THE POWER TO RECOVER

2011-2014 Strategic Plan

Douglas

INSTITUT UNIVERSITAIRE EN SANTÉ MENTALE

MENTAL HEALTH UNIVERSITY INSTITUTE

www.douglas.qc.ca

STRATEGIC PLANNING PROCESS

Nicole Germain
Assistant to the Executive Director

WRITING AND TRANSLATION

Nicole Germain

GRAPHIC AND INTERACTIVE DESIGN / ILLUSTRATIONS

Bivouac Studio

PHOTOGRAPHY

Bivouac Studio

PRINTING

Franza

PUBLICATION COORDINATION

Executive Office of the Institute

DOUGLAS MENTAL HEALTH UNIVERSITY INSTITUTE

6875 LaSalle Blvd.
Montreal, Quebec H4H 1R3

(514) 761-6131, extension 2759

514 762-3043

directiongenerale@douglas.mcgill.ca

www.douglas.qc.ca

Douglas
INSTITUT UNIVERSITAIRE EN SANTÉ MENTALE
MENTAL HEALTH UNIVERSITY INSTITUTE

McGill

Centre collaborateur OMS de Montréal pour la recherche et la formation en santé mentale

Montreal WHO Collaborating Centre for Research and Training in Mental Health

FOREWORD

On behalf of the Douglas Mental Health University Institute, its Research Centre, and the Foundation, we are very proud to present the 2011-2014 Strategic Plan.

This Strategic Plan aims to encourage everyone working at the Douglas, our partners, each person who receives our services, as well as their families and friends, to adopt a vision that is both inspiring and hopeful: **THE POWER TO RECOVER.**

The Plan announces the values and commitments of the Douglas and identifies the main directions that will guide our actions for the next three years. Committed to the recovery of people living with mental health problems, the Douglas values **excellence**, **innovation**, and **human potential** based on **commitment** and **collaboration**. These values are at the core of our strategic directions and objectives.

We are proud of the significant progress made during the course of the last Strategic Plan and our vision stems from these achievements in an effort to strengthen our clinical, research, teaching and evaluation activities as well as knowledge exchange and application.

We are currently experiencing important changes in light of the departure of the Executive Director of the Institute and the Scientific Director of the Research Centre, but we believe that this Strategic Plan will help us stay on course. A leadership change is indeed a significant challenge, but the caliber of our resources and our values are a promise of success for the future.

This Strategic Plan is inspired from the work conducted by the Mental Health Commission of Canada, the *ministère de la Santé et des Services sociaux,* and our own experts. It is the fruit of extensive consultations held in 2010 and 2011, and of the sustained collaboration between the Institute, Research Centre, and Foundation. We would like to thank everyone who took part in this essential process towards the future development of the Douglas.

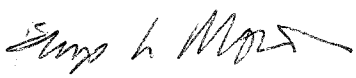
Mr. Michel Dalton
Acting Executive Director

Ms. Claudette Allard
President of the Board of Directors of the Institute

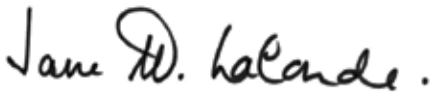
Mr. Alain Gratton, PhD
Scientific Director of the Research Centre

Ms. Jocelyne Lahoud
Administrative Director of the Research Centre

Mr. François Morin
President of the Board of
Directors of the Research Centre



Ms. Jane Lalonde
President and Chief Operating Officer of the Foundation



Ms. Marie Giguère
President of the Board of Directors of the Foundation

TABLE OF CONTENTS

"FOR ME, RECOVERY IS LIVING THE LIFE I WANT TO LIVE!"

JANINA KOMAROFF
Research Assistant

INTRODUCTION

1

Mental health problems represent an incredible burden not only in health care terms, but also at the economic and social levels for the person living with a mental health problem as well as for their family and friends. Mental illness affects every one of us either directly or indirectly.

Approximately 20% of individuals will experience a mental illness during their lifetime, while the remaining 80% will be affected by an illness in family members, friends, or colleagues.[1] In fact, epidemiological data indicate that, each year, roughly 3% of the population will experience a serious mental illness, and that another 17% will experience mild to moderate illness.[2] Other recent studies conducted in the United States show much higher numbers.[3]

A study published in 2008 in *Chronic Diseases in Canada* by the Public Health Agency of Canada[4] evaluated the total economic burden in Canada in 2003 to be about $51 billion using a comprehensive measure of the incremental economic burden of mental illness. This measure takes into account the use of medical resources and productivity losses due to long-term and short-term disability as well as reductions in health-related qualify of life (HRQOL) for both the diagnosed and undiagnosed population with mental illness. This economic burden places mental health problems among the most expensive medical problems in Canada.

It is therefore not surprising to see that the different government levels now recognize mental health as an uncontested priority. The Quebec government has identified priorities in mental health in its Mental Health Action Plan (*Plan d'action en santé mentale – La force des liens*[5]; May 2005), and the Canadian government has done the same in "Out of the Shadows at Last"[6] (May 2006) and "Towards Recovery & Well-Being – A Framework for a Mental Health Strategy for Canada."[7] (November 2009).

1 Health Canada Editorial Board on Mental Illnesses in Canada. *A Report on Mental Illnesses in Canada*. Ottawa: Health Canada, 2002.

2 Standing Senate Committee on Social Affairs, Science and Technology. *Out of the Shadows at Last, Transforming Mental Health, Mental Illness and Addiction Services in Canada*. Ottawa: Parliament of Canada, 2006.

3 Kessler, Ronald C., et al. "Prevalence, Severity, and Comorbidity of 12-Month DSM-IV Disorders in the National Comorbidity Survey Replication." *Arch Gen Psychiatry* 62.6 (2005): 617-627.

4 Lim, K. L. et al. "A New Population-Based Measure of the Economic Burden of Mental Illness in Canada" *Chronic Disease in Canada* (Public Health Agency of Canada) 28.3 (2008): 92-98.

5 Ministère de la Santé et des Services sociaux. *Plan d'action en santé mentale – La force des liens*. Québec: MSSS, 2005.

6 Standing Senate Committee on Social Affairs, Science and Technology. *Out of the Shadows at Last, Transforming Mental Health, Mental Illness and Addiction Services in Canada*. Ottawa: Parliament of Canada, 2006.

7 Mental Health Commission of Canada. *Towards Recovery & Well-Being – A Framework for a Mental Health Strategy for Canada*. Ottawa: MHCC, 2009.

This wave of support for mental health is present in an increasing number of countries around the world.

Our 2006-2011 Strategic Plan allowed us to integrate the different provincial and national strategies, and to translate them into actions specific to the mental health university institute we became in 2006. That Strategic Plan brought with it a number of significant changes both at the strategic and organizational levels.

The current Strategic Plan is based on these achievements as well as on those of the Research Centre. It builds on the accomplishments of the last Strategic Plan and sets a roadmap for the Douglas community for the next three years. It invites us to travel together in the same direction and will guide us to get there.

"FOR ME, RECOVERY IS THE REALIZATION OF A PERSON'S FULL POTENTIAL BEYOND THEIR ILLNESS."

MIMI ISRAËL, MD
Head of the Department of Psychiatry

MEMBERS OF THE STRATEGIC PLAN COMMITTEE

Ms. Claudette Allard
President of the Board of Directors of the Institute

Mr. Pierre Arcand
Member of the Board of Directors of the Institute

Ms. Martha Bishop
Member of the Board of Directors of the Institute

Ms. Anne Crocker, PhD
Director of the research theme "Service, Policy and Population Health"

Mr. Michel Dalton
Director of Financial and Informational Resources

Ms. Amparo Garcia
Clinical-Administrative Director of Clinical Activities, Knowledge Transfer and Teaching

Ms. Nicole Germain
Assistant to the Executive Director and Project Manager of the strategic planning process

Ms. Michelle Gilbert
Director of Human Resources

Mr. André Giroux,
Member of the Board of Directors of the Institute

Mr. Jacques Hendlisz
Executive Director

Mr. Jacques Hurtubise
Member of the Board of Directors of the Institute

Dr. Mimi Israël
Head of the Department of Psychiatry

Dr. Ridha Joober
Director of the research theme "Schizophrenia and Neurodevelopmental Disorders"

Ms. Janina Komaroff
Research Assistant and service user

Ms. Jocelyne Lahoud
Administrative Director of the Research Centre

Ms. Jane Lalonde
President and Chief Operating Officer of the Foundation

Mr. Naguib Mechawar, PhD
Director of the research theme "Mood, Anxiety and Impulsivity Disorders"

Mr. Daniel Mercier
Member of the Board of Directors of the Foundation

Mr. François Morin
President of the Board of Directors of the Research Centre

Mr. Jens Pruessner, PhD
Director of the research theme "Aging and Alzheimer Disease"

Mr. Rémi Quirion, PhD
Scientific Director of the Research Centre

Ms. Hélène Racine
Director of Nursing and Director of Quality

Ms. Renée Sauriol
Director of Communications and Public Affairs

Mr. Ronald Sehn
Director of Technical Services and Facilities

Dr. Jean-Bernard Trudeau
Director of Professional and Hospital Services and Medical Director of Clinical Activities, Knowledge Transfer and Teaching

STRATEGIC PLANNING PROCESS

At the beginning of 2010, the Board of Directors agreed to extend the 2006-2010 Strategic Plan for an additional year and mandated the Executive Director to start the process to draft a new Strategic Plan that would take effect in 2011.

A series of consultative activities then took place in the spring of 2010, which consisted of surveying the following: patients and their families; employees; consultative councils; the Beneficiaries' Committee; physicians; researchers; managers; health care professionals; and several external partners such as the *ministère de la Santé et des Services sociaux* (MSSS), the Montreal Health and Social Services Agency (Montreal Agency), the McGill Integrated University Health Network (RUIS McGill for *Réseau universitaire intégré de santé de l'Université McGill*), hospitals of the McGill network, psychiatric hospitals, community organizations and partner *Centre de santé et de services sociaux* (CSSSs), as well as the Mental Health Commission of Canada (MHCC). In total, close to 250 people were consulted in focus groups, think tanks, or individual interviews.

This wide consultation process allowed us to perform an organizational scan and identify strengths, areas for improvement, and opportunities and challenges in the environment, as perceived by the people consulted. The organizational diagnosis was then presented to the Strategic Planning Committee composed of representatives of the Institute, Research Centre, and Foundation, as well as a service user. The Committee also had the honour of meeting with Professor Henry Mintzberg to discuss the strategic planning process, its pitfalls, and lessons to learn in the future. As we will see later, Professor Mintzberg underlined the need for the Institute to adopt a flexible Strategic Plan that could be adjusted to our changing environment.

A consultative group then met regularly to draft a proposal that specified the values and mission, clarified the mandate and vision, and identified the strategic directions and objectives based on the organizational diagnosis and on the role of the Douglas as a mental health university institute. This small consultative group was composed of representatives of the Institute, Research Centre, and Foundation, and a service user.

The proposals resulting from the group's discussions were then the subject of further consultation with different individuals and groups before being presented to the Strategic Planning Committee and, finally, to the Boards of Directors for adoption.

FRAMEWORK OF THE STRATEGIC PLAN

The present Strategic Plan is inspired by the increasing volume of work conducted by the different governments, researchers, and organizations dedicated to mental health. We particularly note the Mental Health Action Plan of the MSSS[8] and "Towards Recovery & Well-Being – A Framework for a Mental Health Strategy for Canada"[9] of the MHCC. The Plan also responds to the objectives of the MSSS in its 2010-2015 Strategic Plan[10] and of the Montreal Agency in its 2010-2015 Strategic Plan.[11] Furthermore, it is aligned with McGill University strategies and the designation criteria for mental health university institutes and integrates required organizational practices of Accreditation Canada.

[8] Ministère de la Santé et des Services sociaux. *Plan d'action en santé mentale – La force des liens.* Québec: MSSS, 2005.

[9] Mental Health Commission of Canada. *Towards Recovery & Well-Being – A Framework for a Mental Health Strategy for Canada.* Ottawa: MHCC, 2009.

[10] Ministère de la Santé et des Services sociaux. *Plan stratégique 2010-2015.* Québec: MSSS, 2010.

[11] Agence de la santé et des services sociaux de Montréal. *Plan régionale de santé publique 2010-2015 : Des priorités pour des Montréalais en santé.* Montréal: Agence de la santé et des services sociaux de Montréal, 2011.

The 2011-2014 Strategic Plan addresses major stakes in mental health and clarifies the contribution of the Douglas Institute. As stated by the vision of **The Power to Recover**, the Strategic Plan covers the aspects needed for a person living with a mental health problem to realistically aspire to live a fulfilling and satisfying life. The Plan deals with various facets that make recovery possible: destigmatization, integration of people living with mental health problems and their friends and families into the care process, global health, partnership and complementarity, population needs, access to and fluidity of services, service quality and patient safety, prevention, best practices, research, teaching and knowledge exchange and application.

This Plan is also a follow-up to the objectives set in the last Strategic Plan, which brought forth several strategic, structural, and organizational changes in response to the following: the health system reform towards a hierarchical health system and populational responsibility, the implementation of the Mental Health Action Plan, and the criteria related to the mental health university institute mandate.

CONSOLIDATED, INTEGRATED, AND FLEXIBLE STRATEGIC PLAN

CONSOLIDATED

Given the success of the last Strategic Plan, which was more than 90% fulfilled, the current Strategic Plan aims to build upon the achievements of recent years and clarify expectations for the future. The Plan ensures the consolidation of the Institute mandate, the Douglas' role in providing specialized and highly specialized services, and the integration of all aspects of our mission. The Plan builds on the accomplishments of the clinical programs in implementing the Framework for the Consolidation of Clinical Programs developed by the Clinical Activities, Knowledge Transfer and Teaching Directorate (DACTCE for *Direction des activités cliniques, de transfert des connaissances et d'enseignement*), which is based on the Mental Health Action Plan. Finally, the Plan pursues the development of the Research Centre in terms of research themes and teams as well as infrastructure.

INTEGRATION

The 2011-2014 Strategic Plan, as was the case for the 2006-2011 Strategic Plan, is an integrated plan covering the objectives of the Institute, Research Centre, and Foundation and thereby allows the overall Douglas community to share a global and coherent vision of the various directions. An integrated plan makes it possible to link the various components of the organization and ensure that everyone shares the same vision and ambitions and moves in the same direction to achieve objectives.

The constraints of our environment are numerous and expectations wide-ranging. This is why it is important that the Strategic Plan take into account these different aspects and integrate them within a coherent and comprehensive document. Consequently, strategic directions and objectives contained in the plan follow from the last Strategic Plan while at the same time integrating, as we have seen, the requirements of the different government levels in all aspects of the mission of the Institute.

FLEXIBILITY

The last strategic plans allowed us to realize that changes in our internal or external environment have a significant impact on our ability to reach our organizational objectives and that it is therefore wise to integrate a certain level of flexibility in our planning in order to take our environment into account and adapt to it. Furthermore, as Professor Mintzberg

mentioned to us,[12] too often the learning process that occurs during the strategic planning process itself is, once the Plan is adopted, replaced by a more rigid framework that hinders learning, entrepreneurship, and even the vision, hence making it difficult to adapt to the changing environment.

It was therefore decided to provide the Institute with a Strategic Plan that sets major strategic directions and objectives without linking them to stringent, detailed, measurable targets that would hinder our ability to adapt to changes in our environment and seize emerging opportunities. Targets and indicators will be set by each director responsible for individual strategic objectives and adjusted as needed.

Furthermore, the Strategic Planning Committee will meet on an annual basis to review progress in reaching objectives, seize emerging strategic opportunities, and make the necessary adjustments to the objectives and targets in response to changes in the external environment (obligations or expectations) or changes in the internal environment as, for example, the particular challenges related to the departure of the Executive Director of the Institute or the Scientific Director of the Research Centre.

The general model proposed by Professor Mintzberg was embraced by the Strategic Planning Committee in the hopes that it would provide us with a vision and main directions while allowing us to continue the learning process, remain flexible in order to quickly and efficiently adapt to changes, and stay open enough to seize opportunities emerging from clinical programs, research, evaluation, or new partnerships.

"IN A TIME OF DRASTIC CHANGE IT IS THE LEARNERS WHO INHERIT THE FUTURE. THE LEARNED USUALLY FIND THEMSELVES EQUIPPED TO LIVE IN A WORLD THAT NO LONGER EXISTS."

ERIC HOFFER

[12] Summary of the discussions with and the Strategic Planning Committee presentation to Professor Henri Mintzberg, 2010.

THE CONTEXT THE NEEDS

2

The burden of mental illness is significant and the demand for services is changing. It is important to know the clientele well and understand the evolution of their needs in order to plan our strategies and services.

BURDEN OF MENTAL ILLNESSES

FOR THE PERSON

In 1996, the World Health Organization (WHO), together with the World Bank and the Harvard School of Public Health, published the first volume of *The Global Burden of Disease*.[13] Before this publication, illnesses were ranked in terms of their impact on mortality rates. The WHO project aimed to weigh the impact of diseases by integrating other factors. The unit of measurement adopted is disability-adjusted life years (DALYs). This unit measures the number of expectable years of life lost (to death) or lived with disability; a DALY is therefore a healthy year lost. Using this unit of measurement has revealed a drastically different picture of the global burden of disease from that seen when only mortality was counted. It has made it possible to demonstrate the public health burden of psychiatric disorders. According to the WHO, mental health disorders are projected to be, by 2030, the leading cause of morbidity in industrialized countries.[14,15]

Mental illness and addiction are among the most important causes of absenteeism worldwide and now exceed days lost as a result of physical conditions.[16] Substance abuse problems are closely associated to mental health disorders: 25 to 50% of people

LEADING CAUSES OF BURDEN OF DISEASE IN DEVELOPED COUNTRIES	% OF HEALTHY YEARS LOST DALYs
1- Unipolar depressive disorders	**8.2**
2- Ischaemic heart disease	6.3
3- Cerebrovascular disease	3.9
4- Alzheimer's disease and other dementias	**3.6**
5- Alcohol-related disorders	**3.4**

[13] Lopez, A.D., and C.C.J.L. Murray. "The Global Burden of Disease: 1990-2020." *Nature Medicine* 4.18 (1998): 1241-1243.

[14] World Health Organization. *The Global Burden of Disease: 2004 Update.* WHO Library Cataloguing-in-Publication Data, 2008.

[15] Mathers, C. D., and D. Loncar. "Projections of Global Mortality and Burden of Disease from 2002 to 2030." *PLoS Med* 3.11 (2006): e442.

[16] Standing Senate Committee on Social Affairs, Science and Technology. *Out of the Shadows at Last, Transforming Mental Health, Mental Illness and Addiction Services in Canada.* Ottawa: Parliament of Canada, 2006.

FIGURE1: TEN LEADING CAUSES OF BURDEN OF DISEASE, WORLD, 2004 AND 2030

2004 DISEASE OR INJURY	AS% OF TOTAL DALYs	RANK	RANK	AS% OF TOTAL DALYs	2030 DISEASE OR INJURY
Lower respiratory infections	6.2	1	1	6.2	Unipolar depressive disorders
Diarrhoeal diseases	4.8	2	2	5.5	Ischaemic heart disease
Unipolar depressive disorders	4.3	3	3	4.9	Road traffic accidents
Ischaemic heart disease	4.1	4	4	4.3	Cerebrovascular disease
HIV / AIDS	3.8	5	5	3.8	COPD
Cerebrovascular disease	3.1	6	6	3.2	Lower respiratory infections
Prematurity and low birth weight	2.9	7	7	2.9	Hearing loss, adult onset
Birth asphyxia and birth trauma	2.7	8	8	2.7	Refractive errors
Road traffic accidents	2.7	9	9	2.5	HIV / AIDS
Neonatal infections and other*	2.7	10	10	2.3	Diabetes mellitus
COPD	2.0	13	11	1.9	Neonatal infections and other*
Refractive errors	1.8	14	12	1.9	Prematurity and low birth weight
Hearing loss, adult onset	1.8	15	15	1.9	Birth asphyxia and birth trauma
Diabetes mellitus	1.3	19	18	1.6	Diarrhoeal diseases

COPD: Chronic obstructive pulmonary dieases

* This category also includes other non-infectious causes arising in the perinatal period apart from prematurity, low birth weight, birth trauma, and asphyxia. These non-infectious causes are responsible for about 20% of the DALYs shown in this category.

diagnosed with a mental illness have concurrent substance abuse problems.[17] Despite a recent improvement, the suicide rate in Quebec is still one of the highest on the continent and suicide remains the main cause of death in individuals 35 years of age or younger. In addition to high prevalence and cost, mental health disorders are also associated with greater discrimination, significant burden for families, and a number of risk factors (e.g., poverty, social isolation, crime, smoking, suicide attempts, etc.).

[17] Skinner, W. et al. *Concurrent Substance Use and Mental Health Disorders: An Information Guide.* Toronto: Centre for Addiction and Mental Health, 2004.

FOR FAMILIES AND FRIENDS

The burden of mental illnesses is not only heavy for the person living with a mental health problem, but also for their family and friends. Mental illnesses impact school achievement, professional success, as well as personal, social, and familial relationships. According to the MHCC,[18] providing care for a person with a mental health problem or illness can exact a heavy toll – physically, emotionally, and economically. In one study, 27% of caregivers reported a reduction in income and 29% incurred major financial costs.[19]

FOR SOCIETY

A recent study of the Institute of Health Economics[20] shows that:

- At least $14.3 billion in public expenditures went towards mental health services and support in Canada.
- The largest component of costs was pharmaceutical followed by hospitalization.
- In Canada, 7.2% of total government health expenditures go to mental health.
- Non-profit mental health organizations reported receiving $847.9 million from provincial sources, $18.3 million from municipal sources, and $41 million from Federal sources.
- Annually, short-term mental health related disabilities cost between $180 and $300 million to the private sector, while long-term mental health related disabilities cost $135 million.

This same study highlights the difficulty in evaluating the total cost of mental illnesses due to the multitude of players involved both from the public and private sectors who often work in isolation from each other.

A study by Lim et al.[21] attempted to fill the gaps in order to provide a more global economic burden of mental illnesses. According to this study, the total economic burden in Canada in 2003 was about $51 billion, with close to 30% of the cost incurred by the **undiagnosed** mentally ill population. Loss of health utilities was by far the dominating effect, accounting for more than 50% of the total burden, or around $28 billion. The value of work loss from absenteeism (short-term disability) was about 10% higher than the value of work loss from unemployment (long-term disability); together they account for about 35% of the burden. Medical expenses accounted for less than 10% of the total burden.

If the same ratio was applied to Quebec, the total economic burden could reach more than $7.5 billion since health-related expenses in Quebec amount to $757 million.[22]

[18] Mental Health Commission of Canada. *Towards Recovery & Well-Being – A Framework for a Mental Health Strategy for Canada*. Ottawa: MHCC, 2009: 63.

[19] Dore, G., and S. E. Romans. "Impact of Bipolar Affective Disorder on Family and Partners." *Journal of Affective Disorders* 67.1-3 (2001): 147-158.

[20] Jacobs, P. C., et al. *The Cost of Mental Health and Substance Abuse in Canada*. Alberta, Institute of Health Economics, 2010.

[21] Lim, K. L. et al. "A New Population-Based Measure of the Economic Burden of Mental Illness in Canada" *Chronic Disease in Canada* (Public Health Agency of Canada) 28.3 (2008): 92-98.

[22] Ministère de la Santé et des Services sociaux. *Plan d'action en santé mentale – La force des liens*. Québec: MSSS, 2005: 78.

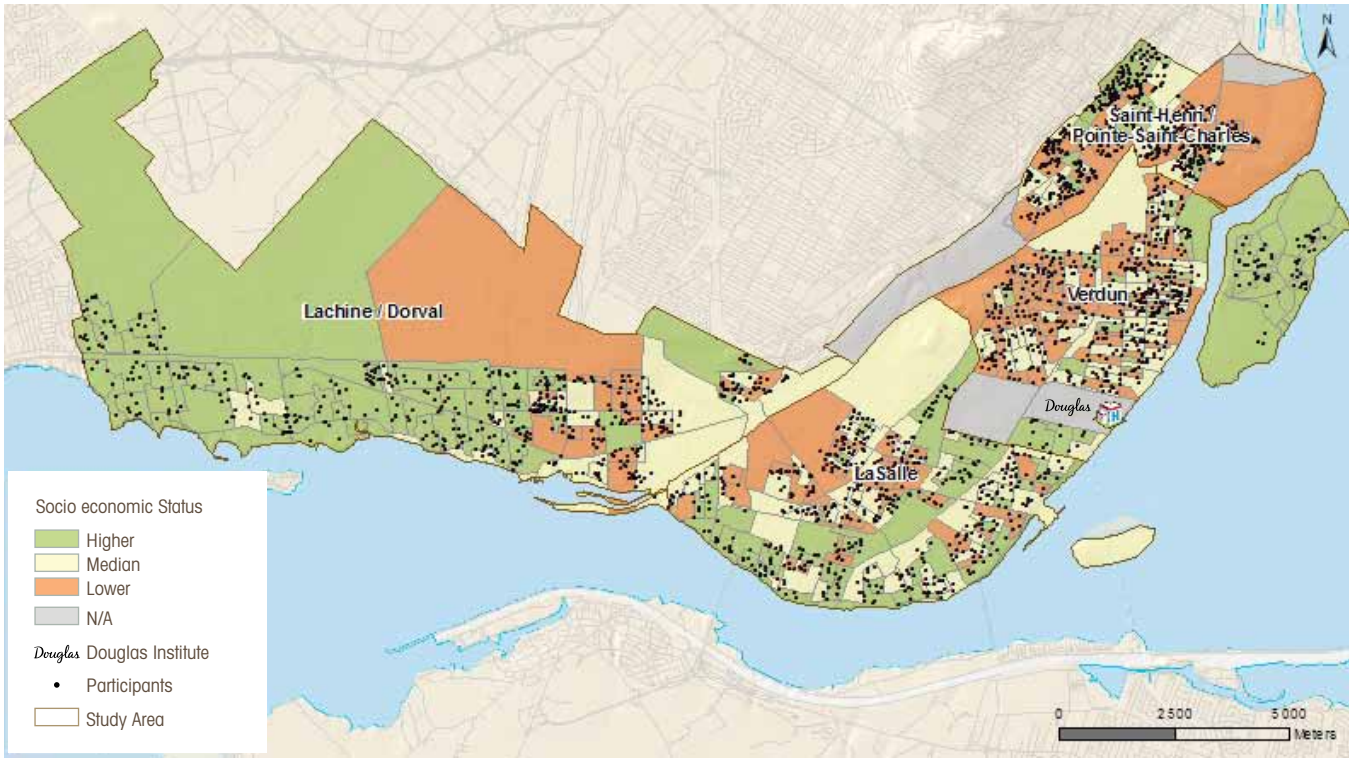
POPULATION TRENDS AND EVOLUTION OF NEEDS

The CIHR[23] Team in Social and Psychiatric Epidemiology Project, directed by a Douglas researcher, Jean Caron, PhD, aims to establish the basis for a permanent tool to develop and transfer mental health knowledge.

The research team, launched in 2005, has set up the first social and psychiatric epidemiology catchment area in Canada. This catchment area is located in the southwest sector of Montreal. It comprises more than 258,000 residents of the neighborhoods of Dorval, Lachine, and LaSalle (CSSS Dorval-Lachine-LaSalle) and Point-St-Charles, Saint-Henri, and Verdun (CSSS South-West–Verdun).

Of this sample, more than 2,400 randomly selected individuals collaborated in the study (i.e. 1,200 residents per CSSS). This project made it possible to identify psychosocial and environmental determinants that affect the population's mental health and quality of life.

As we will see in upcoming sections, the data collected through this project are particularly important to the Douglas as 64% of our clientele come from these two CSSSs.



[23] Canadian Institutes in Health Research.

PREVALENCE

This information, as well as the results of the Canadian Community Health Survey (CCHS), cycle 1.2,[24] allows us to compare the South-West region of Montreal, the province of Quebec, and Canada as a whole with regard to the prevalence of certain disorders (graph 1).

The CCHS also reveals that people who have a low income show, in a greater proportion:

- at least one psychiatric disorder during their lifetime;
- one mood disorder during a 12-month period;
- one anxiety disorder during a 12-month period.

This explains, at least in part, the high prevalence observed in the South-West region of Montreal:

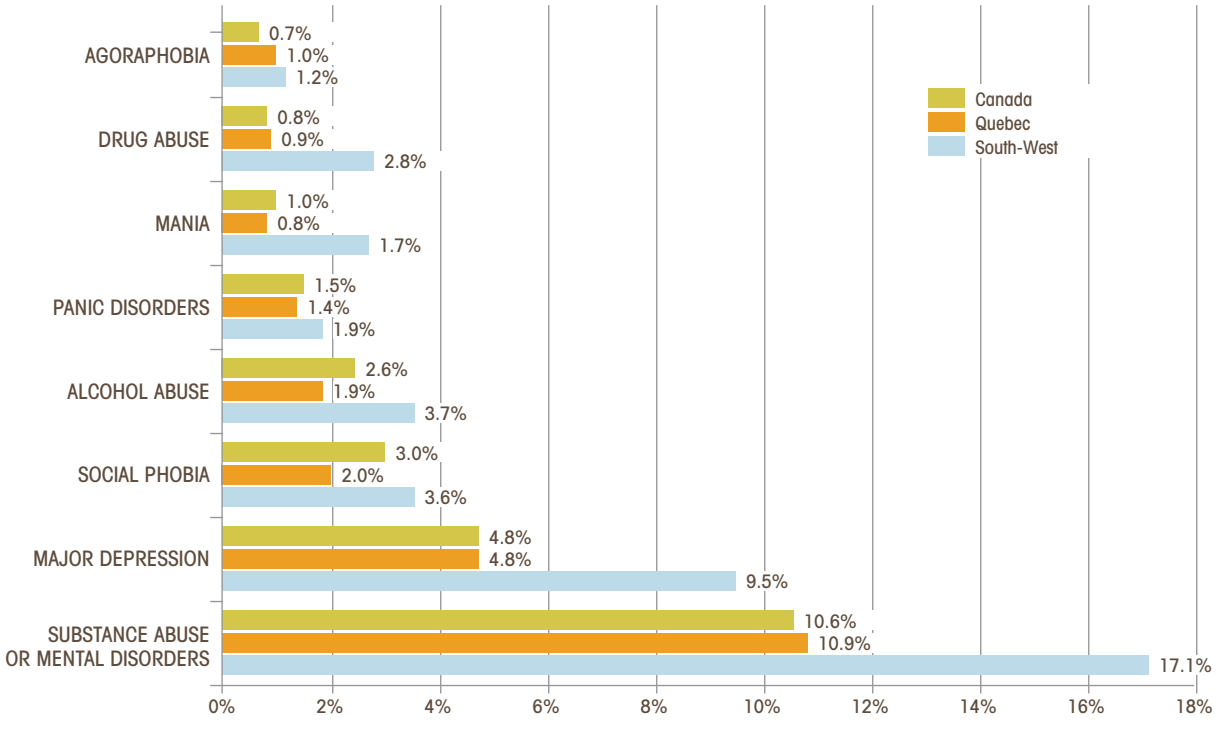
- Canada: ≃ 18% of low income;
- Quebec: ≃ 25% of low income;
- South-West of Montreal: ≃ 33% of low income.

EVOLUTION OF PREVALENCE

Various recent studies looking into prevalence over time seem to indicate a relative stability with a few exceptions:

- **Schizophrenia:** no apparent decrease or increase[25, 26]

GRAPH 1: PREVALENCE OF VARIOUS MENTAL HEALTH DISORDERS



[24] Stats Canada. *Canadian Community Health Survey - Mental Health* (CCHS). Stats Canada, 2011.

[25] Bresnahan, M., and E. Susser. "Investigating Socioenvironmental Influences in Schizophrenia: Conceptual and Design Issues." *The Epidemiology of Schizophrenia*. Cambridge: Cambridge University Press, 2002: 5-17.

[26] Kirkbride, J. B. "Impact of Contextual Environmental Mechanisms on the Incidence of Schizophrenia and Other Psychoses." *Advances in Schizophrenia Research*. Ed. W.F. Gattaz and G. Busatto. New York: Springer, 2009.

- **Bipolar affective disorders:**
  stable or slight increase[27]

- **Depression:**
  In the early 1990s, studies suggested an increase in prevalence[28, 29, 30,31]
  - The situation is less clear in more recent studies:
    - prevalence increase[32]
    - stable or declining prevalence[33, 34]

- **Anxiety:**
  - Increase of the average intensity of symptoms in younger people[35]
  - However, in a recent study, the prevalence has not increased[36]

FIRST ONSET OF MENTAL HEALTH DISORDERS

According to a study conducted in the United States by Kessler et al.,[37] 50% of mental health disorders listed in the DSM-IV (Diagnostic and Statistical Manual of Mental Disorders) first appear before the age of 14 and 75% appear before the age of 24. Just as important, another study of Kessler et al.[38] reports that people with these early-onset disorders often wait more than a decade before seeking treatment, and present with seriously impairing disorders that might have been easier to treat if the person had sought treatment earlier in the course of illness.

The authors therefore stress the importance of early detection and intervention to reduce the persistence or severity of the illness and prevent the onset of secondary disorders.

The Quebec Director of Mental Health noted in his presentation during the 9th *Journées annuelles de santé mentale* held in May 2011[39] that 70% of mental illnesses first appear before the age of 20, but that early intervention allows 70% of young people to recover when issues are addressed at first onset. Therefore, more than 50% of current service users would not need our services if we focused on early intervention.

27 Sherazi, R., et al. "What's new? The Clinical Epidemiology of Bipolar I Disorder." *Harvard Review of Psychiatry* 14.6 (2006): 273-284.

28 Burke, K. C., et al. "Comparing Age at Onset of Major Depression and Other Psychiatric Disorders by Birth Cohorts in Five US Community Populations." *Arch Gen Psychiatry* 48.9 (1991): 789-795.

29 Klerman, G. L., and M. M. Weissman. "Increasing Rates of Depression." *JAMA* 261.15 (1989): 2229-2235.

30 Weissman, M.M., et al. "The Changing Rate of Major Depression: Cross-National Comparisons." *JAMA* 268.21 (1992): 3098-3105.

31 Wickramaratne, P. J., et al. "Age, Period and Cohort Effects on the Risk of Major Depression: Results from Five United States Communities." *J Clin Epidemiol* 42.4 (1989): 333-343.

32 Ompton, W.M., et al. "Changes in the Prevalence of Depression and Comorbid Substance Use Disorders in the United States between 1991-1992 and 2001-2002." *The American Journal of Psychiatry* 163.12 (2006): 2141-2147.

33 Murphy, J. M., et al. "Anxiety and Depression: A 40-Year Perspective on Relationships Regarding Prevalence, Distribution, and Comorbidity." *Acta Psychiatrica Scandinavica* 109.5 (2004): 355–375.

34 Eaton, W. W., et al. "Case Identification in Psychiatric Epidemiology: A Review." *Int Rev Psychiatry* 19.5 (2007): 497–507.

35 Twenge, J. M. "The Age of Anxiety? Birth Cohort Change in Anxiety and Neuroticism, 1952–1993." *J Pers Soc Psychol* 79.6 (2000): 1007–1021.

36 Murphy, J. M., et al. "Anxiety and Depression: A 40-year Year perspective on Relationships regarding Prevalence, Distribution, and Comorbidity." *Acta Psychiatrica Scandinavica* 109.5 (2004): 355–375.

37 Kessler, R. C., et al. "Lifetime Prevalence and Age-of-Onset Distributions of DSM-IV Disorders in the National Comorbidity Survey Replication." *Arch Gen Psychiatry* 62.6 (2005): 593-602.

38 Kessler, R. C., et al. "Lifetime Prevalence and Age-of-Onset Distributions of Mental Disorders in the World Health Organization's World Mental Health Survey Initiative." *World Psychiatry* 6.3 (2007): 168-176.

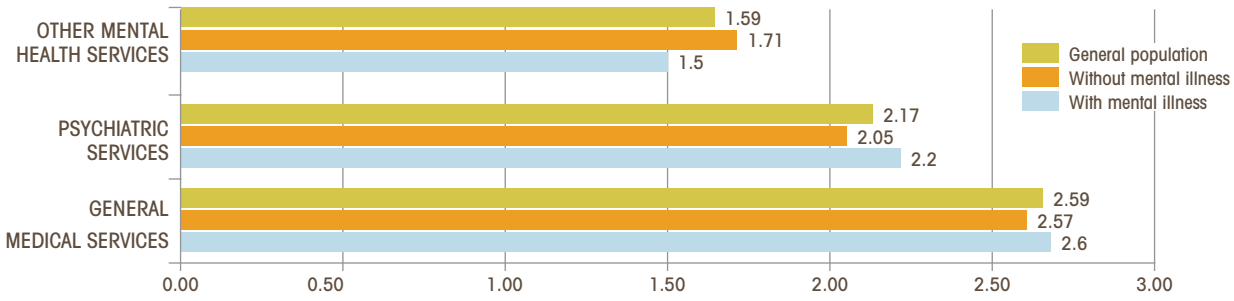
39 Ministère de la Santé et de Services sociaux. "Journées annuelles de santé mentale 2011- La santé mentale s'éclate." MSSS, 2011.

EVOLUTION IN THE USE OF SERVICES

It is interesting to note however that, even though the prevalence in mental illness is rather stable, the use of services has increased significantly throughout the years. A study conducted in the United States[40] clearly shows an increase in the utilization of services for mental health reasons.

PERIOD	PREVALENCE OF MENTAL ILLNESS	UTILIZATION OF SERVICES		
		PEOPLE WITH MENTAL ILLNESS	PEOPLE WITHOUT MENTAL ILLNESS	GENERAL POPULATION
1990-1992	29.4%	20.3%	8.8%	12.2%
2001-2003	30.5%	32.9%	14.5%	20.1%

GRAPH 2: UTILIZATION OF SERVICES THAT INCREASED SIGNIFICANTLY (P<0,05)



Other studies on the use of out-patient services[41] conducted in the United States corroborate this increase in the utilization of services as shown in the table below:

	TREATED DEPRESSION / 100 CITIZENS	TREATED ANXIETY / 100 CITIZENS
1987 - *National Medical Expenditure*	0.73	0.43
1997 - *Medical Expenditure Panel Survey*	2.33	0.83

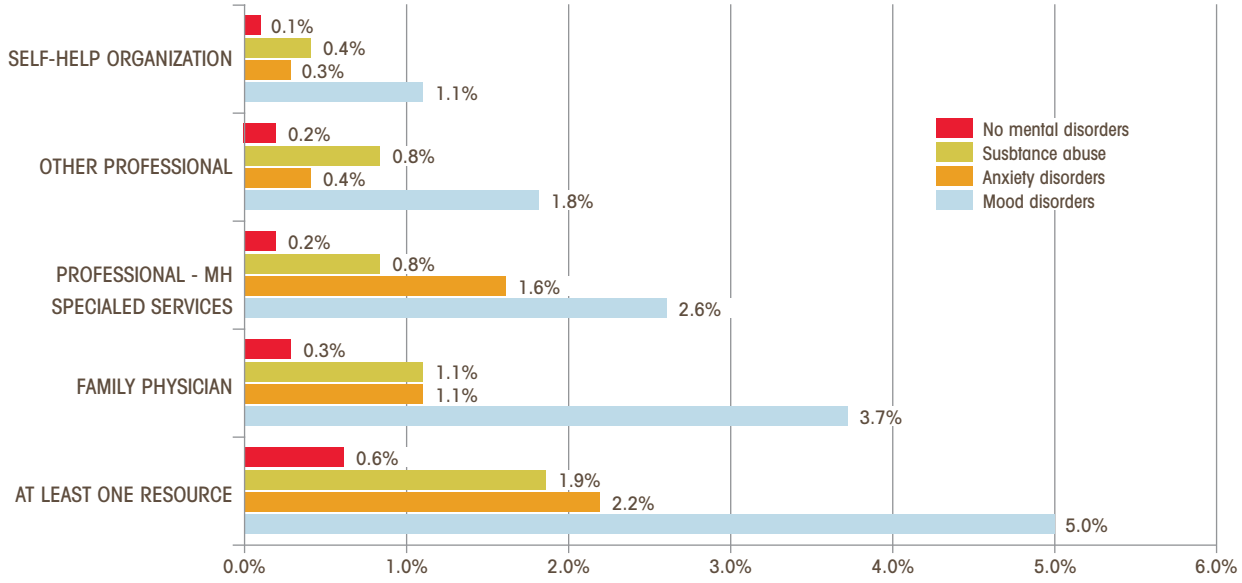
[40] Kessler, R. C., et al. "Prevalence and Treatment of Mental Disorders, 1990 to 2003." *N Engl J Med* 352.24 (2005): 2515-2523.

[41] Olfson, M., et al. "Psychotic Symptoms in an Urban General Medicine Practice." *The American Journal of Psychiatry* 159.8 (2002): 1412-1419.

TYPE OF SERVICES USED ACCORDING TO DIAGNOSIS

Data from the CCHS also show that utilization of services varies depending on the diagnosis. As shown in Graph 3, people diagnosed with mood disorders are more likely to consult 1st line services, especially their family doctor, while people with anxiety disorders have a tendency to consult specialized mental health services.

GRAPH 3: SITUATION IN QUEBEC ACCORDING TO THE CCHS 1.2
PERCENTAGE OF PEOPLE WHO CONSULT BY DIAGNOSIS



In summary:

- Mental illnesses constitute a heavy burden for the person living with one, as well as for their family and friends, and have a major economic impact on society.
- The prevalence of mental illness is high in the South-West region of Montreal as compared to the rest of Quebec and Canada.
- There are no clear data showing an increase in prevalence of mental illness (Axis 1 of DSM-IV).
- Mental health disorders first appear at a young age: 50% before the age of 14 and 75% before the age of 24.
- There is an increase in the use of services for mental health reasons.
- The type of services used varies depending on the diagnosis.

THE DOUGLAS IN THE PAST

3

HISTORY

Founded in 1881 by Alfred Perry as the Protestant Hospital for the Insane, the Douglas Hospital was so renamed in 1965. Having been designated as a university institute in mental health in June 2006, the Douglas changed its name to the **Douglas Mental Health University Institute** in May 2011.

The Douglas was built on the 165-acre site it still occupies to this day. The first patient was admitted in July 1890 and the Institute has continued to devote itself to improving knowledge about and treatment of mental illness ever since.

From the time of its founding to this day, the Institute has had to 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 at the time, the Douglas had to rely even more on the generosity of the public and on volunteerism. These traditions still hold true today and they account for one of the Institute's fundamental values of openness to the community, which led to the creation of the Auxiliary in 1959 and the Foundation in 1972. This openness continues to develop and has allowed us to successfully implement several community reintegration initiatives.

Recognized as a center of excellence, the Institute became 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 Institute has always been at the forefront of modern psychiatry. It was the Douglas that, in 1953, first introduced pharmacological treatment of psychoses to North America, which gave rise to the development of novel and decreasingly restrictive approaches and triggered deinstitutionalization in the mid-1960s.

Around that time, the Institute became increasingly committed to understanding the brain's biological mechanisms in order to improve knowledge about the causes of major mental illnesses. A leader in the field of mental health research, the Douglas Research Centre was officially created in 1979 and developed an outstanding international reputation. It became the first WHO Collaborating Centre in Canada 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 Institute was named the first psychiatric hospital to be accredited by the Canadian Council on Health Services

Accreditation (now called Accreditation Canada) — a testament to the importance we place on quality.

In order to ensure successful achievement of its goals, the Institute also invested into the community by providing seed money to different organizations involved in alleviating the plight of people living with mental health problems. 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. Thanks to a significant increase in out-patient 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 241 in-patients, and close to 10,000 out-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 Institute.

"FOR ME, RECOVERY IS SYNONYMOUS WITH INDEPENDENCE AND LIBERTY."

PIERRE NADEAU
Supervisor, C.A.D.R.E.

In fact, in the late 1990s and at the beginning of the millennium, the Institute catchment population increased by 47%, while budgets were cut by

approximately $10 million and the Institute was investing $4 million 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 due to a large number of 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 Institute opted for a new structure and several changes were implemented, which caused major adjustments in our ways of doing things. Two of these 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.

HEALTH SYSTEM AND THE MENTAL HEALTH ACTION PLAN

More recently, the health system reform towards a hierarchical health system and populational responsibility introduced in 2003, and the implementation of the Mental Health Action Plan in 2005 resulted in the Douglas transferring $5 million worth of resources to partner CSSSs for the implementation of their 1st line access points.

SERVICE HIERARCHY:

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.

3rd line:

Supports 1st and 2nd line services. They are only accessible upon referral. They are geared to address very complex disorders, which have a low prevalence rate and are so complex that they require an expertise not available in 2nd line services. Third-line services integrate research and teaching, and are identified by the RUIS, approved by the MSSS, and provided by university network affiliated hospital centres.

This significant reform of the health system called for the implementation of new local networks, each with a CSSS. The CSSSs have a collective responsibility for their respective catchment population and are therefore the gateway to the system. The reform also announced the implementation of integrated university health networks (RUIS) responsible for providing highly specialized 3rd line services. The Douglas, as a mental health university institute affiliated with the McGill RUIS, is not integrated with a CSSS, but is one of its partners.

The Mental Health Action Plan brought significant progress in promoting mental health, taking people's needs and empowerment into account, and reducing stigmatization, but there is still a long way to go to complete its implementation in the current context of shortage of resources. Certain components of the Mental Health Action Plan have been long to solve, namely the issue of the *psychiatre répondant*.[42] The implementation of the Mental Health Action Plan has also been particularly slow in Montreal due to the region's complexity and its specific challenges. So, even if the Douglas has transferred significant resources to the 1st line, access points are not completely in place and the majority of patients are still followed in 2nd line services, as will be shown later.

Advancements are very real, however, and we must continue to look toward the future. It is with this in mind that the Quebec Director of Mental Health recently announced his objectives in pursuing the improvement of the mental health care system. At the 9th *Journées annuelles de santé mentalé* held in May 2011,[43] he presented priorities that are fully aligned with most recent data as well as our own conclusions from the consultation process and the organizational diagnosis conducted in preparation for the present Strategic Plan.

Priorities particularly deal with: the implementation of a 1st line culture and community-based services; youth services including early prevention, detection, and intervention; adapting structures to needs, particularly when crossing from child to adult services (14-25 years of age); and services to native populations. Access to services remains a central aspect of ministerial directions.

An unavoidable factor in successfully achieving these objectives is psychiatric manpower. Quebec compares well with the rest of Canada in the number of psychiatrists per 100,000 population – Quebec has 13 psychiatrists per 100,000, ranking second after Ontario, which has 14. But, the majority of Quebec psychiatrists are in the Montreal region (22 per 100,000 people). However, the Montreal psychiatric manpower is advancing in age (106 of the 177 Quebec psychiatrists who could retire are in Montreal and 12 of them are at the Douglas). The Ministry recognizes that the situation is particularly difficult at the Douglas where there are only 10 psychiatrists per 100,000 adults while the Montreal average is 19 per 100,000. The pressure is all the more significant at the Douglas as we have a university mandate and our psychiatrists must therefore provide 3rd line services and take part in research and teaching activities.

[42] Psychiatrists in 2nd or 3rd line institutions who serve in an advisory role to 1st line healthcare practitioners.

[43] Ministère de la Santé et de Services sociaux. "Journées annuelles de santé mentale 2011- La santé mentale s'éclate." MSSS, 2011.

ACHIEVEMENTS OF RECENT YEARS

As we have seen, the health care reform was introduced in 2003, the Mental Health Action Plan in 2005, and the Douglas was designated as a Mental Health University Institute in 2006. The achievements stemming from the designation and the implementation of the last Strategic Plan have therefore set the stage for the priorities identified in the present Strategic Plan.

In the last Strategic Plan, our vision was based on three strategic directions:

1. **Require excellence and the integration of clinical, teaching and research activities:** This integrative approach was in line with the philosophy of the learning organization, interdisciplinarity, continued improvement, and search for excellence. It called for a renewed synergy.

   Of the 10 objectives, 8 were achieved while the other 2 have been integrated into the Framework for the Consolidation of Clinical Programs, which is now an objective of the current Strategic Plan. During the last Accreditation Canada survey held in April 2011, the surveyors pointed out the excellent integration of clinical, teaching, and research activities, which they qualified as palpable in the Institute. The Research Centre was also surveyed by the *Fonds de recherche du Québec - Santé* (FRQ-S) in 2011 and was awarded a general evaluation of "Excellent" — two of the four research themes were evaluated as "Exceptional" and the other two as "Excellent." As mentioned previously, the research project in Social and Psychiatric Epidemiology conducted by the CIHR team has allowed us to improve our knowledge of our clientele and forecast future trends and needs. We have also developed a physical environment project that reflects our vision of a modern institute. This novel project, founded on evidence-based design and the concept of a healing environment, has been accepted by the Montreal Agency and is now being evaluated by the MSSS. This project therefore remains a central focus of the current Strategic Plan.

2. **Improve knowledge and influence directions in mental health:** Destigmatization and partnerships underlie this strategic direction, which rests on the leadership of the members of the organization. The premise was that improving and sharing 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 a mental health problem to be integrated into a more welcoming environment. This direction also aimed to encourage people living with mental health problems to seek help without delay, empower themselves, and reach their full potential in the community.

   Our targets have been reached, but we must maintain our efforts. Clinical programs and the Research Centre have multiplied their knowledge exchange activities. Accreditation Canada has even awarded both the Knowledge Transfer Program in Eating Disorders and the Mini-Psych School of the Public Education Program with a mention of "Leading Practice." These activities are supported by the creation of a reference website in mental health that includes a partnership with *PasseportSanté.net*, which publishes mental health information produced by Douglas experts. The Research Centre has continued to develop and even exceed expectations. Finally, as will be covered later, several members of the Institute

take part in decision-making committees, have received appointments, or are solicited for their expertise, thereby ensuring an exceptional presence and influence of the Douglas at the local, regional, and international levels. The present Strategic Plan maintains this strategic direction with an aim to further increase the Institute's scope of influence.

3. **Consolidate a result-based culture:** This strategic direction called for excellence and rigour in order to achieve identified goals within a context of resource rationalization.

   Hence, within the framework of the last Strategic Plan, we have revised and improved our organizational structures to adapt to our environment, to our designation as an Institute, and to the Mental Health Action Plan. We have reorganized our clinical activities and regrouped them under the eight clinical programs we currently have. To achieve higher efficiency, we have also improved our management and decision-making tools and enhanced our overall quality and risk management activities. As we will see later, these achievements have allowed us to increase our volume of activities and drastically reduce waiting times to our services despite a significant reduction in our resources.

In addition to being the basis of the Strategic Plan, our designation as a mental health university institute has been a driving force for change as it **influenced the very culture of the organization**. This influence is reflected not only in the vision, mission, and values of the Douglas, but also in the communal sense of belonging and pride in being part of an organization recognized for its excellence.

The ramifications of this change in status are numerous, and include: the confirmation of the Douglas as a magnet organization for recruitment and retention; credibility with our partners that translates into a marked increase in participation in various training activities; noticeable changes in the organizational culture; and changes in the overall public perception regarding the organization and role of the Institute.

THE DOUGLAS IN THE PRESENT

4

As we have seen in previous pages, the 2011-2014 Strategic Plan is the result of wide consultation and of very stimulating and enriching analysis and reflection. We were thus able to confirm that the last Strategic Plan allowed the Douglas to position itself well in the context of the continually evolving health and social services network and, particularly, of the Quebec mental health network.

Important strategic, structural, and organizational changes were introduced in implementing the 2006-2011 Strategic Plan and, taking into account the advancements made during that period, it was agreed, following the reflection and consultation process, to adopt a plan built on the successes of the last Plan with strategic directions remaining largely the same.

This process has allowed us to further clarify our mission and vision and to validate them with our different partners and collaborators during the course of our consultations.

While the mission describes the fundamental purpose of the organization, the vision provides a preview of what will be a success. The vision is realistic but stimulating. Here then are the mission and the vision that will guide our actions for the next three years.

MISSION

In collaboration with people living with mental health problems, their families, and the community, the mission of the Douglas Mental Health University Institute is to:

- Offer cutting-edge care and services;
- Advance and share knowledge in mental health.

VISION

THE POWER TO RECOVER.

The widely acknowledge definition we are using to describe the concept of recovery in mental health is that of W. Anthony:[44]

> *Recovery is a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness.*

[44] Anthony, W. A. "Recovery from Mental Illness: The Guiding Vision of the Mental Health Service System in the 1990s." *Psychosocial Rehabilitation Journal* 16.4 (1993): 11-23.

Based on this vision, and in response to comments gathered throughout the strategic planning process, we have slightly adjusted our values — while keeping the patient at the center of our concerns — to highlight excellence in practices, innovation in teaching programs, and the significant contribution of research in advancing, exchanging, and applying knowledge in mental health. Essentially, these values have shaped the Douglas and they remain true to this day. We have therefore kept the same values, except for one, which was modified to be more inclusive and better aligned with the concept of recovery. The definitions of our values have also been improved to further reflect recovery and partnership.

These shared values constitute the fabric of the Institute, and are the basis of its organizational culture. They guide our strategic directions and our actions.

"FOR ME, RECOVERY IS ALWAYS HAVING HOPE, DESPITE ONE'S ILLNESS."

AMINE SAADI
Clinical-Administrative Chief

VALUES

Committed to the recovery of people living with mental health problems, the Douglas values **excellence**, **innovation** and **human potential** based on **commitment** and **collaboration**.

- **Excellence:** Have the courage to apply best practices with rigour, to question and assess ourselves, to integrate research into all of our activities, and to be a learning organization. Strive to achieve an optimal level of organizational efficiency.
- **Innovation:** Provide a stimulating and dynamic environment, where new knowledge is developed in order to better understand, share, care, and give hope.
- **Human potential:** Value potential and believe in people's ability to reach new heights. Build on existing knowledge through initiatives supported by sharing and partnering.
- **Commitment:** Carry out our mission to improve the quality of life of people living with mental health problems.
- **Collaboration:** Ensure that patients play an active role in the decisions pertaining to their care, and work with the interdisciplinary team towards their recovery. Develop and strengthen internal, community, academic, scientific, and international partnerships to make our vision a reality.

MANDATE

Article 89 of An Act Respecting Health Services and Social Services (ARHSSS), R.S.Q., Chapter S-4.2, defines an institute as follows: "…any centre operated by an institution which, in addition to carrying on the activities inherent in the mission of such a centre, participates in medical education, mainly in that medical discipline, under the terms of a contract of affiliation entered into under section 110, offers highly specialized or specialized medical services or services relating to family medicine, evaluates health technologies, and manages a research centre or research institute recognized by the Québec Research Fund–Health."

Moreover, in the specific field of mental health, the MSSS had particular objectives in designating university institutes in mental health. These objectives further clarify the scope of action of an Institute. These are covered in the designation report (literal translation):

- Promote a practicing university culture that is a source of useful knowledge for maintaining and developing the quality of services provided to people living with mental health problems and those close to them.
- Anchor teaching and research activities in a rich and diversified practice environment involving both serviced clientele and discipline-related, interdisciplinary, community or inter-sectorial expertise.
- Allow institutions involved, within the framework of their respective mission, to achieve ministerial directions in terms of mental health care in community- and hospital-based services as well as those specialized in rehabilitation and social integration support.

The Mental Health Action Plan added a complementary dimension to the role of a mental health university institute: "…to be innovative in the development of shared care practices, contribute to the best possible linkage between specialized and 1st line mental health services, and support the implementation of social integration measures." (Literal translation).

We can therefore summarize the role of a mental health university institute as a model center of

excellence that develops and shares knowledge in mental health.

More concretely, we define our mandate as follows:

The Douglas is a mental health university institute under the terms of An Act Respecting Health Services and Social Services. As such, the Douglas must, in addition to carrying out the activities inherent to its mission, offer specialized and ultra-specialized services (**Care**), participate in education (**Teach**), evaluate health technologies (**Evaluate**) and manage an accredited research centre (**Discover and Share**).

- **Care:**
  Our interdisciplinary teams provide services to all age groups. The catchment population for the second line services offered by the Douglas numbers close to 300,000 people and covers two territories in South-West Montreal: CSSS Sud-Ouest–Verdun and CSSS Dorval-Lachine-LaSalle. As a mental health university institute and in collaboration with the institutions of RUIS McGill, the third line mandate of the Douglas covers 23% of the Quebec population, including close to 50% of the Montreal population (1.7 M people in total) and approximately 63% of the Quebec territory. Furthermore, in accordance with An Act Respecting Health Services and Social Services, the Douglas is designated as an institution that must provide all of its services in English to the English-speaking population.

- **Teach:**
  Affiliated with McGill University and in partnership with other teaching institutions, the Douglas trains new recruits and provides a state-of-the-art mental health curriculum for all professional disciplines involved. We also help advance best practices by consolidating training programs with our partners.

- **Evaluate:**
  Within a context of continued improvement in practices, our clinicians and researchers assess health technologies and methods of intervention to improve clinical benefits and the efficiency of the overall network.

- **Discover:**
  Our researchers and clinicians are dedicated to the study of both mental illness and mental health, thereby developing knowledge in neuroscience, clinical practices and service optimization.

- **Share knowledge:**
  Our researchers and clinicians advance practices by integrating scientific discoveries into clinical practices and service organization. We train professionals and, together with our partners, disseminate new knowledge and best practices in order to improve the network of mental health services. We develop tools to support clinical practices and decision-making based on the best available knowledge. We also help destigmatize mental illness through awareness programs offered to the general public.

POSITIONING

The Douglas is one of the three mental health university institutes in Quebec and its Research Centre is the largest in Quebec and one of the two largest in Canada devoted to mental health. It was designated as the first WHO Collaborating Centre for research and training in mental health in Canada.

Our clinicians, researchers, and students have won numerous awards and recognitions including honorary doctorates, the Order of Canada and the *Ordre national du Québec*, the *Personnalités La Presse*, the title of Scientist of the year from Radio-Canada, the *Prix de la santé et du bien-être psychologique* from the Quebec Order of Psychologists, the *Prix des médecins de*

coeur et d'action from the *Médecins francophones du Canada* association, the Hector-L.-Bertrand Award of the *Association des cadres supérieurs de la santé et des services sociaux*, the Teaching Clinician Award from the Quebec Medical Association, the *Grand Prix* of the Quebec College of Physicians, etc. They have published many articles and taken part in a great number of prestigious conferences. Several Douglas representatives have also been solicited by different governments or ministries to take part in consultative or decision-making committees for health-related, academic, or scientific issues, which should be seen as a measure of the impact and the scope of influence of the Institute.

The Head of the Department of Psychiatry of the Douglas is also the Chair of McGill University's Department of Psychiatry and is the President of the Montreal region's psychiatry coordinating group. She therefore contributes in a special manner to the scope of influence of our Institute in the entire McGill network and at the provincial level.

Several of our programs integrate research and teaching into clinical activities and clinical researchers play a leadership role, particularly within the McGill RUIS, in areas such as eating disorders, bipolar disorders, depression and suicide prevention, and first-episode psychosis. We have also signed a letter of intent with the Program on Recovery and Community Health at Yale University as part of a collaboration on recovery.

We should also mention the fact that the Scientific Director of the Research Centre was appointed at McGill as Vice-Dean for Life Sciences and Strategic Initiatives in the Faculty of Medicine and Senior University Advisor for Health Sciences Research while also acting as the Executive Director of the International Collaborative Research Strategy for Alzheimer's Disease at the CIHR. He has now left all these functions for a prestigious appointment as Quebec's Chief Scientist. Furthermore, other Douglas representatives have occupied or are occupying prestigious positions such as: President of the Expert Committee on the Modernization of Professional Practices in Mental Health and Human Relations; Head of the McGill Centre for Studies in Aging; Director of the Program for Studies in the Prevention of Alzheimer's Disease; Expert Consultant to the MSSS Health and Welfare Commissioner; Director of the Neurodevelopment Centre in Singapore; and, finally, various positions within the MHCC or different boards of directors such as those of the FRQ-S, the Association of Councils of Physicians, Dentists, and Pharmacists, and many others.

Recognized as a model centre by the FRQ-S, the Research Centre sets itself apart through its novel projects in neuroscientific, clinical, and psychosocial research.

Recent years have been most stimulating and rich for the Research Centre. Two major infrastructure projects (the Neurophenotyping Centre, funded by a grant from the *ministère du Développement économique, de l'Innovation et de l'Exportation* (MDEIE), and the Brain Imaging Centre, funded by a grant obtained as part of the Knowledge Infrastructure Program of the Federal Government in collaboration with the MDEIE) totalling more than $26 million in investments have most certainly contributed to a wave of dynamism in our research teams while ensuring their excellence and their competitiveness in Quebec and abroad.

Our researchers have received prestigious salary grants, such as CIHR grants, important grants from the Canadian Fund for Innovation (CFI) and from the Quebec Government, as well as a FRQ-S grant for the development of the Brain Bank. Of our researchers, seven hold Canadian Research Chairs.

In addition, the Montreal WHO/PAHO Collaborating Centre for Research and Training in Mental Health works with researchers and clinicians of the Douglas

Institute to improve access to mental health care around the world and is particularly active in training mental health professionals in Latin America, Asia, and the West Indies. It was also appointed an Expert Centre for post-traumatic disorders in Haïti.

The Montreal WHO/PAHO[45] Collaborating Centre plays an advisory, scientific, and educational role and calls upon a well-established network of consultants, such as those from McGill University (to which the Montreal Collaborating Centre is affiliated), and those from many other higher learning institutions, health care centres, community organizations, and non-governmental organizations (NGOs) around the world.

It is clear that all of these appointments and associations guarantee the Douglas Institute an exceptional presence and a unique network both on the local and international scenes.

ADMINISTRATIVE, CLINICAL, AND SCIENTIFIC ORGANIZATION

In response to changes in our environment, both internal and external, and particularly the implementation of the Mental Health Action Plan and our designation as a mental health university institute, the Douglas reviewed its organizational structure in 2006-2007. Its Organizational Plan positioned the Douglas within the revised and changing health and social services network. It describes the specialized and highly specialized services we offer.

The Organizational Plan confirms and improves the model of clinical management by program, which is based on **shared governance** and **patient-centered care** as well as the concepts of the **learning organization** and **interdisciplinarity** introduced in the last 1999-2002 Organization Plan. Moreover, the clinical, scientific, and academic structures are well integrated to ensure maximum interdisciplinarity and knowledge-sharing among researchers, clinicians, and students.

The model of clinical management by program suggests that the clinical services offered be organized more flexibly around the various types of clientele serviced in order to improve the natural trajectory of care.[46] Management by program groups together all of the activities and resources needed for a particular treatment process, and links research and teaching activities with them. Furthermore, this model allows for better coordination of and between people and partners since resources are generally organized around particular types of clientele.

The Organizational Plan is also aligned with the scientific organization of the Research Centre in such a way that it facilitates the integration of the various aspects of the university mission and of the mandate as an Institute and a 2nd and 3rd line service provider.

Our research teams are multidisciplinary, and their work spans fundamental, clinical, evaluative, psychosocial, and population health research.

Researchers are grouped within four research themes: 1) Aging and Alzheimer's Disease; 2) Schizophrenia and Neurodevelopmental Disorders; 3) Services, Policy and Population Health; and 4) Mood, Anxiety and Impulsivity Disorders.

This Plan was adapted and adjusted to take into account the changes that stemmed from the transfer of resources as part of the implementation of the Mental Health Action Plan and other changes in our environment.

[45] PAHO: Pan-American Health Organization

[46] Luc, D., and A. Rondeau. "La mise en place d'une gestion par programmes : impacts sur les rôles, responsabilités et rapports d'influence. Le cas de l'hôpital Maisonneuve-Rosemont." Revue *Interactions* (Université de Sherbrooke) 6.2 (2002): 27-42.

CLIENTELE

The DACTCE, which regroups all clinical programs, has developed a Framework for the Consolidation of Clinical Programs in response to a number of objectives of the last Strategic Plan. The first phase of the framework, completed in 2011, dealt with drafting a profile of the clientele of each program. Information on the clientele of the different programs follows below:

Clientele diagnoses: An overview of the most frequent last main diagnoses by program:

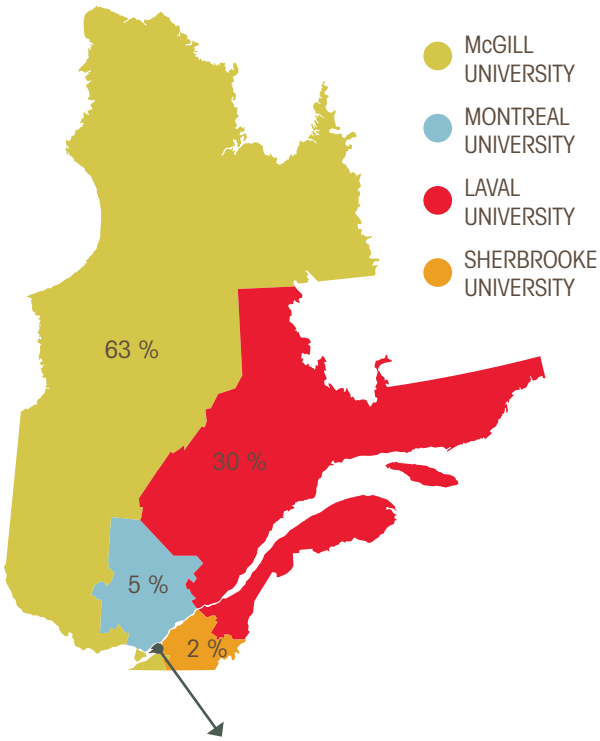
MOST FREQUENT LAST MAIN DIAGNOSES		PERCENTAGE
Child and Adolescent Psychiatry Program	Childhood instability (Attention deficit with or without hyperactivity - ADHD)	26%
	Pervasive developmental disorders	16%
	Adaptation disorders	15%
Mental Health Program for Adults from the South-West Territories	Bipolar disorders	22%
	Schizophrenic psychosis	16%
	Anxiety disorders	10%
Mood, Anxiety and Impulsivity Disorders Program	Bipolar disorders	35%
	Schizophrenic psychosis	17%
	Anxiety disorders	16%
Psychotic Disorders Program	Schizophrenic psychosis	57%
	Bipolar disorders	18%
	Other non-organic psychoses	7%
Eating Disorders Program	Eating disorders	92%
Intellectual Handicap with Psychiatric Comorbidity Program	Intellectual handicap	34%
	Pervasive developmental disorders	13%
	Schizophrenic psychosis	12%
Specialized Psychosocial Rehabilitation and Housing Program	Schizophrenic psychosis	46%
	Bipolar disorders	5%
Geriatric Psychiatry Program	Dementia (including Alzheimer's Disease)	23%
	Bipolar disorders	22%
	Schizophrenic disorders	11%

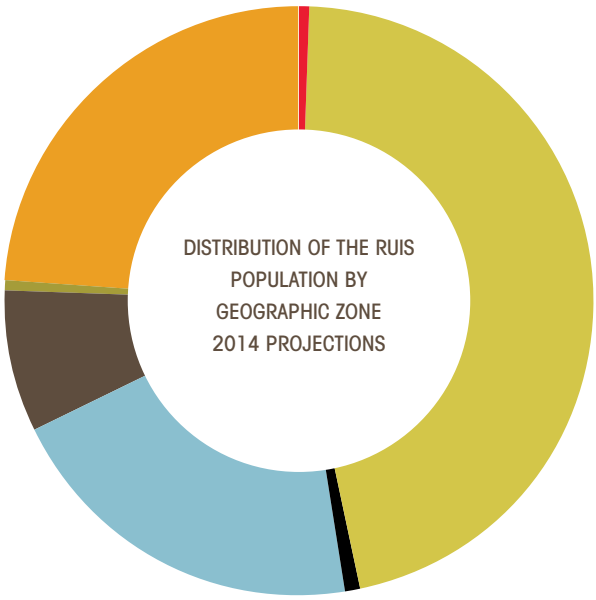
Age profile: The age profile of the clientele has changed between 2006-2007 and 2010-2011:

- The highest increases are found in adolescents 13 to 18 years old (increase of 35.6%), in young adults 18 to 25 years old (increase of 17.6%), and in people older than 75 (increase of 16.7%).
- Several programs have a significant proportion of patients advancing in age (Geriatric Psychiatry Program, Intellectual Handicap with Psychiatric Comorbidity Program, and Specialized Psychosocial Rehabilitation and Housing Program).

Origin of the clientele: The catchment area of the Douglas Institute is, for 2nd line services, composed of the CSSS Dorval-Lachine-LaSalle and the CSSS South-West–Verdun. In the case of 3rd line services, the Douglas serves the overall McGill RUIS territory.

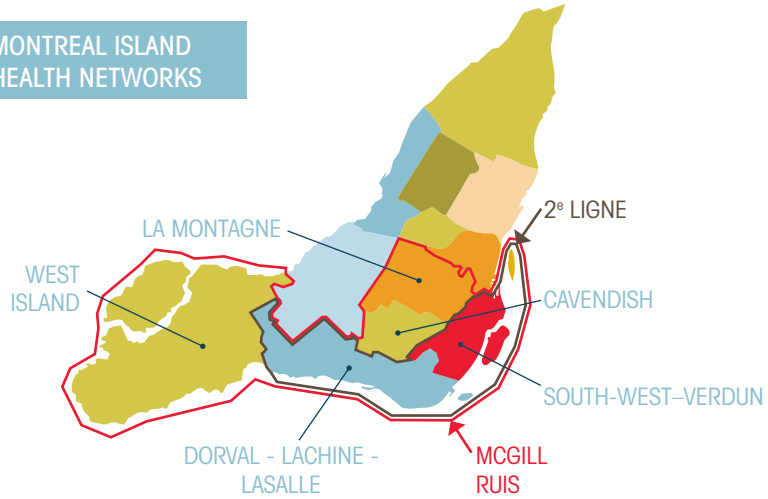
RUIS TERRITORIES





46.22%	MONTREAL
20.18%	OUTAOUAIS
7.71%	ABITIBI-TÉMISCAMINGUE
0.73%	NORTHERN QUEBEC
23.62%	MONTÉRÉGIE
0.65%	NUNAVIK
0.89%	JAMES BAY CREE TERRITORIES

MONTREAL ISLAND HEALTH NETWORKS



It is therefore not surprising that a high proportion (64%) of Institute's patients are residents of either the Dorval-Lachine-LaSalle or the South-West–Verdun CSSS territories. Significant variations, exist, however, since certain programs have a high demand from other Quebec regions due to their 3rd line mandate.

PROGRAMS	ORIGIN BY CSSS TERRITORY			ORIGIN BY RUIS TERRITORY			
	DORVAL-LACHINE-LASALLE AND SOUTH-WEST–VERDUN	OTHER MONTREAL TERRITORIES	OUTSIDE MONTREAL	McGILL		MONTREAL	LAVAL OR SHERBROOKE
				ALL CSSSs	EXCLUDING DOUGLAS CSSS		
Child and Adolescent Psychiatry Program[47]	49%	24%	27%	78%	29%	19%	3%
Adult programs							
Intellectual Handicap with Psychiatric Comorbidity	70%	29%	1%	85%	15%	15%	-
Specialized Psychosocial Rehabilitation and Housing	76%	19%	5%	92%	16%	7%	1%
Mental health for adults from South-West territories							
▸ Emergency Service only (including the brief intervention unit)	71%	16%	13%	84%	13%	14%	2%
▸ Excluding the Emergency	80%	12%	8%	88%	8%	11%	1%
Eating Disorders	10%	44%	46%	37%	27%	55%	8%
Mood, Anxiety and Impulsivity Disorders	75%	13%	12%	85%	10%	13%	2%
Psychotic Disorders	64%	28%	8%	85%	21%	14%	1%
Geriatric Psychiatry Program	71%	15%	14%	87%	16%	11%	2%

This first phase of the framework also allowed us to draw certain inferences with respect to our clientele:

- Hospitalization under An Act Respecting the Protection of Persons Whose Mental State Presents a Danger to Themselves or to Others (R.S.Q., Chapter P-38.001) are relatively frequent:
  - Approximately one out of three (31%) people hospitalized in the course of one year are placed under confinement.
  - Of those, 7% are under the responsibility of the *Tribunal administratif du Québec*.
- The clientele is composed of a slightly higher number of women (52% in 2010-2011) than men (48% for the same year) and approximately 4% of patients are under protective supervision.

[47] It is to be noted that the catchment area for child and adolescent services is different from that for adult services and includes other CSSSs, particularly for the Anglophone population.

Evolution of the demand for services since the implementation of the Mental Health Action Plan

As we have seen previously, several significant changes have taken place in the health and social services network during the period covering the last Strategic Plan. They had a significant impact on the organization and provision of services. These reforms aimed, among other things, to increase the community-based services (1st line) and to reduce the demand for specialized (2nd line) and highly specialized (3rd line) services. To ensure this shift, the Mental Health Action Plan called for the transfer of resources from psychiatric institutions to CSSSs. In spite of the fact the Douglas Institute transferred a significant amount of resources to partner CSSSs, the volume of our activities and the demand for our services increased from 2006-2007 to 2010-2011.

- **Emergency visits:** The number of visits has increased by 11.8%.
- **Hospitalizations:** In spite of the fact the number of beds has remained the same (241 beds):
  - The number of admissions has increased by 11.4%; for short-term units it has increased by 9.33%.
  - The average length of stay has decreased by 19% (from 81 to 66 days).
  - The occupation rate has increased from 108.3% to 114% and is particularly high in the following adult programs:
    - Mental Health Program for Adults of the South-West Territories: 137%;
    - Mood, Anxiety and Impulsivity Disorders Program: 126%;
    - Psychotic Disorders Program: 125%.
- **Out-patient services:**
  - The number of patients followed has increased by 14% (from 8,368 to 9,538 different people).
  - Efforts invested to reduce waiting times have been fruitful as shown in the following table:

SERVICES	VARIATION FROM 2006-2007 TO 2010-2011		
	REQUESTS FOR SERVICES IN%	AVERAGE WAITING TIME	
		IN DAYS	%
All services together	↑ 9.6%	↓ 92 to 53	↓ 41.7%
Adult evaluation-liaison module (access point)	↓ 31.7%	↓ 51 to 20	↓ 61.5%
Other 2nd and 3rd line services to adults and the elderly excluding Eating Disorders	↑ 89.1%	↓ 80 to 26	↓ 67.0%
Eating Disorders	↑ 13.2%	↓ 234 to 116	↓ 50.6%
Child and Adolescent Psychiatry	↓ 14.3%	↓ 131 to 113	↓ 14.9%
▸ Excluding the Pervasive Developmental Disorders team	↓ 27.6%	↓ 146 to 76	↓ 48.0%
▸ Pervasive Developmental Disorders team only	↑ 24.7%	↑ 83 to 201	↑ 142.1%
The overall Institute excluding the Pervasive Developmental Disorders team	↑ 8.7%	↓ 92 to 43	↓ 53.1%

"FOR ME, RECOVERY IS TAKING BACK CONTROL OF YOUR LIFE."

MICHEL PERREAULT
Researcher

STAKES AND CHALLENGES

The consultations conducted during the strategic planning process not only allowed us to evaluate the progress achieved in reaching the objectives of our last Strategic Plan, but also made it possible for us to identify the main stakes and challenges that we need to address in the course of the next three years and that will prove to be well-aligned with federal, provincial, and regional priorities.

The two clear recurring themes throughout the consultation process were **partnership** and **recovery**. These two themes are integrated into the strategic directions and objectives.

PARTNERSHIP

Everyone consulted underlined the importance of partnership, whether internal or external, to improve services, clinical outcomes, and the quality of life of people living with mental health problems.

With respect to external partnerships, the very organization of the health care system creates barriers between many service-programs: physical health, mental health, intellectual handicap and pervasive developmental disorders, youth-at-risk, addiction, loss of autonomy due to aging, etc.; and, on top of these barriers, we have to take into account those between services for children and those for adults. Each service-program has its own financing and organizational structure, which makes links difficult. Yet, mental health has indisputable links with youth-at-risk, addiction, intellectual handicap and pervasive developmental disorders, and loss of autonomy due to aging even in stabilized elderly patients. Other partners are just as important here, such as: the police force, schools, family support resources, and different resources for the homeless, alcoholics, drug users, compulsive gamblers, etc. The health system reform has introduced changes in the provision of services and in the interaction between the different partners. Partners must then renew their efforts to make sure the patient remains at the centre of the decision-making process. Steps taken in implementing the Mental Health Action Plan must be intensified to improve access to and ensure coordination and fluidity in the delivery of mental health services.

Internal partnerships are just as important and take various shapes, including: interdisciplinarity, integration of patients and their families within the decision-making or caregiving processes, and integration of research and teaching within clinical activities. As covered previously, the Douglas has made considerable progress in this area in recent years in spite of the considerable constraints of our internal environment, first among them being the physical space of the Douglas itself, which is divided into 33 buildings. Achievements of recent years must be maintained and even enhanced, particularly with respect to integrating patients and their families into the clinical care process in compliance with the recovery model.

Taking the above into account, it is not surprising that partnership is an underlying theme of our strategic directions and objectives for 2011-2014.

RECOVERY

Another recurring theme throughout our consultations is that of recovery. Everyone agrees to say that this is a personal process that the person living with mental health problems must internalize and undertake for themselves. However, many questioned what the role of a mental health university institute could be in this deeply personal process.

Recent studies by Davidson et al.[48] and Latimer et al.[49] show that evidence-based practices and recovery-oriented services are complementary and make it possible to better define the community-based range of services needed in order to help patients reach their goals while using mental health system resources only as needed. However, access to these types of services remains limited.

The strategic planning process allowed us to identify the role of the Douglas and the steps we can take to support and promote recovery. Our actions focus on the following:

- Giving a credible hope for recovery through:
  - Research and advances in knowledge that make it possible to innovate and find new and more effective medications or treatments;
  - Excellence in services, knowledge exchange, and application of evidence-based practices to ensure that the quality of care and health care professionals is always improving;
  - Secondary and tertiary prevention to delay the onset of the illness or relapse by investing in early detection, diagnosis, and treatment as well as personalized medicine.
- Facilitating peoples' reintegration as full citizens through destigmatization efforts based on knowledge exchange and application, as well as public education.

Besides these two central themes, other important success factors were raised in the course of the planning process and are the object of specific strategic directions or objectives, or have a direct impact on our ability to reach our objectives as well as on service quality and safety. Particularly noteworthy are the physical environment and the psychiatric manpower shortage.

PHYSICAL ENVIRONMENT, QUALITY, AND SAFETY

Problems that stem from our physical environment are considerable and impact the quality of care, safety, clinical outcomes, integration, knowledge exchange and application, and even the organizational culture.

Our current facilities, dispersed in 33 buildings located on a 165-acre land, present major challenges for out-patients and their families and friends since they must travel long distances between public transport stops and our facilities, and must often go from one building to another for various services (clinics, laboratories, rehabilitation activities, etc.). There is no centralized welcome area, public information centre, or space for community partners who support people who use our services.

Difficulties are even more significant for hospitalized patients. Essentially, in-patients are people who are a risk to themselves or to others. These people are experiencing a psychotic episode, major depression, or acute anxiety. Our current buildings make it such that patients must share the very narrow space – even their bedrooms – or be in a crowded Emergency Room or Intensive Care.

Such conditions hinder treatment and delay recovery in addition to posing significant risks. The lack of space, the buildings' layout, and the structural limitations result in:

- No private quarters that ensure confidentiality;
- No spaces for families.

[48] Davidson, L., et al. "Oil and Water or Oil and Vinegar? Evidence-Based Medicine Meets Recovery." *Community Ment Health J* 45.5 (2009): 323-332.

[49] Latimer, E. A., G. R. Bond, and R. E. Drake. "Economic Approaches to Improving Access to Evidence-Based and Recovery-Oriented Services for People with Severe Mental Illness." *Can J Psychiatry* 56.9 (2011): 523-529.

- No safe or adequate therapeutic outdoor spaces: buildings were regrouped at the center of the land to isolate patients from the community; in spite of the green space we have, it is not possible today to integrate our grounds within a safe and adequate therapeutic environment.
- Patients having no control over their environment (choosing the person to share their room, noise, lighting, heating, decoration, etc.). In fact:
  - 56% of bedrooms are shared;
  - 92% of patients share bathrooms;
  - 100% share showers;
  - Patients must leave their rooms to use the bathroom or shower.
- The integration of research and teaching into clinical activities being more difficult.

In addition to the negative impact of our current environment on the mental health and quality of life of people who are using our services and on the working conditions of the staff, our facilities are also inefficient at the functional level. To this end, a time and movement study showed that close to 15% of employees' time was used for travels between pavilions – amounting to an annual financial loss of $7.5 million.

If our facilities remained unchanged for the next 10 years, the costs of maintaining unusable spaces, making necessary updates to aging functional systems, and time lost travelling would amount to more than $185 million.

PSYCHIATRIC MANPOWER

As mentioned previously, the psychiatric manpower shortage at the Douglas is a constant concern, the severity of which is recognized by the MSSS and the Montreal Agency. This problem was pointed out by the Minister when he designated the Douglas as a mental health university institute in 2006 and reiterated by the current Minister in his 2011 letter that confirmed the designation. This shortage of psychiatrists, coupled with a shortage of general practitioners in a large part of our catchment area, results in difficulties in implementing shared or collaborative care and the system of the *psychiatre répondant*[50] as well as covering distant regions such as the James-Bay-Cree-Territories and Nunavik.

This challenge is a most important one as it will affect the success of many of our strategic directions and objectives. Furthermore, it is particularly difficult to surmount since it is, in great part, outside of our control and stems from strict ministerial rules regarding medical manpower. Close collaboration is essential and discussions have started between the Ministry, the Agency, McGill University, and the Douglas to solve the current impasse without delay as requested by the Minister in his August 2011 letter.

[50] Psychiatrists in 2nd or 3rd line institutions who serve in an advisory role to 1st line healthcare practitioners.

THE FUTURE: 2011-2014 STRATEGIC DIRECTIONS

5

As we have seen previously, significant changes have taken place in recent years and have shaped our last Strategic Plan, which resulted in a profound review of our way of functioning and how we are structured and organized. The changes undertaken by the Douglas require clear and thoughtful planning to guide our actions for the next three years.

The Strategic Plan will be used to guide our decisions and better focus our energies in order to achieve our vision: **The Power to Recover**.

As it is strategic in nature, the Plan focuses on strategic directions and objectives in order to guide the Institute, Research Centre, and Foundation management teams to elaborate their respective annual action plans. The Strategic Plan will also be revised on an annual basis so that adjustments can be integrated to objectives and targets in response to changes in our environment.

Focused on patients and on the quality of services they receive, the current Strategic Plan was founded on the Douglas' impressive record of achievements, and the integration and excellence of patient care and services, research, and teaching.

We therefore propose to focus our energies on the six following strategic directions for 2011-2014:

1. **Facilitate recovery, promote empowerment, and improve the quality of life of people living with mental health problems:** Building on the last Strategic Plan, this strategic direction emphasizes excellence in services in order to offer hope – a credible hope based on an integrative approach in line with the concepts of the Douglas as a learning organization, interdisciplinarity, and continual improvement.

2. **Initiate a preventive approach in mental health:** This direction focuses on proven practices in secondary and tertiary prevention in our services, as well as on our researchers' breakthroughs, to allow us to eventually develop a personalized medicine approach in mental health that will put the patient and those closest to him or her at the center of an integrated model ranging from genomic to service quality and access.

3. **Develop a healing environment that promotes best practices, innovation and recovery:** Founded on evidence-based design and the concept of a healing environment, this direction essentially aims to build a new modern institute that is safe and conducive to recovery.

4. **Improve knowledge and influence directions in mental health:** As in the last Strategic Plan, destigmatization and partnerships underlie this strategic direction. By improving and sharing knowledge with our partners and the public, we should progressively decrease prejudice and stigma, and allow people living with a mental health problem to be integrated into a more welcoming environment.

5. **Develop and build on the potential of human resources, and promote operational excellence:** This direction supports the other strategic directions in that it builds on the leadership and excellence of our human resources and on operational efficiency to achieve our mission and our vision.

6. **Promote philanthropy to benefit mental health:** The Douglas Institute Foundation is a key stakeholder in our success, making it possible for us to undertake various novel initiatives, as well as a driving force in recruiting allies to the cause of mental health.

These strategic directions and the objectives that stem from them will guide our actions for the next few years and will allow us to target our actions for future development, reorganization, and allocation of resources.

STRATEGIC OBJECTIVES

DIRECTION 1:

Facilitate recovery, promote empowerment, and improve the quality of life of people living with mental health problems

As we have seen previously, recovery is a very personal process that belongs to each person living with a mental health problem. However, the person who undertakes a journey towards recovery has the right to get the best services possible that are provided safely and without delay.

This direction therefore aims to continue efforts towards improvement undertaken in the course of the last Strategic Plan. In fact, the DACTCE developed a Framework for the Consolidation of Clinical Programs, the first phase of which, dealing with the current services offered, is being completed. The framework also aims to make sure our services respond to needs by closely following the evolution of the clientele using data from our own systems and other sources, as well as results from the CIHR Team directed by Jean Caron, PhD, a researcher of our Institute.

Credible hope for recovery also rests on the implementation of best practices and on the integration

of research and teaching to result in innovation and in the discovery of new, more effective medications or treatments that can then be shared to ensure the improvement of care throughout the health and social services network. Setting up the Program Evaluation Module and the Health Technology and Approach Assessment Unit[51] are but two examples of such initiatives that will allow us to improve clinical outcomes and to pursue the implementation of the framework in each program.

Recovery also hinges on the quality and safety of services within a holistic approach to care. This is a basic premise of "Towards Recovery and Well-Being – A Framework for a Mental Health Strategy for Canada," where it is mentioned that "it has often been – rightly – said that there is no health without mental health."[52] People living with mental health problems often face more physical ailments than the rest of the population and, when their illness is severe, their **life expectancy is 20 years shorter** than the average. The Douglas therefore launched the **Douglas Minds the Body**[53] initiative to encourage people living with mental health problems to be more active and to adopt a healthier lifestyle. It is a well-known fact that physical exercise is beneficial for physical health, but there are also mental health benefits, especially if people become active out in the community. Physical exercise induces neurogenesis. It creates new brain cell growth. Studies have shown that physical activity improves mental health and improves the health and plasticity of the brain.

The third objective in support of recovery aims to continue improving access to services as well as the fluidity between the different services in the patient's trajectory, particularly when reaching adulthood. It is well recognized that early intervention makes it possible to avoid or delay the evolution of the illness while continuity of services helps prevent relapses. As mentioned previously, we have made significant progress in this area in the course of the last Strategic Plan, as has been underlined by the Minister in his letter confirming our designation as an Institute, and would like to continue on this upward trend.

The last objective deals with empowerment, a concept which is central to recovery as noted by Davidson et al.[54] Recovery is directly linked to the amount of control people have over their own lives, whether in the choice of their goals or the means by which they will achieve them. Our role is therefore to support the recovery process and the four following objectives clarify the role that the Douglas intends to play in order to **facilitate recovery, promote empowerment, and improve the quality of life of people living with mental health problems**.

a) Complete the implementation of the framework for the consolidation of interdisciplinary clinical programs, which includes:
   - Needs assessment;
   - Implementation of recognized best practices;
   - Integration of research and teaching;
   - Program and clinical outcome assessment.

b) Optimize the quality of services and patient safety.

c) Invest in programs and services to optimize access, continuity and flow between services: the right service to the right person at the right place and at the right time.

d) Fully integrate patients and their families into the clinical care process.

[51] Referred to as UÉTMIS for *Unité d'évaluation des technologies et des modes d'intervention en santé*

[52] Mental Health Commission of Canada. *Towards Recovery & Well-Being – A Framework for a Mental Health Strategy for Canada.* Ottawa: MHCC, 2009: 2.

[53] *Douglas minds the body – Douglas a le corps à l'esprit,* is an initiative directed by Ridha Joober, MD, PhD, Director of the research theme "Schizophrenia and Neurodevelopmental Disorders" of the Douglas Institute, and William (Bill) Harvey, PhD, Assistant Professor in the Department of Kinesiology and Physical Education at McGill University and a Research Associate at the Douglas Institute.

[54] Davidson, L., et al. "Oil and Water or Oil and Vinegar? Evidence-Based Medicine Meets Recovery." *Community Ment Health J* 45.5 (2009): 323-332.

DIRECTION 2:

Initiate a preventive approach in mental health

The three objectives that stem from this direction, founded on internal and external partnerships, aim to bring about a culture of prevention and, more specifically, secondary and tertiary prevention. They are not only about developing and implementing early detection, diagnosis, and intervention tools to avoid or delay illness, but also about applying best practices to avoid relapses, complications, or concomitant disorders.

These objectives also call upon our researchers in neuroscience, clinical, or psychosocial research who have a variety of unique fields of expertise, including developmental neurobiology, dementias, eating disorders, psychotic disorders, post-traumatic stress disorders, and many others. These research projects allow us to identify at-risk groups and implement different targeted prevention strategies; they also lead to the identification of biological markers that will eventually be used for purposes of indicated prevention and personalized care in mental health, as is already the case in the field of cancer treatment. The Neurophenotyping Centre and the new Brain Imaging Center provide undeniable advantages in the pursuit of our prevention objectives.

"FOR ME, RECOVERY IS HAVING HOPES AND DREAMS FOR ONESELF AND ONE'S FUTURE."

MYRA PIAT
Researcher

PREVENTION LEVELS

Primary prevention: Primary prevention strategies intend to avoid the development of disease. Most population-based health promotion or public health activities are primary preventive measures.

Secondary prevention: Secondary prevention strategies attempt to diagnose and treat an existing disease in its early stages before it results in significant morbidity.

Tertiary prevention: This type of prevention deals with applying treatments with the aim of avoiding relapses or disease-related complications.

PREVENTION TARGETS

Universal prevention: Addresses the population in general or certain groups subjected to the same risk. All individuals, without screening, are provided with information and skills necessary to prevent the problem targeted.

Selective prevention: Focuses on individuals whose probability of developing a specific problem is high ("high risk groups"). Risk factors associated with the targeted problem may be biological, psychological, psychiatric, social, or environmental.

Indicated prevention: Involves people who have already manifested one or several of the behaviors associated with the targeted problem. The intervention is specific to the individual and his or her own risk factors.

Finally, the last objective of this direction aims to better inform our partners and the community on the subject of mental health. 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 illnesses, their treatability, the recovery process, and the human rights of people with mental illness. 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. [...] 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."[55]

Knowledge exchange and application, coupled with efforts to fight stigma and use preventive approaches and interventions, aim to reduce the mental health burden. To **initiate a preventive approach in mental health**, the Douglas intends to:

a) Develop an approach with our partners that puts the emphasis on the early detection, diagnosis, and treatment of mental illnesses.

b) Introduce a strategy to promote the prevention of mental illnesses.

c) Provide our partners and the community with up-to-date, valid, and pertinent information on mental health.

[55] World Health Organization. *The World Health Report 2001 – Mental Health: New Understanding, New Hope.* Switzerland: WHO, 2001: xii.

DIRECTION 3:

Develop a healing environment that promotes best practices, innovation and recovery

As mentioned previously, our buildings serve as reminders of the asylum era. **The Power to Recover** requires that we rethink our buildings so that they represent the values and principles of recovery to which we subscribe. The vision is one of a modern institute that gives hope and that is not a destination but, rather, a place where people living with mental health problems feel supported to go forth and reach their full potential. This is the environment we are proposing.

Scientific studies of recent decades show the link between an inadequate physical environment and health problems such as anxiety, depression, high blood pressure, and the frequent use of pain medication.[56] On the other hand, literature on the healing environment or evidence-based design (EBD) in mental health reveal that:

- To recover, people need to have as much control as possible over their environment;[57]
- Using natural light produces positive effects on treatment and translates into shorter average lengths of stay (2.6 to 3.7 days),[58] a reduced number of beds, and improved clinical outcomes;
- Viewing nature increases positive feelings of calm and reduces anxiety and anger,[59] improving the feeling of safety;
- Noise reduction is a significant factor in improving the environment.[60]

These positive effects are also reflected in the quality of life of workers[61] as well as, as covered previously, operational efficiency. A modern mental health institution that adheres to the values and principles of recovery and of a healing environment must aim for the six undisputed following goals:

- Provide individual bedrooms and washrooms;
- Ensure continuum of care within programs and integrate research and teaching;
- Maintain the provision of services at all times;
- Respect most up-to-date standards with regard to square-footage;
- Eliminate the spreading of the site by concentrating activities within a limited area;
- Avoid recreating tunnels by opting for lighted atriums for common functions and interactive activities.

The prefeasibility study shows that none of our current buildings respect these unquestionable criteria. Only a new construction will make it possible to address needs. To **develop a healing environment that promotes best practices, innovation and recovery**, we propose the two following objectives:

a) Promote a safe environment that is conducive to recovery despite the current physical constraints.

b) Implement the new institute project based on the concepts of evidence-based design and a healing environment.

[56] Dilani, A. "Psychosocially Supportive Design – Scandinavian Healthcare Design." *Design and Health.* International Academy for Design and Health, n.d.

[57] Ashcraft, A., and W. A. Anthony. "Tools for Transforming Facilities." *Behavioral Health Care* 30.5 (2010): 10-13.

[58] Beauchemin, K. M., and P. Hays. "Sunny Hospital Rooms Expedite Recovery from Severe and Refractory Depression." *J Affect Disord* 40.1-2 (1996): 49-51.

[59] Ulrich, R. S. "Effects of Interior Design on Wellness: Theory and Recent Scientific Research." *J Health Care Inter Design* 3.1 (1991): 97-109.

[60] Haslam, P. "Caring for the Total Patient. Noise in Hospitals: Its Effect on the Patient." *Nurs Clin North Am* 5.4 (1970): 715-724.

[61] Tyson, G. A., G. Lambert, and L. Beattie. "The Impact of Ward Design on the Behaviour, Occupational Satisfaction and Well-Being of Psychiatric Nurses." *Int J. Ment Health Nurs* 11.2 (2002): 94-102.

DIRECTION 4:

Improve knowledge and influence directions in mental health

As mentioned above, destigmatization and partnership underlie this strategic direction.

The first objective relies on the leadership and expertise of our professionals and researchers. Based on interdisciplinarity and on the integration of research and teaching, it aims to promote innovation and the development and introduction of new, more effective treatments supported by a structure of knowledge-transfer that will ensure their use throughout the health and social services network. The synergy created in collaboration with our partners will not only improve the quality of services and clinical outcomes, but also influence new research projects and promote translational research that aims to apply scientific advances from fundamental research into clinical practice.

This objective aims to strengthen our scope of influence in terms of mental health directions and policies. Based on our expertise, it relies not only on excellence, but on innovation and new discoveries, on knowledge exchange and application at the local, national, and international levels as well as on the use of new information technologies to make this new knowledge accessible as widely as possible. The Douglas can also count on a key strategic partner, the Montreal WHO/PAHO Collaborating Centre, who is fully committed to the widening of the international scope of influence of the Institute and its Research Centre.

Furthermore, the Public Education Program and its different mental health and mental illness information activities essentially aim to reduce, even eliminate, the stigma attached to mental illness. 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." [62] This was also one of the conclusions coming out of the work of the MHCC: "Despite important progress in recent years, the stigma that still attaches to mental illness, and the discrimination that continues to afflict so many of those with a lived experience of it, remains an important barrier to progress." [63]

In light of this, we propose the following objectives to **improve knowledge and influence directions in mental health**:

a) Innovate, develop, apply, and share knowledge to:
   - Improve the quality of services and clinical outcomes;
   - Influence the development of research projects;
   - Promote translational research;
   - Influence directions and policies in mental health;
   - Optimize the organization of services with our partners to improve access and flow between services.

b) Lead actions so that the community fully integrates people living with mental health problems as full citizens

DIRECTION 5:

Develop and build on the potential of human resources, and promote operational excellence

Achieving success in the previous strategic directions relies on this direction, which is based on the excellence of the people working at the Douglas and

[62] Surgeon General David Satcher. "Introduction and Themes." *Mental Health: A Report of the Surgeon General.* United States, 1999: 6-8.

[63] Mental Health Commission of Canada. *Towards Recovery & Well-Being – A Framework for a Mental Health Strategy for Canada.* Ottawa: MHCC, 2009.

on organizational efficiency. This direction is supported by partnership, interdisciplinarity, the integration of research and teaching with clinical activities, and the implementation of best practices in management.

Professional resources are limited in the health and social services network and, as mentioned previously, the Douglas is faced with a significant shortage of psychiatrists. The Douglas Institute recognizes the contribution of human resources and how important their health and well-being is in fulfilling our mission and our mandate. The Institute is committed to maintaining, strengthening, and further improving the working environment and organizational practices that promote the health and well-being of people working at the Douglas.

The first objective therefore aims to intensify recruitment and retention strategies thanks to the stimulating, dynamic, and collaborative workplace the Douglas offers. In light of this, and taking into account the importance given by the Douglas to people's well-being and the quality of their working environment, the Institute has partnered with ACTI-MENU and created the **Healthy Douglas** club with an objective to further integrate health promotion within the organizational culture. The Douglas is committed to a human resources global health improvement approach and wants to be recognized as a "Healthy Enterprise" (*Entreprise en santé*) by the Fall of 2011.

This direction is also dependent on organizational efficiency to achieve the objectives of the present Strategic Plan. The second objective therefore aims not only to introduce additional training and mentorship programs to continue improving the level of excellence, but also to provide tools to clinicians and managers that promote collaboration and improve efficiency. We therefore intend to implement the electronic patient record, optimize processes, particularly clinical-administrative ones, and improve the reliability and user-friendliness of clinical or management decision-making support tools.

Concerned with environmental responsibility, the Douglas has been granted a level 2 BOMA BESt certification[64] in recognition of initiatives introduced since the implementation of the Go Green project. This recognition certifies that the Douglas applies best practices in terms of energy, water use, reduction of waste and air emissions, interior environment, and environmental management systems. We therefore intend to pursue these goals in the future.

Finally, the Strategic Planning Committee, composed of a service user and representatives of the Institute, Research Centre, and Foundation, will be maintained to ensure that progress is made in reaching the objectives set in the Strategic Plan. This Committee will meet on an annual basis to evaluate progress and make adjustments, if needed, to the Strategic Plan.

The three objectives identified to **develop and build on the potential of human resources, and promote operational excellence** are:

a) Provide an environment where human potential and collaboration are valued.

b) Support professional and management practices with improvement and feedback tools including:
   - Training programs;
   - Updated clinical information systems;
   - Improved processes;
   - Reliable, precise, and useful tools for analysis and decision-making purposes;
   - Sustainable development practices.

c) Implement a process to ensure progress in the Strategic Plan.

[64] BOMA BESt (Building Environmental Standards) is a national program to address an industry need for realistic standards for energy and environmental performance of existing buildings.

DIRECTION 6:

Promote philanthropy to benefit mental health

The Douglas Institute Foundation is a first-rate ally. Its mission is to finance the development of the Douglas Institute: patient care and environment, research in neuroscience and mental health, and education and training. The Foundation collects money for the prevention and treatment of mental illness, enhancing understanding of its causes, improving treatments and public access to mental health services, helping families, educating the population, and sharing knowledge and best practices between mental health practitioners.

To share a few of the projects funded by the Foundation, we would like to highlight its participation in the building of both the Brain Imaging Centre, which allows researchers to study the cognitive functions of the brain and the pathophysiology of various mental illnesses, and the Neurophenotyping Centre, which makes it possible to study environmental and genetic factors involved in the development of mental illnesses.

"FOR ME, RECOVERY IS BEING ABLE TO FULLY PURSUE YOUR DREAMS."

MICHEL VEILLEUX
Stationary Engineer

The Foundation has also funded the creation of a resource centre for youth experiencing or at-risk for psychosis, a therapeutic garden for Alzheimer's patients, the support program for families, the *Info-Trauma* website for victims of a traumatic event, the Mini-Psych School, which was recognized as a "Leading Practice" by Accreditation Canada, and the Peer-Support Program, a first in Quebec offering former patients the possibility to support and mentor those who are currently struggling with similar mental health problems.

These are only a few examples of projects successfully implemented thanks to the Foundation's support since its creation in 1972. These projects are countless and cover a wide range of activities. They are an eloquent testimony to the generosity and commitment of our donors.

To **promote philanthropy to benefit mental health**, the Foundation, in collaboration with the Douglas Institute and its Research Centre, intends to:

a) Conduct a major fundraising campaign to support the development of cutting-edge programs, research and organizational priorities.

ACKNOWLEDGEMENTS

Other than the Strategic Planning Committee and Strategic Planning Task Force, close to 250 people were consulted throughout the planning phase. Others have also been involved in the process, whether by contributing to its organizational framework, identifying the main strategic directions and objectives, or validating the process and conclusions of this Plan. The Strategic Plannnig Committee therefore wishes to thank the following groups who took part in shaping the 2011-2014 Strategic Plan.

In the case of external consultations, we would like to thank the *ministère de la Santé et des Services sociaux,* the Montreal Health and Social Services Agency, our partner health and social services centres, McGill University and McGill affiliated hospitals, partner psychiatric hospitals, mental health community organizations, and the Mental Health Commission of Canada.

As for internal consultations, we would like to thank: the people who took part in the 28 individual or two-people interviews; the 35 employees who participated in the three focus groups (support staff, clinicians, managers); the 48 clients who were involved in the focus groups (patients and families); members of the Beneficiaries' Committee; members of the Executive Committees of the Council of Nurses and the Multidisciplinary Council; members of the Council of Physicians, Dentists, and Pharmacists present during the annual CPDP think tank, and members of the Research Centre who attended the annual think thank of the Research Centre.

Furthermore, we would like to highlight the contribution of several people without whom the present Strategic Plan would not have been possible.

First and foremost, we would like to acknowledge the contribution of Jacques Hendlisz and Rémi Quirion, PhD, respectively Executive Director of the Institute and Scientific Director of the Research Centre, whose vision and leadership guided this Plan.

We would also like to thank Professor Henry Mintzberg for sharing with us his view of a strategic planning process. He convinced us to introduce flexibility so that the institution remain in a constant reflective and learning process.

Thank you as well to Nicole Germain who managed the overall strategic planning project and consultations, as well as the writing of the Plan.

Special thanks go to: Michel Perreault, PhD, researcher at the Douglas, who consulted with the Users' Panel; Anne-Marie Filion, from Apropos Marketing Communications inc., who conducted the focus groups with patients and families; and Jacques Charuest, from Performance Coaching inc., who moderated the employee focus groups. Thank you also to Daniel Rabouin and Eric Latimer, PhD, of our Research Centre for their contribution to the data on the incidence and prevalence of mental illnesses, and to

Michèle Lalonde and Frédéric De Civita for drafting the profile of the clientele.

We also acknowledge the special contribution of the members of the Strategic Planning Committee and of the Strategic Planning Task Force for their work in identifying the vision, mission, values, and strategic directions and objectives.

The support of the Communications and Public Affairs Directorate throughout the process must also be highlighted, specifically their help in chosing a graphic design, drafting the communications plan, and producing communication tools for the Strategic Plan.

Our appreciation equally goes to Émilie Campeau and Micheline Guérin for their involvement in the organization of various activities, meetings, and focus groups.

Finally, we would like to thank Chantal Hanna for the linguistic revision and correction of the French version of the Plan and Tijana Potkonjak for the same work in the English version.

"FOR ME, RECOVERY IS MY MOTHER."

DANIELLE CÉCYRE
Brain Bank Coordinator

GLOSSARY

Montreal Agency:	Montreal Health and Social Services Agency (*Agence de la Santé et des Services sociaux de Montréal*)
DALY:	Disability-adjusted life year
Framework:	Frame of Reference for the Consolidation of Clinical Programs
Collaborating Centre:	Montreal WHO/PAHO Collaborating Centre for Research and Training in Mental Health
MHCC:	Mental Health Commission of Canada
CSSS:	*Centre de santé et de services sociaux* (Health and Social Services Centre)
DACTCE:	*Direction des activités cliniques, de transfert des connaissances et d'enseignement* (Clinical Activities, Knowledge Transfer and Teaching Directorate)
DSM-IV:	Diagnostic and Statistical Manual of Mental Disorders (4th edition)
EBD:	Evidence-based design
CCHS:	Canadian Community Health Survey
CFI:	Canadian Fund for Innovation
FRQ-S:	*Fonds de recherche du Québec - Santé* (Quebec Research Fund – Health)
CIHR:	Canadian Institutes of Health Research
ARHSSS:	An Act Respecting Health Services and Social Services
MDEIE:	*Ministère du Développement économique, de l'Innovation et de l'Exportation* (Ministry of Economic Development, Innovation and Export Trade)
MSSS:	*Ministère de la Santé et des Services sociaux (*Ministry of Health and Social Services)
WHO:	World Health Organization
NGO:	Non-governmental organization
PAHO:	Pan-American Health Organization
RUIS:	*Réseau universitaire intégré de santé* (University Integrated Health Network)
RUIS McGill:	*Réseau universitaire intégré de santé de l'Université McGill* (McGill Integrated University Health Network)
ADHD:	Attention Deficit Disorder with or without Hyperactivity
HRQOL:	Health-related qualify of life
CPDP:	Council of Physicians, Dentists, and Pharmacists

2011-2014 STRATEGIC PLAN EXECUTIVE SUMMARY

The burden of mental illness is heavy and is now an undisputed priority of our various governments. Several actions have been announced to lighten this burden, the bulk of which is carried by people living with mental health problems and their families. Particularly noteworthy are the priorities set in the Mental Health Action Plan of the *ministère de la Santé et des Services sociaux* (MSSS), in "Towards Recovery and Well-Being – A Framework for a Mental Health Strategy for Canada" of the Mental Health Commission of Canada (MHCC), as well as in the strategic plans of the MSSS and the Montreal Health and Social Services Agency. The Douglas, as a mental health university institute, is a key player in reaching these objectives.

On February 16, 2011, the Board of Directors of the Douglas Institute adopted the 2011-2014 Strategic Plan. This plan is the result of a wide internal and external consultative process that included national, provincial, regional, and local partners. On the basis of comments from patients, families, personnel, clinicians, researchers, managers, and partners, this Strategic Plan is an integrated, flexible, and consolidated plan to which the underlying themes of partnership and recovery are central.

Essentially, this Plan builds on the achievements and successes of the last Strategic Plan and on the progress made in implementing the Mental Health Action Plan. As was the case with the last Strategic Plan, this Plan integrates the objectives of the Institute, Research Centre, and Foundation within a coherent and stimulating vision for the overall Douglas community.

OUR VISION

The Power to Recover.

In addition to stating our vision, this process has allowed us to further clarify our mission, values, and mandate and identify the strategic directions and objectives that will allow us to achieve our vision. Here is the result of this process that should guide us through to 2014.

OUR MISSION

In collaboration with people living with mental health problems, their families, and the community, the mission of the Douglas Mental Health University Institute is to:

- Offer cutting-edge care and services;
- Advance and share knowledge in mental health.

OUR VALUES

Committed to the recovery of people living with mental health problems, the Douglas values **excellence**, **innovation** and **human potential** based on **commitment** and **collaboration**.

- **Excellence:** Have the courage to apply best practices with rigour, to question and assess ourselves, to integrate research into all of our activities, and to be a learning organization. Strive to achieve an optimal level of organizational efficiency.
- **Innovation:** Provide a stimulating and dynamic environment, where new knowledge is developed in order to better understand, share, care, and give hope.
- **Human potential:** Value potential and believe in people's ability to reach new heights. Build on existing knowledge through initiatives supported by sharing and partnering.
- **Commitment:** Carry out our mission to improve the quality of life of people living with mental health problems.
- **Collaboration:** Ensure that patients play an active role in the decisions pertaining to their care, and work with the interdisciplinary team towards their recovery. Develop and strengthen internal, community, academic, scientific, and international partnerships to make our vision a reality.

OUR MANDATE

The Douglas is a mental health university institute under the terms of An Act Respecting Health Services and Social Services. As such, the Douglas must, in addition to carrying out the activities inherent to its mission, offer specialized and ultra-specialized services (**Care**), participate in education (**Teach**), evaluate health technologies (**Evaluate**) and manage an accredited research centre (**Discover** and **Share**).

- **Care:**
  Our interdisciplinary teams provide services to all age groups. The catchment population for the second line services offered by the Douglas numbers close to 300,000 people and covers two territories in South-West Montreal: CSSS Sud-Ouest–Verdun and CSSS Dorval-Lachine-LaSalle. As a mental health university institute and in collaboration with the institutions of RUIS McGill, the third line mandate of the Douglas covers 23% of the Quebec population, including close to 50% of the Montreal population (1.7 M people in total) and approximately 63% of the Quebec territory. Furthermore, in accordance with An Act Respecting Health Services and Social Services, the Douglas is designated as an institution that must provide all of its services in English to the English-speaking population.
- **Teach:**
  Affiliated with McGill University and in partnership with other teaching institutions, the Douglas trains new recruits and provides a state-of-the-art mental health curriculum for all professional disciplines involved. We also help advance best practices by consolidating training programs with our partners.
- **Evaluate:**
  Within a context of continued improvement in practices, our clinicians and researchers assess health technologies and methods of intervention to improve clinical benefits and the efficiency of the overall network.
- **Discover:**
  Our researchers and clinicians are dedicated to the study of both mental illness and mental health, thereby developing knowledge in neuroscience, clinical practices and service optimization.

- **Share knowledge:**
  Our researchers and clinicians advance practices by integrating scientific discoveries into clinical practices and service organization. We train professionals and, together with our partners, disseminate new knowledge and best practices in order to improve the network of mental health services. We develop tools to support clinical practices and decision-making based on the best available knowledge. We also help destigmatize mental illness through awareness programs offered to the general public.

OUR STRATEGIC DIRECTIONS AND OBJECTIVES

Focused on patients and on the quality of services they receive, the current strategic plan was founded on the Douglas' impressive record of achievements and the integration and excellence of patient care and services, research, and teaching.

We therefore propose to focus our energies on the six following strategic directions for 2011-2014:

1. **Facilitate recovery, promote empowerment, and improve the quality of life of people living with mental health problems:** Building on the last Strategic Plan, this strategic direction emphasises excellence in services in order to offer hope – a credible hope based on an integrative approach in line with the concepts of the Douglas as a learning organization, interdisciplinarity, and continual improvement. To achieve this, we intend to:

   a) Complete the implementation of the framework for the consolidation of interdisciplinary clinical programs, which includes:
      - Needs assessment;
      - Implementation of recognized best practices;
      - Integration of research and teaching;
      - Program and clinical outcome assessment.

   b) Optimize the quality of services and patient safety.

   c) Invest in programs and services to optimize access, continuity and flow between services: the right service to the right person at the right place and at the right time.

   d) Fully integrate patients and their families into the clinical care process.

2. **Initiate a preventive approach in mental health:** This direction focuses on proven practices in secondary and tertiary prevention in our services, as well as on our researchers' breakthroughs, to allow us to eventually develop a personalized medicine approach in mental health that will put the patient and those closest to him or her at the center of an integrated model ranging from genomic to service quality and access. The objectives linked to this directions aim to:

   a) Develop an approach with our partners that puts the emphasis on the early detection, diagnosis, and treatment of mental illnesses.

   b) Introduce a strategy to promote the prevention of mental illnesses.

   c) Provide our partners and the community with up-to-date, valid, and pertinent information on mental health.

3. **Develop a healing environment that promotes best practices, innovation and recovery:** Founded on evidence-based design and the concept of a healing environment, this direction essentially aims to build a new modern institute that is safe and conducive to recovery. We will therefore:

   a) Promote a safe environment that is conducive to recovery despite the current physical constraints.

   b) Implement the new institute project based on the concepts of evidence-based design and a healing environment.

4. **Improve knowledge and influence directions in mental health:** As in the last Strategic Plan, destigmatization and partnerships underlie this strategic direction. By improving and sharing knowledge with our partners and the public, we should progressively decrease prejudice and stigma, and allow people living with a mental health problem to be integrated into a more welcoming environment. Consequently, our objectives are to:

   a) Innovate, develop, apply, and share knowledge to:
      - Improve the quality of services and clinical outcomes;
      - Influence the development of research projects;
      - Promote translational research;
      - Influence directions and policies in mental health;
      - Optimize the organization of services with our partners to improve access and flow between services.

   b) Lead actions so that the community fully integrates people living with mental health problems as full citizens.

5. **Develop and build on the potential of human resources, and promote operational excellence:** This direction supports the other strategic directions in that it builds on the leadership and excellence of our human resources and on operational efficiency to achieve our mission and our vision. To achieve this, we intend to:

   a) Provide an environment where human potential and collaboration are valued.

   b) Support professional and management practices with improvement and feedback tools including:
      - Training programs;
      - Updated clinical information systems;
      - Improved processes;
      - Reliable, precise, and useful tools for analysis and decision-making purposes;
      - Sustainable development practices.

   c) Implement a process to ensure progress in the Strategic Plan.

6. **Promote philanthropy to benefit mental health:** The Douglas Institute Foundation is a key stakeholder in our success, making it possible for us to undertake various novel initiatives, as well as a driving force in recruiting allies to the cause of mental health. Our objective is to:

   a) Conduct a major fundraising campaign to support the development of cutting-edge programs, research and organizational priorities.

Finally, to ensure progress in achieving our strategic directions and objectives, we have introduced greater flexibility in the process. In fact, changes in our environment are significant, numerous, and sometimes happen at a rapid pace. These changes, whether they are of our own initiative or outside our direct control, require that we take them into account and adjust our actions accordingly. To adapt to our changing environment, an annual evaluation and adjustment mechanism has been integrated into the Strategic Plan implementation process.