AN INTERVIEW WITH EUNICE LEUNG AND MAROSE BELLEHEUMER: Occupational therapists from CMHA’s Mood and Psychosis Early Intervention Team

By: David Janca and Kavin Ly

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Introduction

The Canadian Mental Health Association’s (CMHA) Early Intervention team, also known as the MOD team, is one of Toronto’s first early intervention service providers for psychosis (ref). As a result, they have assumed a leadership role in the area of early intervention for this population. The program is geared towards young persons aged 16-34, who are in the early stages of psychosis. The program aims to improve services by offering the provision and coordination of treatment, education, case management, support, and referrals. This community based, clinical service is recovery focused and promotes consumer participation. The interdisciplinary team consists of occupational therapists, a psychiatrist, nurses, social workers, and family workers. At first glance, it may seem that many of these disciplines have overlapping roles that create a redundancy in the services provided. However, the MOD team has found a way to deliver effective services in an efficient manner. Every member of the team has an important, valued role that compliments every other member of the team. They are a model of excellence in the area of early intervention that leads by example (ref). To understand what makes the MOD team successful as leaders in early intervention, an interview was conducted with the two occupational therapists on the team, Eunice Leung and Marose Bellehumeur. While the interview sheds light on how the team functions as an interprofessional unit, special attention was paid to the role of the occupational therapists. More specifically, the interview illustrates why the work done by these two occupational therapists makes them leaders in mental health.

Background

Bipolar disorder is one of the most common serious mental illnesses. Between 25-50% of individuals diagnosed with bipolar disorder have attempted suicide at least once in their life, with a mortality rate due to suicide of 8.6 - 18.9% (Chen & Dilsaver, 1996). In addition to this, longitudinal studies have highlighted the high rates of hospitalization, psychotic features, suicidal behaviours,
substance abuse, family and legal problems, as well as psychosocial dysfunction among this population (Birmaher & Axelson, 2006). Individuals at high risk of developing psychosis have been found to have significantly poorer scores in functioning ability, quality of life, and depression when compared to individuals who are not at high risk (Granö, Karjalainen, Suominen, Roine, 2011). Given the serious consequences of mood and psychosis disorders, and the typically young age of onset in late adolescence or young adulthood, there should be an urgent focus to alter the trajectory of such illnesses at the early stages of its progression.

Indeed, in recent years the evidence for the effectiveness of early intervention programs directed at managing such mental health issues has grown steadily. For example, Berk et al. (2010) found evidence in their literature review that suggests that both pharmacotherapy and psychotherapy are most effective if instituted early in the course of bipolar disorder, and that with disease progression and multiple episodes there is a noticeable decline in treatment response. Furthermore, they discovered emerging neuroimaging data suggesting that in bipolar disorder, gross brain structure is relatively preserved at first-episode of illness and that it is only with recurrences that there is marked loss of brain volume. Berk et al. (2010) conclude that the progressive nature of bipolar disorder supports the concept that first episode is a period that requires broad-based treatment that could alter the trajectory of the illness, as well as attenuate or even prevent the neuralstructural and neurocognitive changes seen to emerge with chronicity.

While there has been an increasing body of evidence supporting early intervention for mood and psychosis disorders, there are few early intervention programs available to consumers in Ontario. This is highlighted by the Toronto Star article titled “Mental health: Early intervention is key” (Editorial, 2011). The article outlines how Ontario’s services are so scarce and hard to navigate that consumers often don’t get the appropriate help they need until it is too late. Police, judges, emergency room doctors, and even school teachers are faced with the problematic consequences of
Ontarians struggling with untreated mental illness. The Toronto Early Intervention in Psychosis Network (TEIPN) was formed in late 2005 following the release of the Ontario Ministry of Health and Long-Term Care’s (MOHLTC) Program Policy Framework for Early Intervention in Psychosis Programs and the MOHLTC’s funding of several early intervention in psychosis programs across the City of Toronto in response to such issues (TEIPN, n.d.). The TEIPN is a network of 14 hospitals and community mental health agencies, and consumer and family representatives in the City of Toronto that work together to ensure easy-to-access, coordinated, efficient, and effective system of care is in place for individuals experiencing their first episode of psychosis and their families. As Toronto’s first early intervention in psychosis service providers, the Centre for Addiction and Mental Health (CAMH) and the Canadian Mental Health Association, Toronto Branch (CMHA), assumed a leadership role when asked by the MOHLTC to collaborate to convene this city-wide network of early intervention in psychosis programs. Continuing to lead by example is CMHA’s Early Intervention team, also known as the MOD team, which services individuals enrolled in the Mood and Psychosis Early Intervention Program. To understand what makes the MOD team successful as leaders in early intervention, an interview was conducted with the two occupational therapists on the team, Eunice Leung and Marose Bellehumeur. The Canadian Practice Process Framework (Polatajko, Craik, Davis, & Townsend, 2007) was used as an organizational framework to guide the discussion and illustrate the kinds of services delivered by the team. Special attention was paid to the role of the occupational therapists to understand how they employed an occupation-based focus in the delivery of their services, and why their work makes them leaders in mental health.

**Interview**

*Enter/initiate:*

We started our interview by asking Marose and Eunice about how they enter into a therapeutic relationship with their clients. Referrals for the MOD team can come from any number of
different sources. They receive many referrals from hospitals, and not just mental health hospitals like CAMH. When the MOD team was first created they did a lot of outreach to most of the hospitals in the Toronto area to let them know about their services and what they could provide clients. Some of the other common sources of referrals include the clients themselves, their family members, family doctors, teachers, and university counsellors.

In order to help prevent individuals from “falling through the cracks,” the MOD team tries not to have strict or rigid admission criteria that would prevent someone from benefiting from available services. Additionally, the MOD team does not have a waiting list for their services. A waiting list would actually defeat the purpose of an early intervention program, since the client is in need of the services right away. If a referral is received, the team ensures that the potential client is seen as soon as possible. They then proceed with an intake assessment to determine if the client is appropriate and will benefit from working with the MOD team.

Set the Stage:

We then wanted to gain an understanding of how the MOD team sets the stage. During the intake assessment, the client is met with one of the clinicians to determine what the client’s needs and goals are, how the MOD team can help, and if appropriate, who on the team may best act as the case manager for that particular client. Although clinicians on the MOD team may come from different disciplines, a common responsibility is being a case manager. Clients are often assigned to the case managers that are best able to serve their individual needs. For instance, a client wishing to focus on vocational goals may be assigned to the occupational therapist. A client wishing to focus on housing issues may have the social worker as their case manager. Or perhaps a client who wants to focus on medication management may have the nurse as their case manager. In addition to a case manager, the client is also connected to a “mini team” that consists of clinicians from all of the
other disciplines on the team. In this way, the client is able to easily navigate, access, and benefit from the services that all of the disciplines offer.

We asked how the team gets their clients to buy into the services offered, especially at a time when they may be scared or anxious. The OTs noted that it can be challenge as clients often do not want to receive services initially. Engagement was identified as a common challenge, especially because many of the clients are fairly young. Despite the challenges, the team usually finds a way by taking the time to build rapport with their clients. For example, AA was a client who did not want services. The team was having difficulty engaging and developing a rapport with him. He had been isolated in his home for about five years, and he was very suspicious about meeting new people. At first, AA would not even come to the door to greet the clinicians. The clinicians understood that the engagement period for AA may have been longer than with other clients. Thus, rather than getting him to work on his goals and forcing him to accept services he didn’t want, they started by just stopping by his place to say hello. Through persistence and numerous friendly visits, AA became more receptive to the clinicians visiting him. After many visits, AA eventually accepted the services of the MOD team. Eunice was noted to have gone so far as to play cards, and even a friendly arm wrestle with some of her other clients to build rapport with them.

Assess/evaluate:

Next, we asked Marose and Eunice about the advantages of having a large interprofessional team with regards to assessing a client. One of the biggest advantages of having such a large and diverse interprofessional team is that they are able to complete a very comprehensive assessment of each client. This allows them to get a clear picture of who the client is, and where his or her strengths and challenges may lie.
We wanted to know more about some of the kinds of assessments that they, as OTs, use and how they incorporate an occupational focus. From an occupational perspective, there are several occupational therapy specific assessments which are administered. Regardless of who the case manager is, every client enrolled in the Early Intervention program is administered the Canadian Occupational Performance Measure (COPM). This is used as a tool to help the client identify goals that are important to them. The information gathered from the completed COPM is then used by the client, and their mini team, to collaboratively develop a meaningful, client centered recovery plan to achieve their goals. Depending on the identified goals, several other occupational therapy assessments may be administered. In terms of standardized assessments, the Career Abilities Placement Survey (CAPS) is used for vocational and employment exploration. The Independent Living Scale (ILS) is used to determine where a client may have difficulties in independence in daily functioning. The Cognitive Linguistic Quick Test (CLQT) is used as a cognitive assessment. The occupational therapists on the MOD team will also use non-standardized, functional assessments for such things as managing finances, managing homework, or taking the TTC safely.

Agree on Objectives and Plan + Implement the Plan:

We then asked Marose and Eunice to tell us about how they develop and implement their client’s recovery plan. The recovery plan is developed in collaboration with the client, focusing on the actions required to achieve the client’s goals identified in the COPM. Since the MOD team is interdisciplinary, the client benefits from a wide range of services. The client’s identified goals dictate who they receive services from. For example, clinicians on the team will often refer to OTs for their expertise in managing issues related to their client’s daily living skills. They often implement plans in a graded fashion in order to build up the client’s confidence, ultimately allowing them to become more functionally independent. One example of this would be when teaching a client how to use and navigate the TTC. BB was a particular client who was extremely anxious about taking the
TTC because she was experiencing psychotic symptoms. In addition, she was not familiar with the TTC system because she was new to Canada. As a result, the client felt trapped in her home due to her perceived lack of community mobility. Keeping the importance of occupation in mind, the OT wanted to build the skill of community mobility in order to enable the client to engage in other functional occupations such as shopping, attending appointments, and visiting family. This plan was graded in the following manner. First, the OT would arrive at the client’s house and help her get ready and then take the TTC together. In the next step, the OT would arrive at the client’s house but wait for the client outside before taking the TTC together. After this step, the OT would meet the client at the bus stop before taking the rest of the route together. Next, the OT would meet the client at the transfer point, and then take the rest of the route together. Finally, the OT would meet the client at the end of the route. This method of grading the task was successful in this case as it demonstrated to the client that they were able to do it, and thus increasing her self-efficacy.

When asked to describe how they incorporate an occupation based focused, they gave us an example. CC was a client whose main goal was to return to school. At the time, his writing consisted of illegible scribbles and he was having a hard time achieving his goal on his own. Unfortunately, many of the services and programs dedicated to helping individuals in this area would not help him. Due to his mental illness, many of these programs could not acknowledge that he was ready to improve his academic performance. Instead, they would deviate from his original goal and focus on improving other skills, such as his social skills. Rather than focusing on CC’s impairments, Marose employed an occupation based focus to determine what skills were necessary for CC to return to school. After identifying these, she took it upon herself to provide some academic training to CC. Together, they read math equations, paragraphs, and so on. After several sessions together, CC was able to acquire the skills required to pass the Redirection through Education (RTE) admissions test and got accepted into the program. This is just one example of how the OTs on this team employ a
client centered, occupation based focus to help their clients

**Monitor and Modify:**

Next, we wanted to know how the OTs knew that their services were helping the clients. They told us that on the level of the individual client, the COPM is re-administered to monitor progress towards the identified goals. On a program level, the MOD team’s effectiveness and success is monitored with a program review that is administered every few years. This review includes quantitative data such as the number of client relapses and hospital admissions, as well as education and employment statuses of their clients pre and post intervention.

**Conclude/exit:**

We asked the OTs about the process of discharging clients from the Early Intervention program. Clients enrolled in the Early Intervention program receive services from the MOD team for up to three years. If clients are doing very well and do not require further services from the MOD team, they may be discharged earlier. As clients graduate from the program, there is an option for them to receive additional supports. Clients that are not ready to be completely independent are enrolled into an Alumni program. Here, clients may receive less formal services and support for up to a year. It serves as a transition program so that the client is eased into independence. Should further support be required, referrals outside of the program are made.

**Leadership**

After obtaining a more comprehensive understanding of the kind of services that the MOD team offers, we asked the critical question, “What about the MOD team makes them leaders in mental health?” As one of the first early intervention service providers in Toronto, their work has
influenced and shaped the practice of other early intervention service providers. As a team they are very client centered, supporting their clients to take an active role in their recovery and working to achieve their clients’ goals. As one of the largest teams in the community, they are well equipped with clinicians that come from a variety of disciplines, each bringing with them their own experience and expertise. The agency supports them in continuing their professional education so that they can supplement their skill set and expertise, which ultimately benefits their clients. They encourage and inspire each other to do a good job. There is a respect for differing points of views amongst each other, as well as their clients. This team dynamic is reflected in the services that they provide to their clients. When one clinician is stuck and not sure how to manage an issue, they come together as a group to support each other and problem solve. There is also a strong emphasis on recovery and consumer participation that is apparent in the delivery of their services. In sum, the MOD team is a model of excellence that leads by example.

When asked if there are any gaps in early intervention services that they would like to have addressed, the OTs identified a few areas. For example, while all health care professionals involved in early intervention are important, there are insufficient psychiatry services available to consumers. As a result, clients often do not receive the psychiatry time they need. While the MOD team has a psychiatrist on the team to provide their clients with this time, this is not very common, especially for a community based team. One gap that they identified within their own program was that there may not be enough support relating to their young clients’ common goal of wanting to work. The OT’s described that they previously referred out, resulting in lost time due to all the paper work required. However, they are currently looking into an in house service to address this gap and make their services more efficient. The ability to identify and address gaps in services to further benefit their clients is just another example of what makes these OTs, and the MOD team, leaders in mental health.
Conclusion

CMHA’s Mood and Psychosis Early Intervention Team is a model of excellence in the area of early intervention that leads by example. They are one of the largest, community based early intervention teams in Toronto that have influenced and shaped the practices of other early intervention service providers. While every member of this interdisciplinary team has an important and valued role that makes them leaders in their own right, the occupational therapists on the team do their part to contribute as leaders in mental health. They use their expertise to identify goals that are meaningful to their clients, which the team uses to focus their interventions. In this way, the occupational therapists ensure that the services provided to the clients are client centered. By employing an occupation based focus, the occupational therapists also ensure that their services are functionally relevant. The ability to identify and address gaps in services is one way that the occupational therapists, and the MOD team, ensure that their clients receive the best services possible.
References


