DEMONSTRATION PROJECT

OCCUPATIONAL THERAPY SERVICES IN MENTAL HEALTH: SUPPORTING TRANSITION TO THE COMMUNITY

CAOT · ACE

Canadian Association of Occupational Therapists
Association canadienne des ergothérapeutes

Saskatchewan Society of Occupational Therapists

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Funded by the Saskatchewan Ministry of Health Workforce Planning Branch, this project was developed by the Canadian Association of Occupational Therapists (CAOT) and the Saskatchewan Society of Occupational Therapists (SSOT) in collaboration with the Saskatoon Health Region (SHR).

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EXECUTIVE SUMMARY

This project was developed to assist adults with mental health problems transition successfully to the community after a hospitalization. At this time there is a marked gap and no occupational therapy services to ensure appropriate transition from hospital to the community for those with persistent and complex mental health issues. This creates additional demands on emergency and hospital services that may have been averted if appropriate services had been available. In Saskatchewan, access to occupational therapy services for persons with mental health concerns is well below the national average (CIHI, 2009).

This purpose of this project was to demonstrate the impact of occupational therapy services on the transition and integration into the community for persons with complex mental health concerns in a way that has not previously been available in the province of Saskatchewan. Clients who did not meet criteria to access occupational therapy elsewhere in the Saskatoon Health Region (those that 'fell through the cracks') were the primary focus of this project. Referrals were accepted from hospital and clients were followed as they transitioned from inpatient care to the community. The services provided included both assessment and intervention. Assessment involved individualized evaluation of clients' goals, abilities, limitations and barriers that may interfere with community functioning, and the desired occupations to which they wanted to return. Interventions were specific to the clients goals and included education, accessing resources, skill building, developing coping strategies and establishing 'bridges', if necessary, to transition to longer term support services.

The results of this project demonstrated a significant reduction in both emergency room visits and hospital admissions for clients who received moderate to high intensity transition occupational therapy services. Data also emphasized themes of professionalism, quality of service, continuity of care and the unique perspective of occupational therapy that was essential for the transition process. This project has established occupational therapy services as essential for persons with complex mental health issues to successful transition from the hospital to the community.

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INTRODUCTION

Saskatchewan has a long history and takes pride in a health care system that provides services to address the needs of its citizens. In keeping with this history and to improve outcomes for adults experiencing significant mental health difficulties as they transition and return to the community following a hospital stay, this demonstration project focused on the impact of occupational therapy services during this transition process.

This 2-year project, which operated from January 1st, 2008 to December 31st, 2009, was funded by the Saskatchewan Ministry of Health Workforce Planning Branch. It was developed by the Canadian Association of Occupational Therapists (CAOT) and the Saskatchewan Society of Occupational Therapists (SSOT) in collaboration with the Saskatoon Health Region (SHR).

THE PROBLEM

This project was implemented to determine the impact of occupational therapy transition services for persons with mental illness who were returning to the community after hospitalization.
This project was deemed essential to address a recognized gap in the care continuum where clients leave hospital and fail to connect with the necessary community supports. The gap is the 'disconnect' between the use of hospital services and the use of community supports and services. It was observed that clients who were unable to bridge this gap independently used emergency room visits and sought hospital re-admissions to have their needs met.

Through establishing a therapeutic relationship with clients in hospital, assisting clients to connect with community supports, and building skills for maintaining connection in the community, this project was developed with a purpose of reducing clients' unnecessary use of acute care services.

PURPOSE

This project was developed to assist adults with mental health problems transition successfully to the community after a mental health hospitalization. In Saskatchewan, access to mental health occupational therapy is well below the national average (CIHI, 2009). There are many different mental health and addiction services in Saskatchewan though these services do not have occupational therapy expertise and are not able to address complex client needs comprehensively.

The focus and primary purpose of this program was to facilitate the successful return of adults with mental health problems to the community following a hospitalization and to enable them to participate in meaningful occupations, continuing to live life in a manner that is fulfilling while reducing the need to access emergency and inpatient hospital services.

The goals of this project are:

1. To provide occupational therapy transition services that support and maintain successful community re-integration for adults with mental health problems
2. To demonstrate the efficacy of occupational therapy transition services for adults with significant mental health problems as they return to the community following a hospitalization
3. To participate on the interdisciplinary team by offering occupational therapy transition services as well as support service provision for the overall benefit of the client
4. To reduce the use of emergency and inpatient hospital services for those with complex mental health problems transitioning to the community after hospitalization

Clients and their caregivers had the opportunity to access occupation focused mental health services from an occupational therapist though this project. The transition occupational therapy service aimed to facilitate a smooth continuum of care through the transition from acute hospitalization to life in the community. Once clients were home in the community, the transition occupational therapist assisted with changes that lead to improved health and more effective use of community services.

OCCUPATIONAL THERAPY TRANSITION SERVICES PROGRAM

The services of occupational therapy included both assessment and intervention. The assessment service involved individualized evaluation of goals and desired occupations and incorporated measures to gather information on client's abilities, limitation and barriers to functioning in the community and maintaining independence. Assessment included an evaluation of cognitive, emotional and physical ability accounting for social, financial and physical contexts. When relevant, assessment of client specific environments included the workplace, school, community centers, etc., to ensure that the intervention was appropriate, feasible and enduring.

Occupational therapy treatment intervenes at several functional levels. The intervention involved adapting the environment, providing specialized equipment, facilitating skill acquisition, and was specific to the individual's goals, desired occupations, real life contexts and resources. This diverse mode of treatment assisted the client to incorporate therapeutic strategies in as many relevant situations as possible. The goal could be as basic as dressing oneself, following a medication regime, and/or improving safety and mobility around their home. The focus of intervention in the community addressed occupations such as using public transportation, going grocery shopping, and/or taking part in social groups. Other interventions included time management and organization, managing finances, facilitating readiness for education or employment pursuits, and developing strategies for reaching vocational goals.

The occupational therapy program involved the clients and, as appropriate, the family, case managers, caregivers, care homes, client's workplace, education system and educators, as well as community and long-term care centers. Involving and educating the social network as part of the occupational therapy transition program was essential to the initial and ongoing/enduring integration in the community.

Process

A number of logistic and professional processes were incorporated into this program. These included:

- initial contact and referrals to this program were generated and supported by the inpatient psychiatry interdisciplinary team at the Royal University Hospital in Saskatoon
- statistics were tracked through an existing intranet program of the Saskatoon Health Region
- assessments were based on the individual client's specific needs, and took place by individual standardized testing, group assessments, and/or clinical observation
- functional assessments in the home environment were completed to provide the most realistic assessment
- short-term community follow-up supported the client's return to the community, and ensured that issues not previously identified could be remediate as smoothly as possible
- as issues arose for individuals from this program living in the community, re-engagement with occupational therapy transition services was simple to access, though on a limited consultation basis to minimize long-term involvement
- linkages were established with other acute and crisis service providers ensuring continuity of care when the needs were beyond the scope of this program

- assessment results and recommendations were provided in report to caregivers and other team members when appropriate

CLIENTS

There are a large number of consumers with significant mental health problems that do not meet the criteria to receive in-hospital or community occupational therapy services through Saskatoon Mental Health and Addiction Services. These are the adults who "fall through the cracks" and who are in dire need of service and support to ensure a successful return the community following a hospital stay.

When the transition occupational therapy services project began, it was clear that the many clients with mental illness did not have access to existing occupational therapy services in mental health. (Refer to Appendix A for occupational therapy services for persons with mental illness in Saskatoon at the ontset of this project) Clients who did not meet criteria to access occupational therapy elsewhere were the primary focus of this project. Meeting clients in hospital and working with them as they transitioned from inpatient care to the community ensured these clients did not "fall through the cracks".

Demographic distribution of clients

Overall the project involved 78 clients between January 1, 2008 and December 31, 2009. The demographic characteristics of the clients are presented in Table 1. The clients ranged from 20 to 94 years of age, with an average age of 49 years. Gender distribution was fairly evenly with 53% males and 47% females.

Half of the clients were single, while 26.9% were divorced or widowed. Married or common-law relationships were reported by 15.4% of the clients. Regarding housing, 37.2% of clients lived with family, 29.5% lived alone and 26% of the clients lived in an institution (care home or long-term care). Unemployment was a reality for 34.6% of the clients, while 22% were retired and 19% of clients received long term disability. Only 16.6% were employed full or part-time.

Table 1: Description of the population by demographic characteristics

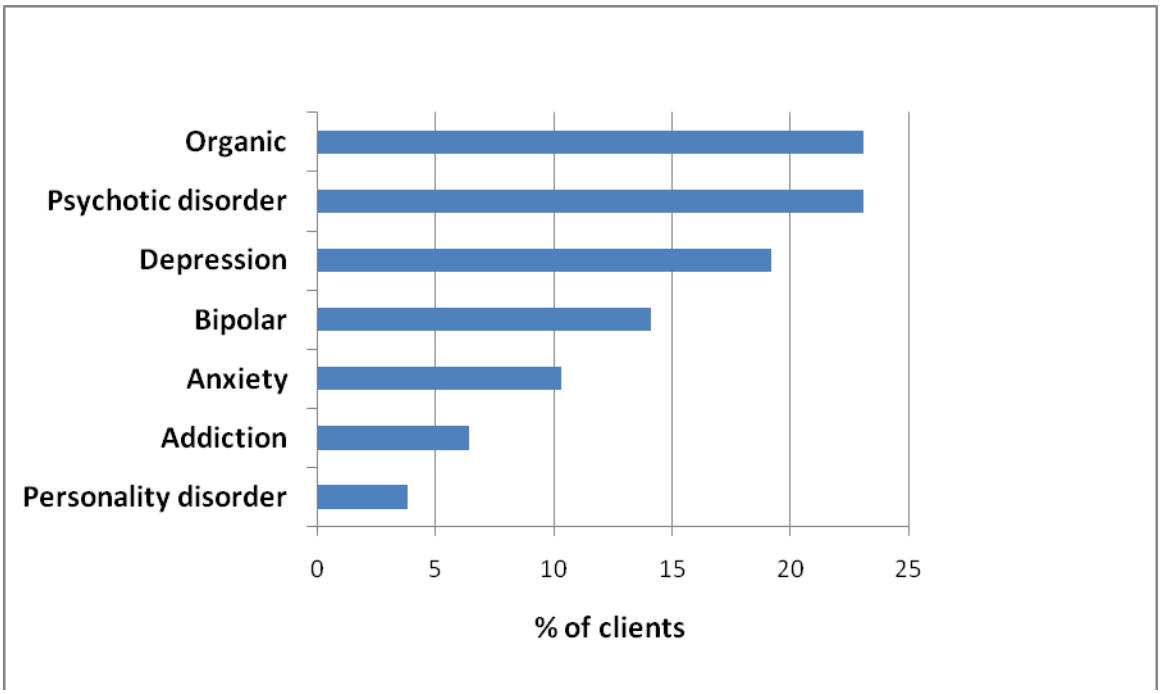
	n	%
Total	78	100
Gender		
Male	41	53
Female	37	47
Age group		
20-34	23	29.6
35-49	17	21.8
50-64	20	25.6
65+	18	23.1
Marital status		
Single	39	50
Divorced / Separated / Widowed	21	26.9
Married / Common law	12	15.4
Unknown	6	7.7
Housing		
With family/ relatives	29	37.2
Alone/ Roommate	23	29.5
Institution	20	25.6
Unknown	6	7.7
Employment		
Unemployed	27	34.6
Retired	17	22
Sick leave / Disability	15	19
Full time/ Part time/ Self employed	13	16.6
Unknown	6	7.7

Diagnosis

Many clients had more than one diagnosis. Some clients have numerous diagnoses and were often referred to as "complex clients". For the purpose of this project, clients were categorized by the diagnosis that was most problematic at the time of referral to transition occupational therapy.

Figure 1 below outlines that organic brain disorders such as dementia, acquired brain injury, autism or developmental delay comprised 23% of the diagnosis. Another 23% of diagnoses related to psychosis such as schizophrenia, schizoaffective disorder, delusional disorder or psychosis not otherwise specified. Depression was the predominant diagnosis for 19% of clients, and bipolar disorder for another 14%. Anxiety disorders (panic, obsessive compulsive disorder, hoarding, eating disorders) affected 10% of clients, and 6% had diagnoses related to substance use/addictions.

Figure 1: Distribution of client diagnoses



SERVICES

The occupational therapy transition services provided were organized into the following categories: cognitive functional assessment, single consultation, goal planning and skill building, assessment of home and other environments, community transition and integration services, adaptive equipment prescription and training, case management, and education for family and caregivers. This section provides the frequency (see Table 2) and description of the transition occupational therapy services administered during the project.

Cognitive functional assessment Standardized tools were used to provide an objective assessment of cognition that assists the team determine diagnosis, evaluate side effects and symptoms, guide treatment plans and assist with discharge planning. Cognitive functional assessment of occupational functioning within a given environmental context is a valuable contribution to the interdisciplinary team and is a common referral request of occupational therapy in many areas of practice.

Single consultation This service was provided when the client had an already existing support team that was seeking an occupational therapy perspective. This category also refers to situations where a brief screening allowed services to be appropriately redirected elsewhere.

Goal planning and skill building Included in the provision of this service was short and intermediate term goal planning that accompanied training and development of skills necessary to achieve these goals. This service involved guiding recovery and working with clients who were committed to making changes in their lives. The transition occupational therapist provided these clients with occupation focused guidance and support.

Assessment of home and other environments The environment greatly influences clients' functioning. Most clients benefit greatly from the supportive environment of hospital. The environment a client returns to in the community must support recovery and function. A home assessment may involve assessing the client's ability to take public transportation to and from home, the physical state of their environment (including accessibility if the client has mobility problems), and their ability to perform fundamental activities of daily living such as using the telephone, sorting through mail, paying bills, obtaining groceries and preparing a basic meal on the stovetop. The inclusion of this service contributed to, supported and ensured the inpatient treatment plan was carried through and was integral for preventing clients going home to unsafe and/or unhealthy environments.

Community transition and integration services Many clients are referred to and often placed on waiting lists for community services while they are in hospital. This service involved establishing a therapeutic relationship with clients in hospital and maintaining contact after discharge until a successful connection with longer-term community services could be established. Working with newly discharged patients can be daunting for community programs as new clients tend to have high needs and can overwhelm already full community caseloads. This service was able to prepare clients for what to expect and engaging in problem solving and to introduce them to the new services. Community services could be reassured that this transition OT service would stay involved until the client was less acute and more ready for community programs.

Adaptive equipment prescription and training This service involved providing and teaching clients with physical disabilities how to use adaptive equipment (wheelchairs, bathroom equipment, pressure relieving surfaces, etc). This was a critical service as clients with mental health challenges often experience marked difficulties that prevent them from obtaining and using the proper adaptive equipment.

Case management For some clients, after the occupational therapy intervention was completed, it was clear that additional ongoing support would be necessary. Clients may not have met criteria for other community case management services as their needs appeared to be too acute or complex. The support that occupational therapy case management offered allowed other community programs to accept clients with more confidence and thorough understanding of the client's needs.

Education for family and caregivers With a thorough assessment completed, this intervention focused primarily on supporting families and caregivers to understand the client's needs, to problem solve difficult behaviours, and to facilitate optimal function of the client. This service also assisted family and caregivers to facilitate the transition process rather than unknowingly work against it.

Table 2 – Frequency of the occupational therapy transition interventions

Intervention	N	%
Total	78	100
Cognitive functional assessment	23	29.5
Brief consultation	16	20.5
Goal planning/skill building	12	15.4
Home/community assessment	9	11.5
Community transition/integration	6	7.7
Adaptive equipment	4	5.1
Case management	4	5.1
Educate caregivers/family	2	2.6
Small group	2	2.6

DATA COLLECTION

To understand the impact of this demonstration project a number of strategies and various types of data were collected. These data included;

1. emergency room (ER) and hospitalization statistics (from hospital database) for the clients involved in this project prior to and following the onset of the occupational transition services (see Table 3 for the timeline and periods of this data)
2. intensity and type of occupational therapy transition services
3. satisfaction with occupational therapy transition services from clients and caregivers perspective as well as that of the interdisciplinary teams involved in the project

Table 3 – Timeline for Data Collection

Periods	Activity	Dates
1. 'before'	ER visits and hospital admissions prior to the occupational therapy transition services as outlined in this demonstration project	Jan 1, 2006 – date that transition OT services commenced with a client
2. 'Rx'	The duration of this demonstration project	Jan 1, 2008 – Dec 31, 2009
3. 'after'	ER visits and hospital admissions following client discharge from the occupational therapy transition services as outlined in this demonstration project	April 1, 2008 – March 31, 2010[1]

[1] The date overlap between periods 2 and 3 occurred for clients provided occupational therapy transition services early in the project that were discharged from services. The tracking of data for these clients related to ER visits and hospital admissions began immediately upon that discharge.

RESULTS

Emergency Room Visits and Hospital Admissions

A comparison of the number of ER visits and the hospital admissions prior to the OT intervention and post intervention is provided below in Table 4. This data was available from January 1st, 2006- March 31st, 2010 (Refer to Table 3 for the data collection timeline).

Table 4 illustrates the statistically significant drop in ER visits and hospital admissions following the occupational therapy transition intervention compared to before treatment. This decrease in ER visits and hospital admissions was evident for both men and women, across all age groups and, in particular, for those who were employed.

Table 4 - Average ER visits and hospital admissions before and after OT intervention

n= 78		ER visits			Hospital admissions			Average OT hrs	
		before	after	p-value	before	after	p-value		p
Average # per client		2.0	0.7	<0.01	1.5	0.9	0.04	12.6	
Gender									
	Males	2.3	0.5		1.5	0.8		12.3	
	Females	1.7	0.9		1.5	1.0		12.9	0.42
Age group									
	20-34	2.3	0.8		1.9	0.8		14.3	
	35-49	2.5	1.1		1.2	1.0		12.8	
	50-64	1.7	0.6		1.9	0.9		9.3	
	65+	1.4	0.2		0.8	0.9		13.9	0.96
Employment									
	workers	3.7	0.3		2.2	0.7		18.7	
	non workers	1.7	0.8		1.4	1.0		11.9	0.36
Housing	w/ family	1.7	0.9		1.3	0.7		12.9	
	Alone	1.9	0.3		1.5	1.0		16.6	
	Institution	2.7	0.6		1.8	0.9		10.7	0.52

*All variables do not distribute normally, therefore, non-parametric tests were applied.

Intensity of Occupational Therapy Transition Services

To further understand the impact of occupational therapy transition services clients were divided into categories based on the intensity of the services received. Table 5 outlines these categories. ER visits following occupational therapy transition services decreased for all levels of service. Hospital admissions decrease for the very complex clients involved at the service levels 4, 5 and 6.

Table 5 – Intensity of Occupational Therapy Transition Services

Service Level	# of hours of OT transition services	N (%)	ER visits		Hospital admissions		Average OT hrs
			before	after	before	after	
1	2.0 - 0	20 (26%)	2.8	0.6	1.1	0.7	1
2	3.9 - 2.1	13 (17%)	0.8	0.3	0.8	1.1	2.9
3	7.5 - 4.0	14 (18%)	1.5	0.7	0.8	0.9	5.8
4	19.9 - 8.0	15 (19%)	2.8	0.9	2.5	1.1	12.2
5	39.0 - 20.0	9 (11%)	1.5	0.9	2.7	0.9	27.4
6	95.0 - 40.0	7 (9%)	1.7	0.6	1.4	0.7	58.6

Of the 78 clients involved in this demonstration project 45 (57%) clients received more than 4 hours of occupational therapy transition services and their utilization of emergency room visits and hospital admissions was further analyzed (see Table 6). Overall, a significant reduction in both ER visits (from 2.8 to 2 per client) and hospital admissions (from 2.5 to 1.8 per client) for these moderate to high intensity recipients of occupational therapy transition services. This is a significant reduction in medical services required by this complex group of clients that lasted after the transition OT service ended. These clients received an average 20.5 hours of occupational therapy transition services.

Table 6 – Emergency room visits and hospital admissions before and after moderate to high levels of occupational therapy transition services (OT hours ≥4)

N=45		ER visits				Hospital admissions				Average OT hours
		total	before	after	p	total	before	after	p	
	Total	2.8	2.0	0.8	<0.001	2.5	1.8	0.9	0.03	20.5
Gender										
	Males	2.9				2.5				20.8
	Females	2.6				2.4				20.2
Age group										
	20-34	2.8				3.0				23.8
	35-49	4.0				2.5				18.7
	50-64	2.7				2.6				14.4
	65+	1.2				1.6				25.8
Employment status										
	employed	3.7				3.2				26.6
	Not employed	2.6				2.4				18.8
Housing status										
	w/ family	2.5				2.4				23.4
	Alone	2.0				2.2				23.1
	Institution	3.9				2.9				14.4

Satisfaction with Services

Surveys and self-addressed envelopes were mailed to clients and their caregivers who received more than 4 hours of service. Nine of these surveys were completed and returned. The survey had 2 questions.

The first question asked client and caregivers to indicate if occupational therapy transition services made a difference in their life. Responses to this question (possible range from 1 being completely dissatisfied to 7 being completely satisfied) from all respondents were either a 6 or 7 with an average score of 6.7 out of 7 indicating a very high level of satisfaction with occupational therapy transition services.

The second question asked clients and caregivers to rate their satisfaction with the help received from occupational therapy transition services. Again responses were either a 6 or 7 with the average response score being 6.9 out of 7, again suggesting a very high level of satisfaction among respondents.

Respondents also provided comments that reflected on the quality and professionalism of services, appreciation for someone to talk to, and filling a gap. One respondent stated,

> *"I wish I had met up with [the Transition OT] the last time I was hospitalized. The info provided may have prevented my last court appearance… it is very important to be able to talk confidentially to someone who can help put your life back on track after the embarrassing effects of mental illness. "*

Surveys were also distributed to professionals that had worked with the Transition Occupational Therapist. Five of these surveys were returned.

The first question asked the professional to rate occupational therapy transition services as to the benefits afforded to Mental Health and Addiction Services programs. The average response to this question was 6 out of 7 suggesting these services were beneficial.

The second question asked the professional to rate the impact of occupational therapy transition services for clients. The average score for this question was 6.4 out of 7. Themes emerged from the comments that centered on appreciating the continuity of care and access to a service not available previously.

> *"Access to inpatient OT with transitioning to the community has sped up the discharge for a number of my patients. The patients themselves have told me how helpful the transition OT was for a successful return to the community… I have no doubt that the position prevented a number of revolving door readmissions. The position provided for assessments I could not have otherwise obtained during a comprehensive work up."*

A case study has been provided in Appendix B that provides a narrative example of the work completed by the Transition Occupational Therapist with one client.

Unanticipated outcomes of this project

There were two unanticipated outcomes of this project related to service provision in Saskatoon and Saskatchewan as a whole. First this project was developed to add occupational therapy transition services to existing mental health care services i. With this fundamental addition, each profession on the inter-disciplinary team was enabled to focus more specifically on their unique expertise leading to an overall higher quality of care, collaborative approach and efficacy.

Second, the timing of this project aligned with program planning for the Irene and Leslie Dube Centre for Mental Health. The Transition Occupational Therapist was asked to co-chair the Model of Care Committee and was actively involved with the development of the Model of Care Guiding

Principles. There was a strong call to move away from the medical model, and as a result, additional therapies were added to the staff compliment.

Though at the end of this project there has not been a commitment from the Saskatoon Health Region to continue this Transition OT position, there has been a commitment to expand the interdisciplinary services in the Dube Centre for Mental Health to include 2 new occupational therapy positions.

CONCLUSION

This 2-year occupational therapy transition services demonstration project resulted in a number of significant outcomes. Data clearly indicated a significant reduction in both emergency room visits and hospital admissions for clients who received moderate to high intensity Transition Occupational Therapy services. Client and caregiver satisfaction data showed a marked satisfaction with services that resulted in benefits to their lives. Their feedback emphasized themes of professionalism, quality of service, continuity of care and the unique perspective of occupational therapy.

This project demonstrated that occupational therapy transition services has systematic benefits of reduced hospitalization and use of ER visits of as well as the compelling impact these services have on the everyday lives for persons with mental health challenges.

REFERENCES

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Appendix A

Occupational Therapy Service Access at Onset of Demonstration Project
Mental Health and Addiction Services – Saskatoon Health Region

Mental Health and Addiction Service	Program	Number of Clients	Program Description	Type of OT Service
Acute Care	Saskatoon City Hospital	18 bed inpatient	Acute care inpatient facility for adult and seniors	0.7 OT position provides group and individual assessment and intervention
		Bridges Program	Once/week outpatient support group	0.1 OT position (outpatient group facilitation)
	Royal University Hospital ***	38 bed inpatient	Acute care inpatient facility for adolescents, adults and seniors	0.75 OT position provides group and individual assessment and intervention
	Acute Mental Health Home Care	Region wide	Preventing mental health hospital admissions to all areas of the health region- 14 day mandate	None
Community Mental Health	Centralized Intake	Access point for mental health services	Initial screening and directing clients to appropriate services	none
	Mental Health Rehabilitation Services	~600 clients	Community based service for adults with persistent and enduring mental health problems	1.25 OT positions provide individual assessment and brief intervention, group services
	Adult Community Services		Community services to adults 18 years and over unable to cope with daily living and relationships	none

Community Mental Health (continued from previous)	Child Mental Health Services		Community service to children ages 0-11 years and their families	none
	Youth Mental Health Services		Community service for youth ages 12-18 and their families	none
	Youth Resource Centre		12-18 year olds school based program when unable to cope with regular school system	0.2 OT position for consultation
Addiction Services	Calder Center	32 adult beds 12 youth beds	4 week residential chemical dependency program	none
	Larson House	18 adult beds	Voluntary detoxification residential program	none
	Youth and Family		Adolescents ages 12-18 and their families affected by chemical dependency	none
	Specialized Services		Specialized adult services for problems such as dual diagnosis, gambling	none
	Community Services		Education and early intervention for addictions through group and individual therapy	none

*** Focus of OT demonstration project

APPENDIX B

Case Study

Mary was admitted to the hospital after the police brought her to the ER. She had been found wading in the river and was not able to describe why or how she got there. She was referred to transition occupational therapy services for a brief cognitive screen before being discharged from hospital. Mary's scores on standardized testing did not account for her reported memory loss, but her scores were in a borderline range for independent living. Mary's doctor concluded that these cognitive difficulties were likely related to a life-long developmental delay, and that Mary seemed to have "street smarts" that would, to a certain extent, compensate for her cognitive disability. She was discharged after a very brief admission.

Mary was re-admitted several days later. The police brought her to the ER again for bizarre behaviour and reported memory loss. This time a referral was initiated for transition occupational therapy services promptly for further assessment of independent living skills such as money management and meal planning. This second admission was much longer, and Mary became much more comfortable as an inpatient. Within a week, discussions about discharge caused Mary to feel anxiety and panic. She was referred to several community support services, but she either didn't fit the correct diagnostic category for their service, had previously refused their services, or she had 'burned bridges' with their programs in the past. It seemed that many programs knew Mary and her history, but none were prepared to take her as their client. She was discharged again, this time with community follow-up from transition occupational therapy services and the street outreach team.

Mary was very resourceful and was experienced at gaining resources from numerous charities and social services. She was selective with the information she provided and had tremendous street smarts that helped her cope with many stressors. She knew not to stay involved long enough for people to get to know her. She had learned that in order to get attention from crisis services, she needed to be in a crisis. She was frequenting the ER more and more reporting memory loss and blackouts. She focused on physical illness, and did not tell anyone about the stressors in her life. The Transition Occupational Therapist advocated for a non-crisis program to accept Mary as a client anticipating that with regular, routine follow-up and clear boundaries, Mary would learn that being proactive about her stressors would gain her more support than crisis would. The Transition Occupational Therapist also assisted Mary write and sign her own "do not admit for psychosocial problems" crisis plan which was put on file at the ER.

The truth was that Mary had been evicted, had no food in her apartment and owed social services thousands of dollars. Mary's solution to her financial problems was to make more money by getting a job at a fast-food restaurant. The Transition Occupational Therapist supported Mary to meet this goal, assessing her function all along. When she successful obtained a job, her life seemed to stabilize momentarily as she had less free time. Unfortunately Mary accepted most of the overtime shifts she was offered and her stress started to mount. Due to the trusted relationship that had developed and past successes working with the Transition Occupational Therapist, Mary invited the Transition Occupational Therapist to a meeting with her boss and learned about the number of hours Mary was actually working. The Transition Occupational Therapist advocated for a routine work schedule to be established without the option of picking up extra shifts.

It became clear that Mary did not understand how her employment income affected her social services financial support. She had been spending both her paycheque and her income from social services, and submitting her pay-stubs to social services after the fact. As a result, she was accumulating a significant overpayment, and social services was no longer paying her utilities and rent.

The Transition Occupational Therapist, having established a trusting therapeutic relationship with Mary and having completed standardized assessments of her capacity, was able to assist Mary to understand these financial circumstances. She confided that she had a financial trustee up until one year ago. She consented for the Transition Occupational Therapist to contact this trustee and it was clear that Mary's risky behaviour and constant crisis correlated closely with her financial independence. Mary, who had been extremely guarded and private, voluntarily agreed to re-connect with her trustee and arranged for her pay cheques to go directly to her trustee. With a trustee providing financial stability, a routine and regular job, and a non-crisis support system checking in regularly, Mary's need to access acute care and crisis services was extinguished.