Embracing Leadership in Mental Health Settings: Tara Laing

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Enter/Initiate

In order to understand the role of Occupational Therapy (OT) in mental health, it is important for us as future OTs to take action now and investigate what truly defines a leader in OT. Dr. Lynn Cockburn, our professor, has called us to action to find out what we as OTs can do to make a difference in the lives of our clients. In accordance with the Canadian Practice Process Framework (CPPF) (Craik, Davis & Polatajko, 2007), this first stage of enter/initiate involved us learning about this inspirational assignment and making a decision to respond accordingly. Together, we consulted with Dr. Lynn Cockburn and ourselves to understand our own learning objectives and decide on how best to proceed. Through this collaboration, we decided that the best way for us to further understand OT leadership, we would seek out a current leader in the field to share their story.

Set the Stage

During this stage it was important for us to establish a working relationship with each other and our chosen topic. To best establish a working relationship with each other we felt it was important to clarify our beliefs, assumptions and expectations for this assignment. To be specific, we both agreed that there is a role for an OT to be a leader in a mental health setting, however we both assumed that this was role was likely inhabited by experienced OTs in a managerial position. Furthermore, we both expected that this leadership role would be a highly structured position that only takes place in particular settings. Thus, one of our goals then for this assignment was to explore these expectations and assumptions. After we had jointly decided on collaborative goals and expectations, we felt it was important to further clarify our idea and chosen topic. Due to the fact that we both have a keen interest in understanding and working with young adults, we both knew we wanted to focus in on this specific population. We have both worked in different settings where we have interacted with individuals who are living with mental health issues, and our ability to connect
and understand them and the challenges they face, sparked a desire within us to explore what else can be done for them. We wanted to look beyond the notion of medical and pharmacological recovery, and truly understand what else is available for individuals after a first episode psychosis. Looking beyond the biomedical model, we asked ourselves “are there any non-pharmacological resources in the community that can better help young adults recover from a first episode psychosis?” According to Barrett (1996), she believes there is, as it was suggested that a more holistic and integrated approach is necessary to address the complex issues involved in recovery from mental health issues. Furthermore, a family friend of SC also inspired us to explore this topic. This individual had been diagnosed with schizophrenia at the beginning of high school and as a result was unable to receive her high school diploma. When trying to find a job, she struggled due to a lack of educational and vocational skills. This individual was unable to properly navigate the educational and employment systems of Toronto, and felt discouraged by her lack of progress. Ultimately SC also felt discouraged by her lack of progress and bothered by the gap in the system. Due to this gap she was keen to further explore potential resources in the community that could have helped her friend.

Therefore, based on our above learning objectives we wanted to understand the roles OTs can play in and outside of an institutional setting, with a specific emphasis on available resources for young adults in the community. We wanted to particularly focus on recovery and ways in which young adults are able to access services or programs to increase their chances of occupational performance and satisfaction. With this in mind, and based on our desire to seek out a leader in the field, we felt that it was important for us to hear firsthand from an individual who was directly involved in this process. As students, our most engaging lectures have been the ones that have been given by individuals who are truly passionate about their OT role. Based on this, we both decided that
interviewing a leader in the OT field, with experience working with young adults after a first episode psychosis would best suit our personal interests and learning needs.

Throughout our collaboration, we also felt it was vitally important to establish the social and practice contexts related to OT leadership in mental health, specifically those that might affect young adults in Toronto. In accordance with the CPPF, we are all positioned within a broad societal context composed of cultural, institutional, physical and social environmental elements (Craik, Davis & Polatajko, 2007). Due to the fact that we are all unique individuals who have engaged in different occupations throughout our lives, we understood that we needed to be mindful of the diverse beliefs and attitudes that we both shared, as well as any other individuals we would encounter throughout this journey. In order to understand the societal context at hand, we jointly decided to remain open and non-judgmental regarding each other’s beliefs about OT, mental health and leadership. We hypothesized that being a leader would require a deeper understanding of how personal experiences; culture and one’s background can affect their attitudes towards the concept of leadership. We therefore shared our thoughts with one another, exploring ideas that differed between us, and agreeing upon specific components that we felt described a leader.

Furthermore, in order to continue to explore OT leadership in mental health, specifically looking at resources for young adults, it was important for us to understand the context that may impact this population. Although at this point, we had not definitely decided on a specific interviewee, we both knew we wanted to focus on an individual with experience working at the Centre for Addiction and Mental Health (CAMH). Therefore, we decided that an important first step would be to educate ourselves on CAMH in Toronto. Through online research and anecdotal evidence, we discovered that CAMH is one of the largest mental health teaching hospitals in Canada, and therefore understanding this cultural context fit within our learning needs. Furthermore, due to the fact that we are future OTs, we both agreed that it was important for us to understand the
workplace culture that affects OTs at CAMH. By understanding the scope of the OT role at CAMH, we would be able to further understand specific programs that might target recovery after first episode psychosis for young adults. Additionally, by speaking to clinicians and fellow students who have worked at CAMH, as well as educating ourselves via online sources about CAMH and its role in our health care system, we began to understand CAMH on an institutional level, specifically understanding particular policies and procedures related to OT.

Through this exploration, we gained a deeper understanding of the role of the OT and the types of teams involved in client-care at CAMH. Furthermore, during our interprofessional week learning about pain management, we both made a special effort to truly understand the roles of the health care professionals that may be involved in a client’s care. This included asking appropriate questions and taking notice of specific roles or skills that certain health care professionals possessed. Finally, we decided that it was important to brush up on our own OT professional standards in order to be able to truly understand the role of an OT within our scope of practice. Therefore, once we felt comfortable about our level of understanding around the practice context, we decided we were better equipped to prepare for our interview.

In accordance with this stage of the CPPF, it was important for us to consult and clarify which frames of reference and theoretical perspectives we would use to guide our understanding of this topic. In accordance with adult learning principles we, believed that we needed direct, concrete experience to understand and apply our learning (Ammon-Gaberson, 1987). Additionally, adult learners enter situations with various past experiences; therefore we once again clarified with our need to remain non-judgmental of each other and our potential interviewee (Ammon-Gaberson, 1987). Furthermore, because we are keen to understand the role of an OT leader in a mental health setting, specifically working with young adults, we felt it would be most appropriate to guide our thinking through a cognitive behavioral lens. In this frame of reference, the therapist becomes an
educator and a facilitator, and someone who guides treatment through collaboration (Bruce & Borg, 2002). Due to this understanding, we felt using this idea to guide our exploration would be most appropriate. In an effort to understand leadership in mental health, with a specific emphasis on recovery, we would need to find someone or something to guide us and educate us on this topic. Similarly, cognitive behavioural therapy (CBT) suggests that thinking and thought processes affects our actions and behaviors (Bruce & Borg, 2002). With this in mind we felt comfortable learning more about OT leadership in a mental health setting, with the goal that new information could not only enhance our education, but possibly change our assumptions, behaviors and actions towards each other as colleagues, and towards our clients as future OTs working in a mental health setting. Great connections!

Assess/Evaluate

During this time we felt it was important to evaluate our progress thus far. In order to do this, we set up a meeting with Lynn to ensure that we were on the right track and were taking the necessary steps to complete this assignment. During this process we decided to further clarify our topic, ask any relevant questions, and ensure our learning objectives were being met.

Agree on Objective and Plan

At this point on our CPPF journey, we had agreed that our topic would explore the role of an OT in a mental health setting, specifically working with young adults after a first episode psychosis. In order to move forward, we conducted a preliminary online search and came across an educational video that was created by an OT targeting young adults after a first episode psychosis. Right away, we knew that we wanted to interview this inspirational OT, believing she could ultimately help us understand the role of an OT working with young adults after first episode psychosis. Tara Laing is an inspirational leader in the field today that has truly set the bar for what a difference one OT can
make. Through her revolutionary work in the LEARN program, as well as her groundbreaking achievements at CAMH, we both decided that she would be an excellent choice for our interview. At this point, to begin building a rapport with Tara, we initiated email contact and shared our desire to interview her for this assignment. By establishing an email relationship, we were able to clarify our roles, learning objectives and expectations.

Through our initial contact, we decided the best way to meet our objective of understanding the role of an OT working with young adults, we would set up a time for us to meet and conduct an informal interview. Furthermore, in order to further clarify our objectives we sent Tara a list of questions we would potentially ask her during our interview. This was for Tara to gain a better understanding of the content we were interested in. We felt that by conducting an in-person interview, we would truly get a sense of Tara’s role as an OT. Furthermore, we felt that by meeting with her at her own office at CAMH, we would be able to further understand the setting in which she works and what her daily schedule might look like. Great description of your process!

Implement the Plan

We conducted our interview at Tara’s office at CAMH. Due to the fact that we had previously sent over questions, our interview was efficient and very informative. For the purpose of this assignment, we have only included highlights from the interview that are specifically relevant to our topic. The interview below has been paraphrased to ensure efficiency and direct quotations have been transcribed verbatim to ensure accuracy.

S/T: Can you describe your current role at CAMH and any prior roles you have had?

TL: I graduated from Queens University in 1999. My first job was a 1-year contract at CAMH (Queen Street), in an outpatient access schizophrenia team. Out of 9 other practitioners, I was the only OT on the team at that time. A lot of my job involved dealing with people living
in boarding homes, with no real family contact. These individuals had been diagnosed a while ago and were currently suffering from occupational deprivation with minimal income or community resources. Some individuals were stable, and some were not. I ended up working on this unit for almost three years. Generally, it was a good experience and allowed me to get to know more about how the city of Toronto “deals with mental health issues,” like housing, ODSP, and community resources. I really began to see that there is a lack of resources available for these people. Another aspect of this job involved me starting a group bringing people out into the community. So, if 3 weeks of the month was devoted to education, 1 week was devoted to being fun and social. I started doing more extracurricular activities (e.g. camping) with my clients, and it was really interesting to see how “people thrive in different situations, and I was surprised by the skills that you never knew [certain] clients had.”

My next job was at a day centre at CAMH, and this place has truly transformed since I worked there. When I began working there, the centre had recovery programs for their clients, but the term “recovery” was still so new and just starting to be used with clients. The groups that I ran when I worked there were social recreation groups and a pre-vocational group. It was a very interesting setting and most of my time was spent with the recreational therapist who worked on the team. I really enjoyed working in this setting but found it difficult too because it was a “drop-in” centre where anyone could come and join in. Only having two staff made this difficult and often I felt like a manager with lots of interruptions and stressors, rather than an OT. However, despite this challenge, I learned a lot about group facilitation.

After working at the day centre, I was invited to apply for a job at the LEARN (Learning Employment Advocacy Recreational Network) centre. When I got the job, LEARN had only
been around for about a year and at that time there was a plethora of resources and staff. A wealthy family had donated money to start LEARN as a way to support early intervention and increase the likelihood that young adults would receive care fast. When I first started working at LEARN, there were no groups taking place, except for a GED group being facilitated by a teacher. The OT before me was mainly doing assessments with the clients. I ended up utilizing the skills and tools I gained at my last job as well learning more about psychosis in general, and I started a psychosis education group at LEARN. This group was a recovery group that was very much based on a chapter written by Gene Addington. During my time at LEARN, I also helped to create a proposal to get funds for a food security(?) program, started a cooking program where clients could “make it and take it,” and facilitated lunches where clients could build skills and be like a community. I also did some creative writing and expressive arts with my clients along with camping and picnics. Groups were always centered around advocacy, and one year we participated in the schizophrenia walk as the “youth aware” team and created posters and t-shirts together. I also started an alumni group at LEARN where people who were doing well in their recovery could come back and share stories.

I stayed at LEARN for 7 years and I have recently taken on an OT role in an early intervention clinic part of the mood and anxiety program at CAMH.

S/T: When researching online about recovery after first episode psychosis, we came across your video “Expectations from First Episode to Recovery,” can you tell us your reasons behind making this video?

T/L: As I mentioned above, I started an alumni group for people who were doing well in their recovery to come back to LEARN and talk to current clients who enjoyed hearing first hand
from people who had gone through similar situations. Throughout this time, I worked with and talked to people about “recovery,” and I created a focus group to get a better sense of what was going on. I had made movies before, and I was keen to have a movie made about recovery after first episode psychosis. It was a difficult task and “without my determination it would not have happened.” My manager at the time had said that there were some funds leftover and I could create a proposal pitching the video idea. I independently researched how to make a proposal and completed one and handed it in. Ultimately, I was given the go ahead to make the movie and I directed and produced most of the film. I had to do all of the planning for the video, but I had to hire someone to receive the check because it was a conflict of interest if I was given the money directly. It was a hassle and became a really tense situation. A lot of money went into the video, including a lot of my own money. But finally, it came through! I had to ensure that appropriate consent was obtained and that my clients knew they were not directly receiving money for sharing their story and had to disclose all the risks and consequences for participating in the video. Ultimately, my motivation behind making this video was because I wanted to share the success I was seeing with my clients with the broader population. With other clients, families and clinicians who needed inspiration and a reminder that “people do get well.” I also wanted to raise awareness about stigma. The video was accepted to a film festival but I felt like I wanted to get it out there even more. I was able to co-write the booklet and package that came along with the video, explaining how the project started and who would benefit from it. The video is now available from CAMH publications, with a short version on youtube.

S/T: What makes a ‘leader’ in the mental health profession?

TL: From the very beginning I remember “staying calm and sitting in silence and absorbing” everything and from everyone around me. Although I felt it was important to develop my own
style, part of that involved learning and understanding from others around me. Also, at LEARN, I had a really supportive manager who always encouraged me to go out there and share and absorb all of the information I could. Whether that meant going to conferences, or teaching or taking on students, I have always tried to “keep on my toes.” Taking on students especially has allowed me to really increase my energy and stay “fresh with what’s going on at school.” I think of myself as a leader in this sense as I have taken on 28 students in the last 8 years. Also, in my experience, what has made me a leader has been the fact that I have always been a “yes woman.” I have always tried to take on new things, constantly saying yes and always looking for positivity. In my current role, I am the only OT on the team and transferred my acquired leadership skills in order to successfully work as a case manager. I have “brought the recovery focus here,” and I have started new groups and advocated for more funding. So, in my eyes, leadership is all about advocating for yourself and trying to take on as many new experiences as you can.

S/T: What advice can you give new grads about becoming future leaders in OT in mental health?

TL: I believe it is important to “tap in with other students,” where you can combine forces and work together. Also, looking to outside sources will really be helpful for further education. I think it’s important for new grads to absorb all of the information that they can, “read a lot of books, partner with the community, explore the OT community and really be open to whatever is around.” Also, it is very important not to be “overly intimidated with other people telling you what to do.” Rather, it is important to build up confidence and establish your own OT role. Whether that means, “educating other members of your team on what OTs do.” Finally, it is important to stay positive and enthusiastic throughout, and try and try “avoid getting sucked into toxic energy.”
Monitor and Modify

During our interview, we monitored our thought processes throughout to ensure that our line of questioning was in accordance with our desired outcomes. We worked as a team to ensure that we stayed on track and used our allotted interview time to cover all of our intended questions. We were cognizant of our learning objectives and assumptions prior to our interview, and made note of answers that shifted our viewpoint or changed certain expectations. The information we received from Tara during our interview, had a significant impact on our expectations and beliefs about not only the role of an OT leader in a mental health setting, but about the unique potential for leadership that exists within institutional settings. For instance, we were both genuinely excited about the notion that even little changes could have larger scale impacts to those in the community. Furthermore, we realized that being an advocate is a leadership quality within itself as advocacy often leads to positive changes for clients. Therefore, rather than having to modify our plan to fit our perceived objective and assumptions, we found ourselves modifying our beliefs and expectations regarding the role of an OT leader.

Following our interview, we debriefed with Tara, sharing with her our assumptions about leadership prior to our meeting. While Tara’s conversation confirmed our belief that there is a role for OT leadership in mental health, her experiences and innovations in a variety of roles at CAMH inspired us to think creatively and innovatively about the possibilities of being an OT leader in a mental health setting. Specifically, she motivated us to seek out leadership opportunities where we previously did not believe they existed. Similarly, while we perceived the role of an OT leader to be limited to OTs in experienced, managerial positions, Tara’s experiences demonstrated to us that there are no limits on the possibility of being an OT leader, regardless of position, or years of experience. Even during her first year practicing as a clinician, Tara was creating a niche for herself, leading group retreats and proposing new programming ideas to her team.
Following our interview, we modified our understanding of the diverse roles an OT can play both within and outside an institutional setting, as well as the types of resources available to connect with young adults, such as social networking, media outlets and alumni connections. Working within a cognitive behavioral frame of reference, one that suggests that thought processes could affect our actions and behaviors; we ultimately enhanced our education and altered our initial assumptions (Bruce & Borg, 2002). These changes ultimately affected our behaviors and will continue to affect our actions working as future OTs. Recovery is a process – one in which an OT can play a crucial part. We initially believed that recovery had a strong medical component and was managed in a structured fashion by a variety of professionals. We perceived the OT role to be limited to one-on-one discussions with the client involving return to work scenarios, CBT and strategizing potential changes in lifestyle. However, Tara’s video exemplified the varying types of recovery processes that exist for different people, and the expansive and paramount role an OT can play in the lives of their clients. Recovery can be a group process, aided by individuals who have survived and want to share their experiences; but recovery can also be about advocating, and educating others on what it means to experience and recover from a mental illness. Tara’s creativity and her inspirational clients showed us a creative side of recovery, and more so, she showed us a creative side to the OT role in mental health.

Evaluate Outcome

After debriefing with one another following our interview findings, we felt it was important to self-reflect individually on this experience and what it taught us about our assumptions about mental health and leadership, as well as our assumptions about practicing as clinicians in mental health. While self-reflection can be done through thought records or journals, we found reflecting individually and then sharing our musings with one another gave us a good perspective on how our thoughts had changed throughout this experience. Both having keen interests in pursuing careers in mental
health, we felt it was important to understand and appreciate how Tara Laing impacted how we both will approach working in a mental health setting and the types of opportunities we can create for ourselves in such a field.

Interviewing an OT leader in mental health was an inspiring and eye opening experience, revealing innovative paths to becoming an OT leader. Tara Laing demonstrated the importance of constantly brainstorming new ways to reach out to clients and inspired us as future OTs to challenge ourselves to find new ways to reach out to clients and expand our capacity in whatever setting we choose to work. Her creativity and success as a leader in a mental health setting as an OT will serve as encouragement to think outside the box as therapists, to always keep an open mind and create new opportunities where they might not yet exist. Tara truly defined herself as a leader by showing us how she is constantly shaping her future as an OT in mental health, and has inspired us to do the same.
References


Centre for Addiction and Mental Health (2009). Beyond psychosis: Exceeding expectations from first episode to recovery. Received April 1<sup>st</sup> 2011 from http://www.camh.net/About_CAMH/Guide_to_CAMH/Mental_Health_Programs/Schizophrenia_Program/video_beyond_psychosis.html


Appendix A

Adapted from First Episode Psychosis: A Guide for People with Psychosis and their Families © 2001, Centre for Addiction and Mental Health

Psychosis Mental Health Fact Sheet

There are often many assumptions made about ‘psychosis’ that contribute to the stigma that surrounds mental health illnesses. The Psychosis Mental Health Fact Sheet educates readers on the mental illnesses associated with psychosis, as well as symptoms, causes, treatment, and recovery information.

Psychosis refers to a loss of contact with reality. When people can't tell the difference between what is real and what is not, it is called a psychotic episode. A first episode of psychosis is often very frightening, confusing and distressing, particularly because it is an unfamiliar experience.

Psychosis usually first appears in a person's late teens or early 20s. Approximately three out of every 100 people will have a psychotic episode in their lifetime. Psychosis occurs in men and women and across all cultures and socioeconomic groups.

Psychotic illnesses seem to affect women at a later age than men, when women may be farther along in their social and work lives. On the whole, women respond better than men to most treatments. However, women have times when the risk of relapse is greater.

These times are before their period is due, after childbirth and around menopause. This suggests that women's hormones may in some way affect psychosis.

A number of mental illnesses can include psychosis as a symptom, including:

- Schizophrenia: A person has some psychotic symptoms for at least six months, with a significant decline in the person's ability to function.
- Schizophreniform disorder: A person has some psychotic symptoms for less than six months.
- Bipolar disorder: With this type of illness, the symptoms of psychosis relate more to mood disturbance than to thought disturbance.
- Schizoaffective disorder: A person will have symptoms of schizophrenia and symptoms of a mood disturbance, either at the same time or alternating over time.
- Depression with psychotic features: A person has severe depression and symptoms of psychosis without the mania associated with bipolar disorder.
- Drug-induced psychosis: The use of drugs such as marijuana, cocaine, LSD amphetamines and alcohol can sometimes cause psychotic symptoms to appear.
- Organic psychosis: Symptoms of psychosis may appear as a result of a physical illness or a head injury.
- Brief psychotic disorder: This illness usually lasts less than a month. It is usually triggered by a major stress in the person's life, such as a death in the family.
Delusional disorder: This type of psychosis consists of very strong and fixed beliefs in things that are not true.

Post-traumatic stress disorder: This usually lasts more than a month, and happens after a person has seen or experienced a very traumatic event. The person may have flashbacks or hallucinate.

**Symptoms**
Psychosis can come on suddenly or can develop very gradually. Symptoms of psychosis can vary from person to person and may change over time. Some common symptoms are:

- changes in thinking patterns (difficulty concentrating; loss of memory; disconnected thoughts)
- delusions (fixed, false beliefs that are not consistent with the person's culture, and have no basis in fact)
- hallucinations (people hear, see, taste, smell or feel something that does not actually exist)
- changes in mood (finding it hard to express feelings; feeling inappropriate or intense bursts of emotion; feeling empty of any emotions; depression)
- very disorganized behaviour (cannot complete everyday tasks such as bathing, dressing appropriately and preparing simple meals)
- thoughts of death or suicide.

**Causes**
In most cases, we do not know what causes a first episode of psychosis. Current research shows that biological and genetic factors raise the risk of having psychosis. Brain chemistry may affect psychosis. A person who is having symptoms of psychosis should have a thorough medical assessment, to rule out any physical illness that may be the cause.

**Treatments**
Psychosis can be treated, and many people make a good recovery, especially if they get help early. Treatment may be either on an outpatient basis or in hospital. Treatment usually consists of medication and psychosocial interventions (counselling, for example). Throughout treatment, families can receive support and education during sessions with the treatment team.

Medication called antipsychotic medication is usually essential. It relieves symptoms of psychosis and may prevent further episodes of illness.

A case manager or therapist can provide emotional support, education about the illness and its management, and practical assistance with day-to-day living. They may also recommend programs in the community and provide supportive psychotherapy and vocational counselling.

**Recovery**
Recovery from a first episode of psychosis varies from person to person. Sometimes symptoms go away quickly and people are able to resume their regular life right away. Other people may need several weeks or months to recover. Some people will need medication and support for the rest of their lives.

Adapted from *First Episode Psychosis: A Guide for People with Psychosis and their Families* © 2001, Centre for Addiction and Mental Health
Appendix B

Beyond Psychosis: Exceeding Expectations From First Episode to Recovery

In this inspiring video, five young people discuss their experiences with psychosis and recovery. This video was the thought project of Tara Laing, who felt hearing stories of survivors of first episode psychosis would inspire and educate, changing how people recovering from a mental illness are perceived by society.

- This is a snapshot from an inspiring video created by Tara Laing and produced by CAMH’s LEARN Program featuring the stories of the clients below.

Credit: Sarah Moffatt

The longer version of this video is available by contacting CAMH Publications, at publications@camh.net.

http://www.camh.net/About_CAMH/Guide_to_CAMH/Mental_Health_programs/Schizophrenia_/Program/video_beyond_psychosis.html
Appendix C

First Episode LEARN
(Learning Employment Advocacy Recreation Network)

Information from CAMH’s LEARN program (Learning Employment Advocacy Recreation Network) has been provided to give readers a more in-depth understanding of the setting Tara spent many years working in, the population she worked with, and the goal of the program.

LEARN offers a range of social, educational, and vocational services for young people experiencing a first episode of psychosis. The goal is to build social roles that increase involvement in community life. To access LEARN services, individuals must have a psychiatrist and a case manager affiliated with the Schizophrenia Program at CAMH.

LEARN offers a wide range of services that help clients:

- decide what their employment needs are and find employment
- meet their educational goals
- become more active socially
- take part in leisure activities

Programming at LEARN Includes:

General Educational Development (GED)

- This program is developed for young people with psychosis. Individuals are offered the opportunity to prepare for the Grade 12 equivalency exam, in both individual and classroom formats, at a pace that suits their own needs. It provides accommodation in the classroom and for exams.

Recovery Program

- A range of individual and group supports are available to meet to needs of clients during the recovery process including: education about psychosis; peer support; therapeutic and recovery-based groups; help with addressing substance use; a range of structured and unstructured activities to help people reintegrate into social networks and the community after a first episode of psychosis; and help resuming non GED-educational roles, like college and university.

Family Program

- A first episode of psychosis can be distressing for the whole family. A family worker is available to provide families with education, support and/or counseling throughout the recovery process. Families have opportunity to learn more about psychosis and the management of the illness, allowing them to be involved in their loved one’s
treatment. Family psychosis education groups are available, as well as taking care of the caregiver groups. Individual family support is also available.

The LEARN team includes an occupational therapist, a social worker, a teacher, a peer recovery facilitator, psychiatrist and an employment specialist.

For more information, you can read the guide [Promoting Recovery from First Episode Psychosis - a guide for families](PDF format, 500 Kb).

For LEARN, please complete the “Adult Referral Form”

For the GED program, please complete the “Adult Referral Form”:

Referral Required: Yes. Self referrals are welcome. See related links box for referral form.

Contact: (416) 535-8501, ext. 6528

Contact: Fax: (416) 260-4197

Location: 1709 St. Clair Avenue West, Toronto, Ontario

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