYs for a disease are the sum of the years of life lost due to premature mortality (YLL) in the population and the years lost due to disability (YLD) for incident cases of the health condition. The DALY is a health gap measure that extends the concept of potential years of life lost due to premature death (PYLL) to include equivalent years of 'healthy' life lost in states of less than full health, broadly termed disability.

21 On the issue of DALYs and progress in evaluating the burden disease, see Murray CJL, Lopez AD (2000). Progress and directions in refining the global burden of disease approach: response to Williams. *Health Economics*, 9: 69-82.

22 Thornicroft, G.; Tansella, M.: What are the arguments for community-based mental health care? 2003.

Chart 2: Burden measured in DALYs and YLDs



burden is twice as great as that caused by cancer, no matter the type, and is higher than cardiovascular diseases. Chart 2 also shows that the burden is clearly higher, in proportion, for the Americas. According to the WHO, 5 of the 10 main causes of disability are linked to mental disorders.

Discrimination and prejudice

The WHO²³ proposes that one in four families is likely to have at least one member with a behavioural or mental disorder. These families not only provide physical and emotional support, but also bear the negative impact of stigma and discrimination. The United States Surgeon General's Report on Mental Health described the impact of stigma as follows: "Stigma erodes confidence that mental disorders are valid, treatable health conditions. It leads people to avoid socializing, employing or working with, or renting to, or living near, persons who have a mental disorder." Furthermore, "stigma deters the public from wanting to pay for care and, thus, reduces consumers' access to resources and opportunities for treatment and social services. A consequent inability or failure to obtain treatment reinforces destructive

23 The World Health Report 2001 – Mental Health: New Understanding, New Hope.

patterns of low self-esteem, isolation, and hopelessness. Stigma tragically deprives people of their dignity and interferes with their full participation in society.”

Stigma and discrimination are important causes of delays or failure to seek help when symptoms appear. To this, we can add the burden on families, ranging from economic difficulties to emotional reactions to the illness, the stress of coping with disturbed behaviour, disruption of household routine, and restriction of social activities. It is clear that mental disorders profoundly disrupt the lives of people who are ill and their families. A number of studies have reported on the quality of life of individuals with mental disorders, concluding that the negative impact is not only substantial, but sustained.²⁴ It has also been shown that quality of life continues to be poor even after recovery from mental disorders, as a result of social factors that include continued stigma and discrimination. Stigma is sometimes a greater obstacle than the illness itself. It is therefore crucial to promptly fight prejudice and discrimination in society.

TO IMPROVE THE ORGANIZATION OF SERVICES IN RESPONSE TO NEEDS

The MHSS has made a significant strategic choice, which shapes the overall measures taken in the MHAP and, to a large extent, this Strategic Plan. In fact, the priority given to readily accessible 1st line services to the entire population forms the basis of the MHAP. This choice should lead to less congested 2nd and 3rd line services for everyone needing these types of services. Second-line services provide specialized expertise. They must support 1st line services and treat people who cannot get adequate treatment at that level.

The Hospital catchment population for 2nd line services regroups more than 260,000 people and covers two CSSSs: the LaSalle and

Figure 4:
RUIS Territories

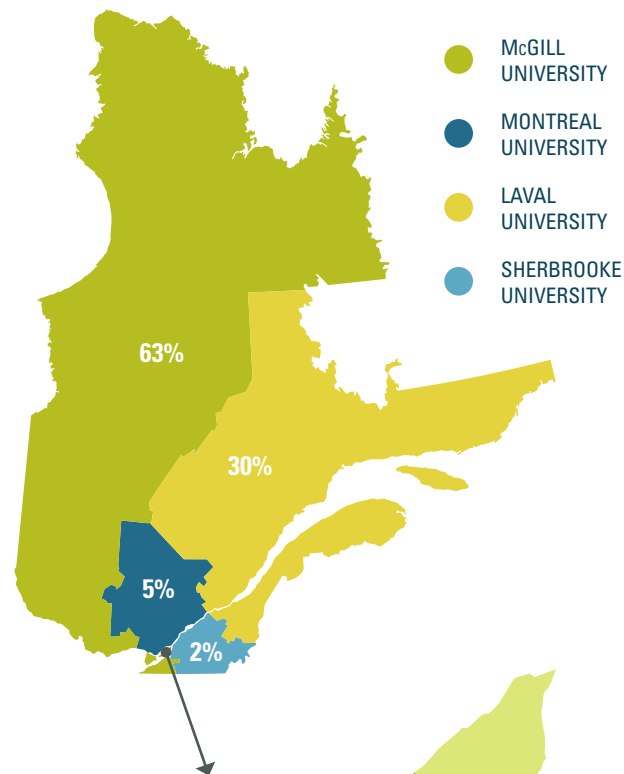


Figure 5: Montreal island health networks

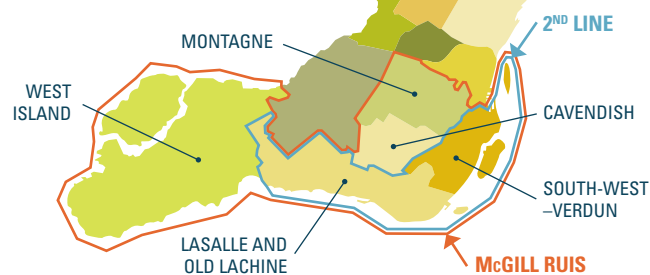
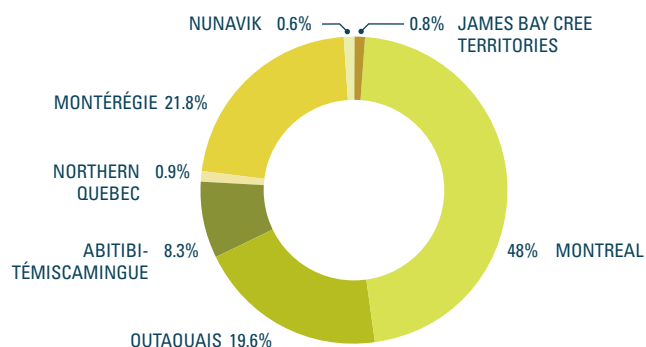


Chart 3:
Composition of McGill RUIS population



²⁴ UK700 Group (1999). Predictors of quality of life in people with severe mental illness. *British Journal of Psychiatry*, 175: 426–432.

TABLE 1: UNIVERSITY INTEGRATED HEALTH NETWORKS

TERRITORY	% of Quebec land surface	% of Quebec population	Population	Density pop/km ²
McGill U. RUIS	63.23%	22.76%	1,647,200	1.73
Laval U. RUIS	30.02%	23.43%	1,695,910	3.75
Montreal U. RUIS	5.15%	40.35%	2,920,080	37.62
Sherbrooke U. RUIS	1.60%	13.46%	974,220	40.44
Quebec	100.00%	100.00%	7,237,410	13.46

Table 1: Information on the four Quebec RUISs (data based on the 1996 census):

TABLE 2 POPULATION PROPORTION BY AGE GROUP – 2005 FORECASTED VARIATION OF POPULATION 2005-2010

	POPULATION		PROPORTION BY AGE GROUP – 2005			FORECASTED VARIATION OF POPULATION 2005-2010			
	2005 Estimate		0-17	18-64	65+	total	0-17	18-64	65+
CSSS 2	135,108		18.63%	64.83%	16.54%	2.30%	-1.93%	2.33%	6.94%
CSSS 3	137,214		18.51%	67.71%	13.78%	4.13%	2.18%	4.49%	5.00%
Montreal	1,882,561		19.02%	65.83%	15.15%	3.66%	1.66%	3.62%	6.39%
McGill RUIS	1,742,891		21.73%	65.41%	12.86%	3.34%	-3.64%	3.77%	12.92%
Quebec	7,566,409		20.31%	65.89%	13.80%	2.24%	-5.29%	1.93%	14.82%

Table 2: Details on the population, age-group distribution and the forecasted evolution of the population from 2005 to 2010.²⁵

Old Lachine CSSS (CSSS 2) and the South-West–Verdun CSSS (CSSS 3) (see areas circled in blue in Figure 5).

The Douglas also has a 3rd line mandate as a University Institute in mental health member of the McGill RUIS. For 3rd line services, the catchment population of the McGill RUIS totals 1.7 million people (23% of Quebec’s population) and covers 63% of Quebec’s territory (green section in Figure 4) including the western section of Montreal (area circled in red in Figure 5), as well as the regions of Outaouais, part of Montérégie, Abitibi-Témiscamingue, Northern Quebec, the James Bay Cree Territories, and Nunavik. In the Montreal region, the McGill RUIS regroups five of the 12 CSSSs. These count for close to 50% of Montreal’s population. Chart 3 shows the composition of the RUIS McGill population according to the regions served.

With the exception of the Abitibi-Témiscamingue region, the other regions which comprise the McGill RUIS are the ones with the highest concentration of English-speaking population. The Douglas Hospital is designated, in accordance with the Act, as an institution that provides services in English. In comparison with the entire Quebec population (where 82% of the population has French as a first language, and where 95% of the population

states knowing French), knowledge of French in the region of Montreal decreases to 86%. For the part of Montreal served by the McGill RUIS, this rate is still lower, at 80%, with only 44% naming French as the first official language spoken at home. (*Institut de la statistique du Québec, 2001*).

Table 3 provides certain characteristics of the 2nd line population. Data from our two CSSSs are compared to Montreal, to the province of Quebec and, in some cases, Montreal is compared to other large Canadian cities. One can note that the South-West–Verdun CSSS (CSSS3) is clearly disadvantaged.

Data from the Public Health Department, published in 2002, provides information on the prevalence of certain types of mental disorders for the different Montreal sub-regions (Table 4). The South-West region corresponds to the 2nd line territory served by Douglas Hospital while the West, South-West and part of the Centre-West regions correspond to the 3rd line Montreal territory served by the McGill RUIS.

25 Ministry of Health and Social Services web site – Statistics and Indicators – *Estimation de population selon le territoire de réseau local de services (RLS), le sexe et l’année d’âge, au 1er juillet, 2001 à 2026.*

TABLE 3: POPULATIONAL DATA

	CSSS 2	CSSS 3	Montreal	Quebec	Montreal compared to Calgary, Ottawa, Vancouver, Winnipeg and Toronto
Sociodemographic Data					
Density (habitants per Km ²)			3767.5	5.7	3 rd highest
Immigrants	20.0%	17.0%	28.0%		
Recent immigrants	3.0%	5.0%	6.0%		
Single parent families among families with children	33.3%	42.4%	33.0%	24.1%	highest
Socioeconomic Data					
Population 20 years and over without a highschool diploma	29.7%	32.8%	26.5%	22.0%	2 nd lowest
Social assistance rate	10.4%	21.3%	12.4%	7.3%	
Unemployment rate	7.6%	9.7%	9.2%	9.2%	highest
Below the low income threshold	23.3%	36.0%	28.7%	23.4%	highest
Median revenue of private households (*approximation)	\$39,365 *	\$31,708 *	\$35,910	\$40,468	
Data on Youths					
Youth victimization rate	2.1%	4.1%	2.1%		
Youth acting-out rate	1.5%	2.4%	1.4%		
Pregnancies in adolescents	2.9%	4.3%	2.8%	2.0%	
Juvenile delinquency rate	7.7%	10.1%	6.1%	6.0%	
Health and Social Related Data					
Intense stress (18 years and over)			30.6%	30.1%	highest (Canada: 26.1%)
Consultation - mental health professionals			9.0%		4 th rank
Hospitalizations for mental health issues	4.05%	4.95%	5.14%		
Mortality rate linked to suicide per 100,000	10.0	20.0	15.0	19.9	highest of Canadian large cities, but lowest of Quebec regions
Rate of avoidable mortality per 100,000	71.0	81.0	63.0		

TABLE 4: PREVALENCE OF CERTAIN TYPES OF DISORDERS

TYPES OF DISORDERS	Sub-regions of Montreal					
	West	North	South-West	Centre-West	Centre-East	East
Unspecified Mental Disorder (n=4234)						
Lifetime ¹	23.2%	22.8%	32.9%	28.1%	35.5%	30.9%
Last 12 months	* 9.8%	9.3%	10.2%	11.0%	14.5%	10.9%
Anxiety Disorders (n=4430)						
Lifetime ¹	11.4%	11.4%	16.4%	10.9%	14.5%	15.3%
Last 12 months	* 6.2%	* 5.4%	* 7.1%	* 5.5%	* 6.3%	6.1%
Mood Disorders (n=4330)						
Lifetime ¹	14.3%	13.3%	22.0%	18.5%	23.1%	19.9%
Last 12 months	** 3.9%	* 3.9%	* 4.7%	* 5.3%	* 6.5%	5.8%
Addiction Disorders (n=4234)						
Lifetime ¹	* 6.5%	* 6.1%	10.4%	7.3%	13.8%	7.9%
Last 12 months	** 1.4%	** 1.8%	** 3.1%	** 2.5%	* 6.8%	* 2.2%
Comorbidity						
Lifetime (n=1346)	37.6%	37.5%	46.8%	31.0%	39.5%	38.3%
Last 12 months (n=533)	** 25.0%	* 30.4%	* 34.1%	* 26.2%	* 33.8%	* 28.1%

* Variation coefficient between 15 and 25; to be interpreted with caution.

** Variation coefficient higher than 25%; imprecise estimate provided as an indication only.

¹ p < 0,001.



Organization of Services According to Needs

To respond to its clientele’s needs and those of its partners, the Hospital provides a variety of specialized and superspecialized services.

The Hospital’s clinical organization, being based on age groupings, is well adapted to the MHAP and better suited to the clientele’s needs, because partners and collaborators involved in networks sometimes differ significantly from one age group to another. Different specialized and superspecialized clinical programs can be found in each age group (Figure 6).

The Hospital has successfully conducted a significant shift to ambulatory care, as shown in Chart 4. Changes we have implemented in the last few years are consistent with the MHAP, but must increase even more in the next few years. In fact, we will witness a transfer to 1st line services. We should also note a significant shift in 2nd line service delivery. The 2nd line should focus increasingly on a shared care model in support of 1st line services, in order to reduce as much as possible the demand for 2nd line services. Finally, as already mentioned, this shift will be most significant to our role as a University Institute in mental health member of the McGill RUIS. This should translate into an investment level increase in 3rd line services, in support of our vision: **Recovery Through the Integration of Care, Teaching and Research – From Neighbourhood to Neuron.**

Chart 4 eloquently demonstrates the extent to which we have implemented the shift to ambulatory care. It shows how mental healthcare delivery has evolved through history, especially in recent years, when the out-patient population has more than doubled.

Figure 6:
Integrated Organization

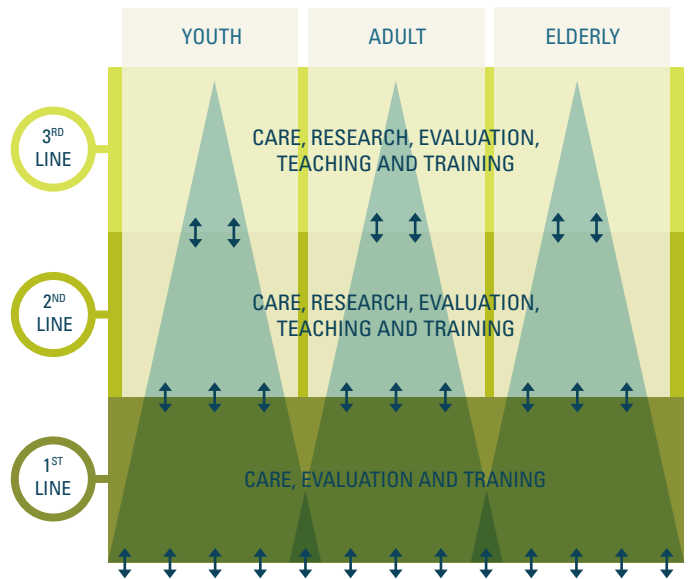
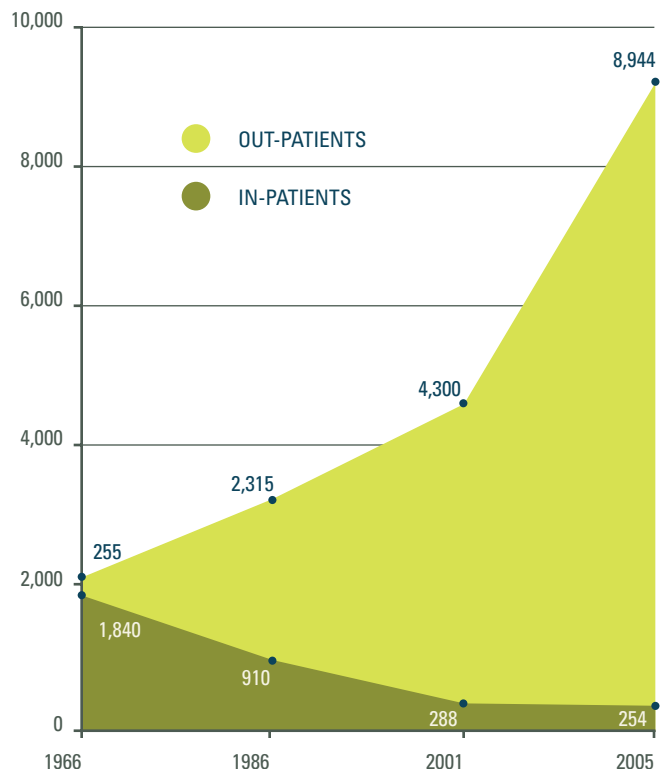


Chart 4:
Progression of in-patient and out-patient population





TO CREATE A WORKING MILIEU THAT IS STIMULATING AND SENSITIVE TO THE NEEDS OF HUMAN RESOURCES IN A CHANGING ENVIRONMENT

The healthcare system reform, implemented by the Ministry of Health and Social

Services, includes several measures amending the organization of labour to allow for increased latitude in the management of human resources adapted to a more current philosophy where flexibility, mobility and interdisciplinarity are valued. The Strategic Plan, based on the MHAP and the healthcare system reform, announces a shift in human resource organization.

As is commonly known, the Quebec health network and the Canadian health network are experiencing a significant shortage of healthcare professionals. Furthermore, recent national studies on different types of work environments have shown that healthcare professionals are the ones who have given the lowest marks in regards to their working climate.

These challenges are even more significant because the sole technology in the field of mental health is its human resources. Organizational changes and those announced in the MHAP, budget constraints and performance requirements are all different types of pressures, which are accumulating and which we need to address. It is therefore essential to support our human resources by improving our response to and management of change, as

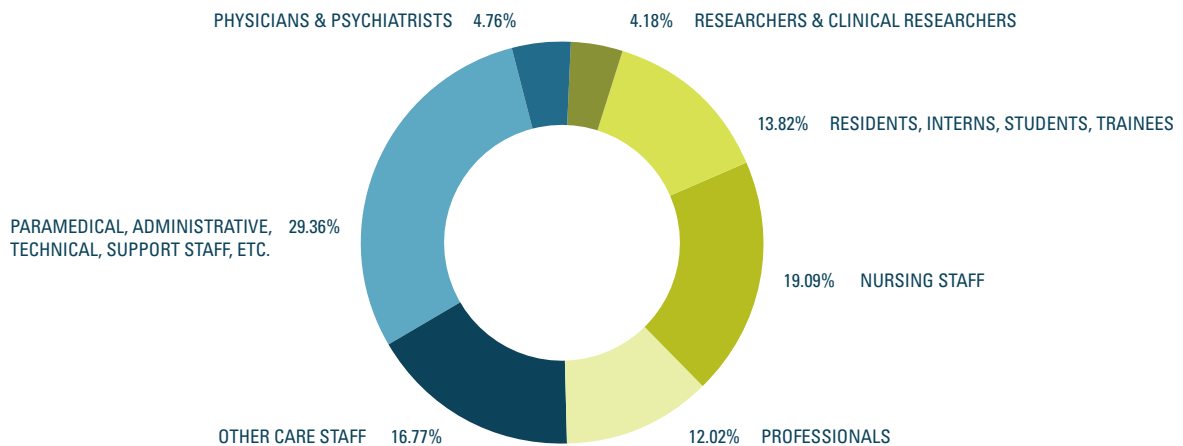
well as the quality of the working environment, in order to have a climate that is healthier and conducive to learning, innovation and excellence. Our commitment is reflected in these pledges: “Be a learning organization that inspires pride and a sense of belonging” and “Be an interdisciplinary environment that stimulates partnership and knowledge exchange”.

Considerable efforts have already been invested, which have resulted in a significant reduction in absenteeism and in a safer and more enjoyable environment. A study on interdisciplinary team functioning was conducted jointly by the three councils²⁶, a first in Quebec. Results from this study made it possible to identify excellent avenues for improving team functioning, as they clearly reveal the most significant factors influencing team work: 1) Definition of, understanding of, and commitment to, objectives, and 2) Shared decision-making process.

These efforts not only need to be maintained, but increased, to support our human resources in times of change, and to create a stimulating environment conducive to achieving our objectives and our vision: **Recovery Through the Integration of Care, Teaching and Research – From Neighbourhood to Neuron.**

²⁶ Council of Physicians, Dentists and Pharmacists; Council of Nurses; Multidisciplinary Council.

Chart 5: Human Resources Distribution



TO OPTIMISE SCIENTIFIC AND ACADEMIC ALIGNMENT AND INTEGRATION

The Douglas Hospital Research Centre has developed through the years by building and strengthening innovative research programs based on new scientific, clinical and psychosocial approaches in the field of mental health. The Centre distinguishes itself, based on the performance of its scientific team, which has succeeded, in the past five years, in doubling the number of grants obtained from granting agencies, training numerous students at different academic levels, and producing hundreds of articles and book chapters. Several overhead financial grants (Canadian Fund for Innovation (CFI) and *Programme d'appui au financement des infrastructures*²⁷ (PAFI) etc.) have also been secured, thereby allowing the implementation of state-of-the-art laboratories in line with researchers needs. The Centre was identified as a Model Centre by the *Fonds de recherche en santé du Québec*²⁸ (FRSQ).

Significant challenges lie ahead in coming years. We have to continue the development of our mental health research by strengthening our links with community needs, in order to, on the one hand, better understand family, socioeconomic and environmental factors influencing the functioning of the brain and the onset of mental illness and, on the other hand, contribute to knowledge exchange with community caregivers.

Our goals are consistent with the McGill University strategic plan and the FRSQ, which give priority to a multidisciplinary approach, closer links with community activities, the further development of neurosciences, and their relevance to mental health.

Our Strategic Plan aims to consolidate links with the Montreal WHO Collaborating Centre for Research and Training in Mental Health, based at the Douglas Hospital Research Centre. It is one of three WHO collaborating centres in mental health in Canada.

27 Could be translated as Overhead Financing Support Program

28 Could be translated as Quebec Health Research Fund

WHO COLLABORATING CENTRE - Added Value:

KNOW that, as a collaborating centre, our organization is recognized as a centre of excellence in mental health at the national and international levels.

CONDUCT watchover activities related to models and approaches linked to WHO priorities.

EVALUATE the extent to which our participation in the collaborating centres network allows us to keep regular contacts with internationally-renowned mental health actors and research leaders.

BENEFIT from contacts resulting from our membership in the collaborating centres network to enrich our own knowledge and practices.

REALIZE that, because of the technical help we provide to developing countries, including help in formulating mental health policies, we make a tangible contribution to improving the mental health of their populations.

NOTE the significant level of knowledge transfer taking place in our training programs.

Together with other members of the global mental health community, the Centre promotes sound mental health policies to help 450 million people worldwide suffering from mental, neurological or behavioural problems. The challenge is to increase the visibility of our areas of excellence at the international level, namely through the WHO, and to involve a greater number of researchers and qualified people in WHO Collaborating Centre programs.

Teaching and training also constitute a strategic field of activities. In fact, 75% of new professionals have been recruited at the Hospital through our teaching and training programs. This is clearly a very productive investment, not only in the short term, but also in the long term as these candidates show a very high retention rate. Efforts invested in this area have allowed us to significantly increase the number of students, trainees, and residents, while also developing our continued education programs. We have therefore not only invested in the development of new recruits, but also in our current human resources who, as we have already mentioned, constitute a strategic strength. We are also proud of the training programs provided in the Research Centre to students at the PhD, MD and post-graduate levels that attract, thanks to our affiliation with McGill University and the WHO, trainees from all over the world.

TO IMPROVE RESOURCE UTILIZATION

The coming years will see significant changes in resource utilization to keep in line with the hierarchical health system. These changes will involve a transfer of resources, both human and financial, evaluated at approximately 15 to 25% from 2nd line services to 1st line services. This will allow 1st line services to cover 70% of the demand for services. There will also be a reorganization of 2nd line services in order a) to support 1st line services and b) to cover 29% of the demand for services. Finally, changes will also imply an improved integration of clinical, academic and scientific activities in 3rd line services to cover 1% of the demand for services. As a University Institute in mental health, member of the McGill RUIS, we will be the driving force for innovation and for sharing new knowledge and new practices.

Financial Resources

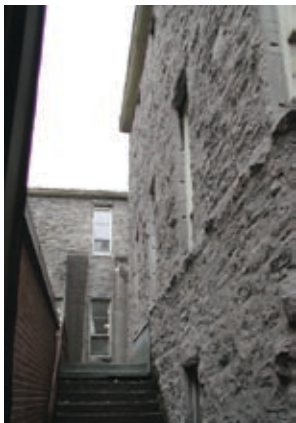
As we have already seen, our human resources constitute our most important resource. It is therefore not surprising to note that human resource costs cover 72% of the Hospital's budget and 63% of the Research Centre's budget.

Chart 7 shows how funds are currently used. Once the MHAP and the Strategic Plan are fully implemented, this distribution will have changed significantly. In fact, as previously mentioned, these two plans call for a significant shift in the use of resources. Firstly, resources used for 1st line services should be transferred, in addition to part of our residential resources. Secondly, research, teaching and training budgets should increase, as well as budgets allocated to 3rd line services, to be identified by the MHSS upon recommendation by the McGill RUIS. With regard to the portion "Others", which includes all paramedical, technical, technological and clinical support, and administrative services, should also be reduced, but remain relatively stable in proportion to the global budget.

It is well known that the health network is plagued with a significant shortage of resources, which is impossible to cover through an increase in taxpayer contributions. Adding to this is the fact that mental health is an area where prejudice and stigma is strong and where, therefore, it is harder to attract philanthropic commitments. These challenges have not hindered the efforts invested by the **Douglas Hospital Foundation**, which is an essential strategic partner in achieving our goals to improve care and to further develop research in mental health. Because of the inspiring generosity of our donors, we have been able to raise \$2.1 million in 2004-2005 in support of the Douglas Hospital and mental health. The Foundation can count on several corporate and individual donors, as well as on the support of the organization's human resources, whose contributions have shown a marked increase through the recently implemented Family Campaign.



Figure 7: Illustration of the geographically-dispersed layout



Physical Environment

The Douglas celebrates its 125th anniversary in 2006, and 60% of its buildings have been erected before 1940. Our structures are old and need major maintenance and repairs. Several buildings need to be renovated or even rebuilt.

Geographical dispersion also represents a significant challenge at several levels: it causes higher overhead costs (heating, housekeeping, technological overhead etc.) and it also causes communication difficulties between the different elements of the organization. The decentralized organizational structure, coupled with the significant geographical dispersion (Figure 7), creates a feeling of isolation and this situation hinders our attempts to improve our collective sense of belonging. Modern mental healthcare requires modern buildings and equipment.

As we cannot count exclusively on public financing or on the generous contributions of Douglas Hospital Foundation donors, who are already investing tremendously in support of the Hospital and the Research Centre, we are exploring the possibility of using our excess land to cover part of the costs needed to build a modern University Institute in mental health.

This objective not only aims to improve the physical environment and to reduce overhead costs, but mainly to improve care and critical synergies needed to achieve our goals of excellence.

Informational and Technological Resources

One of the fastest growing areas at the Douglas in recent years is, without a doubt, our informational resources and communications technologies. Our geographical dispersion requires that we implement systems to allow us to improve communications amongst ourselves and with our partners. Furthermore, our role as a University Institute in mental health within the McGill RUIS network calls for our organization to play

a major role in providing services to a population covering 63% of Quebec's territory. Hence, we are actively taking part in various telehealth projects such as teleconferencing, teleconsultation, telemedicine and others. Technologies and information exchange are therefore called on to play a predominant role in an integrated network vision of services. Furthermore, our commitment to "Be passionate in seeking excellence and quality" and "Focus on outcomes in moving towards evidence-based practices"

requires that our information systems be aligned with our goals. Balanced scoreboards have been developed in collaboration with caregivers, and several performance measures are now produced for the board of directors, senior managers and managers, in pursuit of continued quality improvement. This information is helpful in setting priorities, as well as in identifying development opportunities in a context of resource shortage and rationalization.

Chart 6:
Sources of financing - 2004-2005 Budget

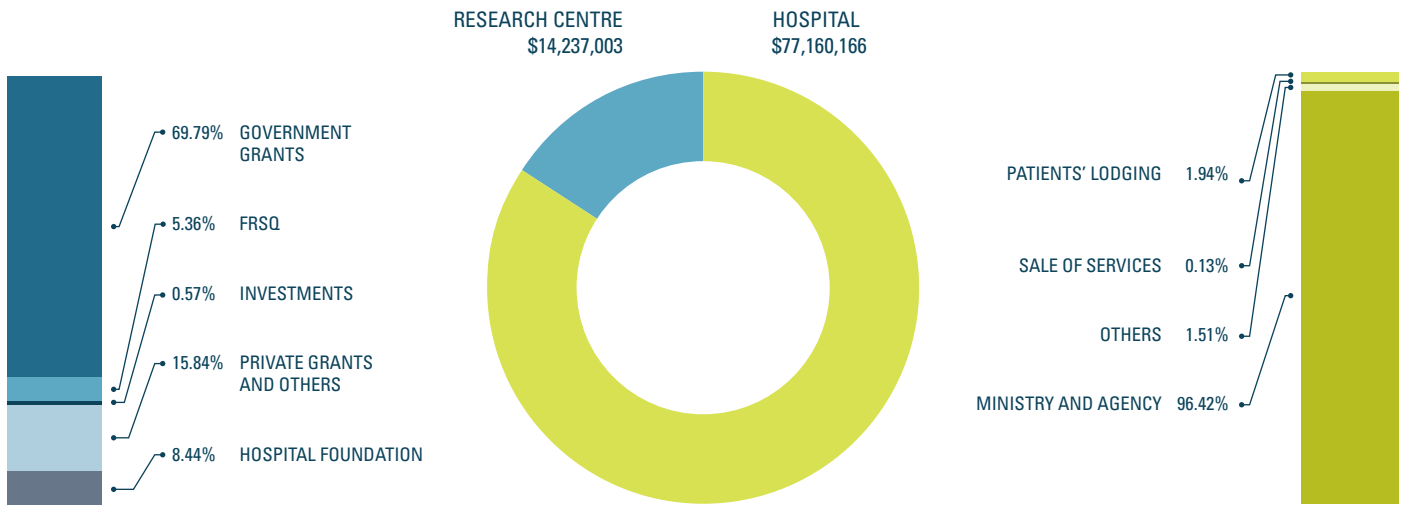
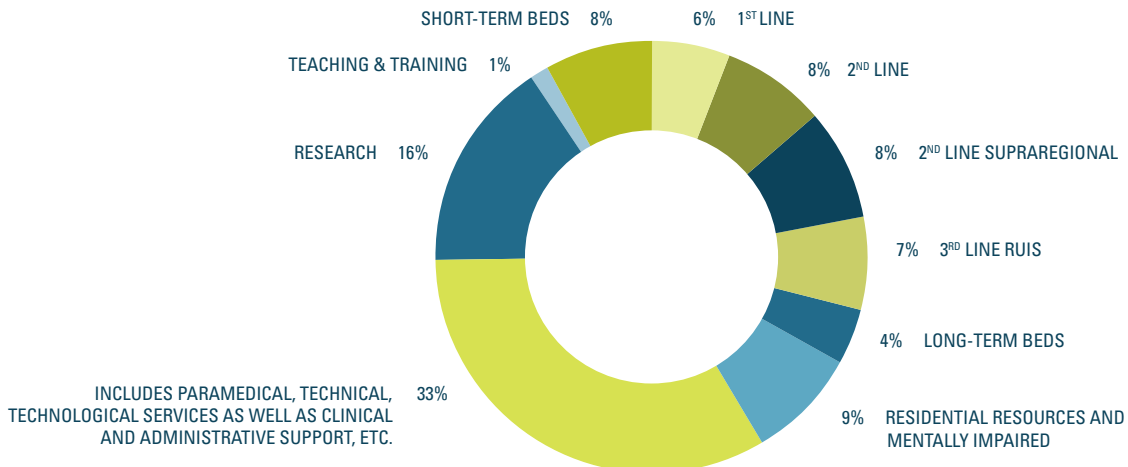


Chart 7:
2004-2005 Budget Utilization



INTRODUCTION

THE DOUGLAS - AN OVERVIEW

WHY CHANGE?

HOW TO CHANGE?

APPENDICES



.03

HOW TO CHANGE?

THE 2006-2010 STRATEGIC PLAN

As shown throughout the document, the Douglas is evolving in an extremely complex and turbulent environment. This situation makes it essential for us to have a clear and careful plan, which will allow each member of the organization to know where we are going and why.

The 2006-2010 Strategic Plan is the result of a very stimulating and enriching wide consultation, conducted with patients, their families and friends, caregivers, and our partners in the clinical, scientific and academic networks at the local, regional and provincial levels.

The Plan will be used to guide our decisions for the next four years and to better focus our efforts in resource utilization in accordance with chosen strategic directions and their underlying objectives to achieve our vision: **Recovery Through the Integration of Care, Teaching and Research — From Neighbourhood to Neuron**. This vision calls for the involvement of all components of society, the healthcare system, as well as the scientific and academic networks, and calls for the cooperation of all stakeholders.

As the plan is set at the strategic level, it is limited to strategic directions and objectives. The Hospital, Foundation and Research Centre, together with the WHO Collaborating Centre, will each develop a specific annual action plan in order to implement the 2006-2010 Strategic Plan. These action plans will include more specific goals and measures linked with these objectives.

Strategic objectives identified in the Plan are SMART objectives:

- ▶ **Specific:** Must be clearly defined.
- ▶ **Measurable:** In order to know if objectives are achieved, they must be measurable.
- ▶ **Accepted/Aligned:** They must be accepted by stakeholders, teams, the organization, clients, etc. and must be aligned with the vision and mission.

- ▶ **Realistic:** In order to ensure that objectives are achievable, they must be realistic. If they are set too high they will be demotivating because they are impossible to achieve. If they are too low, they do not lead to excellence.
- ▶ **Time Bound:** Objectives require a deadline. In the present case, it is set at March 31, 2010. However, annual action plans will be used to identify a time schedule for services, programs and directorates to implement identified priorities.

This will allow us to objectively measure how objectives are achieved throughout the time period covered by the Strategic Plan.



VISION

RECOVERY THROUGH THE INTEGRATION OF CARE, TEACHING AND RESEARCH – FROM NEIGHBOURHOOD TO NEURON.

Recovery

The recovery approach first arose in the United States as part of the civil rights and consumer survivor movements. It was developed to help people with serious psychiatric problems manage their own illness, contribute to society, and have meaningful lives, despite ongoing disabilities or symptoms. Great emphasis is placed on the rights of individuals to make meaningful choices and on encouraging society's support of their goals. The approach also stresses that, with today's improved medication and better treatment approaches, recovery is possible—a fact supported in the scientific literature.

Through increased emphasis on rights and responsibilities, recovery transforms the way affected people view themselves and how their mental health services are delivered.

Essentially, recovery is everyone's business. It encompasses every aspect of our lives, from neighbourhood to neuron.

Integration of Care, Teaching and Research

We believe that the best outcomes can only be achieved through the integration of care, teaching and research, as well as through partnerships with clinical, academic, scientific and community partners. We can only achieve our objectives by working together.

Our vision calls for collaboration and knowledge sharing because integration brings better results than what the sum of individual parts could hope to attain.

From Neighbourhood to Neuron

From Neighbourhood to Neuron means that:



Community needs guide research initiatives;



Research must lead to improved knowledge of factors influencing mental disorders, as well as newer and more efficient diagnostic and treatment tools;



Reorganization in healthcare delivery and research into best practices must serve to improve training programs;



To eliminate stigma and prejudice, these initiatives must serve to keep the population better informed; so that



People suffering from mental disorders will actively seek out help and be better accepted in their own environment;



Together, these initiatives can increase the potential for recovery and reaching one's full potential.



VALUES AND COMMITMENTS

Our values and commitments represent our ticket to success. They reflect our developing organizational culture and are witness to our willingness to implement the shift announced in this Plan by building on a stimulating work environment, which is sensitive to the needs of our clientele and our human resources.

Values and commitments also constitute a crucial element in the organizational fabric because they guide our choices in recruitment strategies. They therefore allow us to closely link our recruitment efforts to the organizational vision, in order to optimize outcomes in retention and objective achievements.

VALUES

The Douglas values **excellence** and **innovation**, based on **commitment, collaboration** and **education**.

- ▶ **Excellence:** To apply best practices with rigor.
- ▶ **Innovation:** To be a stimulating and dynamic environment, where new knowledge is developed to improve understanding and care.
- ▶ **Commitment:** To be dedicated to achieving our mission.
- ▶ **Collaboration:** To work within interdisciplinary teams, and with internal, community, university, and international partners.
- ▶ **Education:** To be a learning organization that values its human resources and evolves through knowledge exchange and continued education.

COMMITMENTS

The Douglas is committed to:

- ▶ Be a learning organization that inspires pride and a sense of belonging;
- ▶ Be passionate in seeking excellence and quality;
- ▶ Focus on outcomes in moving towards evidence-based practices;
- ▶ Inspire new ideas and innovation to improve care and services;
- ▶ Be an interdisciplinary environment that stimulates partnership and knowledge exchange;
- ▶ Improve the mental health of populations through developing international projects;
- ▶ Fight discrimination against people suffering from mental illness.



MISSION

A University Institute in mental health, the Douglas is affiliated with McGill University and the World Health Organization. It is an international leader in care, research and teaching in mental health. A centre of excellence, it:

- ▶ Provides specialized and superspecialized services within a continuum of care, together with first-line partners;
- ▶ Contributes to destigmatizing mental illness, in keeping with prevention and recovery principles;
- ▶ Contributes to the advancement of knowledge and best practices through state-of-the-art research and teaching.

It is renowned for innovation, multiculturalism and bilingualism. The Hospital reflects humanism and openness, and can count on solid philanthropic support. Founded by the Montreal community, it has a proud collaborative tradition with numerous partners.

MANDATE

As a University Institute in mental health, the Douglas has a triple mandate to **care**, **discover** and **teach** within a knowledge exchange environment:

Care

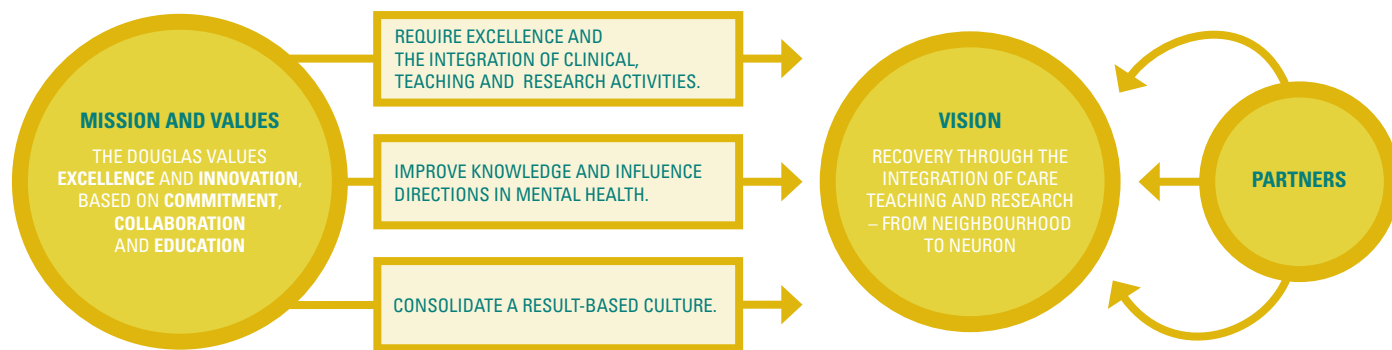
Our interdisciplinary teams provide services to all age groups. Specialized and superspecialized services are provided for the population of the entire McGill University network and to Health and Social Services Centres of South-West—Verdun and of LaSalle and Old Lachine.

Discover

Our scientists are dedicated to discovering better treatments and the causes of mental disorders – whether their cause is genetic, environmental, cultural, social or psychological in nature. We contribute to the advancement of knowledge on the functioning of the brain, the organization of service delivery, developing diagnostic tools, treatment and technology evaluation, and identifying prevention methods.

Teach

Affiliated with McGill University and other teaching institutions, we train new recruits and provide a state-of-the-art mental health curriculum for all professional disciplines involved. We also contribute to progress in best practices by consolidating training programs, which also support 1st line services.



STRATEGIC DIRECTIONS AND OBJECTIVES

As we have already mentioned, needs are not only changing, they are increasing, while resources, on the other hand, do not follow the same path. The network within which we are evolving is complex and in turmoil. It is therefore important to focus our efforts on a clear and shared vision.

The MHAP introduces a new organizational model for service delivery in order to optimise resource utilization, as well as outcomes. As for McGill University, it also identifies, in its White Paper, specific priorities for academic and scientific development for its future. The 2006-2010 Strategic Plan is consistent with this vision and serves to clarify the role that the Douglas intends to play as a centre of excellence and a University Institute in mental health, as part of the McGill University RUIS.

The 2006-2010 Strategic Plan is the result of a comprehensive consultation and validation process. The Douglas can therefore clearly identify its strategic directions for the next four years. They clarify our role in a network of services that is improved through the integration of research and teaching. Our strategic directions are based on our expertise and on collaboration and partnership.

Our strategic directions also testify to our commitment to achieve our vision:

Recovery Through the Integration of Care, Teaching and Research – From Neighbourhood to Neuron.

and we propose to focus our efforts on three strategic directions:

- 1. Require excellence and the integration of clinical, teaching and research activities:** This integrative approach is in line with the learning organization, interdisciplinarity, continued improvement and search for excellence philosophy. It calls for a renewed synergy.
- 2. Improve knowledge and influence directions in mental health:** Destigmatization and partnerships within Quebec, Canada, and international partners underlie this strategic direction, which is based on the leadership of the members of our organization. To improve and share knowledge with our clinical, scientific and academic partners, as well as with patients, their families and friends, and the public, should progressively decrease prejudice and stigma, and allow people living with mental illness to develop in a more welcoming environment. This should allow them to ask for help without delay, lead to empowerment and increase chances for reaching a full potential in the community.
- 3. Consolidate a result-based culture:** This strategic direction calls for excellence and rigor in order to achieve identified goals within a context of resource rationalization.

These strategic directions and objectives will guide our decisions in coming years. They will guide our choices in relation to development, reorganization and resource allocation.

1. REQUIRE EXCELLENCE AND THE INTEGRATION OF CLINICAL, TEACHING AND RESEARCH ACTIVITIES

This strategic direction aims to improve quality in all fields of activities in a continued search for excellence. First, it aims to ensure that our services address population needs by closely monitoring the evolution of the clientele and the health network. As we showed in the section dealing with prevalence of mental illnesses, data available on clientele and their needs are often conflicting and need to be improved. It is in response to this need that one of our objectives proposes an epidemiological approach.

Excellence is also a result of recruiting and retaining qualified people committed to our triple mandate of care, teaching and research. Human resources represent the strategic hub of the organization. A modern working environment that is stimulating and responsive to needs is therefore essential in the drastically changing environment that lies ahead. It represents a critical success factor of the present Strategic Plan. We want the Douglas to be a preferred environment in which to work and learn, and to stimulate cooperation and interdisciplinarity.

This strategic direction of excellence is based on applying best practices at all levels of the organization, as well as on raising team performance requirements in terms of integrating the triple mandate, publications, quality and outcomes.

As mentioned previously, our teaching and training activities represent a key strategy in recruiting and retaining qualified candidates both for the Hospital and the Research Centre. Accordingly, one of our objectives aims to raise requirements dealing with training and teaching activities. This objective also aims to expand our partnership network as well as to increase our scope of influence at the international level by increasing training and reference activities through the Montreal WHO Collaborating Centre, which is a key partner in achieving our vision.

Another critical success factor is based on partnership and collaboration. Three objectives of this strategic direction specifically address this key issue. The first one aims to increase knowledge transfer activities to improve synergies

and integration of our triple mandate. The second one is in line with priorities identified by McGill University and specifically addresses academic and scientific partnerships in response to highly specific and specialized needs. The third and last, but not least, objective also represents a critical success factor. In fact, the unconditional support of the Foundation, a strategic partner of both the Hospital and the Research Centre, represents a guarantee of success for this 2006-2010 Strategic Plan.

Hence, here are the objectives stemming from the strategic direction to **require excellence and the integration of clinical, teaching and research activities:**

- 1.a Based on an epidemiological approach, increase population needs indicators by 50%, to improve knowledge of our clientele.
- 1.b Recruit and achieve an 85% retention rate of candidates who adhere to our triple mandate and demonstrate qualities of excellence and innovation.
- 1.c Ensure that 100% of our care models are based on best practices.
- 1.d Increase, by at least 20%, the number of integrated services, in accordance with our triple mandate.
- 1.e Increase by 15% the number of Hospital and Research Centre publications in renowned journals.
- 1.f Increase by 15% the number of students and trainees in the Hospital and the Research Centre, including those recruited through the Montreal WHO Collaborating Centre.
- 1.g Increase by 25% activities related to knowledge transfer aimed at integrating care, teaching and research.
- 1.h Consolidate partnership links with McGill University and other clinical collaborators through a 20% increase in researchers belonging to more than one department and the development of joint research projects.
- 1.i Draft a physical master plan, reflecting our vision of a modern mental health institution integrating care, teaching and research.
- 1.j Increase philanthropic revenues by 50% to support organizational strategic objectives.

2. IMPROVE KNOWLEDGE AND INFLUENCE DIRECTIONS IN MENTAL HEALTH

As previously mentioned, this strategic direction is in line with our efforts to fight stigma and improve partnerships. It is based on our proven leadership as a University Institute in mental health, as well as on our recognition as a centre of excellence. Our expertise and leadership will allow us to influence and even change public perceptions with regard to mental illness and those who suffer from such disorders. In fact, as stated by the United States Surgeon General, “It has also been shown that quality of life continues to be poor, even after recovery from mental disorders, as a result of social factors that include continued stigma and discrimination. Stigma is sometimes a greater obstacle than the illness itself. It is therefore crucial to promptly fight prejudice and discrimination in society.”²⁹

In its World Health Report, the WHO recommends that “Public education and awareness campaigns on mental health should be launched in all countries. The main goal is to reduce barriers to treatment and care by increasing awareness of the frequency of mental disorders, their treatability, the recovery process and the human rights of people with mental disorders. The care choices available and their benefits should be widely disseminated so that responses from the general population, professionals, media, policy-makers and politicians reflect the best available knowledge. This is already a priority for a number of countries, and national and international organizations. Well-planned public awareness and education campaigns can reduce stigma and discrimination, increase the use of mental health services, and bring mental and physical healthcare closer to each other.”

As our expertise becomes increasingly recognized and our scope of influence expands, our opportunities to influence authorities also increase. This strategic direction is linked to development priorities identified by McGill University and the *Fonds de recherche en santé du Québec* (FRSQ) and therefore aims to consolidate our expertise, not only through excellence,

but also through innovation, new discoveries, the sharing of new knowledge at the local, national or international level, and new technologies, to make this improved knowledge accessible to the largest public possible. The Douglas can also count on a strategic partner in this effort. The Montreal WHO Collaborating Centre fully supports this strategic direction and has committed itself to contribute to the international scope of influence of the Hospital and the Research Centre.

It is therefore with this goal in mind that we propose the following objectives to **improve knowledge and influence directions in mental health**:

- 2.a Increase by 25% knowledge transfer activities with our partners in order to consolidate first-line services.
- 2.b Increase, by at least 25%, the visibility of specialized clinical services through publications in renowned journals, and presentations at national and international conferences.
- 2.c Increase, by at least 25%, our clinical, academic and scientific activities generating best practices.
- 2.d Pursue program development in the four research themes in order to reach a total of 45 principal investigators.
- 2.e Increase, by at least 25%, our multidisciplinary research projects and exchange of expertise and knowledge.
- 2.f Create a mental health public education program for the McGill RUIS population using new communication technologies such as the Internet and Telehealth.
- 2.g Develop a reference mental health web site in collaboration with McGill RUIS and other partners.
- 2.h Increase by 15% active participation by members of our organization on decision-making committees at various government levels.
- 2.i Increase by 25% recognition of the Douglas Hospital and requests for expertise by the media.

²⁹ Mental Health: A Report of the Surgeon General, 1999, United States Surgeon General, chap. 1, “Overarching Themes”, “The Roots of Stigma” see: http://www.surgeongeneral.gov/library/mentalhealth/chapter1/sec1.html#roots_stigma.

3. CONSOLIDATE A RESULT-BASED CULTURE

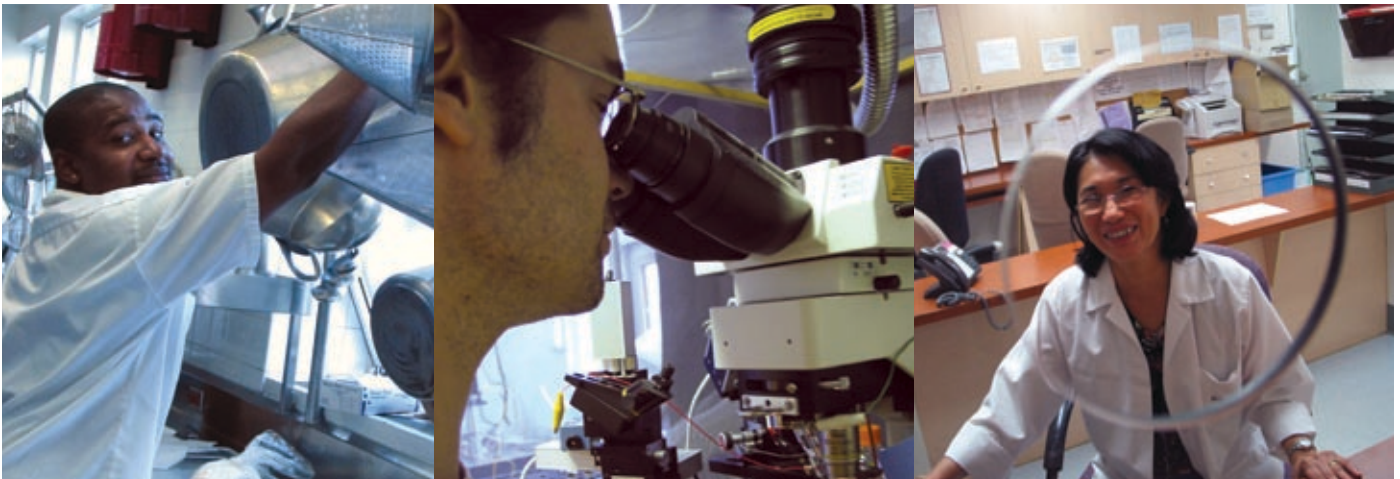
Needs increase and change, but resources remain limited. It is therefore essential to aim for excellence based on rigorous processes that will allow us to achieve our objectives and secure the organization's development within a context of resource shortage while, at the same time, adhering to the highest standards of quality, such as those established by the Canadian Council on Health Services Accreditation.

The MHAP proposes a new organization of services aimed at optimizing outcomes, as well as resource utilization, and also announces transfers of resources to 1st line services. It is therefore vital for our organization to carefully evaluate our activities in order to quickly realign our resources towards achieving our objectives and our vision.

This strategic direction is in support of the two first strategic directions and will allow us to measure our achievements. It aims to raise our level of performance and our efficiency, to guide our decisions in resource allocation and utilization as well as in identifying development priorities. It will allow us to focus our efforts more efficiently in our reorganization efforts and to meet the changes that lie ahead.

The following strategic objectives aim to **consolidate a result-based culture**:

- 3.a Develop a result indicator for each objective, whether it be for action plans or other proposed projects, in order to ensure coherence between goals, actions taken, and outcomes.
- 3.b Ensure that individual performance evaluations include measurable outcome criteria of agreed-upon objectives.
- 3.c Improve team and service performance indicators by introducing measures to evaluate:
 - ▶ patient satisfaction
 - ▶ outcome
 - ▶ working climate
 - ▶ interdisciplinary work integration
 - ▶ integration of the triple mandate
- 3.d Promote a safe environment by introducing risk management measures to team and service performance indicators.
- 3.e Ensure that all projects impacting the way large numbers of people do their work include a support and coaching approach in keeping with change management.
- 3.f Review the organization plan, to ensure coherence with the Strategic Plan and the need to clarify process management.





JOAN BESNER
Executive Secretary

For me, strategic planning determines where the Hospital is going over the next year or more, how we are going to get there and how we will know if we got there or not.



SUZANNE KING, PhD
Researcher

The hospital's strategic plan is reassuring for researchers because it means that growth is well planned within a vision that encompasses the integration of clinical care and teaching with research.



DORITA SHEMIE
Social worker

This strategic plan represents the will to involve and include all stakeholders in the definition of the vision and the future of the organization.



Standing: GINETTE LEFEBVRE, DIANE LAVINSCAS, JEAN CASSIS;
Sitting: ANDREA PRUPAS, TERRANCE FAGAN
The Recreation and Leisure team

For us, the Strategic Plan is in line with the coming changes in mental health.



GUSTAVO TURECKI, MD
Psychiatrist and researcher

The importance of having a strategic plan is that it provides a clear vision on how the hospital plans to implement, achieve and integrate its different, but equally important, clinical, research and education missions.

INTRODUCTION

THE DOUGLAS - AN OVERVIEW

WHY CHANGE?

HOW TO CHANGE?

APPENDICES



.05 APPENDICES

LEXICON

ADRC	Alcohol and Drug Rehabilitation Centre
AMC	Associated Medical Clinic
CAU	<i>Centre affilié universitaire</i> (translated as University Affiliated Centre)
CC	Childcare Centre
CFI	Canadian Fund for Innovation
CHPsy	<i>Centre hospitalier de soins psychiatriques</i> (translated as Psychiatric Care Hospital Centre)
CHSGS	<i>Centre hospitalier de soins généraux et spécialisés</i> (translated as General and Specialized Care Hospital Centre)
CHSLD	<i>Centre hospitalier de soins de longue durée</i> (translated as Long Term Care Hospital Centre)
CHU	<i>Centre hospitalier universitaire</i> (translated as University Hospital Centre)
CLSC	<i>Centre local de services communautaires</i> (translated as Local Community Services Centre)
CSSS	<i>Centre de santé et de services sociaux</i> (translated as Health and Social Services Centre)
DALY	Disability adjusted life years
FMG	Family Medicine Group
FRSQ	<i>Fonds de recherche en santé du Québec</i> (translated as Quebec Health Research Fund)
MHAP	Mental Health Action Plan (translation of <i>Plan d'action en santé mentale</i>)
MHSS	Ministry of Health and Social Services
PAFI	<i>Programme d'appui au financement des infrastructures</i> (translated as Overhead Financing Support Program)
RCMI	Rehabilitation Centre for Mentally Impaired
RUIS	<i>Réseau universitaire intégré de santé</i> (translated as University Integrated Health Network)
WHO	World Health Organization
YC	Youth Centre
YLD	Years of life lived with disability

STRATEGIC PLANING PROCESS

Strategic Plan Committee

The Strategic Plan is the product of intensive work over several months by the Strategic Plan Committee. This committee was composed of the following people, representing the boards of directors of the Hospital, the Research Centre and the Foundation, as well as senior management. The members of the committee were:

Claudette Allard	President of the Strategic Plan Committee and of the Board of Directors of the Douglas Hospital
Jacques Hendlisz	Director General
Martha Bishop	Representing the Beneficiaries' Committee, Douglas Hospital
Danielle Corbeil	Representing the Council of Nurses, Douglas Hospital
Michel Dalton	Director of Financial Resources, Douglas Hospital
Josianne Gauthier	Organizational Development Advisor, Douglas Hospital
Nicole Germain	Assistant to the Director General, Douglas Hospital, and Project Manager
Michelle Gilbert	Director of Human Resources, Douglas Hospital
Jacques Hurtubise, PhD	Member of the Douglas Hospital Board of Directors representing McGill University
Mimi Israël, MD	Chief of the Department of Psychiatry, Codirector of Clinical Activities and Codirector of Teaching and Training, Douglas Hospital
Robyne Kershaw-Bellemare	Director of Nursing, Codirector of Clinical Activities and Codirector of Teaching and Training, Douglas Hospital (until April 2006)
Jocelyne Lahoud	Administrative Director of the Douglas Hospital Research Centre and Project Manager
Jane H. Lalonde	President and Chief Operational Officer, Douglas Hospital Foundation
Stéphanie Lassonde	Communications and Public Affairs
Eric Latimer, PhD	Director of the Services, Policies and Population Health Research Theme, Douglas Hospital Research Centre
Ashok Malla, MD	Director, Clinical Research Division, Douglas Hospital Research Centre
Paul Marcotte	Member of the Douglas Hospital Research Centre Board of Directors, Representing the Public
Michael Meaney, PhD	Associate Scientific Director of the Douglas Hospital Research Centre
Rémi Quirion, PhD	Scientific Director of the Douglas Hospital Research Centre
Joseph Rochford, PhD	Coordinator of the Teaching and Training Bureau, Douglas Hospital and Douglas Hospital Research Centre
Ronald Sehn	Director of Technical Services, Douglas Hospital
Dorita Shemie	Representing the Multidisciplinary Council, Douglas Hospital
Jacques Tremblay, MD	President of the Council of Physicians, Dentists and Pharmacists, Douglas Hospital
Jean-Bernard Trudeau, MD	Director of Professional and Hospital Services and Codirector of Clinical Activities, Douglas Hospital
Claire-Dominique Walker, PhD	Director, Neuroscience Research Division, Douglas Hospital Research Centre

Working Group

This working group has played a key consultative role in helping the two project managers identify priorities. Chaired by Nicole Germain and Jocelyne Lahoud, the group was composed of Josianne Gauthier, Mimi Israël, MD, Robyne Kershaw-Bellemare, Jane H. Lalonde, Stéphanie Lassonde and Dorita Shemie. This group made it possible to identify values, clarify commitments and propose a vision and mission, as well as strategic directions and objectives. These were then proposed to a large group of stakeholders involved in a very stimulating and productive validation process.

Consultation

In addition to the members of the Strategic Plan Committee and the working group, a large number of people representing the Hospital, the Research Centre and their partners were consulted throughout the Strategic Plan exercise, whether to produce the diagnosis, identify the main objectives and the principal strategies or, finally, to validate the process and the different findings contained in the Plan. The Strategic Plan Committee wishes to thank the following persons who took part in the process leading to the 2006-2010 Strategic Plan.

External Consultation

Samuel Benaroya, MD	Associate Dean, Faculty of Medicine, McGill University and Responsible for Interhospital Affairs, McGill University Integrated University Health Network (McGill RUIS)
Guy Bibeau	Chief of Program Administration, LaSalle and Old Lachine CSSS
Michael Bond, MD	Chief of the Department of Psychiatry, Montreal Jewish General Hospital
Hélène Bourque	Administrative Director, Robert-Giffard Hospital Research Centre
Marc Boutin	<i>Projet suivi communautaire</i>
Madeleine Breton	Mental Health Office, Ministry of Health and Social Services
Rita Cavalière	Montreal Health and Social Services Agency
Lucie Côté	Impact and President of the Committee of Mental Health Partners of the South-West (called <i>COPASM</i> for <i>Comité des partenaires en santé mentale du Sud-Ouest</i>)
André Delorme, MD	Director of Mental Health, Ministry of Health and Social Services
Johanne Desrochers	Manager of the Telehealth Project, McGill RUIS
Lianne D'orsomiens	<i>Portage</i>
Eric Fombonne, MD	Assistant Chief of the Department of Psychiatry – Child and Adolescent Psychiatry – McGill University Health Centre (Montreal Children's Hospital)
Danielle Fortin, MD	Physician, South-West—Verdun CSSS
Pierre Gagnon	Director General, Pierre-Janet Hospital Centre
Diane Gauthier	Assistant to the Director General, Louis-H. Lafontaine Hospital
Captain Richard Gilbert	Salvation Army
Fiona Key, MD	Clinical Chief of Child Psychiatry, McGill University Health Centre (Montreal Children's Hospital)
Suzanne Lamarre, MD	Chief of the Department of Psychiatry, St. Mary's Hospital

Gilles Lanteigne	Visitor from the Canadian Council of Health Services Accreditation
Michel Lemay	Associate Director General, LaSalle and Old Lachine CSSS
André Lemieux	Director General, Louis-H. Lafontaine Hospital
Danielle McCann	Director General, South-West—Verdun CSSS
Angela Murphey	Project PAL
Joel Paris, MD	Chief of the Department of Psychiatry, Faculty of Medicine, McGill University
Paul Perreault	Director General, LaSalle and Old Lachine CSSS
Pierre Pinard	Responsible for Mental Health Program, South-West—Verdun CSSS
David Poirier	<i>L'Entretoit</i>
Kathleen Primard	Mental Health Program, LaSalle and Old Lachine CSSS
Serge Routhier	Assistant to the Director General, Robert-Giffard Hospital
Hélène Roy	Visitor from the Canadian Council of Health Services Accreditation
Captain Valérie St-Pierre	Salvation Army
Warren Steiner, MD	Assistant Chief, Department of Psychiatry – Adult Psychiatry, McGill University Health Centre
Louis-Paul Thauvette	South-West—Verdun CSSS
Afruditi Vahaviolos	<i>Portage</i>



Internal Consultation

Internal consultations have taken place in two phases. The first one helped establish the organizational diagnosis, and the second phase was used to validate proposals put forth by the working group. The following is the list of people consulted during these two consultation phases:

Claudette Allard	Natalie Grizenko, MD	James McDonald
Jean-Claude Armand, MD	Gaston P. Harnois, MD	Michael Meaney, PhD
Sylvain Bernier	Jacques Hendlisz	Marc Pineault
Martha Bishop	Lynn Hewitt	Susan Potter Lee
David M. Bloom, MD	Jacques Hurtubise, PhD	Jens C. Pruessner, PhD
Colette Boucher	Hani Iskandar, MD	Rémi Quirion, PhD
Francine Y. Bourassa	Mimi Israël, MD	Joseph Rochford, PhD
Jacqueline Burck	Lydia Ivanus	Willine Rozefort, MD
Yves Careau	Robyne Kershaw-Bellemare	Ronald Sehn
Sheilagh Cahill	Hélène Laberge	Dorita Shemie
Denis Claveau, MD	Philippe Lageix, MD	Joan Simand
Danielle Corbeil	Jane H. Lalonde	Daniel Sirois
Bartholemew Crago	Martine Lalinec, MD.	Howard Steiger, PhD
Michel Dalton	Marc-Paul Lasnier	Nathalie Trastour
René Desautels, MD	Stéphanie Lassonde	Jacques Tremblay, MD
Johanne Dubé	Eric Latimer, PhD	Jean-Bernard Trudeau, MD
Amparo Garcia	Gérard Lebel	Marielle Turcotte
Josianne Gauthier	Ashok Malla, MD	Claire-Dominique Walker, PhD
Michelle Gilbert	Elaine Mancina	Camillo Zacchia, PhD
Francine Giroux	Paul Marcotte	
Rachel Green, PhD	Carlos R. Martinez	

Focus Groups

Human Resources:

- ▶ **General Focus Groups:** 43 people, from different sectors of the Hospital (one for each division and one general group) took part in five focus groups in order to enrich the strategic planning process.
- ▶ **Specific Focus Group:** Three other focus groups were held to cover following subjects: Research; Quality; and Teaching, Training, and Organizational Development.

Clients: Four focus groups were also conducted, regrouping patients and members of their families. A total of 28 people, representing various areas of the Hospital, took part in these focus groups. The main subjects covered were: evaluation of services received, perception of the value of research, and stigma associated with mental illness.

ACKNOWLEDGEMENTS

Several people have taken part in making this project a success. We would like to underline the participation of André Delorme, MD, Director of Mental Health for the Ministry of Health and Social Services, for agreeing to make a presentation on the major points of the MHAP, as well as Alain Rondeau, professor and Director of the Centre for Research on Organizational Transformation of HEC Montreal, for agreeing to act as moderator during the Strategic Plan Committee visioning exercise day. We must also underline the contribution of Jacques Charuest and Jean-Pierre Charest for organizing and conducting employee focus groups.

Our most sincere thanks also go to Michel Perreault, PhD, and his team for organizing, coordinating and conducting client discussion groups (patients and families). We wish to thank other collaborators who made these focus groups a success: Louise Beauvais, MSc Nursing, Clinical Advisor in Specialized Care, who conducted two of the client focus groups (Child and Adolescent Psychiatry, and Geriatric Psychiatry); Suzanne Gareau-Forget, Nursing Department Secretary, and Chito Ferrer, BSc Nursing, for their role as translators and observers during these focus groups; the entire caregiving team of the Wellington Centre

for their collaboration and, in particular, Nicole Lahaie, Planning and Programming Agent, for taking part in the discussions, for recruiting participants and co-animating the meeting; Louise Beauchesne, Clinical-Administrative Chief for Adult Programs, Esther Thibeault, Assistant to the Beneficiaries' Committee and Francine Y. Bourassa, Hospital Ombudsman, for taking part in one of the discussion groups; and Julie Vadeboncoeur, Research Coordinator in the Adult Services Division, who wrote the focus group report for the Geriatric Psychiatry Day Hospital.

We also wish to thank Eric Latimer, PhD, and Ritz Kakuma for their part in collecting populational, sociodemographic and epidemiological data and for analysing this information in light of most recent epidemiological discoveries in the field of mental health.

Lastly, we would like to thank Stéphanie Courtois for expertly organizing the numerous activities and meetings needed throughout the long strategic planning process, as well as each and every person who graciously took part in editing both the French and English texts.

Photographs:

- p.19 Camillo Zacchia, PhD, Professional Chief – Psychology
Joan Simand, Professional Chief – Social Services
Hélène Laberge, Professional Chief – Occupational Therapy
- p.27 Andrew Gregory Reid, medical student
Hani Iskandar, MD, Medical Chef, Intensive Care Unit
- p.28 Marc Pineault, Quality and Risk Management Coordinator
Louise Beauvais, Clinician Advisor in Specialized Care
Robyne Kershaw-Bellemare, Director of Nursing (until April 2006)
- p.32 Stefin Noel, Recall List
Jean-Guy Chabot, Researcher, Neuroscience Division
Lillian Diaz, Nurse, Moe Levin Centre

- p.38 Left photo:
Candelaria Conti, Nurse, Research Centre
Xing Dai, research trainee, Centre for the Advancement of
Clinical Research

Centre photo:
Pierre Bernhardt, Clinical Coordinator, McGill Group for Suicide Studies

Right photo:
Marc Pelletier, research trainee, Neuroscience Division
Amélie Achim, Research Assistant, Psychosocial Research Division

SUMMARY OF 2001-2005 STRATEGIC PLAN ACHIEVEMENTS

The 2001-2005 Strategic Plan identified four strategic objectives and four operational objectives. The following is a summary of achievements for each objective of the Plan.

1. Continue Improving Clinical Excellence

Significant progress has been made in achieving the first objective, pertaining to clinical excellence. An evaluation of all clinical services was conducted using various productivity, accessibility, intensity and availability indicators. Results from this study allowed us to focus our actions, in order to improve the quality of services, and measure service efficiency and effectiveness on a regular basis.

Gains in clinical excellence have included the creation of: 1) PEPP-Montreal for the treatment of first psychosis episodes; 2) the Moe Levin Centre for the treatment of dementia associated with psychiatric disorders; the IPS Program (*Individual Placement and Support*) for individualized employment placement and support; and the ADHD Clinic for youths suffering from attention deficit disorder, with or without hyperactivity. Improvements were also made to the Emergency Department where the medical manpower was stabilized and where various activities were also implemented to increase links between internal and external partners.

Evaluation projects, intended to measure patient satisfaction, have been implemented within each division. Efforts are currently underway to better link these projects together. The C-SAFE Committee (Committee for a Substance-Abuse Free Environment) was also created to implement intervention methods to track, diagnose and treat patients with a double diagnosis. Furthermore, in collaboration with the Research Centre, a brief contact intervention for patients with addiction related disorders has been put in place.

Improvements in 2nd line services are continuing with the implementation of the Evaluation-Liaison Module. This service allowed us to considerably reduce delays prior to evaluation. We have developed links with referring resources, and shared care projects are underway with the two networks within the Hospital's catchment territory. Efforts must, however, be invested to strengthen services in accordance with best practices.

The following activities have improved links between the various departments and the flow of patients in the system: 1) the implementation of the bed management tactical team, which coordinates bed utilization in order to ensure adequate flow between the Emergency and admitting units, and to prevent clogging of services; 2) the Clinical Activities Coordination Committee, which oversees the overall management of clinical activities; and 3) another committee was also created to ensure the integration of services, following the merger of two previous adult divisions into one single adult division.

The Child and Adolescent Psychiatry Division and the Geriatric Psychiatry Division have also reorganized their services. Other reorganization projects will be started, in keeping with MHAP's framework.

Service quality was also improved in the following areas:

- ▶ Residential Resources: This department was reorganized and new quality standards were developed. An evaluation program to survey all residential resources is currently underway;
- ▶ Code White: A Code White team was created to ensure a rapid and expert response to acts of aggression;
- ▶ Night, Evening and Week-End Coordinators: They allow us to evaluate quality management and be rapidly informed of high risk situations, and develop a preventive action plan for each event requiring their intervention etc. Because they are on-site and have a systemic scope of action, they can act quickly in high-risk situations, thereby preventing potential sentinel events.
- ▶ Reorganization of diagnostic-technical support: This reorganization has allowed us to improve synergies between different diagnostic tools.

2. Obtain Designation as a University Institute: Consolidating Scientific and Academic Excellence

At the invitation of the Ministry of Health and Social Services, the Hospital submitted its candidacy to be designated as a University Institute in mental health in October 2003. A subsequent visit was conducted by a team of experts, mandated to evaluate our candidacy. This visit took place in October 2004 and an additional visit took place in early 2006.

To achieve our goal of becoming a University Institute, the Hospital focussed on three specific aspects: excellence in teaching, excellence in research, and integration of these two aspects to clinical activities.

The decision to designate institutes had been postponed several times since the first proposed date of March 2004. The Douglas was finally designated as a University Institute in mental health in the Spring of 2006.

2.1 Excellence in Teaching

In conformity with Strategic Plan objectives, we have created the Teaching and Training Directorate and the Teaching and Training Coordination Bureau, which have allowed for improved coordination of all teaching and training activities. More effort, however, must be invested to improve links between these activities and organizational objectives, and to encourage greater integration between Hospital and Research Centre activities.

The Hospital also implemented an e-learning project, aimed at optimizing staff training by using the Internet and intranet. This allows staff to participate in continuing education activities, regardless of the time of day or night, or the location. Thanks to these achievements, there is renewed collaboration with our partners in relation to organizing, and participating in, various teaching and training activities.

2.2 Excellence in Research

The Douglas Hospital Research Centre is recognized as a “**Model Centre**” by the *Fonds de recherche en santé du Québec (FRSQ)*. It

is the most important mental health research centre in Quebec, and the highest performing mental health research centre in Canada, receiving the largest number of peer-reviewed grants. Since the last Strategic Plan, at the request of the FRSQ, the number of research themes was reduced from seven to the following four: Schizophrenia and Neurodevelopmental Disorders; Mood, Anxiety and Impulsivity-Related Disorders; Aging and Alzheimer Disease; and Services, Policy and Population Health. Adjustments, however, are needed to improve unity within certain of the new research themes, and to improve synergies between research themes and divisions during this period of rapid growth at the Research Centre.

The DHRC is renowned for the quality of its scientists, their scientific performance, and their role in training students (at the masters, graduate and postgraduate levels), as well as for the level of integration of research into clinical and teaching activities.

2.3 Integration of Research and Teaching with Clinical Activities

The third component, dealing with the integration of research and teaching into clinical activities, has also shown significant progress. These achievements have been made possible, mainly through the creation of the Centre for the Advancement of Clinical Research, and the Teaching and Training Coordination Bureau as well as through the Services, Policies and Population Health Research Theme.

Achieving this objective also stems from our recruitment efforts. The Hospital now only recruits professionals who are committed to our triple mission. The calibre of recruited professionals, and of the staff in general, has also improved, as witnessed by the number of our MDs/PhDs, residents, bachelor nurses etc. This attracts additional high-calibre clinicians and researchers, and spurs a continued increase in staff calibre. These recruits are integrated into current programs or develop new ones, thereby improving integration.

Our 3rd line clinical programs are considered as models in their fields. Each of these teams apply best practices and contribute to the advancement and implementation of new knowledge,

ensure the training of new qualified recruits, and contribute to knowledge exchange between Hospital clinicians and their respective network of partners. We must, however, increase our efforts to improve integration in other 2nd line services, where integration is sometimes uneven. Integration incentives must be developed and service performance indicators must take integration objectives into account.

3. Improve the Synergy of the Objectives of the Foundation, the Hospital and the Research Centre

Progress has been made in achieving this objective. Regular meetings are held between the directors of the three entities. The Hospital and the Research Centre have taken part in drafting objectives for the upcoming major fundraising campaign, to be held in 2006, the 125th anniversary of the Hospital. The new logo is the result of collaboration between the Hospital, the Research Centre and the Foundation. The first integrated annual report was published in 2002-2003, showing the close links between the three entities, and helping to achieve objectives of excellence. It is also significant that the current Strategic Plan joins the three entities in achieving common goals. Recent changes in the presidencies of the Research Centre and of the Foundation, as well as of the Foundation's executive director, should also bring a renewed impetus in achieving synergies. We must, however, continue our efforts to involve the Foundation more closely in different Hospital committees where its input would be useful. We also need to improve internal communication strategies to correct certain perceptions and to better communicate the Foundation's vital contribution.

4. Reposition the Hospital's External Image

As planned in the 2001-2005 Strategic Plan, we have changed our logo to improve the corporate image, give it a more contemporary look and harmonize it with Hospital values. The name of the Hospital may be revisited, now that the Hospital has been designated as a University Institute in mental health.

A communications plan was developed and implemented to improve our external scope of influence. Several members of the organization take part in committees and advisory groups at the provincial, regional and local levels: Montreal Island Chiefs of Departments of Psychiatry Table, McGill RUIS, *Fonds de recherche en santé du Québec* (FRSQ), various ministerial committees, Canadian Institutes of Health Research etc. Specific communication strategies have been identified for each targeted audience. The web site was completed, and particular approaches were developed targeting different media. External communications have been developed significantly, as witnessed by the positive presence of the Hospital in different media, and by the fact that journalists increasingly use the Hospital as a reference centre in mental health. These efforts must be maintained, and even increased, to continue improving perceptions with regard to mental illness, and to improve recognition of the Douglas as a centre of excellence and a leader.

5. Consolidate Key Elements of the Organization Plan

The Organization Plan was revised in 2003, confirming the effectiveness of the clinical management model, which is based on shared management, a patient-centered approach, and principles of learning organization and interdisciplinarity, introduced in the previous organization plan. Decentralization of the decision-making process was also implemented through budget decentralization. Initiatives to clarify the role of professional chiefs were established in the areas of recruitment, evaluation of the quality of clinical acts, and teaching and training, but more effort is still needed to give the role of professional chief its full recognition and significance.

The survey on the organizational climate brought to light several questions with regard to shared management at certain levels in the organization, and a further study (HEC research project) was conducted to further improve functioning.

6. Consolidate and Link Human, Financial and Technical Resources Objectives with Strategic Objectives

As part of the last Organization Plan adopted in 2003, Technical Services and Financial Resources were divided into two distinct directorates.

The Financial Resources Directorate has completed implementation of the new financial system and budgets have been decentralized according to the Organization Plan, thereby improving our information systems. Several improvements have been made to financial reports, which now correspond better to management needs and are distributed electronically to managers with greater speed.

The Technical Services Directorate has revised the Physical Master Plan in light of the Strategic Plan, and its implementation is progressing well. A new food production and distribution system was implemented, thereby improving the quality and cost-efficiency of this activity. A program to evaluate cleanliness satisfaction was implemented by the Housekeeping Department, which allows us to evaluate all areas on a quarterly basis. The directorate has also implemented a Hospital-wide inspection program in order to set quality standards throughout the organization. A multidisciplinary team (composed of representatives from Technical Services, the Beneficiaries' Committee and clinicians) visits all areas on a regular basis. This allows them to identify and document physical deficiencies and plan future priorities. These inspections are conducted over and above regular continued supervision by Technical Services managers and the usual repair requests made by various clients. The preventive maintenance program is another example of continued quality improvement efforts. Measures have been implemented to monitor preventive and corrective maintenance activities. This allows us to improve planning needs and priorities with regard to building upkeep. The Technical Services Directorate has also drafted an Emergency Procedures Manual and all human resources have been trained in its application.

The Human Resources Directorate conducted an organizational climate survey, as well as a review of its own functioning. Concrete actions have been taken to improve service quality. The Human Resources Development Plan was adopted. The directorate created an Organizational Development Service, mandated to

implement various development activities for managers, support and administrative staff, change management etc. Considerable efforts were also invested in implementing changes stemming from healthcare reform and, in particular, the reorganization of negotiation units within the health network.

7. Consolidate Relations with Our Partners

A wide variety of networks support our different clientele, based on their specific needs (children and youth, the elderly, the mentally impaired etc.), and are linked to the different components of the organization. They include the McGill network, the COPASM network, the scientific network, the academic network etc. As a show of support, these numerous partners have supported our candidacy as a University Institute in mental health.

We have developed links with the principal psychiatric hospitals in Montreal and throughout Quebec, and we have signed collaboration agreements with them.

The Hospital must maintain and even improve partnerships, particularly in the context of healthcare reform and the MHAP, with the goal being to implement a well-integrated network of services, based on knowledge and information sharing.

8. Continue Improving Communications, and Consolidate Communications and Management Information Mechanisms

An internal communications plan has been developed and implemented and has shown great results. Particularly noteworthy are *douglas.comm*, *Douglas Express* and the intranet site, as well as various information bulletins, such as the one dealing with healthcare reform, the MHAP, and the reorganization of adult services. Efforts must still be invested to improve hierarchical communications, which still pose a major challenge.

In regard to management information, balanced scoreboards have been developed, in collaboration with the caregivers involved. Several performance measures have been developed for the Board of Directors, senior managers and managers, in order to improve the quality of services. These measures were used to evaluate the performance of all clinical activities, and efforts are being made to constantly improve them.

MAJOR EVENTS OF RECENT YEARS

Several events have marked recent years at the Hospital and the Research Centre. Some of them, more strategic in nature, deserve particular attention.

Logo

The Hospital decided to redesign its logo in conformity with Objective 3 of the 2001-2005 Strategic Plan. The goal was to build awareness of the Douglas Hospital and its fields of expertise: care, research and teaching; change negative perceptions; and contribute to demystifying mental illness. Following a large consultation process, the new logo was chosen and it was also decided to use different colors for each of the three entities. The logos are as follows:



The design was chosen to show networking, partnership and knowledge exchange, with the patient surrounded by the treating team, the Hospital surrounded by its partners, and research and

teaching initiatives serving patients etc. The main focus is the significance of teamwork at the Hospital and in mental health. For researchers, the image is also reminiscent of a stylized cross-section of the brain, which is their most precious tool in the search for answers to mental illness.

This new logo represents our tripartite mission: care, teaching and research in mental health. It is also more modern and in harmony with our progressive, warm, and inviting culture, an image we want to portray.

Accreditation

Two accreditation surveys have been held since the last strategic plan. In April 2002, the Canadian Council on Health Services Accreditation (CCHSA) surveyed the Hospital and granted a three-year accreditation with report. Another survey was conducted from April 18 to 21, 2005, following which we were granted a three-year accreditation with a request to produce a progress report on certain specific issues in June 2006. This last visit allowed us to validate the outcomes of the diagnostic phase of the current strategic plan.

Visit by the *Fonds de recherche en santé du Québec (FRSQ)*

The 2003-2007 Development Plan, produced by the Research Centre, was submitted to the FRSQ, as is customary every four years. As part of the review process, the Centre was surveyed by a group of experts, who conducted an on-site evaluation. They awarded the Centre a global rating of "excellent"; they recognized the quality of the research, pointed out the expertise and leadership of Scientific Director Rémi Quirion, PhD, and emphasized the Hospital's support to the Research Centre.

Survey of Organizational Climate

At the end of 2002, the Hospital mandated the firm of Léger Marketing to conduct a survey of the organizational climate. At the beginning of 2003, 1,246 questionnaires were sent to all employees, of which 623 were completed (a 50% response rate).

The diagnostic report was submitted in Summer 2003. The Hospital then started a wide consultation process to develop an action plan to address the challenges identified in the survey. These issues were grouped into four large categories, i.e.:

- ▶ Communication and partnership between management and employees;
- ▶ Workload and stress;
- ▶ Safe work environment;
- ▶ Harassment and discrimination.

In January 2004, the Board of Directors approved the three-year action plan to improve the organizational climate. This plan included 68 actions to be undertaken between 2004 and 2006. Most of these actions have been implemented and completed, and the next step will consist of developing a tool that will allow us to evaluate the climate on a regular basis. This tool should be developed in 2007.



The 4Cs of Quality

In an effort to bring quality to the forefront of each of our actions, the Hospital implemented a quality program, commonly referred to as the “4-Cs”. This program conforms to the four dimensions of quality of the Canadian Council on Health Services Accreditation (CCHSA).

What do the 4-Cs mean and what are their links with the four dimensions of quality of the CCHSA?

Quality of Client Services – RESPONSIVENESS

The organization anticipates and responds to changes in the needs and expectations of the (potential) client and/or community populations, and to changes in the environment.

Quality of Internal and External Collaborations – CLIENT/COMMUNITY FOCUS

The organization strengthens its relationship with the client and/or community. The organization does this by encouraging community participation and partnership in its activities.

Quality of Organizational and Professional Competence – SYSTEM COMPETENCY

The organization consistently provides services in the best possible way, given the current and evolving state of knowledge. The organization achieves the desired benefit for clients and/or communities, with the most cost-effective use of resources.

Quality of the Organizational Climate – WORKLIFE

The organization provides a work atmosphere conducive to performance excellence, full participation, personal/professional and organizational growth, health, well-being, and satisfaction.

In summary, this program promotes the sharing of expertise in terms of quality. It is used in developing annual objectives, as well as in the performance evaluation process. It allows the organization to be aware of strengths, and of areas requiring improvement in a continued development effort.