include research & teaching
8% - program D
longitudinal approach to research

Restructuring the Adult Services of Douglas Hospital

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1 Executive Summary

This proposal to restructure the adult clinical programs at Douglas Hospital, attempts to address the following five problems: a) barriers to the movement of patients from one treatment setting to another; b) difficulties in allocating resources; c) shrinking budgets; d) changing roles played by general hospital departments of psychiatry; and e) changing roles played by community resources.

The hospital's mandate is to provide second and third line psychiatric services to three categories of patients: a) those from our geographic sector; b) from outside our sector (and especially McGill network hospitals) needing third line treatment; and c) from anywhere in Quebec where english-language services are unavailable.

The proposed structure for the adult services of Douglas Hospital is based on the following principles: segregation of second line services for the geographic sector; separation of services according to second line or third line; segregation of services for "institutionalized" patients; regrouping of services for both acute and chronic patients; no indefinite-length "prise en charge" for out-of-sector patients.

The proposal does not address: teaching or research (although both of these will be enhanced in the context of a logical and coherent structure of programs); management issues internal to programs; the continued existence or need for individual treatment services within programs; philosophy of different management models; job descriptions; the future of psychogeriatrics, child and adolescent services, or emergency and intensive care (however, it would be relatively easy to apply the principles enumerated above to any proposed restructuring of these programs).

This proposal recommends the creation of three clinical programs to replace the existing CPC, STRP, and Rehabilitation programs. The first, program A, would be mandated to provide second line services such as short-stay admission, day treatment, OPD clinics, and auberge, and also residential services, for geographic sector patients.

Program B would provide third line (ultraspecialized) treatment for both sector and out-of-sector patients. In general, such treatments would be intermediate to long term, and would be available only to patients who already belong to a program or hospital providing for their second line treatment needs. Following Program B treatment, patients would return to the referring program or hospital. This new program would be created by combining the specialized treatment programs which exist within STRP and the Rehabilitation Program.

The third new program, Program C, would provide custodial inpatient care and associated transitional day treatment and OPD services to the existing Douglas Hospital population of institutionalized patients (those on Perry long stay units). As these patients age, die, or are transferred to other programs or hospitals, the size of program C would progressively diminish, until the program can be closed.

The five problems enumerated above would be dealt with as follows: since little movement of patients between these three programs would be necessary, the current problems of barriers to patient movements would diminish. Questions of resource allocation would be easier to solve: the government's funding formulas for general hospital departments of psychiatry would apply to Program A; funding for Program B would depend on meeting standards for performance; the custodial care to be

provided by Program C has well-established funding requirements. Since Program C is intended to diminish in size and eventually close, the ever-shrinking budgets imposed on the hospital can be accommodated. Because Program B will not accept patients "forever", they will always have a turnover and therefore will not become clogged. This will permit continued access to these ultraspecialized treatments by general hospitals. Finally, with the responsibility for sector patients clearly assigned to Program A, it will be easier to collaborate with community resources.

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2 Introduction

This document presents an alternative proposal to the recommendations made by the Comité ad hoc de la planification concertée chargé d'étudier la structure clinique, in their rapport final, which was discussed at the comite de planification concertée on 7 april 1993 and subsequently.

The following proposal addresses several problems related to the existing distribution of mandates across the various clinical programs in the hospital. These problems are enumerated; following that, the mandate of the hospital is presented in a fashion which allows the program structure to be easily addressed. After an explanation of the philosophy guiding the proposed restructuring, a list of the subjects that this report does not deal with is included. The next section describes the proposed program structure, including the type of care to be provided, the patient population to be served, the existing programs from which patients and resources would be obtained, and approaches to funding.

For patients who would fall outside of the mandates of these proposed new programs, a number of recommendations are made in the next section of the report.

The report closes by returning to each of the problems listed in the first section, to explain how they would be ameliorated with the proposed program structure.

3 Problems Related to the Existing Structure

3.1. Barriers to the movement of patients from one treatment setting to another

For example, a CPC patient who requires long term institutional treatment available only in STRP is faced with a long waiting list.

3.2. Difficulties in Allocating Resources

The government uses formulas to determine the appropriate levels of funding and staffing for second line treatment of patients in a geographic sector. For third line psychiatric treatment, or for services for patients outside of the geographic sector, no such funding formulas exist. Resource allocation to such services are based on whether equivalent services are available elsewhere, or on the quality of the service offered.

At Douglas Hospital, all of the five clinical programs (and also the emergency room and intensive care services) offer second and third line services to both sector and non-sector patients. None of these programs is able to easily determine which portions of its budget should go to which types of treatment services.

For STRP, which has a mandate to provide at least custodial care to its institutionalized patients, there is the ongoing problem of the more glamorous specialized treatment services, such as eating disorders or the clinical research unit, bleeding off resources which might otherwise go to expand the treatment options for the long term patients in Perry.

3.3. Shrinking Budgets

In today's economic and political climate, there is mounting pressure to reduce mental health care expenditures. Douglas Hospital will be called upon to carry its share of the burden. When we've eliminated all the "fat", we will have no option but to cut services. Which services should be cut, and how do we decide? Is there surplus capacity in any area?

3.4. Changing Roles Played by General Hospitals

At one time, Douglas Hospital received all the psychiatrically ill patients who presented to any of the anglophone general hospitals in Montreal. As these hospitals created their own departments of psychiatry, DH no longer treated the "neurotic" patients from these general hospitals, although we continued to look after their "psychotic" patients. Eventually, the general hospitals developed the capacity to care for these patients also, and the role of DH shrank to looking after its own geographic sector patients and providing long term institutional care to "treatment resistant" patients referred by the general hospitals.

Today, the role is again changing. The ministry expects each general hospital department of psychiatry to develop the resources to look after its own (ie sector) long term (chronic) patients. The funds to set up the appropriate treatment resources may be appropriated from DH. In the future, then, we might expect that referrals from these hospitals to DH will be more and more oriented towards ultraspecialized psychiatric treatment.

3.5. Changing Roles Played by Community Resources

With transfers of funding from institutions to community-based resources, the less problematic or less difficult psychiatric patients are increasingly being cared for by the so-called "Ressources alternatifs". For the "new chronic" patient, this means a "revolving door" relationship with DH or with general hospital departments of psychiatry, instead of long-term institutional care.

Moreover, our attempts to provide "community-based" psychiatric care are beginning to be viewed as competition by the CLSC's and other resources who have been mandated to provide first line psychiatric treatment.

4 The Hospital's Mandate

As defined in the mission statement of the hospital, we provide second and third line psychiatric treatment to patients in our geographic sector, to patients from outside the sector who can benefit from third line psychiatric treatment not available in their sector (especially patients from McGill network hospitals), and finally, patients from anywhere in Quebec who do not have access to services in english.

The types of patients and the treatments they would receive can thus be broken down into a matrix, as follows:

		Sector	Outside of Sector
2nd line services	acute care (admission, day treatment, OPD)	**A**	**note 1**
3rd line services	specialized treatment, including rehabilitation	**B**	**B**
can be considered as either 3rd line, or community-based	treatment-refractory, needing indefinite-length institutional care	**note 2**	**note 3**
	existing institutionalized patients	**C**	**C**

5 Philosophy Underlying the Proposed Program Structure

The proposed structure for the adult services of Douglas Hospital is based on the following principles:

5.1. Segregation of second line services for the geographic sector

Because funding formulas exist and are applied for the provision of second-line services to populations based on census counts, it makes sense to regroup such services and to segregate them from services which are funded differently, such as third line services or services not identified with geographically delimited general populations.

5.2. Separation of services according to second line or third line

Following this principle will facilitate resource allocation decisions (see above) and will emphasize the fact that evaluation of performance differs greatly for these two types of services.

5.3. Segregation of services for "institutionalized" patients

It is generally agreed that the population of inpatients who were "inherited" from the days when Douglas Hospital functioned like a state hospital (mostly chronically psychotic patients housed in Perry Pavilion and also in Porteous) benefit the least from the advances in treatment methods and from improvements to the quality of life that are taken for granted in other areas. Important factors include the redirection of resources away from these patients to more "glamorous" activities such as ultra-specialized services, combined with a sense that clear goals or directions are lacking for these services and for their clients.

In this proposal, competition for resources will be reduced by segregating services for this patient group from more "glamorous" services. Based on individual assessments of the clients, those who can benefit from rehabilitation treatments will be referred to the appropriate programs, while humane custodial care can be rendered to the others. Recognizing that this population is shrinking (both because young chronic patients tend to be treated on a "revolving door" basis instead of extremely long hospitalizations which contribute to institutionalization, and because of attrition through death or de-

institutionalization) the treatment program will also be designed to get smaller and eventually disappear.

5.4. Regrouping of services for both acute and chronic patients

Most psychiatric illnesses are of a chronic nature, although there are often acute exarcerbations requiring different treatment approaches. By grouping all second-line services into one program, barriers to the transfer of patients between programs will cease to be a factor in providing continuity of care.

5.5. No indefinite-length "prise en charge" for out-of-sector patients

Out-of-sector patients who are eligible to receive ultra-specialized services from Douglas Hospital will be evaluated and admitted or registered for specific, time-limited treatments. Afterwards, responsibility for their care returns to their sector hospital. This ensures that there will always be a turnover of clients, thereby eliminating the blockages that plague our long-term programs currently. Moreover, evaluating performance of such services will be easier, as length-of-stay and size of waiting list will become relevant indicators.

6 What this proposal does not address

- teaching or research (although both of these will be enhanced in the context of a logical and coherent structure of programs)
- management issues internal to programs
- the continued existence or need for individual treatment services within programs
- philosophy of different management models
- job descriptions
- the future of psychogeriatrics, child and adolescent services, or emergency and intensive care. However, it would be relatively easy to apply the principles enumerated above to any proposed restructuring of these programs.

7 Proposed Program Structure

7.1. Program A (geographic sector care)

7.1.1. Type of care

Second line psychiatric treatment, including short-stay admission, day treatment, outpatient clinics, auberge.

This program would also provide residential services (group homes, transitional homes, pavilions) for its patients.

Could include emergency, crisis intervention, and intensive care treatments.

7.1.2. Patients served

All patients with treatable psychiatric disorders, whether acute or chronic, living in the geographic sector of the hospital.

By arrangement with neighbouring hospitals, itinerant patients on a rotating basis.

Patients sent to DH under court order or lieutenant-governor's warrants.

7.1.3. Provenance

The units, services, staff, and budgets from the existing CPC program.

Could include the existing emergency and intensive care teams.

7.1.4. Funding

Funding needs to be based on the existing government formulas relating to the size of the sector population.

Special circumstances, such as the relative poverty of the area, or the high concentration of old DH patients residing in the sector, should be used to justify modifications to the formulas.

7.2. Program B (specialized treatment)

7.2.1. Type of care

Third line (ultraspecialized) psychiatric treatment, such as programs aimed at eating disordered patients or mentally handicapped clients with severe behaviour problems, specialized rehabilitation treatments for institutionalized patients, or specialized settings which include teaching or research. In general, the length of treatment offered would be intermediate (six months) to long term (two years or more).

Since rehabilitation treatments for institutionalized patients are often combined with residential programs, responsibility for associated group or transition homes would also reside with this program. However, these residential facilities would not be used for durations of stay longer than the associated treatment program.

7.2.2. Patients served

Only patients who already belong to a program or hospital providing for their second line psychiatric treatment needs. Such patients would be referred by that program or hospital, evaluated for suitability by the specialized treatment program, and accepted only with the understanding that at the end of the third line treatment, responsibility for the patient returns to the referring program

7.2.3. Provenance

This program would regroup the specialized treatment programs which

currently exist within STRP and within the Rehabilitation Program.

Optionally, the Clinical Research Unit might be part of this program.

7.2.4. Funding

As these third line treatments are not considered baseline or essential services by the ministry, their funding must be based on a number of considerations:

Is there an ongoing need for the treatment (determined by the size of the waiting list);

What is the mix of sector to non-sector patients utilizing the service?

Do the clients and the referring services express satisfaction with the specialized treatment?

Does the ministry consider the type of service being offered a high priority?

Does the research and/or teaching associated with the specialized treatment make it worthwhile?

Does the treatment demonstrate satisfactory results?

Is the treatment cost-effective?

7.3. Program C (deinstitutionalization program)

7.3.1. Type of care

Custodial inpatient care; transitional day treatment or day care; transitional outpatient treatment.

In general, each custodial care unit could provide its own transitional outpatient care, with patients needing readmission returning directly back to their unit.

Patients would be assessed regarding their potential for being deinstitutionalized; suitable patients would be referred to Program B (specialized treatment) for appropriate treatments intended to enable them to live outside the hospital. Once deinstitutionalized, the patient would then be followed by their sector program (either DH's program A, or by another hospital).

7.3.2. Patients served

The existing Douglas Hospital population of institutionalized patients (those on Perry long stay units).

The number of patients in this program would decrease steadily, as patients age and are thus transferred to psychogeriatrics; as patients die; or as they are successfully treated (by program B's specialized treatments) and deinstitutionalized, or as they are transferred to specialized indefinite length of stay institutional care settings.

Once the number of patients remaining is small enough, this program should be closed, and the remaining patients transferred to the sector program.

7.3.3. Provenance

This program would regroup the existing long term care units within STRP, as well as a part of the STRP outpatient clinic.

7.3.4. Funding

Initially, this program's budget would be that which is being used to provide custodial care, with some additional funds for transitional OPD and day programming.

Eventually, this program would disappear and require no funding. Its budget might be used to provide for the budget shrinkage imposed by the ministry; alternatively, it might be used to provide for the indefinite length of stay institutional care required by a proportion of the patients of this program and of the sector program.

8 Other Patients

8.1. Note 1

As indicated in the chart, there are non-sector patients requiring acute care services who are being followed at present by existing DH programs. Since the restructuring will not provide for second line psychiatric treatment by DH for these patients, they will need to be referred to their sector hospital. This would not preclude their being referred back to DH's program B (specialized treatment) for third line treatment with a specific time frame.

8.2. Note 2

In spite of the best treatment efforts, there will always be a small percentage of psychiatric patients who do not respond, and who will require specialized institutional care settings, possibly for the rest of their lives. Such patients do not usually require intensive psychiatric treatment, but do need custodial care in settings where the physical facilities and the staffing are specific to their needs. The types of patients include groups such as aggressive chronically psychotic patients; patients who are unable to care for themselves in terms of activities of daily living; demented patients, etc.

To meet these needs, new funds will need to be found, or alternatively the ministry may choose to use a part of the hospital's existing budget to serve the regional needs. The hospital has the option of including this type of care under its umbrella, or allowing other agencies to provide it.

8.3. Note 3

The same considerations as described in note 2 apply to non-sector patients. Given the small numbers of patients involved in each category, whatever institutional care facility is set up will have to service regional needs, and not just the needs of one sector.

9 How This Proposal Addresses the Problems Enumerated Above

9.1. Barriers to the movement of patients from one treatment setting to another

With the proposed structure, little movement of patients between programs will be required. The sector program will have responsibility for all patients who live in the sector, whether acute or long term. There would be no transfer of patients to the specialized treatment program, as this program would accept to treat patients only on the basis of specific treatment "contracts" for defined time periods, after which the patient would go back to the referring program. With respect to program C, patients would remain within the program until they have been successfully deinstitutionalized (eg living in the community for, say, one year).

9.2. Difficulties in Allocating Resources

The proposed restructuring simplifies the problem of resource allocation, as each program will have a clearly defined mandate and target population. Program A will provide only second line psychiatric treatment and only to patients from its geographic sector; accordingly, it would be comparable to general hospital departments of psychiatry and the usual funding and staffing formulas, based on sector population, would apply.

Program B can initially start with the resources currently allocated to the specialized treatments that exist in STRP and in the Rehabilitation Program. Continued funding will depend on performance as measured by factors such as mentioned above under "Program B: funding".

For program C, the budgets required to provide adequate levels of custodial care are relatively well known. With a very specific mandate, there would be little internal competition within the program for resources, such as exists at present within STRP.

9.3. Shrinking Budgets

With the proposed restructuring, it will be easy to identify which services can be reduced or eliminated. In fact, Program C is identified ahead of time as being slated for elimination. Within program B, individual specialized treatments are not considered essential, and therefore must continually justify their continued existence. Through the attrition of services which are inefficient or no longer respond to changing needs, it will be possible to free up funds even for new development.

9.4. Changing Roles Played by General Hospitals

With program B specifically set up to provide third line psychiatric treatment without an indefinite "prise en charge" of patients, the problem of access to specialized treatment being reduced over time as the available beds become filled by long term patients who cannot be discharged, as happens presently, will disappear. The general hospitals will continue to have access to specialized treatment provided by program B, because it will be able to "turn over" patients in its programs.

9.5. Changing Roles Played by Community Resources

Under the proposal, the responsibility for the care of sector patients, whether acute or chronic, rests with program A. Community resources will therefore have an easier time in finding the appropriate service or resource person with whom to collaborate regarding treatment planning or delivery.

10 Differences from Rapport du comité ad hoc de la planification concertée chargé d'étudier la structure clinique

page 8, IV, 4.1, Programme de soins aigus: The present proposal calls for no ultra-specialised services in Program A (serving the needs of the sector).

page 8, IV, 4.1, Centre de réadaptation Newman: the present proposal creates a new program (Program B) which combines the existing rehabilitation services of the existing Centre de réadaptation Newman, with ultraspecialized services presently provided by STRP. The new program would also be able to admit patients into ultraspecialized inpatient units (eg eating disorders), rather than simply treating "clients inscrits".

page 9, IV, 4.1.2, Programme de soins aigus: Again, the present proposal would not include "services de troisième ligne" in Program A.

- Services internes: Program A would serve only sector patients, and provide both acute and chronic care. Program C would serve the shrinking population of "institutionalized" patients.

- Services externes, Programme de jour: The present proposal makes no recommendations regarding the structure of individual services within a program.

- Services ultra-spécialisés: In the present proposal, these would all come under Program B.

- Organisation physique et géographique du programme: Again, the present proposal makes no recommendations about physical or geographic issues affecting services internal to a program.

page 11, IV, 4.1.3, Programme de soins psychiatriques chroniques: The present proposal calls for a separate treatment program, Program C, not for all chronic patients, but only for the so-called "institutionalized" patients (ie those living in some of the Perry units). For any of these which correspond to the "Groupe 1" patients for which social reinsertion is possible, the specialized rehabilitation services would be provided by Program B, with the eventual responsibility for the patient returning to Program C after Program B's treatments have been completed.

- Services internes: No ultraspecialized beds in Program C. Résidence Durost would become part of Program B in the present proposal. Program C would not have acute beds, either. Typically, a patient discharged from a Program C unit would be kept on ALV status for a sufficiently long time (eg 3 months) to ensure that the discharge was successful, following which the patient would be transferred to Program A (if in the hospital's sector) or to the appropriate sector hospital for subsequent treatment, both inpatient and outpatient.

- Services externes: Program C would have only transitional types of outpatient services, eg an outpatient clinic associated with an inpatient unit, to provide followup for patients on ALV or in transitional housing.

- Services spécialisés: For consistency, all ultra-specialised (ie third-line) treatments, including rehabilitation, would be provided by Program B. However, the types of rehabilitation treatment normally associated with inpatient services, such as educators, rehab monitors, etc. which are part of second line treatment, would be provided by Program C for its units.

page 13, IV, 4.1.5, Centre de réadaptation Newman: In the present proposal, Program B would regroup not only the existing Newman services but also the ultra-specialized treatments now in STRP. Since these include inpatient services, Program B would have both admitted and "inscrit" patients. With respect to residential resources, only in cases where a residence is an integral part of the treatment program and the length of stay in that residence would not exceed the treatment duration, would such a residence be part of Program B.

page 20, Conclusion: The present proposal recommends that the care of all sector patients between 18 and 65 be within one program, without reference to whether the illness is acute or chronic. Thus, care for patients with chronic psychiatric illness will improve, as there will be no competition with ultra-specialized services for resources and no barriers between programs with respect to transfer of patients. Services to sector patients will improve, as Program A will limit itself to providing high quality second line treatment, without pressure to distribute any of its resources to third line treatment services or for non-sector patients. Program B will be able to measure, and therefore improve, the quality of its services, because without a mandate to provide indefinite-length care, length of stay becomes a useful measure, as does the waiting list as a measure of demand for its services. Moreover, since Program B is structured to have a turnover of patients, there will always be access to its treatments for McGill network hospitals.

Addendum

Reseach & Teaching

If the ultra-specialized treatments and services are all concentrated within a single program, program B, what would happen to the research and teaching which at present takes place within CPC and STRP? Some, for example the research and teaching associated with the Eating Disorders Service, would move to Program B. Others would remain in Program A, such as the medical student and psychiatric resident teaching which takes place on admission units.

A clear division between second and third line services will make it easier to plan teaching: For example, mandatory psychiatry rotations for medical students, nursing students, psychiatric residents and others would naturally take place in Program A, while optional or elective rotations which address sub-specialty topics would take place in Program B.

A concern has been raised about the difficulty the proposed program structure would present for research involving the longitudinal followup of certain chronic mental illnesses, such as occurs in the existing specialized schizophrenia or affective disorders clinics in CPC. In reality, longitudinal followup studies can be carried out in settings which do not provide for long-term care; the ultraspecialized programs in Child and Adolescent Services provide examples, as does the Eating Disorders Service.

Prog A & C have clinical service as 1° mandate; for program B, research & teaching are 1°

Program D

It is believed by some that a mandate to provide indefinite-length institutional care for treatment-refractory patients (see notes 2 and 3) has been assigned to Douglas Hospital. In this case, such patients could receive care (not active treatment, however; by definition, these patients have been tried on all the appropriate treatments and have not responded adequately) in a fourth program, Program D. Patients from Programs A and C, as well as from other hospitals, would be referred to Program D for institutional care only after adequate trials of Program B treatments.

If the funding for Program D has to be found within the hospital's existing resources, then the funds gradually liberated by the progressive shrinkage of Program C could be a source.

Matrix Management Model

The Task Force proposal suggests that the matrix management model, which is partially applied in the hospital, be universally applied. I fully support this, and would stress the necessity to adopt this model's philosophy regarding distribution of and control over financial resources.

In existing successful organizations which use matrix management such as engineering firms, the funds used to pay professional personnel are initially allocated to the program or project which uses those funds to "buy" the needed services from the professional group which employs the individuals. Failure to do this results in situations in which the responsibility for satisfactory performance is assigned to programs which do not have control over the resources necessary to provide that performance, ie responsibility without authority.