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# Therapeutic Relationships: From Hospital to Community

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## **Therapeutic Relationships: From Hospital to Community**

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## Key Implications for Decision Makers

- This new way of helping people with mental illness make the difficult transition from hospital to community saved more than \$12 million through shorter hospital stays while improving how patients function. The savings were achieved through the early discharges of patients on 13 wards, in four cities, over the period of one year.
- This model saves the most money and is most beneficial when targeted at individuals who say they are lonely.
- Patients under the new model of treatment who were characterized as “lonely” — describing their quality of social relationships as neutral or unsatisfactory at enrolment — used an average of \$20,300 less per person in hospital and emergency room services during the year after discharge, and reported improved costs, quality of life and level of functioning. Those receiving usual care consumed just over \$1 million more in hospital and emergency room services than the “lonely” people who received the new model of care.
- Partnerships between mental healthcare consumer organizations and professional mental health services were crucial in yielding cost savings. Consumer organizations will need ongoing funding of peer support programs to continue offering these services. Treating just one “lonely” person per year would pay for a part-time volunteer co-ordinator through reduced hospital and emergency room costs.
- Those receiving the new model of treatment used an average of \$4,400 less per person in hospital and emergency room services during the year after discharge (three-quarters of whom didn’t describe themselves as lonely.) This number was not statistically significant.
- Because patients under the new model had a support network ready for them, hospital staff could discharge them about four months earlier than patients who did not have the same type of support. A more flexible role for hospital staff that has them act as a transitional caregiver in the hospital and in the community leads to the shorter lengths of stay, since discharge is less dependant on how available community resources are and because clients can access supports immediately.
- Patients getting help from community peer support groups reported improved social skills and feelings of well-being. They also appeared to be further along in the therapeutic recovery process than those getting the usual care.
- As this study progressed, wards with usual care started to implement the new model of care based on a strong belief in its value.
- As a clinical trial using a randomized cluster design, the study was highly rigorous in looking at the experiences of 390 patients in 26 wards in London, St. Thomas, Whitby and Hamilton.

## Executive Summary

This study tested a new approach to supporting people with chronic mental illness as they make the transition from the hospital to the community. It involved 390 discharged patients from the Regional Mental Health Care London/St. Thomas (formerly London/St. Thomas Psychiatric Hospital), the Centre for Mountain Health Services (formerly Hamilton Psychiatric Hospital), and the Whitby Mental Health Centre.

The transitional model focuses on interpersonal relationships. It includes two important elements: the first is peer support for one year from former clients of the mental healthcare system who promote friendship, provide understanding, teach community living skills, and encourage current clients in making a transition from psychiatric hospital to community. The second element is an overlap of in-patient and community staff in which the in-patient staff continued to treat clients until the clients have a working relationship with a community care provider, which can take up to one year.

The model was developed and tested in a pilot project developed at Hamilton Psychiatric Hospital. The pilot demonstrated significantly improved quality of life for nine participants who were given transitional support, while resulting in savings of \$496,862.55, during a one-year trial. A diagram, which depicts the model, is included in the full report as figure 1.

The research had two components: a randomized cluster design and a qualitative critical ethnographic component. Outcome measures included quality of life and costs. It was hypothesized that, in the year following discharge from a psychiatric hospital, individuals participating in the transitional discharge model would have improved quality of life and incur fewer health and social services costs compared to individuals receiving standard care.

There were 26 psychiatric tertiary care psychiatric wards included in the study. They were matched into 13 pairs of similar wards (treatment focus, staffing level, average length of stay). Of each pair, one ward was randomly selected to implement the new intervention while the other was to continue offering treatment and discharge as usual. To implement the intervention, extensive staff training of 12 hours per staff member was offered to all members of the multi-disciplinary team. The intervention wards were connected with consumer groups who had agreed to offer the peer support component. There were 17 mental health consumer groups involved throughout the study. They recruited volunteers, offered a standardized 10-session peer training program, matched volunteers to patients about to be discharged and provided ongoing support to volunteers. They were greatly assisted by a three-year grant from the Trillium Foundation.

An advisory committee of members of the research team, the pilot ward, the participating hospitals, the consumer groups and community agencies greatly assisted in the implementation.

Intervention participants were able to be discharged at an average of 116 days sooner than control ward participants. One nurse in London, eager to finish her training so she could help with her client's transition into the community had commented "With this model, my patient can leave after six weeks, instead of six months." The client was one

that was difficult to refer to an appropriate community services in a timely manner, but discharge was not delayed by the need to find appropriate community-based services.

The data showed this change in practice was significant and widespread. At a rate of \$632.30 per day — the cost of a bed in a psychiatric hospital — the people in the intervention group consumed \$12,212,242 less in hospital costs than the group receiving regular, standard care, prior to discharge from the pre-enrolment admission. In the first year after discharge, the intervention group consumed \$4,400 less hospital and emergency room services per person than the group receiving regular, standard care. This trend was not statistically significant. Despite the significantly shorter length of the intervention group’s hospital stay, they did not need more services after discharge, and actually had a trend for fewer hospital services after discharge.

The intervention group showed a trend toward improved quality of life on global quality of life, but this was not statistically significant. However, quality of life related to social relations, the specific area target by the intervention, did improve significantly for intervention participants.

The intervention group had higher general levels of functioning one year after discharge as measured by the global functioning subscale of the Colorado Client Assessment Record.

Twenty-six percent of the participants identified themselves as feeling negative or neutral about their social support at the beginning of the study. This was identified by three questions on the Lehman scale about how they felt about the things they do with other people, the amount of time they spend with other people and the people they see socially. This group was termed “the lonely group.” The lonely subgroup in the intervention group used \$20,300 less in one year per person in hospital and emergency room services than the group receiving usual discharge care. The people receiving usual care consumed a total of \$1,078,900 more hospital and emergency room services than the “lonely” people receiving support. All outcomes (costs, quality of life and level of functioning) improved using the new model of care on the lonely subgroup. Only the level of functioning was still significant when examining the differences between the people under the new model of care and the people under the usual care who were already satisfied with their social relations. Therefore, although all may gain through improved functioning, the lonely group makes far greater gains generally.

Both contamination (when the regular standard-care wards began to implement the intervention) and under-implementation (by two wards in the intervention group) were issues. As the project progressed, regular standard-care wards identified that the intervention groups were getting better results with discharge and readmission. They then began to gradually attempt to implement parts of the intervention. Although they did not implement as fully as 11 of the 13 intervention wards, this weakened the results that would otherwise have been available. Similarly, the two wards that did not fully implement reduced the size of the differences between intervention and control wards.

## **Recommendations**

Partnerships between consumer organizations and professional mental health services can yield cost savings and improved care. Consumer groups will need ongoing funding of volunteer co-ordinators to continue offering this service. Treating just one lonely person per year would pay for a part-time volunteer co-ordinator through reduced hospital and emergency room costs.

A more flexible role for hospital staff that has them act as a transitional caregiver in the hospital and in the community results in shorter lengths of stay, since discharge is less dependant on how available community resources are and because clients can access supports immediately.

Hospital staff needs access to client records and systems for documenting care following discharge. Budgeting needs to include time and transportation costs for staff to provide this service.

The intervention has the most benefit when targeted at individuals who perceive themselves to be lonely.

Consumer groups should be considered part of the treatment team. Regular weekly time should be provided for consumer organizations to meet with hospitalized patients. Community outings from hospital should regularly include consumer groups.

Further study is needed to better understand why some wards more readily adopted the intervention than others.

## **The Project**

In Canada, only heart disease surpasses mental illnesses in hospitalization costs. Mental health care reform is decreasing the number of psychiatric beds available, and increasing the number of clients served in the community. The use of appropriate models of discharge planning, and community integration is critical for success.

This study tested a new approach to supporting people with chronic mental illness as they make the transition from the hospital to the community. It involved 390 discharged patients from the Regional Mental Health Care London/St. Thomas (formerly London/St. Thomas Psychiatric Hospital), the Centre for Mountain Health Services (formerly Hamilton Psychiatric Hospital), and the Whitby Mental Health Centre.

The overall objective of this study was to assist individuals hospitalized with a chronic mental illness in successful community living. The specific objectives were to determine the cost and effectiveness of a transitional discharge model of care, and compare it to the standard model of discharge. The transitional model focuses on interpersonal relationships.

This new model includes:

- a) Peer support for one year, which is assistance from former clients of the mental health care system who promote friendship, provide understanding, teach community living skills, and encourage current clients in making a transition from psychiatric hospital to community, and
- b) Overlap of in-patient and community staff in which the in-patient staff continue to treat clients until the clients have a working relationship with a community care provider. This can take up to one year.

The model was developed, and tested, in a pilot project developed at Hamilton Psychiatric Hospital. The pilot demonstrated significantly improved quality of life for 11 participants who were given transitional support, while resulting in savings of \$496,862.55, during a one-year trial. A diagram which depicts the model is included as figure 1 (see cover).

Outcome measures included quality of life and costs. It was hypothesized that, in the year following discharge from a psychiatric hospital, individuals participating in the transitional discharge model will:

- a) Have an improved quality of life; and
- b) Incur fewer health and social services costs compared to individuals receiving standard discharge care.

Sub hypotheses were that there would be better functioning, less hospital use and fewer legal events with the intervention group. While it is further hypothesized that these benefits will endure into the second year, after the support has been completed, this paper describes the findings of the first year of post discharge follow-up.

## **Design**

The overall approach for this project has been participatory action with involvement of key stakeholders throughout the project. The research had two components: a randomized cluster design and a qualitative critical ethnographic component.

**For the randomized cluster design**, the clusters, or units of randomization, were psychiatric wards, while patients on these wards were the units of analyses. This design eliminated the logistical problems of differentially treating selected patients on the same ward. A total of 26 wards from 4 hospital sites were paired, and then randomized to either the experimental group using the new transitional discharge model, or to the control group, which received usual care. A range of types of wards was included in order to create the best test for the model. These ranged from general admission wards, to forensic units, and specialty programs.

Participants were enrolled at the time of discharge. They were interviewed at enrolment, one month post-discharge, at six months post-discharge, and at one year post-discharge. Interviews will also be conducted at 18 months and at 24 months post-discharge, however results reported here are for the first year of follow-up. The Research Assistants were blind to the ward assignment in the study.

Enrolments began early in 1998, and were completed in spring of 2001. Interviews were conducted wherever the participant was at the time. Research assistants traveled throughout an area bounded by Peterborough, Tobermory, Windsor and Niagara Falls.

**For the critical ethnography**, information was obtained from a number of sources. At all data collection points with individual participants, open ended questions about the process of discharge or follow-up were asked including what was working and what needed improvement. All wards, both intervention and control, submitted monthly summaries of their activities and any identified issues or concerns. Similarly, consumer group partners who provided the peer support also submitted monthly reports of activities, issues and concerns. Field notes were kept of contacts with the wards and consumer groups, as well as any critical incidents that occurred throughout the study. Media was monitored throughout the study at the cities where the hospitals were situated. This was primarily saving newspaper clippings of issues related to mental health in each of these communities but if radio or television coverage was identified, it was also noted

## **Instruments**

Data were collected from individual participants using a demographic questionnaire, the Lehman Quality of Life-Short Form, the Colorado Client Assessment Record (CCAR), Utilization of Health & Social Services, the Discharge/Process of Follow-up

Questionnaire, and the Criteria for Degree of Treatment Implementation Form. Copies of instruments are in the appendices.

### **Implementing the Intervention**

To implement the intervention staff on the intervention wards had to change their usual practice and consumer groups had to provide peer support in a more standardized fashion.

### **Staff Training**

Presentations of the model were made on each of the 13 intervention wards and staffs were asked to identify what they needed to know in order to implement the intervention. The information from this process was used to generate a list of 12 educational sessions. This list was validated with staff and then learning modules for each of the 12 topics were developed. The staff on the intervention wards received 12 hours of training each to allow them to implement the new model of care. The training was completed by over 300 multi-disciplinary staff members. A survey was later sent to staff to evaluate the teaching/learning. Staff confirmed that they found the training useful and were generally able to change their practice based on what was learned. The inpatient staff member who had the best therapeutic relationship with the client would continue to see the client after they leave the unit, until the client established a working therapeutic relationship with the community based service provider.

### **Staff Training Topics** included:

1. CNO Quality Assurance Program (for Nurses only)
2. Peer Support Workers
3. Therapeutic Relationships: Establishing and Maintaining
4. Therapeutic Relationships: Termination
5. Therapeutic Boundaries
6. Discharge Planning
7. Community Resources
8. Community Workers' Safety
9. Problem Solving Approach to Crisis Intervention
10. Telephone Advice
11. Negotiating Skills
12. Your Partners in the Community

## **Peer Support**

Planning for the peer support program began prior to the CHSRF funding with meetings with a small core of consumer survivor groups. These groups identified the core components of peer support and the core components required of a peer training program. The Mental Health Rights Coalition of Hamilton and Can-Voice of London developed a training program for peers. This includes a generic training manual and lesson plans. Each consumer survivor organization adapted the generic manual to their agency. For example, there was a section of the history of the particular consumer group that varied with each group, and the information of community resources was specific to each community. Rural consumer organizations tended to offer full day workshops for training due to transportation challenges. The same content would be offered in once or twice weekly sessions in urban areas. The consumer/survivor organizations recruited volunteers to provide peer support, and provided 10 hours of training for each person.

A total of 17 different organizations (listed in appendices) were involved in providing peer supporters for participants discharged all over southern Ontario. Many of the groups were not funded to provide this service. Working with the groups to identify potential sources of financial support was important during the initial year of the study. One research assistant worked with the groups on this and successful proposals were shared amongst other groups. A consortium of 13 of the groups, lead by Can-Voice in London, was successful in getting 3 year funding of \$665,000 from the Trillium Foundation of Ontario to assist them in providing the peer support required by the intervention. Generally this was used to hire part-time volunteer coordinators who assist in recruiting, training and matching volunteers as well as providing support to the volunteers. Small funds were also used to offset transportation costs and for volunteer recognition activities such as an annual dinner. Approximately 240 consumer volunteers were trained. The most common reason for losing volunteers was that they had gone onto paid employment. Peer support was provided for the client for one year following leaving the hospital by the local consumer/survivor agency.

### **Peer Volunteer Training Topics included:**

1. Introduction to Consumer Groups
2. Introduction to Connections
3. How Well Do You Listen?
4. Handling Stress
5. What Is It Like To Be A Buddy?
6. Common Symptoms
7. Medications
8. First Aid
9. Community Resources
10. Other Resources
11. References

## Advisory Committee

An advisory committee was chaired by Ruth Schofield, who had been co-principal investigator for the pilot phase of the project. It was comprised of members of the research team, the pilot ward, the participating hospitals, the consumer groups and community agencies. A full list of members is included in the appendices.

## Results

### *Baseline Ward Data*

Table 1 summarizes the ward data after the randomization occurred. The wards appeared well matched. In particular, the average length of stay differed by less than one day. The randomized cluster design assumes that participants within the wards would be more similar to each other than participants from other wards and accounts for this in the sampling and analysis.

*Table 1: Wards at Baseline*

<b>Ward Characteristic</b>	<b>Control (n=13)</b>	<b>Intervention (n=13)</b>
Average Census	25.5	20.1
Average Length of Stay	185.5	184.6
Percentage Male	63.6	51.2
Percentage Female	36.4	48.8
Diagnoses (percentages):		
Schizophrenia	53.5	42.7
Mood Disorder	19.1	36.7
Substance Related	6.1	2.4
Personality Disorder	2.9	5.0
Anxiety Disorder	2.0	1.8
Developmental Delay	5.2	8.0
Other	7.7	10.4

### *Baseline Enrolment Data*

The characteristics of the participants who were enrolled in the study were similar to the baseline ward data and the intervention and control participants appear similar. The major difference between the two groups had to do with length of stay before discharge. The average length of stay for the control ward participants was 333.5, while the average length of stay for the intervention ward participants was 217.5. (This is higher than the ward data since the study only enrolled participants who had had a minimum 10-day admission.) The only ward level change had been the introduction of the transitional discharge model being tested by the study. Anecdotal comments from staff had signalled that the model was causing changes in discharge practices. One nurse in London, eager to finish her training so she could 'bridge' her client had commented, "With this model, my patient can leave after 6 weeks, instead of 6

months.” The client was one that was difficult to refer to an appropriate community service in a timely manner.

In another instance, a nurse in St. Thomas, on completing her training, had commented that there was no community support available yet, but she would continue to see the client until appropriate services could be involved. The nurse manager on that ward later informed the researchers that they had never found a service for the client, but after a year of ‘bridging’, the nurse had discharged the client as there was no further need for any mental health services at the time. The client was doing well.

In both of these instances, clients were discharged when they were ready to leave hospital. Discharge was not delayed by the need to find appropriate community based services. The data showed this change in practice was significant and widespread. At a rate of \$632.30 per day cost for a bed in a psychiatric hospital, the people in the intervention group consumed \$12,212,242 less in hospital costs than the control group, prior to discharge from the pre-enrolment admission.

<b>Participant Demographic and Baseline Characteristics by Group</b>		
<b>Characteristic</b>	<b>Control (n=189)</b>	<b>Intervention (n=201)</b>
Female	87 (46%)	103 (51.2%)
Male	102 (54%)	98 (48.8%)
Average Age	39.5	43.4
Age of Onset of Illness	20.8	21.9
Lifetime Hospitalizations	2.5	2.1
Length Current Admission	333.5	217.5
Primary Diagnosis (%):		
Schizophrenia	53.0	41.2
Mood Disorder	34.6	45.7
Substance Related	0.0	0.5
Personality Disorder	2.2	4.0
Anxiety Disorder	1.1	1.5
Developmental Delay	2.2	3.0
Organic Disorder	1.6	0.0
Schizo-Affective Disorder	0.5	1.0
Other	4.9	3

### ***Main Hypotheses***

Hypothesis 1 stated the within one year, the participants would have a better quality of life. Data collected using the Lehman Quality of Life Interview-Short Form was tested using a t-test. The intervention group showed a trend toward improved quality of life on global quality of life, but this was not statistically significant (p=.27). However,

quality of life related to social relations, the specific area targeted by the intervention, did improve for intervention participants. ( $p = .015$ ).

Hypothesis 2 stated individuals participating in the transitional discharge model would incur fewer health and social services costs compared to individuals receiving standard care. The data set with respect to costs is very large and is only partially analyzed at this point. In the interim, the use of hospital and emergency room services were selected for analysis since they are the most costly services likely to be accessed. In the first year after discharge, the intervention group consumed \$4,400 less hospital and emergency room services, per person, than the control group. This trend was not statistically significant ( $p = .09$ ). It is interesting that the largest cost savings was actually prior to discharge due to the shortened length of stay as described. Despite this significantly shorter length of stay (average 116 fewer days per person), the intervention group did not need more services after discharge, and actually had a trend for fewer hospital services post discharge.

The benefits of the staff and peer support in keeping people out of hospital were supported by a case described by a nurse in Whitby. They had a patient who had never been able to stay out of hospital more than 3 months. The nurse spoke with pride of how the woman was still out after 6 months, and doing well, with the staff and peer support. She said all of the staff were so impressed by this success that they would not revert to usual care, even if the study failed to have any “significant” findings.

### ***Sub Hypotheses***

The intervention group had higher general levels of functioning one year post-discharge ( $p = .048$ ) as measured by the functioning subscale of the CCAR (Colorado Client Assessment Record).

There were too few legal events to analyze. Of the entire sample there was only one day in jail by one person. Given the inclusion of forensic wards in the sample, this would suggest that the hospitals are doing a good job of preventing further legal problems.

The sub hypothesis related to hospital use was already covered in the discussion of costs.

### **The Lonely Group**

Within the sample at baseline, 26% of the participants identified themselves as feeling negative or neutral about their social support. This was identified by 3 questions on the Lehman scale: How do you feel about A. The things you do with other people, B The amount of time you spend with other people, C. The people you see socially. This group was termed “the lonely group.”

Since the intervention is interpersonally focused, we wanted to examine the difference it would make for people who perceived a problem in this area the differences are summarized in the following table:

<b>Statistics By QOL Subjective Social Relations Score (#4 vs. &gt;4) {mean (sd)}</b>				
<b>Outcome at 1 Year</b>	<b>QOL Social Relations Score</b>			
	<b>Lonely Group</b>		<b>Social Group</b>	
	#4		>4	
	<b>Control</b>	<b>Intervention</b>	<b>Control</b>	<b>Intervention</b>
<b>QOL - General Life Satisfaction</b> <b>Higher scores = greater satisfaction</b>	4.1 (1.4)	4.8 (1.5)	4.9 (1.2)	4.8 (1.3)
<b>Level of Functioning – Overall</b> <b>Lower scores = higher functioning</b>	5.8 (1.3)	4.9 (1.6)	5.3 (1.3)	4.9 (1.2)
<b>Hospital/ER Costs (in \$1,000)</b>	31.2 (49.4)	10.9 (16.4)	23.3 (41.1)	23.5 (39.5)

The lonely subgroup in the intervention group used \$20,300 less in one year, per person, in hospital/ER services than the group receiving usual discharge care. The people receiving usual care consumed a total of \$1,078,900 more hospital/ER services than the “lonely” people receiving the support. All outcomes (costs, quality of life, and level of functioning) improved using the intervention with this subgroup. Only level of functioning was still significant when examining the differences between intervention and control participants who were already satisfied with their social relations. Therefore, although all may gain through improved functioning, the lonely group makes far greater gains generally.

### **Contamination vs. Implementation**

Both contamination (i.e. the control wards using the intervention) and under implementation by some intervention wards were issues. The degree of implementation/contamination was evaluated on individual interviews at each data collection period. For example, all discharged clients were asked questions to determine if they were receiving peer support or ongoing contact with hospital staff. The monthly ward and consumer group data also gave information about referrals and follow-up. At all times the intervention group received more of the intervention than the control group. However, 2 of the 13 intervention wards appeared similar to the control wards with respect to degree of implementation. In addition as the study progressed, control wards started to increasingly implement the intervention.

The control wards noticed the differences in intervention wards despite efforts to avoid this problem. At one month post discharge the control ward participants were 40% more likely to be readmitted on the control wards and, as mentioned, the length of stay was shortening on the intervention wards. There were some staff changes between intervention and control wards. Staff were de-briefed and requested to not implement the intervention on control wards. However, since staff stated they had “seen it work” they

frequently continued to offer care in the new ways rather revert to previous practice. Much of the contamination was more ad hoc and given to clients they considered particularly needy. However, towards the end of the enrolment process two wards actually contacted 2 different consumer groups in an effort to establish a relationship and systematic system of referrals. In both cases, the consumer groups requested the wards wait until the end of the study. However, individual clients seeking peer help from the consumer groups, even if from control wards, were not turned down. Shortly after the study sample was enrolled (but not completed follow-up) one entire hospital implemented a peer support program. Since these issues occurred later in the study, and did not involve the systematic staff training and consumer group relations as the intervention wards, they did not implement to the degree expected of intervention wards. However, the wide extent of contamination would certainly reduce the effect size of the intervention. All analysis was on an “intent to treat” basis. This means, for example, that a participant would be counted in the control group if they were on a control ward regardless if they actually got the intervention. While the researchers considered it a positive issue to have people feel so passionately about the intervention that they refused not to do it, it did reduce our ability to accurately assess all differences between intervention and control wards.

The 2 intervention wards that did not implement reported to a single middle manager. After the first month follow-up of approximately 20 clients from these wards it was obvious that none had received the intervention. Several meetings were held at several administrative levels. The hospital administrator sent memos and personally met with staff on the unit to encourage adoption of the intervention, and for a period the research coordinator attended discharge planning meetings to ensure the intervention was being put in place. The next discharges did demonstrate gradual adoption of the intervention. Unfortunately, by this point the control wards were beginning their gradual adoption so these 2 wards continued to be very similar to the control wards with respect to degree of implementation.

### **Wards and Consumer Groups: How to Make It Work**

Consumer groups experienced a range of welcome on the wards even within the same hospital. This related to actual referrals received and degree of implementation. As an example of a negative reception, one volunteer coordinator asked to use a washroom while on the ward. The staff explained she wasn't staff, so couldn't use that washroom & wasn't a patient so couldn't use those washrooms. Since she must therefore be a visitor she would have to go to the front of the hospital to use the facilities (at least a 10 minute walk). On the other extreme the project research coordinator had to get the consumer group representative to let her off the ward on a different intervention ward. The consumer literally had the keys to the ward.

Strategies that seemed to work best involved regular, minimum weekly presence of the consumer group on the ward. Several consumer groups had once or twice weekly groups they ran on the wards to meet and know clients prior to discharge. This knowledge assisted with the matching process to find a suitable volunteer with similar interests. Several wards also had regular planned “outings” to the consumer groups. These activities portrayed teamwork and made it easier for the client in accepting peer support.

Consumer groups also helped out each other with training and referrals. For example, at one point the peer support group in Windsor was having a change in leadership and staff that made it difficult to provide peer support through the transition. For a period, a local consumer run business helped out with support from other consumer groups, despite not usually doing this sort of service. However, when a large number of referrals came closely together, trained volunteers from a different organization in Chatham ended up going to Windsor until the original Windsor agency was back on its feet with a cadre of trained volunteers. There were several similar examples of groups helping each other out. Consumer organizations had regular meetings of volunteer coordinators and executive directors to share strategies and suggestions. These groups had not worked together prior to this project.

Hospital ward staff found they need to develop specific systems to track discharged clients, and to develop documentation plans. The problem was that generally information on a client was not on a ward after discharge. Most ended up keeping some clinical records on the ward for tracking and documentation rather than requiring staff to make frequent visits to clinical records or the out patient department. Most wards also developed calendar systems where planned follow-up meetings could be scheduled and planned for from a staffing perspective.

Staff described that it was challenging but rewarding to have to learn to know former patients in a new way. One staff described having a peer volunteer arrive that she had formerly nursed. She had considered the person to be someone who would always be dependant on the mental health system (a “lifer”). When she saw that not only was this person doing well out of hospital, but he was now able to help others, she said she was forced to really sit back and re-evaluate her assumptions. She stated, “If I was so wrong about him, who else might I be wrong about? This has really changed the way I nurse.”

Both wards and consumer groups found differences in the intervention when adopted in a rural area. Transportation and the time required to get to remote areas was a concern. Both consumer groups and wards adopted a system of having some phone contact and some “in person” contact for rural clients. In contrast almost all contact in the urban areas was “in person”.

### **The Process of Discharge and Follow-Up**

Clients were asked to describe the discharge and follow-up process. Both Intervention and Control participants consistently identified contact and services by mental health professionals/workers to be key to both discharge and follow-up. However, intervention participants described feeling more positive about discharge. They described it as a step forward. In contrast control participants were less positive and described being “cut adrift” when leaving hospital

Participants were asked to describe the ways in which they were getting help. Three themes were consistently identified by both intervention & control subjects throughout the initial year:

1. Contact and services by mental health professional/workers;
2. Medication; and,
3. Financial help. Some in both group felt they were not getting help.

In addition the Intervention group identified:

1. talking to someone;
2. support from others; and,
3. *regular* professional contact.

When asked what further help was needed, some participants in both groups identified they needed no further help. Financial concerns were identified by both groups. The control group also had the following needs:

1. to talk with someone;
2. more participation in programs & activities.

The Intervention group identified ongoing medication issues. Six months after discharge the intervention participants identified the need for ongoing counselling issues. These were far more specific than the “talking” requested by the control group. For example, participants requested “anger management” or “I need to come to terms with my previous sexual abuse”. They requested specific strategies to manage symptoms. Similarly, at one year post discharge the intervention group continued to identify the need for specific counselling and working through issues while the control group still simply identified the more general need to talk to someone. It would appear from the qualitative responses that the intervention group had more insight and was further along in the therapeutic recovery process.

### **Dissemination Strategies**

Major stakeholders were involved throughout the research process. Regular meetings were held with hospital administrators and consumer groups. The principal investigator presented information about the project to all mental health implementation task forces in the catchment area and was invited to participate on the Southwest Region Implementation Task Force Coordinating Committee. Earlier, the project was presented to administrative staff at all provincial psych hospitals at one of their regular meetings.

The principal investigator and staff met with officials at the Ministry of Health and Long Term Care throughout the study. Although the Ministry had just settled a strike, during which time communication was difficult, they had a representative come to London to attend the first dissemination conference. The plan is to set a meeting with the Minister, to discuss the results of the trial and the need for policy and funding support to change practice to incorporate this model of care.

The Advisory Group (see appendices) was a key strategy both for dissemination and for identifying new dissemination strategies. It was through this group that the strategy was suggested of using McDonald's tray liners for recruiting peer volunteers. Dissemination conferences were held in London May 15, Hamilton May 22 and Whitby May 29, 2002. A subcommittee of the advisory committee was formed for each area to plan the event. Multi-media strategies involving different art forms augmented the scientific presentations. For example, artwork from the pilot ward depicting their initial vision of the new model of care was displayed. One participant at the London conference was moved by the artwork that he wrote a poem that was then read at the conference (see appendices). Some of the qualitative data was used by Tanya Lysiak-Globe, our research assistant from Hamilton, to create a song used at the beginning and close of each conference. The closing song was accompanied by a consumer musician and included a photo montage. Meetings were held with a local theatre playwright in London to share qualitative data and develop it into a theatre format. Phil Arnold directed members of Can-Voice, London to perform the short play. Similarly, a different play using audience participation and movement theatre was developed in Hamilton and used members of Mental Health Rights Coalition as actors. Pens with the website were distributed.

Scientific presentations for the dissemination conferences included: the main study results, a panel presentation from consumer groups emphasizing the effect on the groups and volunteers, a related qualitative study examining similarities and differences between peer and nursing support, and an evaluation of the staff education component. A Scottish research team reported on their findings in replicating our project. The visiting team included a researcher, two consumers and a transitional nurse from Inverness. The Scottish replication randomized patients rather than wards so avoided much of the problem of contamination and under implementation. In that study, participants were 7 times more likely to be readmitted if in the control group. A summary of the evaluation of the conference is included in the appendices and copies of the booklets distributed are available.

More traditional dissemination strategies used throughout the project include a website, fact sheets, business summary booklets, and numerous scientific presentations.

### **Recommendations/ Implications**

- Partnerships between consumer organizations and professional mental health services can yield cost savings and improved care. Consumer groups will need ongoing funding of volunteer coordinators to continue offering this service. Treating just one lonely person per year would pay for a part-time volunteer coordinator through reduced hospital/ER costs
- A more flexible role for hospital staff, that has them bridge services to the community, results in shorter lengths of stay since discharge is less dependant of availability of community resources and clients can access supports immediately.
- Hospital staff needs access to client records and systems for documenting care following discharge. Budgeting needs to include time and transportation costs for staff to provide this service.

- The intervention has the most benefit when targeted at individuals who perceive themselves to be lonely.
- Consumer groups should be considered part of the treatment team. Regular weekly time should be provided for consumer organizations to meet with hospitalized patients. Community outings from hospital should regularly include consumer groups.
- Further study is needed to better understand why some wards more readily adopted the intervention than others.

## **Conclusion**

"New ideas pass through three periods:

- It can't be done.
- It probably can be done, but it's not worth doing.
- I knew it was a good idea all along!"

— Arthur C. Clarke.