EXAMINING CHALLENGES, BARRIERS AND STRENGTHS IN THE IMPLEMENTATION OF AN EARLY INTERVENTION PROGRAM IN NORTHERN BRITISH COLUMBIA FOR PEOPLE WITH PSYCHOSIS

by

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Abstract

The best practices research on early psychosis intervention states that with early and effective intervention with individuals presenting with psychosis, the chance of a positive outcome is greatly increased. The author spent a four month practicum term working in an early intervention program for people with mental illness in Prince George, British Columbia. This practicum provided an opportunity for the author to research this topic of interest, to practice in this area of social work, and to conduct a focus group regarding the program. The program has not been named by the author, however, it is written about throughout this report. The research involved conducting a focus group, with the practitioners or case managers of the program being the participants. The intent of the study was to highlight challenges, barriers and strengths of the program, and to disseminate the information to the team at the end of the author's practicum term. Three themes were identified from the results of the focus group, which were labeled as follows: flexibility, transitions, and societal shadow. It was found that each theme had its own distinct challenges and strengths as they relate to the early psychosis intervention program.

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Chapter One: Literature Review

Statement of Research Question

The title for this practicum project is: Examining Challenges, Barriers and Strengths in the Implementation of an Early Intervention Program in Northern British Columbia for People with Psychosis. The rationale for this research was fourfold: to gain personal insight and to further my understanding in this field of social work as I develop my career in this direction; to add to the existing literature on social work in the north and mental health services for people in the north; to assist my practicum agency by increasing the base of research conducted in this setting; and to generate suggestions for improved service delivery to clients.

Introduction

In order to prepare for my practicum, a review of the literature regarding psychosis and early intervention was necessary. The development of an understanding of psychosis and the importance of early intervention will comprise the bulk of this literature review; however, it will begin with a brief overview of the demographics of the city of Prince George, British Columbia. This review will also explain a handful of early intervention services around the world, in this province, and in Prince George.

Prince George

The city of Prince George is located near the geographical centre of the province of British Columbia, Canada. To someone who is not from this area, there may be an assumption that Prince George would be a central community to the province, however,

being that the vast majority of the province's population resides within the Lower Mainland, Prince George is considered by many British Columbians as a northern city. This community of over 84,000 residents (Statistics Canada, 2009) has etched out an identification of being named BC's northern capital (Halseth, 1998). One could argue that Prince George is not only north, but central and south as well. Depending on one's lens, Prince George could be argued to be both a rural community and an urban centre. The unique characteristics that make up the flavor of a city such as Prince George have an impact on how its community social services are run. By some points of view, the city of Prince George has a large population, as it is the largest community in the northern half of the province of British Columbia (McGillivray, 2000). When compared to the lower mainland, however, which has a population of 2.7 million residents (Statistics Canada, 2009), Prince George's population can seem quite small and rural. An Early Intervention Program for people with psychosis was first developed in the lower mainland of British Columbia (Tee & Hanson, 2004). Given the uniqueness of the community of Prince George, certain attributes, as well as unique strengths and challenges are present within Prince George's Early Intervention Program for people with psychosis. It is my hope that this report will create a deeper sense of understanding of Prince George's Early Psychosis Intervention program for not only myself as I continue my career as a social worker in the mental health field, but also for the readers of this report. Also, I hope that this process and the results of this research can better inform the Early Psychosis Intervention program on ideas for improved service delivery.

Psychosis

To begin, it is important to provide an answer to the question; what is psychosis? Psychosis is broadly defined as a disorder in the brain that leads to a loss of contact with reality (American Psychological Association [APA], 2001).

Psychosis manifests itself through many symptoms which can be categorized as either positive symptoms or negative symptoms (Durand & Barlow, 2000). Positive symptoms are different forms of disordered thinking that are added on to the individual's experiences (Norman, McLean & Malla, 2000) such as hallucinations and/or delusions, as well as disorganized speech and behaviour (APA, 2001). A hallucination is an experience of a sensation that is not grounded in reality, such as hearing voices or seeing things that do not actually exist. People can also experience hallucinations through other senses as well including tactile (through touch), olfactory (smell), or gustatory (taste). Delusions are firmly held beliefs about something by the individual that are not grounded in reality (Durand & Barlow, 2000) for example, a person who believe that his television in speaking directly to him and sending him messages would be a delusion. Negative symptoms, which are seen especially in schizophrenia, are considered to be a set of behaviours or moods that are taken away from the individual as a result of the psychosis, "the negative symptoms usually indicate the absence or insufficiency of normal behaviour" (Durand & Barlow, 2000, p. 379). Examples of negative symptoms are avolition, alogia, asociality and anhedonia. Avolition is an inability to involve oneself in day-to-day activities or the inability to take the initiative to perform everyday actions. Alogia involves a poverty of speech (APA, 2001), meaning an individual's use of language is impeded, usually resulting in that individual refraining from conversation or

being unable to carry on a basic conversation. Asociality is the lack of ability or desire to form or maintain social relationships. Anhedonia involves the lack of ability to display a variation of nonverbal facial features such as smiling, laughing, showing concern. It also is believed to involve a lack of ability to experience pleasure or enjoyment. (Durand & Barlow, 2000). Also increasingly evident in people with schizophrenia is slowed cognitive processing (Schatz, 1997).

There are three stages that individuals with psychosis tend to experience: prodromal, acute and recovery. In the prodromal phase, symptoms such as irritability, suspiciousness, sleep disturbance, and mood fluctuations begin to present themselves. Duration of this stage varies from person to person. The second is the acute phase, in which typical positive and negative symptoms tend to elevate. This presentation may be accompanied with significantly decreased mood, anxiousness, sociality, drug use, problems with day to day functioning and severe sleep disturbance. The recovery phase occurs when individuals respond to treatment. The recovery process moves at different rates and recovery has different meanings for different people. Relapse into acute psychosis can occur during this phase for some people as well (Psychosis: Information and Coping Strategies, 2003).

The broader label of psychosis will receive a more identifiable diagnosis by a psychiatrist after close monitoring of symptoms over time when specific criteria are met under the Diagnostic and Statistics Manual of Mental Disorders (DSM). This manual lists psychotic disorders as Schizophreniform Disorder, Schizoaffective Disorder, Delusional Disorder, Brief Psychotic Disorder, Shared Psychotic Disorder, Psychotic Disorder due to a general medical condition, Substance Induced Psychotic Disorder, and Psychotic

Disorder Not Otherwise Specified, and finally, Schizophrenia (APA, 2001). This list of disorders was created to differentiate between severity of certain symptoms, length of duration of symptoms, and the mixture of other observed symptoms such as disturbances in mood or personality.

About 3% of people will have a psychotic episode in their life (What is Psychosis, 2006). Schizophrenia, the most common psychotic disorder, has affected people around the world at rates of between 0.5%-1.5% of the population (APA, 2001). The age of onset of a first psychotic episode ranges from the early teens to people in their thirties (Howell, 1999). It has been observed that first episodes generally occur later in life for females than males (Ehmann, & Hanson, 2004; APA, 2001).

Causation of psychosis has generally been agreed upon to be the result of multiple contributing factors in an individual's life. The main determinant is biological, meaning that certain individuals have a genetic vulnerability to psychosis (Durand & Barlow, 2000). The second is environmental, implying that the onset of psychosis is exacerbated by a stressful lifestyle or life events (Ehmann & Hanson, 2004). The diathesis-stress model explains that some people are genetically predisposed to a mental disorder, yet their symptoms remain latent until a stressful life event serves as a catalyst to its onset (Ehmann & Hanson, 2004; Walsh, 1999). Examples of stressful life events may include the loss of a job, the death of a family member, poor achievement in school, or experiencing a traumatic event such as a car accident or natural disaster. Illicit drug use such as marijuana, cocaine, or crystal methamphetamines can also significantly contribute or serve as a catalyst in the onset of psychotic symptoms or episodes (Early Psychosis Intervention, 2003).

Drugs and Their Relationship with Psychosis

An individual with a concurrent disorder is one who has a mental illness such as schizophrenia, depression, anxiety disorder, or bipolar disorder, but who is also using one or more psychoactive substances such as alcohol, marijuana, cocaine, heroin, or methamphetamines (Durand & Barlow, 2000). Historically, mental health and addictions were viewed as two separate issues and were treated in different locations with separate philosophies, models and theories. Unfortunately, for those who struggled with both mental health issues as well as addictions issues concurrently, services were unable or unwilling to meet their needs. Recently, there has been an increased focus on client centered practice, which involves recognizing the multiple facets of their presenting issues, and addressing all presenting issues together (Cooper & Calderwood, 2004). Also, it is in the best interest of the client when agencies with different mandates and areas of expertise are able to communicate together and cooperate in order to provide comprehensive and consistent service to the client, known as *continuity of care* (C. Painter, personal communication, February 5, 2010) .

Mental health issues and addictions issues have been associated with one another since before modern science has been keeping records of it. Recently however, Cooper and Calderwood (2004) state that concurrent disorders have recently received increased attention among the medical and social work professions. The prevalence of concurrent disorders range depending on the specifics of each study, but to no surprise is alarmingly high. One study found that 20-30% of the population of people with psychosis have substance abuse related issues (Rabinowitz et al., 1998, as cited in Ehmann, Hanson & Friedlander, 2004). Cannabis abuse has been reported in 5%-40% of all schizophrenic

patients (Hambrecht & Hafner, 2000). Cannabis is the most frequently used illegal substance by this population, followed in decreasing popularity by stimulants, hallucinogens and depressant drugs (Ehmann, Hanson & Friedlander, 2004). The risk of psychiatric problems are exponentially increased when substances are used (Cooper & Calderwood, 2004). People with schizophrenia and substance abuse issues have higher anti-social tendencies, higher rates of depression, higher levels of uncontrolled positive and negative symptoms, and poorer long-term outcomes (Hambrecht & Hafner, 2000; Hinton et al., 2007). Cleghorn et al. (1991) found that people with schizophrenia who used cannabis tended to have a higher and more severe rate of positive symptoms. Linzen, Dingemans and Lenoir (1994) found an increase in frequency and level of further psychotic breaks for people who used cannabis. Rais et al., (2008) found that first episode schizophrenia patients who used cannabis had reduced brain volume after five years than those who did not use marijuana. In a remarkable study by Hambrecht and Hafner (2000), 232 young people who had schizophrenia were studied in order to better understand the impacts of schizophrenia and marijuana use on one another. From the findings, the authors were able to create three categories of people; those who had used cannabis use around the same time as their illness, those who used before the onset of schizophrenia, and those who used following their diagnosis of schizophrenia. The first group was called the *vulnerability group.* This group included people who used cannabis prior to any psychotic symptoms. In this group, mental health deteriorated after the point of using. The vulnerability group members later developed schizophrenia. The research suggests that had this group not used cannabis, they would have been vulnerable for psychosis, but may not have become psychotic in their life. The second group, the *stress group,*

consisted of already vulnerable people who began using cannabis around the very same time as their first onset of schizophrenia. The authors suggest that the stress group's cannabis use may have been responsible for triggering a psychotic episode and subsequent psychosis. The third group, which the authors labeled the *coping group,* had no use of cannabis until after the onset of their schizophrenia. The study suggested that this group used cannabis to cope with the symptoms of their psychosis, and used cannabis as a form of self-medication.

Other drugs can be associated with psychosis as well. Use of the street form of methamphetamines has been linked to causation of drug induced psychosis. It is estimated that between 10-20% of crystal methamphetamine users develop a drug-induced psychosis (Early Psychosis Intervention Program, 2003; Bacon et al., 1998, as cited in Ehmann, Hanson & Friedlander, 2004). Further, acute periods of psychosis may present themselves when cocaine is used. Short term periods of psychosis can also occur during the withdrawal period from benzodiazepines in amphetamines, sedatives, hypnotics, barbituarates, and even alcohol (Steinberg, 1994).

The Costs of Psychosis

Psychosis and the long-term mental illnesses that can develop from it can carry a large burden at individual, familial and societal levels. At the individual level, psychotic episodes severely interrupt the crucial social and psychological development of adolescents and young adults in their life, which then can affect life functioning throughout later stages in the life span. The World Health Organization estimates that psychosis can reduce the life span of an individual by ten years (Ehmann, MacEwan &

Honer, 2004). McFarlane (2001) writes that the estimated cost of lifetime schizophrenia for one person amounts to $10,000,000. Johannessen at al. (2001) argues that the long-term duration of the disorder places a burden on the individual and the family that is beyond measurement. The family is often forced into a caretaking role over their ill family member (McFarlane, 2001) who would otherwise be experiencing a period of increased independence from family care. It is a difficult time for the individual with psychosis when he or she is struggling with "deterioration in performance, prodromal symptoms or signs of social withdrawal" (McFarlane, 2001, p. 204). This time can also be quite stressful for family members as well. Family members commonly experience periods of self blame, grief, dismay, and disagreement over the best way to respond to the ill individual. Norman, McLean and Malla (2000) estimate that approximately five thousand people are diagnosed with psychosis each year in Canada alone.

Perhaps it is those who are known to suffer from psychotic mental illness and who never benefit from the potential treatment that is available tell the most devastating stories. Take, for example, the high profile case of Vince Li, the man responsible for the repeated stabbing and decapitation of an innocent bus passenger on a Canadian bus in the summer of 2008. In a Winnipeg newspaper article entitled Attacker was psychotic during Greyhound decapitation, McIntyre and Rollason (2009) reported:

> Dr. Stanley Yaren described Li as a 'decent person' who was clearly out of his mind when he believed he was acting on God's orders to eliminate 'the force of evil' and attacked Tim McLean…Li rode the bus from Edmonton to Erickson, Manitoba, where he got off for 24 hours and spent most of that time sleeping and sitting on a park bench. He also sold or burned many of his possessions. Li boarded another Greyhound bus the following day -- the same one carrying McLean…A couple hours later, just west of Portage la Prairie, Li attacked

> McLean without provocation, stabbing him numerous times in the back and chest in front of three dozen horrified witnesses. [1]

Despite the common myth that people with psychosis are violent and dangerous, statistics show that they are less likely than the general public to be involved in acts of violence. Myths such as these are the result of lack of public knowledge and media portrayal of mental illness in general (Howell, 1999).

Early Intervention of Psychosis

Prevention as a form of intervention is explained by Shaefor and Horejsi (2003) as taking actions to eliminate various social problems before they occur or drastically worsen. The authors explain three levels of prevention, which are *primary, secondary* and *tertiary* prevention. Primary prevention involves taking actions to completely prevent a problem before it occurs, while secondary and tertiary prevention involve addressing problems while they are in their early stages or later stages with the intent of stopping further deterioration or harm. Secondary and tertiary prevention can be applied to the intended goals of early psychosis intervention. The following section can be summarized in the phrase by Ehmann & Hanson (2004), "…for all psychotic disorders, the better the short term course, the better the long-term outcome" (p. 9). McFarlane (2001) writes that there is a period between the onset of psychotic symptoms and treatment that averages one to two years, and that the longer period of time before the ill individual undergoes treatment, the more resistance that he/she will have to medical treatment, and the higher the potential severity of these symptoms. Mental illness can be life long, and range in

severity. Early intervention can potentially result in a dramatic improvement of long-term outcomes.

Harrigan, McGorry and Krstev (2003) studied the effect of duration of untreated psychosis (DUP) on outcome of psychosis. The authors found that early detection and intervention for individuals with psychosis can play an important role in improving the outcome of people with psychosis. Further, employing effective early intervention service was one of the only factors that could be influenced by health care professionals in the outcome for many individuals. Other predictors such as sex of the ill individual, age of onset, overall health prior to illness, and family history of mental illness may be more fixed and unpreventable. One of the main roles of the early intervention clinician should be to assist the family in providing a stable, calm environment that allows the ill individual to cope and heal at his/her own pace (Norman McLean & Malla, 2000). Hafner and Maurer (2001) studied the prodromal phase of psychosis, which is the period in which the first symptoms begin to occur until the first psychotic break is experienced. The authors concluded that the prodromal and first psychotic periods in individuals with psychosis are critical times that can be a major factor in dictating the course of their illness along the life span. When symptoms remain untreated for long periods of time, quality of life can drop, substance abuse can increase as a coping mechanism, cognitive functioning can deteriorate, and interpersonal relationships can erode. De Haan, Linszen, de Win and Gorsira (2003) found that delaying intensive psychosocial treatment for patients with schizophrenia was a predictor for longer periods of negative symptoms for these clients.

Ehmann and Hanson (2004) stress the important role of the early intervention clinician in increasing the general public's knowledge and understanding of psychosis. Education should be targeted to not only the general public, but to high risk populations, such as school age groups. This has shown to decrease the stigma around psychosis, as well as educate individuals on how to recognize the symptoms of early psychosis, and thus increase chances of detection and early treatment. Johannessen et al., (2001) recommended "multileveled, targeted community psychoeducation directed at the general public, health professionals and schools" (p. 164). This education must work in conjunction with easily accessible mental health services that offer all inclusive treatment in order to prevent and reduce lifelong psychosis. Ehmann and Hanson (2004) agree with this, and recommend that service access for individuals with psychosis should be easily accessible and present with minimal barriers. They suggest there should be the opportunity for self, and/or family referral, and that intervention time should be minimal. The authors emphasize that a major role of early intervention clinicians is offering psychoeducation to the ill individuals and their families. Psychoeducation involves teaching about such topics as recovery trends, self management and awareness of one's illness, and coping methods. The authors stress that the primary targets of psychoeducation should be to increase patient self-awareness, promote control over one's own illness, improve self-esteem, prevent relapse, and help the wellbeing of the family.

Early Intervention Programs Worldwide

Early intervention programs are being employed around many parts of the world. The following section does not offer a complete list of programs globally, but explains

many of the programs that were discussed by the best practices guidelines by Ehmann, MacEwan and Honer (2004). The differing programs in different countries touch on the various barriers, obstacles and solutions that other countries worldwide have faced in light of early psychosis intervention.

The United Kingdom has aggressively increased its early intervention services as of 2004. Studies in the UK were pointing to the links between long periods of untreated psychosis and their effects on individual well being, suicides, violence, crime, and societal cost, and of course, as is repeatedly shown in the literature, a poor long-term prognosis. To address these issues, the Government of Britain created a goal to offer fifty new early intervention services throughout the UK, and named it the National Service Framework for mental health (Bywaters, Birchwood, Shiers, Smith & Davis, 2004).

In 1992, Australia formed a centralized program called the Early Psychosis Prevention and Intervention Centre (EPPIC) in the state of Victoria, and also a National Mental Health Strategy throughout the country. These large structures had the vision of reducing the need for mental health treatment in a hospital setting, which is called inpatient service. This could be done by increasing community based intervention towards mental illness, and by increasing the focus on prevention and early intervention of mental health issues including psychosis. Goals and strategies in Australia included increasing prevention and early intervention services at community levels; increasing the timeliness of access for individuals to these services; the development of resources to increase public awareness; and increasing research and efficacy of these programs (Gleeson et al., 2004).

In Hong Kong, an early intervention pilot project was established to begin addressing psychosis for individuals up to the age of 25. Chen (2004) explained that public perceptions of mental illness are very low in Hong Kong, and consequently, stigma is high towards people with schizophrenia and psychosis, who are viewed by the public as dangerous. The aims of this new pilot project were to increase public awareness through education, develop a system of assessment in order to only treat individuals with psychosis, establish intervention services through intensive case management, promote team building and development to ensure that clinicians in the Hong Kong based program worked consistently and collaboratively, and conduct evaluation of the program. As of 2004, the program was two years into implementation, and evaluation results had not been disseminated (Chen, 2004).

In Switzerland, a re-prioritization of funding was necessary to address early intervention, as new funding was not offered by the Swiss government. The Lausanne Early Psychosis Project re-structured its services to offer a community based early intervention team that could provide in-home assessments, developing assertive case management specific to people with psychosis which was previously non-existent in Switzerland, and by reserving hospital beds for psychotic patients (Conus, 2004). It would seem that early intervention for psychosis has not been given the same level of priority as other countries such as Australia and those in the UK.

As nations around the world move to adopt their own early intervention model for psychosis, it is clear that there is an increasing shift towards this style of care. Because this form of mental health treatment is still in its early years, efficacy studies on the above mentioned programs are limited. It is likely that over the next few years, such

studies will be published to compare the effectiveness between programs in different countries, and also that of the early intervention model around the world.

Early Intervention in Canada and British Columbia (BC)

Services for psychosis differ among the Canadian provinces; however, it would appear that most provinces have endorsed an early intervention strategy for people with psychosis. Most notable is the Prevention and Early Intervention Program for Psychosis (PEPP), which originated in London, Ontario, in the late 1990's (Canadian Psychiatric Association, n.d.).

The first Early Psychosis Intervention (EPI) programs began in BC in 2000. BC embraced standards of practice earlier than many other provinces and countries (Ehmann, 2009). BC comprises about nine percent of Canada's land mass (Information on BC, 2009) and is geographically twice the size of France. BC's health services are divided up into six health authorities (Ministry of Health Services, 2002). The smallest authority geographically, is Fraser Health, and the largest is Northern Health, which covers the Northern half of the province. The Fraser Health's EPI program began in 2000, with the vision to "improve the mental health and quality of life of young people with psychosis by promoting early identification and providing rapid access to intensive, phase specific treatment in the critical period of the early years of psychosis" (Tee & Hanson, 2004, p. 131). It uses a hub and spoke model with a centralized team of mental health professionals being the hub, and several community teams comprising the spokes. Initial early psychosis clients receive assessment, medical treatment and direction from the central 'hub' team, and are eventually referred to the appropriate community team for

ongoing mental health service. Research and evaluation of services is also carried out by professionals from the central team.

Early Intervention in Prince George

The Early Intervention program in Prince George is where I completed my practicum. To my knowledge, there has been no research conducted and no literature written on this program to date. In the following section, I will discuss the Early Intervention program and the youth mental health and addictions services offered by Northern Health.

Conclusion

This literature review offers an overview of psychosis as well as early psychosis intervention programs around the world and in this province. Of all the statistics and explanations offered in this literature review, one point should stand out over all others, which is that early and effective intervention for people with psychosis is vital to improving long term outcomes. In the following section, Prince George's Early Intervention program will be explained in further detail, as well as the other youth mental health and addictions programs that are offered by Northern Health in Prince George.

Chapter 2: Practicum

Description of Practicum

The practicum agency with which I studied in falls under an umbrella of services called the Youth Mental Health and Addictions Department, within the Northern Health Authority. Four programs run within this department in the city of Prince George. These four programs are: the Eating Disorders Clinic, the Adolescent Psychiatric Assessment Unit, the Nechako Youth Treatment Centre, and the Early Intervention Program. I will begin by explaining in detail the program that I spent the majority of my time with, and then discuss the three other programs in less detail.

Early Intervention Program

The Early Intervention Program provides a combination of clinical and community services for people experiencing first break psychosis as well as addictions issues. As I saw firsthand, psychosis and addictions issues are often closely combined, and as the literature suggests, the two often present with each other. There are typically five case managers who work in this agency, each with a client load of between fifteen and twenty five. Clients are primarily from Prince George. Age ranges of the clients vary for people with first break psychosis, and some clients are in their early twenties, however, the majority of the caseload are in their teens. Services offered within this voluntary program are: assessment, individual case management, group therapy, psychological testing, psychoeducation, education on substance use, clinical psychiatric sessions, and referral to other programs as appropriate. My four month practicum term ran full time from September to the end of December, 2009, totaling over 560 practicum

hours. During this time, I observed weekly clinical psychiatric assessments and follow up appointments with the program's psychiatrist and case manager. Throughout the practicum, I accompanied my practicum supervisors on community counselling sessions with clients. This was a time for me to observe the counselling process, learn appropriate techniques, meet the youth using the service, and to discuss these sessions with my supervisors after the meetings. By the end of my practicum, I managed a caseload of 6 clients. After the first couple of weeks, I began to work with my own caseload until the completion of my practicum. This was the most valuable learning experience for me. In doing this, I had the opportunity to conduct assessments, offer drug education and psychoeducation, create treatment plans with clients, and build working relationships with clients as their counsellor. I regularly completed progress notes using the mental health charting system. I took part in the intake process, conducting and presenting new intakes to the mental health team. In addition to individual counselling, I was the co-facilitator of two weekly groups throughout the four months. The first was a support group for youth with addictions, and the second was a support and educational group for people with psychosis. Finally, with a fellow student, I did a major presentation for youth with addictions about substance misuse.

Eating Disorders Clinic

Another program that falls under the umbrella of mental health and addictions services is a clinic for people with eating disorders. This is an outpatient program that typically employs one medical doctor, one registered dietitian, one youth counsellor and one adult counsellor. As the only program of its kind in northern BC, it accepts referrals

by anyone within the Northern Health catchment area. It serves people of all ages with bulimia, and anorexia and eating disorder NOS (not otherwise specified). Nearly all people treated within this program are females. Other mental disorders such as anxiety, posttraumatic stress disorder, depression, personality disorders, obsessive compulsive disorder as well as substance misuse commonly are seen to be co-occurring with eating disorders (Brewerton, 2007). The counsellors in this program offer individual counselling as well as family and group counselling. They also spend time countering the stigma attached to eating disorders through community education.

I learned from the clinicians in this program that like psychosis, eating disorders are treatable and a recovery is achievable. The longer eating disorders occur over a person's life time, the lower the likelihood of a full recovery. I also learned that counselling is a long term process where small steps towards health are the goal, and patience is essential.

Adolescent Psychiatric Assessment Unit (APAU)

APAU is a six bed inpatient psychiatric ward for youth between the ages of 12-17. The nature of the ward is that it is a low stimulus environment. It is a setting where acutely mentally ill youth from all over the North can be safe from themselves and others, and observed by a multidisciplinary staff team, to better understand their symptoms, and to accurately provide a diagnosis and treatment plan. The ward is staffed by a multidisciplinary health team which includes youth care counsellors, psychiatric nurses, recreation therapists, a psychiatrist, a psychologist, a waitlist manager, and school teachers. Most youth are certified under the Mental Health Act, which means that due to

their mental health condition, they are required to be in hospital care for a period of time. This helps to ensure the safety of the client and others.

During my practicum, I had the opportunity to spend one day at APAU to observe a day of operation. On this day there were two youth on the ward who were acutely psychotic. I learned of the nature of the interactions between professionals and the roles of the professionals while on the ward. I had some opportunity for interaction with two of the youth, however, their cognitive and mental state at the time was quite impaired, so on this particular day, the interactions were limited. Many of the youth on the ward require very low stimulus levels initially, until their mental illness is stabilized. In this situation, client centered counselling means giving them space, allowing them to rest frequently, avoiding over stimulation, and sharing observations with the team. Although it seems counter intuitive to avoid interaction with the patients on the ward at the time, it was important to do so, because they were struggling with hallucinations, paranoia and racing thoughts. Initially, from an outside observer's lens, it seemed that the clinicians on this ward were not engaging, integrating and relationship building with the youth. However, after discussions with the staff members on the nature of working on the ward, I learned that these interactions or lack thereof were calculated, caring and appropriate to the needs of the clients.

Nechako Youth Treatment Centre

I spent two days at the Nechako Youth Treatment Centre. I interacted with the youth, and attended a check in group as well as a life skills group. This addictions treatment program is an inpatient residential facility for up to six youth, as well as one

short term acute bed for youth to detoxify from substances in their bodies. The program is open to youth from anywhere in BC, however, priority is given to youth from Northern BC. It is a voluntary program meaning that the youth attend the program willingly. Lengths of stay average three weeks. Some youth choose to leave early and some stay longer. Days for the youth at Nechako tend to be quite structured, with school, group counselling, one to one counselling, as well as swimming or exercising at local facilities in the community. The group process is used quite extensively in counselling the youth in this program. Groups focus on increasing self reflection and understanding of the biological, psychological, social and spiritual aspects of oneself; life skill enhancement; goal setting; and daily reflection. Individual counselling varies depending on the youth, the counsellor's theoretical foundation, and what the youth wishes to discuss or avoid discussing. Typically, individual counselling involves going through a treatment plan and adding, deleting, working through or modifying existing treatment goals with the youth.

Learning Goals in Practicum

At the outset of my practicum, it was my responsibility to create several learning goals to accomplish during my practicum (See Appendix 4). I had the opportunity to assess my accomplishment of these goals with my supervisors at the midterm and final evaluation point of my practicum. I designed my learning goals to prepare myself for a clinically rich experience that allowed me to learn through experience and observation what I had studied in the literature review. I also wanted to know more about other services for this client population that existed within Prince George and how the agencies interacted with one another.

Reflections, Learning Experiences and Implications for Improved Personal Practice

While working through this practicum project, I was able to undergo a thorough process that began with reviewing the literature on Early Psychosis Intervention, observing Early Psychosis Intervention in actual practice, and finally working with this client population under supervision. I found that in many ways, the literature is not always able to account for the host of complexities that accompanies the human condition. In this section, I discuss the struggles, reflections, and inconsistencies between what I have learned throughout this process.

When studying the etiology of psychosis and best practices to treat it, I was not initially able to fully appreciate the impact that alcohol and drugs play on triggering psychosis and interfering with the healing of the brain. The best practice literature on early psychosis intervention states that early identification followed by rapid treatment means increasing the chances for a healthy recovery (Ehmann & Hanson, 2004). Not always mentioned in this equation is that drug use and other psychosocial stressors, such as a chaotic family structure, poverty, resistance to change by the client, and/or a history of childhood abuse can play a role in the interference of achieving a healthy recovery. A couple of things became apparent as I met more and more clients and reflected upon their paths in healing; cannabis was highly correlated with a longer, slower, less full recovery, and that those clients who had a supportive family structure had a much higher chance for success than did those who lived in families that were unstable, stressful, unhealthy and uncooperative.

As I look back at my experiences over the past four months, I find myself humbled by my role as a counsellor. Too often I have lapsed into trying to fix people or

change them, and I recognize that I always need to challenge my own lack of patience with clients. It is as if I worry that I need to help a client change by a measurable amount before the end of my time with them. In reality, people do not work this way. Patience is needed, and so too, is flexibility as my ideas for my clients may not fit with their ideas for themselves, or the timing simply may not be right. Maisel and Raeburn (2008) remind me of this when they explain the principles of Motivational Interviewing, which involve meeting the client where he/she is at in their process of recovery. The manner of the therapist seems simple, but cannot be disregarded. Simply put, the authors explain the goals of the therapist being to "stay empathetic and nonjudgmental towards the client's stated position; maintain a curious, caring and interested stance while helping clients safely explore their honest ambivalence; avoid arguments, power struggles, and an authoritarian, controlling attitude; and stay with the client's actual stage of change instead of jumping ahead without him or her" (p. 126). Gil (1998) explained that through play therapy, the traumatized child is able to work through his/her traumatic experiences in a place where they are safe and not pushed to go to places that they are not ready to. This protects the child from being triggered by the traumatic event and subsequently re-traumatized. Presbury, Echterling and McKee (2008) write that theoretical wizardry or technical magic tricks are not necessarily required in the counselling setting for both the client and the therapist to successfully meet their goals with one another. They emphasize the importance of using the concepts of listening and engaging with the clients in a non-judgmental manner.

In this experience, I gained an appreciation of the process of counselling and the power of the counselling relationship itself as a catalyst for change. Hubble, Duncan and

Miller (1999) attribute the therapeutic relationship in itself as accounting for approximately one third of the change that clients experience in therapy. It should be noted that the authors found that the client's own change separate from therapy accounted for 40% of the change that occurs during therapy. During my practicum, I had a client who, at the time of my first assessment with him had chosen to stop smoking marijuana on his own for about two weeks. I worked with him weekly for about five weeks and the client was able to continue to stay away from marijuana throughout this time. On the last meeting between us, the client thanked me for all the help I had been to him, which was quite interesting because the client was the one who had done all the work, not me. This to me points to the power of the combination of the two factors mentioned above, the therapeutic alliance and the client's own resiliencies.

I learned many valuable lessons related to counselling youth with addictions. When I began my practicum, I naively believed that the issue of addictions could be worked on in isolation. However, I soon learned that even though we can separate an issue such as addictions from other presenting problems, the helping professional cannot simply focus on the addiction and strategies towards changing it without looking at broader, more holistic issues that surround the addiction. Though these strategies may be useful in certain specific situations, I learned that in using substances such as cannabis, alcohol or crystal methamphetamines, a specific purpose is served, and that purpose is not always 'to get high.' I learned to ask the question, "what is it that you like about your drug of choice?" the answer was never the feeling of being intoxicated. Typical answers were that drinking was what you did with friends to have a good time, or when things are getting stressful at the house, "I'll just leave and smoke some pot" or "when I use meth, I

feel invincible." The underlying theme of these answers is that using drugs were a means to fill a need (social acceptance, escape from stress, or power) that would not otherwise be filled. This theme implies that the goal of counselling becomes less about teaching abstinence or harm reduction, and more about helping the client get to a place in his life where these needs are filled without the assistance of harmful substances. Though this paper does not attempt to focus on the issue of addictions, I saw this lesson as crucial to the development of my professional practice.

The atmosphere of the early intervention program is casual, which was apparent in many factors. The style of dress of the staff tend to be casual for a professional setting. The general style of communication among staff was open and there were times when staff would share humor among the team to cut through the stress and tension of the work being carried out. The one large open office shared by the case managers brought a cohesiveness to the team. The casual attitude seemed to be an antidote to the otherwise stressful and hectic work environment that often existed due to the nature of the clients in the program and many of their erratic, dangerous, unstable lives. I learned that this team has a very collaborative approach to doing their work. It is common for several impromptu discussions about different clients to arise throughout the day, allowing staff to think out loud and gain new perspectives on the best course of action for their clients.

The physical working space used is a large open room with six desks surrounding the outside walls, each used by a different case manager, including myself. In the middle of the room sits a round table, which is used every Tuesday for a staff meeting, which offers a chance to cover housekeeping issues, and communicate messages. More importantly, Tuesday meetings are the time when new referrals are discussed and case

managers are able to collaborate on appropriate courses of action for each client. Wednesday mornings are booked for the psychiatrists to conduct clinical assessments, and follow ups with the clients of the case managers. These mornings would begin with the team meeting around the table to go through the day's appointments and the psychiatrists would review each of these clients with the assistance of the case managers. Following this briefing, the psychiatrist and case manager would meet the client in an observation room with a one way mirror and certain members of the team would watch behind the glass and discuss their observations and opinions on best care for the client. Towards the end of the session, the psychiatrist consults with the team and asks for other people's opinions. As a student, actively taking part in this process was extremely valuable for enhancing my learning and professional development. Discussion is welcome, open, technical and professional. I found the round table in the centre of the room symbolic of the open and equal forums for discussion of opinions between psychologists, psychiatrists, social workers, nurses, students and counsellors.

Chapter Three: Research Methods

Research Framework

I conducted my research portion of my practicum from a qualitative paradigm, using a focus group as my primary means of data collection. Patton (2002) explains that a benefit of focus groups is that they can be effectively performed with groups of staff members to evaluate a program's strengths and areas of improvement. An additional benefit of conducting a focus group was a way to allow the clinicians to build on each other's ideas about a particular topic. This research provides a formative evaluation on the Early Intervention Program in Prince George. A formative evaluation has the purpose of improving a program or intervention by focusing on its strengths and weaknesses and offering recommendations for improvement (Patton, 2002). The participants of the focus group were case managers who work in the Early Intervention Program. These professionals come from different educational backgrounds including social work, counselling, and nursing. Most of the participants had a Bachelor's degree, while one had a Master's degree. Because I only conducted one focus group, I was unable to compare one data set with another. Instead, I used thematic analysis to evaluate the data, scrutinizing it for repetitive phrases, and opinions that fit within the intent of the research. In doing this, I found three themes that emerged, all of which contained their own challenges, barriers and strengths. These themes were flexibility, transitions, and societal shadows.

Locating Self in Research

In qualitative research and writing, it is critical for the author to locate him/herself and his/her stance within the study. Rather than eliminating biases, they must be recognized, critically evaluated and portrayed in research. Patton (2002) describes this as reflexivity, and discusses the importance of being aware of one's own "cultural, political, social, linguistic, and ideological" (p. 65) views as well as those views of the subjects of inquiry.

Marlow (2005) writes that qualitative data analysis follows a circular and fluid pattern in its formation and can often begin prior to the completion of data collection. I worked closely with the clinicians of this program and within the program itself for four months and, as a result, developed an emic perspective into the subject that I researched as a participant observer. An emic perspective is achieved when the researcher adopts an insider's view of a research setting, thus becoming a *participant observer*. The participant observer immerses him/herself within the setting of inquiry, experiencing and learning on an intimate level aspects of that setting, while at the same time, observing and reporting the findings to outsiders (Patton, 2002).

I have embraced the medical model of mental illness, which view the root cause of mental illness to be related to a diagnosable disorder in the brain. Pharmacological treatments are typically used for people with mental illness as a main tenet of treatment (Beecher, 2009). Often, there are debates within the social work profession regarding the strengths and weaknesses of the medical model and the social worker's role within it, however, this is not the focus of this report. It is important to note that I practice social work from a strengths perspective, which means that helping professionals focus their

efforts on identifying and improving the client's existing strengths, rather than working to remove their deficiencies (Sheafor & Horejsi, 2003). This perspective has indeed influenced the approach as well as the findings of my research.

Recruitment & Data Collection

Through the use of emails and personal contact, all Early Intervention clinicians were informed of the research and invited to participate (See Appendix 2). Of the five clinicians working in the agency, four agreed to participate.

At the time of the focus group, I arranged all participants together in a secure and confidential meeting area, and used an audio recorder as well as hand written notes to capture the data from the group. Prior to asking questions, I reminded the members of the voluntary nature of the participation, as well as steps in confidentiality that I would take as the researcher to protect their identity. I assured the group members that I would keep the taped information in a secure location. I asked that the group keep confidential what was discussed during the interview. Following this, I began with the interview. In addition to reading the interview questions aloud, I had a visual write up of each question that the members could read to better stay on topic.

Data Analysis

I analyzed the data from the focus group interview using transcript based analysis, which is emphasized by Krueger (1998) as the most rigorous and thorough form of data analysis. This method of data analysis for focus groups involves recording, transcribing

and combining the information from the transcription, the field notes and the discussion from the debriefing.

Krueger (1998) offers a systematic process to analyze a focus group which includes the following steps. 1. Sequencing questions to allow maximum insight. I was careful and thorough in my ordering of questions into a logical flow, and found that participant's answers to many of the questions almost naturally flowed into the next (See appendix 1). I sequenced the questions so that clinicians can explain their roles as early intervention workers, discuss areas that could improve client service delivery, and close with a discussion of the strengths that they and their program have. 2. Recording the data. Data recording is preferable to relying solely on field notes or memory. 3. Transcribing the audio recording and coding the data. I found that the process of transcription itself was an important way of mentally processing the data and allowing time for me to reflect on the data. Data coding can be done by attaching labels to specific themes that are noticed through careful examination of the data. 4. Seeking participant verification. I used member checking with one of the focus group members to ensure the accuracy of the findings as well as to ensure that this member was comfortable with all of the information in my presentation prior to my presentation of findings. 5. Seeking participant verification and debriefing. Immediately following the interview, I had a debriefing period with the participants off the record. 6. Sharing data with the stakeholders. This involved a power point presentation for the youth services team where I discussed my practicum experience, my research and the results of my research.

Chapter Four: Results and Discussion of Findings

Results: Identified Themes

The findings in this section were presented to members of the Early Intervention Program and the Eating Disorders program. I identified three themes from the data. I labeled these themes as follows: flexibility, transitions, and societal shadow.

Theme One: Flexibility

To be flexible is to be adaptable to changing circumstances; to be versatile, and not rigid. In the context of the Early Intervention program, flexibility can be divided into three sub-categories; flexibility of focus, flexibility of schedule, flexibility of setting. Flexibility of focus is about assessing and responding appropriately to clients according to their basic needs beyond the narrow scope of addictions or mental health. A standardized tool widely embraced by the mental health clinicians involved in my research is the Global Assessment of Functioning (GAF) Scale. This scale rates people according to their level of functioning using a number score between 0-100. The criteria for a GAF are based on impairments in everyday social and functioning as well as the presentation of psychological symptoms (Midwest Behavioral Health Network, 2009).

Also used as a measurement of functioning, is theory derived from Abraham Maslow, which explains that people strive to meet certain needs in order of importance. The first level of needs are physiological, such as food and shelter. These must be met before an individual can focus on meeting higher needs, such as the need for safety, and following this, the need for both love and acceptance (DeCarvalho, 1991). The implication for counsellors is to address the client at the appropriate level of need that

most fits the client, and attempt to move that client towards striving to achieve the next level of need. It is assumed by this theory that working with clients on higher levels of functioning such as changing patterns of substance use will be unsuccessful if he or she is struggling with meeting such basic needs as food, shelter, and clothing. One of the case managers from the focus group has a caseload that largely is comprised of street involved youth saying this about the flexible nature of work with clients, "I'm just saying my focus isn't solely on therapy with clients. It's that whole balance of their functioning. Because you can't really do therapy. You couldn't talk about drama if somebody doesn't have a home or you can't get them into school if they don't have access to food."

The theme flexibility also related to the manner of the clinicians, who always attempted to be available to clients in need of their support. I found that this involved clinicians working with clients at opportune times for the *client*. The schedules of the clinicians were flexible to the needs of their clients. This meant that it was not uncommon for case managers in this program to receive crisis calls from clients and to squeeze in an appointment over their lunch break, or triage clients and shuffle scheduled meetings at a moment's notice because a client needed to see them. One of the participants commented, "because we can prioritize clients like I've had clients bumped who are going to see [the Psychiatrist], saying this kid is really sick, we need to see him right now. And that's possible. That's done right there just by everybody agreeing that yes we need to do this, we need to make some adjustments." It should be noted that the focus group participants all appreciated the open access to the psychiatrist and psychologist, who were just a phone call away from collaboration. These professionals were relied upon heavily by the case managers.

Not only were times made to suit the needs of the client, often the setting in which counselling is carried out is done flexibly. "You can do a lot of counselling when you're driving, when you're taking somebody somewheres…those are some of the best times." Of course, this non-traditional approach to counselling had its challenges. As mentioned previously, the office setting is openly constructed, which means that sometimes there are few options at the agency to carry out face to face counselling in a confidential, controlled and secure setting. A lengthy discussion ensued during the focus group on the challenges of this lack of office space,

> I think that to do the counselling piece in the winter is difficult because we don't have our own private space. You can't do a counselling session in Tim Horton's because it's really loud and distracting and not private and not confidential. It's great to do outreach when the weather's good. You can go outside, you can go for walks, you can sit at a picnic table. But in the winter I find it really challenging when you do need to just do that talk piece and there's no private space to do it.

Other challenges that I saw throughout my practicum and which were touched on by focus group participants were that sometimes the flexibility of scheduling resulted in case managers being overwhelmed at times. Though Case Managers have the flexibility from management to schedule their workdays with clients as they need to, and it is not encouraged by management to book more appointments with clients than is manageable, the reality of the work is that on occasion, their schedules would become overwhelming. Case Managers would have five or six appointments booked in a day and they would be spread out all around the community, and a crisis would occur for a client on their caseload. This can have a detrimental effect to the client(s) involved and the case manager and quality of work can suffer, as can the mental health of the clinician. "If you're seeing five, six people for hour sessions, your brain's not there."

Theme Two: Transitions

This theme refers to the ease of moving clients into appropriate programs that can offer them the proper care and service they need. With any social service agency in a large centre, clients are ideally referred into the service available that most closely fits their unique needs, ages, and demographics in a smooth fashion and within a relatively short time frame. The focus group participants spoke of difficulties and frustrations in this area. In my practicum setting, clients received referrals mainly from what Ehmann and Hanson (2004) call "gatekeepers." Gatekeepers are professionals who are likely to interact with these groups of people who are at the highest risk of psychosis. Examples of gatekeepers are teachers, school counsellors, police officers, and family doctors. After the program receives a referral, the team decides on the most appropriate course of action for the client. If the new referral has displayed symptoms of psychosis or is drug involved, he/she can be seen within one or two weeks by a case manager, and a comprehensive assessment can be conducted with the client. If the client has substance abuse issues and/or is experiencing psychosis, then these clients are appropriate for service in the program, if they are willing to be involved. If however, the symptoms displayed are not related to psychosis, but are due to another mental health concern, they are referred to another community program that works with broader mental health disorders in children and youth. If the referrals are of adult age and are not displaying a first break into psychosis, they may be transferred to the adult mental health system.

The focus group participants mentioned challenges that they had with referring into these programs. For example, one participant stated, "they seem to be very very busy and not able to provide as much outreach. They're an assertive outreach team as well, but

it doesn't seem that they are able to provide as much." Another comment that builds on this is "...services for adults, I think they have really large caseloads...and they're not, like when were transitioning clients to adult services, they're not really getting picked up like we'd like them to."

The mandate of the Early Intervention program is limited to youth with addictions, and to people of any age who experiencing first break psychosis. When new referrals present with mental health issues that did not appear to fit this mandate, they are referred to other mental health agencies. Unfortunately, a smooth transition into other mental health programs was not always realized for clients. From the opinions of the focus group members, there was a recognition that these other agencies seemed to have lengthy waitlists and be short of the required staff to meet the needs of all clients in the community. This points to larger systemic barriers that are not uncommon for many social service providers in our society, and who are increasingly forced to provide more service with fewer resources (Mulally, 1997).

There were also difficulties associated with transitioning clients successfully and smoothly from residential care back into the home environment. For example, clients moving from highly structured and closely monitored residential programs such as APAU or from the Nechako Youth Treatment Centre directly into community was often too large a step towards independence for many clients to be successful. As a result, clients may experience relapse into substance misuse, or may decompensate into compromised mental health states. One suggestion to reduce this issue that was raised in the focus group was to establish residential programs that offered a smaller, more manageable transition towards independence, such as a half way house for people

involved in the corrections system. "Somewhere that's a semi independent supported living environment where they could live for several months to transition them back…" In summary, the theme transitions was apparent in several contexts and improving client transition between programs and care environments would help lead to better care and client outcomes.

Despite these difficulties, the participants agreed on the strengths of the structure of their own larger department with regards to openness of communication with other professionals. The staff were appreciative that the waitlist social worker for their department was located in their office and was always available to check on the availability of spaces in the drug treatment centre for youth and the youth psychiatric ward, "we're all connected like we all know each other so we can phone the other service up and say hey when can this kid get in?"

Theme Three: Societal Shadow

One of the strengths of the early intervention program is its direct response time and minimal waitlists to see a case manager. Referrals can usually be addressed within one week. The best practices research highlights the importance of rapid intervention at its earliest possible phase (Ehmann & Hanson, 2003), and this is met through this program. In a perfect scenario, gatekeepers such as parents, counsellors or teachers will pick up on the ill individual's initial symptoms and refer them to the Early Intervention program. Unfortunately, this is not often the case. "We do get kids here and at the other place that, they've been ill for a long time, and nobody seems to notice or nobody seems to pick up on it…" The problem identified was that the people in the ill individual's life

had not intervened with the youth by calling the early intervention program. This leads to the third identified theme, which is *societal shadow*. The shadow being referred to is meant to symbolize the larger stigma and lack of knowledge of mental illness that exists in society. Stigma involves holding a negative view towards mental illness, and can result in individuals with psychosis receiving less social or familial support, and can lead to personal shame and dejection (McFarlane, 2004). The lack of knowledge of the signs and symptoms of psychosis can play a major role in linking people with untreated psychosis to the appropriate services such as the Early Intervention program. Ideally, gatekeepers should be able to recognize that there have been changes in the ill individual over time and should be able to refer them to the specialized early intervention program for service in as timely a manner as possible. Solutions posed in the focus group were to "Educate the other services as well the teachers and other counsellors to pick up on those things, the subtle symptoms… educate the Doctors as well." Ehmann and Hanson (2004) echo this idea and view it as a vital role for early intervention programs to educate these gatekeepers to be aware of the signs of psychosis and know where to turn. One of the focus group members speaks on public education, "I think it's about getting our name out there so they know we're here right rather than thinking…this is something that I have to deal with on my own." Also mentioned was that in some instances, there needs to be awareness on behalf of the ill individual,

> Well, one thing I've come across…is them not telling anybody that they're having those symptoms and maybe it goes on for a year or two years and they think that nobody else or they don't know this is any sort of illness and they don't ever speak about it and I don't ever know what could improve that other than more public awareness.

This is where lack of awareness, lack of insight and the fears of becoming stigmatized work in cooperation to keep an ill individual from seeking help. "Yeah stigma, like kids going 'I'm not telling anyone I'm hearing voices' right 'they might think I'm nuts,' perhaps it would be more awareness or something included in a school program for awareness of mental health I don't know". The focus group participants generally agreed on the bad reputation that mental illness has in society and where this misrepresentation comes from,

> to the general public opinions of mental illness are presented in media. Movies, TV, radio and they're often inaccurate. Or they're connected with reports of violence when most people who are mentally ill are not violent. But those are the one's you'll hear about on TV.

The participants in the focus group agreed that they battle stigma on a daily basis, as do people struggling with mental illness. It was more than mere consequence that during the focus group, the same example of the media's impact on mental illness arose that I highlighted six months earlier when writing the literature review. "The guy who was on the Greyhound bus. Everybody knows about that and everybody knows that that guy was schizophrenic." The focus group members whose careers involve advocating on behalf of their mentally ill people were quick to come to their defense during the focus group, exclaiming that "statistically they are more likely to have violence against them."

Study Limitations

There are drawbacks and limitations to conducting research as a participant observer working from an emic perspective. First, in working closely in this agency, identifying challenges and barriers objectively is quite difficult. This practicum was a very positive experience for myself and during my practicum, and I became quite close to

the clinicians that I worked with, more as a colleague than an outsider. When moving from day to day duties in my practicum to reflecting on the Early Intervention program, I needed continuous awareness of being both an insider while observing a program subjectively. "The challenge is to combine participation and observation so as to become capable of understanding the setting as an insider while describing it to and for an outsider" (Patton, 2002, p. 268). A second limitation is that the research focused on the opinions of the case managers alone. As the results of the research implied, there are difficulties with communication between the agency of study and surrounding community agencies. Thus, other perspectives from outside the agency, such as gatekeepers, current, potential or former clients, outside community agencies, or management were excluded. While the perspectives of the case managers are valid and provide valuable information, ideas from others outside of the agency may be a useful next step for further research.

My perspective is in line with that of the practitioners in the program, rather than from clients, members of the community, program administrators, or practitioners from other communities. I do not inquire into the strengths, challenges and limitations of the psychosis program from any of these other groups, and perhaps this would be a useful future direction for literature. Due to the limitations of resources, the focus group data could have gone much further if it could have been compared with other focus groups, perhaps from other agencies that work in Early Psychosis Intervention. Ideally, I would have had the opportunity to see firsthand the operations of the Early Psychosis Intervention programs in the Lower Mainland as a means of comparison.

Implications for Improved Service Delivery

The intent of my research and practicum was to observe research and report on a program for people with psychosis and offer suggestions for improvement. My first day of practicum began on September 8th/2009. The day I conducted my focus group was on October 8th/2009, and the presentation of my findings to the team was on December 3rd/2009. As I worked within this program, and conducted research with my colleagues in this program, I struggled with the very idea of explaining my findings to them and listing ways in which the program could be improved; especially given that my time spent in practicum was far shorter than the length of time these practitioners had been working there. I was extremely hesitant to offer suggestions for improvements, and instead, I passed on direct suggestions made by the focus group participants to the audience, while focusing more on the themes I had developed. I was concerned about the optics and dynamics of being an outsider, a student who enters into an organization for a small period of time and offers my opinions of what should be changed within a program. Most of the suggestions came up during the focus group, as was the intent of this research. I wanted to be sure of the accuracy of these suggestions, so as is the nature of the work in this program, I brought the list of suggestions to one of my supervisors in a collaborative manner before I completed this report or presented them to other practitioners within the agency. I also did this to ensure that my supervisors, who both were subjects of the focus group were comfortable with what I had written. I wanted the suggestions to be for the benefit the program, from the point of views of not only myself but of those who participated in the focus group.

The first suggestion has been recognized as an ongoing issue and is related to the physical environment of the office space. While the open office allowed for open communication and idea sharing, the staff agreed that more options for a confidential counselling setting would improve the service. This lack of setting was identified as a problem, especially in the winter months.

The clinicians also advocated for increased residential spaces for the youth in northern British Columbia. To put some perspective to this argument, APAU has only seven beds to serve the needs of all severely mentally ill youth in the Northern Health Catchment area. Related to the theme transitions, the group members discussed the benefits for clients to having a specialized group home that was mandated to act as a transition between the youth psychiatric ward and the community.

Like most social service agencies, more clinicians to share the client load eases the burden on all parties. It was no surprise that the focus group participants suggested having more clinicians to meet the demands of the program, specifically, another psychiatric nurse, as one is currently working on the team and brings a valuable medical perspective and skill set to the program. Another suggestion was to add a life skills worker to the team, who could focus primarily on enhancing client's functioning by teaching such valuable proficiencies such as cooking, banking, grocery shopping, resume writing, attending medical clinics, and apartment seeking. It was acknowledged within the agency that there needs to be improved communication between the early intervention program and other community mental health programs for youth. Improved alliances with other agencies ultimately means better service for clients.

Finally, public education needs to be continually and more adequately addressed with regards to psychosis, and other mental illnesses. Gatekeepers as well as the youth themselves would benefit from increased awareness of the signs and symptoms of psychosis. The message that psychosis is treatable must continue to be spread.

Directions for Future Research

To my knowledge, this is the first piece of literature that discusses this program in northern British Columbia. This report offers an explanation of an early psychosis intervention setting, as well as identification of some of the strengths, barriers and challenges of this program. Future research that compares the views of case managers in this northern program with those in other Early Intervention programs around British Columbia would be beneficial. Research that asks the consumers of these services what was helpful, unhelpful and their suggestions for improvement would be a useful future research direction. Finally, as the ten year mark of the establishment of an early psychosis intervention program is reached, perhaps some research on the outcomes of these programs in this province would also be beneficial.

Conclusion

There are many strengths of the Early Intervention program in Prince George, British Columbia for people with psychosis. The major strengths identified and highlighted in this report were the flexibility of the program to meet the unique needs of clients with psychosis, and the effective transition processes that increase the intervention time and decrease the delay of untreated psychosis, as per best practices with this population. One of the major barriers and challenges that this program faces stems from

the overall lack of public awareness of psychosis in general, and what signs and symptoms are typical of this mental disorder.

Suggestions for improved service delivery are made. These include adding more private office space, increasing specialized practitioners to the team such as psychiatric nursing and a life skills worker, improving the communication between the Early Intervention program and other programs that clients may be transitioned to, adding a semi independent residential program, and increasing public education in order to fight stigma and improve awareness of the signs and symptoms of psychosis.

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Appendix One- Focus Group Protocols and Questions

I intend to conduct a focus group in order to gather data on my research topic. Patton (2002) explains that a benefit of focus groups is that they can be effectively performed with groups of staff members to evaluate a program's strengths and areas of improvement. Furthermore, conducting a focus group is a way to allow the clinicians to build off of each other's ideas about a particular topic (Patton, 2002).

Because I will be conducting my research in the same setting that I will be completing a practicum in, I may be working with some of the practitioners who volunteer to be in the focus group. Therefore, I will avoid biasing answers to questions in the focus group by refraining from discussing my research topic with members of my practicum setting, with the exception of my practicum supervisor, who will not be a participant in the focus group. I will include a section in my letter of consent for participants to confirm that I have not discussed the topic of my research with them prior to the focus group.

In order to maintain anonymity, there will be no names used during the focus group. If a name is accidentally used during the focus group interview, it will not be transcribed, nor will it be included in the written portion of the data results.

Questions will be posed in a manner that focuses on challenges within the community, and public perceptions of mental illness in the north. Also, questions will be posed that focuses on the unique strengths of this program in the north. During the interview, as the mediator of the focus group, and by posing questions in this manner, this focus group interview will not examine barriers, weaknesses or drawbacks of the individuals working in your agency, or the agency itself. This is because I recognize and

will avoid the potential for risk to the individuals or the agency. **It is not my intention to highlight problems within the agency setting, but rather the unique challenges of implementing practice in the north.**

Questions for Focus Group

1. Without divulging the particular agency you work in, please describe your roles as mental health clinicians.

2. BC's first early intervention services were implemented in the Lower Mainland of BC. What is different about the early intervention program here in Prince George?

3. How would you describe the available services for people with psychosis throughout the Prince George community?

4. What mental health services for people with psychosis may be missing in Prince George that could improve the wellbeing of your clients?

5. What barriers exist for people with (or at risk of) psychosis in accessing the appropriate mental health services in Prince George?

6. Awareness and public perceptions play large roles in assisting individuals and families to access appropriate services and to experience strong mental health. How would you describe public perception of mental illness and mental health in Prince George?

7. Research suggests that the longer the delay in untreated psychosis (DUP), the poorer the long term outcomes for people with psychosis. In your opinion, are

people with (or at risk of) psychosis able to receive timely service to meet their needs? How could DUP be reduced in Prince George?

8. What services within your agency could be developed to improve the service to clients with psychosis?

9. What would you describe as unique strengths of the program that the clinicians here today implement for people with psychosis?

10. Is there anything else anyone would like to comment on or ask about before we end today?

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Appendix Two: Letter of Recruitment for Focus Group

This recruitment letter will be sent in email form or paper copy to clinicians of the mental health service for youth that I will be completing a practicum with.

Title: Examining challenges, barriers and strengths in the implementation of an early intervention program in northern British Columbia for people with psychosis.

Purpose and Method of Research: The purpose of this research is to identify how early psychosis intervention clinicians see their program having specific challenges and strengths unique to the northern setting of Prince George. After a focus group has been conducted with yourself and between 2-4 others from the agency that you work in, the researcher, Joshua Van der Meer, will summarize and present the findings to the mental health program that you work in, and offer any suggestions for improved service delivery to youth consumers of mental health services in Prince George. In addition, this research will be presented as Joshua Van der Meer's Master's Practicum Report, and thus contribute to the current literature on northern social work, and mental health services in the north. The focus group will occur in the Fall of 2009, at a time that will coincide with all participant's schedules. It will require approximately 45-60 minutes of your time and the content will be audio taped. You and your colleagues have been chosen for this research because of your experience and insight in working in an early intervention program for youth with psychosis.

Who will have Access to the Audio Taped Information? All records will be secured in a cabinet in the researcher, Joshua Van der Meer's home. Only Josh Van der Meer and the Thesis Supervisor, Heather Peters will have access to the data. The information will be kept until the final project and Thesis Defense is complete. The records will be kept locked at the researcher's home for a maximum of two years before it is destroyed. Throughout the project, Joshua Van der Meer will ensure the confidentiality of yourself and the mental health program within which you work by refraining from the use of any names of practitioners or clients in the written report.

Voluntary Nature of Participation: Participation in this project is entirely voluntary. You can choose not to participate, and if you do choose to participate, you can withdraw from the focus group at any time. If you chose to withdraw from this research, the information you have shared will be withdrawn from the study as well. During the focus group interview, you can choose not to answer specific questions for any reason.

Potential Risks: The researcher, Joshua Van der Meer, will be asking your opinion on questions pertaining to challenges, barriers and strengths involved in the work you do. Josh Van der Meer will not be able to ensure complete confidentiality over what is discussed during the focus group interview as there will be 2-4 other members sharing information during this time. At the beginning of the focus group interview, Josh Van der Meer will explain the importance of keeping information shared confidential amongst the members. In the unlikely case of research subjects revealing any information that has potential to harm yourself, your colleagues, your clients, your agency, or agencies in the community, the researcher will protect the above mentioned parties by withholding any harmful specific details of this information from the study's results. The names of yourself, your colleagues and your clients will not be used in this practicum project. Prior to the undertaking of this research project, the content was thoroughly reviewed by the Research Ethics Board at the University of Northern British Columbia.

Potential Benefits: By participating in this focus group, you will be contributing to the academic literature available in the north regarding mental health services. You will also be better informing the researcher as to what challenges exist in the implementation of the program within which you work.

Dissemination of Results and Recommendations: The researcher will conduct a presentation to your mental health service agency which you are welcome to attend. During this presentation, a summary of the research findings as well as recommendations will be provided. You can also contact the researcher by email at vander1@unbc for more information or speak to him in person.

Complaints: Complaints pertaining to the research may be sent to the UNBC Office of Research, reb@unbc.ca or 250-960-5650

Thank you for your consideration of participation in my research project.

Sincerely,

Joshua Van der Meer, BSW, MSW (c)

Appendix Three: CONSENT FORM

Examining challenges, barriers and strengths in the implementation of an early intervention program in northern British Columbia for people with psychosis.

I understand that Joshua Van der Meer, who is a graduate student in the Masters of Social Work Program at the University of Northern British Columbia, is conducting a research project pertaining to the challenges of implementing mental health services in northern British Columbia.

I am a clinician within an agency that provides mental health services to youth, and I have volunteered to participate in a focus group in this topic. This consent is given on the understanding that Joshua Van der Meer will use his best efforts to guarantee that my identity, as well as the identity of the agency with which I work in is protected and my confidentiality is maintained. My name, as well as the name of the agency that I work in will not be used in this practicum report.

Confidentiality has been explained to me and I give my consent freely and understand that I may withdraw from the interview at any time with no penalty.

Joshua Van der Meer has not discussed the questions of this focus group with myself, prior to the focus group interview, and other than the topic of research, Joshua Van der Meer has not attempted to influence the ways in which I will answer questions in any way.

I am aware and am in agreement that the information that I give to Joshua Van der Meer will be treated as follows:

- The focus group interview will be audio taped, and the facilitator (Joshua Van der Meer) will keep motes on the process of the focus group interview as it progresses. Audio Tapes will be kept secure for a maximum of two years and then be destroyed.
- All notes taken during the focus group will be stored in a locked cabinet in his private residence, and destroyed within a maximum of two years of the focus group interview.
- The results of the focus group interview will be analyzed and used in partial fulfillment of the requirements of Joshua Van der Meer's Masters Degree of Social Work from the University of Northern British Columbia.
- Once analyzed and summarized, the results of the focus group will be used by Joshua Van der Meer to provide and disseminate recommendations to the agency that I work in as well as in Joshua Van der Meer's Practicum Defense for UNBC.

If I have questions for Joshua Van der Meer, I can email him at vander1@unbc.ca

If I have any complaints regarding this research, I can contact the UNBC Office of Research at reb@unbc.ca or 250-960-5650 or Joshua Van der Meer's thesis supervisor, Professor Heather Peters at petersh@unbc.ca or 250-991-7519.

A copy of this agreement will be provided for myself, the UNBC ethics board, and the other copy will be kept in a locked cabinet for a maximum of two years and subsequently destroyed.

NAME: _____
SIGNATURE:_____DATE:_____

RESEARCHER:_____
SIGNATURE:_____DATE:_____

Appendix Four: **MSW Practicum II: Learning Contract**

Student: Josh Van der Meer
Practicum Supervisor: Chris Painter, Sara Garner, Sandi De Wolf
Academic Supervisor: Heather Peters
Agency: Northern Health Youth Mental Health and Addiction's Dept.
Length of Placement: From: Sept 8th/2009 To: Dec 10th/2009
Hours of Work: Monday-Thursday 07:30-17:00

Learning Objectives

1. To Familiarize myself with the use of the Early Intervention Program's intake and assessment procedures.

i. Action Plan- To complete at least two initial screening forms independently
-To complete at least one client assessment independently under clinical
-To receive feedback from practicum supervisor regarding my progress on the above screening and assessment tools
-To utilize a variety of assessment tools which are used within the agency (SASSI, BPRS)

ii. Evidence of Achievement- At least one of each of the above mentioned forms will have been completed with clients and completion of this goal will be signed by my practicum supervisor

2. To learn about the other existing programs within NH's Youth Mental Health and Addiction's Department

i. Action Plan- To spend minimum one day in observation of both the Adolescent Psychiatric Assessment Unit and the Nechako Youth Treatment Centre.
-To meet with the Clinician of the Eating Disorder's program to discuss its operation
-To record my experiences, thoughts, learning, observations and questions

ii. Evidence of Achievement-To write about these services and my experiences within them in my final practicum report

3. To gain more clinical experience in youth mental health and addictions

i. Action Plan- To attend and participate in all Wednesday clinical team sessions with, clinicians, psychiatrists and clients.
-To attend community visits with practicum supervisor and his clients
-To receive formal feedback on my progress from supervisors
-To carry a caseload throughout the semester as appropriate

ii. Evidence of Achievement-A written explanation of my clinical experiences will be included in my practicum report
-Progress will be noted by Practicum Supervisor during mid and final evaluations

4. To continue to gain clinical documentation skills and experience

i. Action Plan -To chart all meetings with clients throughout the semester
-To have practicum supervisor review all chart notes

ii. Evidence of Achievement-I will keep note of how many times I have charted in my learning journal
-Practicum Supervisor will evaluate my charting progress during mid and final evaluations

5. To practice and improve upon group counselling skills

i. Action Plan -To Co-facilitate the weekly addictions group
-To attend the 'Surviving Psychosis' group when possible
-To attend other groups held at either the Adolescent Psych Assessment Unit or the Nechako Treatment Centre

ii. Evidence of Achievement- I will document my learning and personal evaluations in my learning journal throughout the semester
-I will receive bi-monthly formal feedback from practicum supervisor
-Progress to be assessed during mid and final evaluations

6. To expand knowledge on existing community services in Prince George for youth.

i. Action Plan –I will learn about and visit many of the program for youth around the community and how they interact with the Early Intervention Program.
-When appropriate, I will use these services as referral sources, information resources, etc.

Signatures

Student: Date:

Practicum Supervisor: Date:

Practicum Supervisor: Date:

Academic Supervisor: Date: