# Preliminary outcomes from an individualised supported education programme delivered by a community mental health service

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Mental illness, psychosis, supported education, supported employment.

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This paper describes the implementation and preliminary results of a supported education programme designed to complement a youth-oriented supported employment programme.

*Method:* The programme was delivered by occupational therapists employed by a community mental health service in the Hunter New England region, New South Wales, Australia. Twenty mental health service users were assisted with their course of study over an 18-month period.

*Results:* Education outcomes were promising, with 70% of service users either continuing or completing their chosen course of formal study. The education support provided was modelled on the Individual Placement and Support approach to supported employment.

*Conclusion:* Occupational therapists working in public mental health can use this promising approach to supplement supported employment programmes, which should also be closely coordinated with the mental health service.

## Introduction

Occupational therapists working in the public mental health system are well positioned to promote evidence-based practices actively in order to improve employment outcomes for people with a mental illness (Lloyd et al 2004). Two forms of assistance are now recommended as evidence-based practice for helping young people to establish careers or to recommence a career path following the onset of severe mental illness. These forms of assistance are supported employment (Bond 2004, Bond et al 2008) and supported education (Unger 1990, Unger et al 1991, Bellamy and Mowbray 1998, Bond et al 2004, Best et al 2008, Neuchterlein et al 2008). However, these forms of assistance are not routinely incorporated into community mental health services (Murphy et al 2005, Rapp et al 2005).

Career development is often interrupted by the onset of severe mental illness, which typically presents at ages 10 to 30 years (Jablensky et al 1999, Waghorn et al 2007). Disruption to secondary and higher education, and school to work transitions, may flatten career trajectories to entry-level jobs or less skilled jobs, resulting in reduced status and income (Waghorn and Lloyd 2005, Waghorn et al 2007). However, among people with severe mental illness, those with bipolar affective disorder often have higher educational attainment than the minimum required by their current job (McPherson et al 1992, Tse and Walsh 2001).

Educational attainment is associated with improved employment outcomes for people with mental illness in both the United States and Australia (Mechanic et al 2002, Waghorn et al 2004). Waghorn and Lloyd (2005) reported employment status from a large Australian community survey. Employment outcomes for people with psychotic disorders increased from

11.6% among those not completing secondary school, to 22.1% among those who completed secondary school and to 34.3% among those with vocational qualifications, reaching 46.7% among university graduates.

Given the many benefits associated with educational attainment and employment for people with psychiatric disability, it is surprising that supported employment and supported education programmes are not yet routinely provided by public mental health services in all developed countries. Although supported employment is becoming more widely available (Bond 2004, Bond et al 2008), supported education is less frequently available (Unger 1990, Waghorn et al 2004) even though youth in particular benefit from the joint provision of both supported employment and supported education services (Murphy et al 2005, Porteous and Waghorn 2007, Killackey et al 2008).

Reports from experimental studies of the effectiveness of supported education are promising (for example, Collins et al 1998). Unger (1990) described three methods by which supported education is typically provided: the self-contained classroom model, the on-site support model and the mobile support model. The self-contained classroom model involves courses run separately for people with a disability, with additional support from either educational or mental health staff. The on-site support describes a model in which students attend mainstream classes and receive additional support from education facility staff. The mobile support model offers slight variation to the on-site support model, with individualised support to students provided by mental health staff either on or off campus.

Little is known about how supported education programmes can be used to complement supported employment programmes (Murphy et al 2005) and whether the joint programme enhances career development. There is also insufficient information to determine which support method is most effective (Waghorn et al 2004). A recent report (Best et al 2008) examined the self-contained classroom method in Australia. Although this study noted promising course completion rates, the self-contained classroom method limits choice of education pathways to those of the host institution.

The limited research into supported education programmes is in contrast to the extensive evidence on the efficacy of supported employment for people with severe mental illness. A recent review of 11 randomised controlled trials showed that supported employment achieved competitive employment commencements of 62%, compared with 25% among the best available local vocational services that were used as controls (Bond et al 2008). It has been suggested that supported employment, when supplemented with supported education, enhances long-term employment outcomes for people with severe mental illness (Murphy et al 2005). Nuechterlein et al (2008) suggested that the principles of the individual support and placement (IPS) model of supported employment can be applied to supported education, resulting in a flexible and individualised approach.

The aim of this report is to describe the implementation and initial outcomes from a supported education programme provided by a community mental health service as a routine part of ongoing mental health care.

## Method

The mental health service established a supported education programme that extended the principles of IPS to supported education. The supported education programme was also coordinated with a larger supported employment programme and applied the following principles:

(a) The primary goal was participation in mainstream education. Service users were assisted with accessing mainstream education courses that matched their study preferences and were congruent with a viable career goal, rather than attending courses reserved for people with disabilities such as in the self-contained classroom approach to supported education.
(b) The assistance provided was individualised and based on individual preferences. Consumers were offered individual assistance to access suitable courses matching their individual preferences at a variety of educational institutions, rather than being limited to choices available from a single institution.
(c) Assistance aimed to achieve rapid enrolment and commencement of formal study. Lengthy assessment and pre-education preparation was avoided. Service users' interest and motivation to study was the primary entry criterion. Service users were assisted to access their preferred course of study as soon as practicable. Psychosocial rehabilitation interventions were provided as required in support of individual education goals.
(d) Whenever possible, communication was established between the mental health service and any on-site student support services at the educational institution.
(e) Ongoing support for education as well as for employment goals was provided by mental health service staff.

Staffing consisted of two full-time-equivalent occupational therapists, who worked across both the supported education and supported employment programmes. Their role was to act as dedicated vocational specialists within the mental health service. In order to maintain a vocational focus, the occupational therapists did not perform case management or general care coordination duties. This support was maintained by the primary mental health team.

The occupational therapist's role in the supported education programme included the provision of clinical interventions in support of education goals. This often involved contacting the education institution's disability support unit on campus. Interventions included assessment of support needs in education, assistance with enrolment, career planning, relapse prevention, disclosure counselling, anxiety management, time management and study skills. In addition, the supported education service offered an ongoing peer support group for service users. This group

followed a solution-focused approach and provided a forum for students to discuss concerns and provide peer support to assist with the challenges of studying.

The role of the disability support unit on campus varied by institution and by campus. Service users attending the local technical and further education (TAFE) institution had access to one hour of individual tuition each week, provided by a faculty teacher. In addition, they had access to reasonable accommodations, such as extended examination times or extensions on assessment tasks, as negotiated with the institution.

Those attending the local university did not have access to individual tuition through the disability support unit, although they could attend a learning support centre on campus which provided individual and group tuition on essay writing and on library and computer skills. Service users enrolled with the disability support unit at the university also had access to accommodations, such as extended examination times and extensions on assessment tasks.

The occupational therapists in the supported education programme maintained contact with the disability support units on campus in relation to any changes in the mental health or support needs of service users. They also made recommendations regarding accommodations required throughout the programme.

### Participants

The programme targeted young people aged 16-30 years who had been diagnosed with psychotic or related disorders in the previous 5 years. To facilitate access to interested health service users, the occupational therapist staff were co-located with the early psychosis rehabilitation team. Referrals were accepted from 11 local mental health teams, including acute, rehabilitation, specialised rehabilitation and non-acute inpatient units. The inclusion criteria were as follows: (1) service users needed to be current clients of the Hunter New England Mental Health Service; (2) they expressed interest or motivation to participate in mainstream education; (3) they were currently in a non-acute phase of illness; and (4) they were living in relatively stable accommodation.

### Measures

Demographic information collected at baseline included age, gender, ethnicity, education and employment history, duration of illness, and drug and alcohol use. Diagnostic details were obtained from the treating medical officer. The self-reported course of illness scale (Waghorn et al 2003) was used to ascertain the course pattern of illness severity. The Brief Psychiatric Rating Scale (BPRS, Ventura et al 1993) was used to rate symptom severity at programme entry. Engagement in education was monitored throughout. Education outcomes recorded included subject and semester completions, grades attained and reasons for study termination when study ceased.

### Ethics approval

Advice was received from the Hunter New England Area Human Research Ethics Committee that publishing the results from this project did not require formal ethics approval, provided that the assessments, data collection, data management and analysis of results were carried out by supported education service staff and the client information was not exported to third parties.

## Results

The availability of both supported education and supported employment programmes seemed to benefit young clients of the mental health service. Of all suitable referrals to the employment programme a substantial proportion (20 of 51, 39%) requested education assistance. Of these, half sought only education assistance and half requested simultaneous assistance with both education and part-time employment. Participant characteristics are shown in Table 1.

Applying IPS principles to the delivery of the individualised supported education programme seemed to help clients to access both types of service according to their career progress and their changing priorities. From a staff perspective, consistent principles seemed to facilitate the delivery of client-centred assistance in both programmes.

**Table 1. Participant characteristics at baseline**

| Participant characteristic | Number (unless indicated otherwise) |
|---|---|
| Males | 12 |
| Females | 8 |
| Age, years (mean, SD) | 25.8 (3.74) |
| Diagnosis | |
| – Schizophrenia | 5 |
| – Psychosis | 7 |
| – Bipolar with psychotic features | 4 |
| – Depression | 1 |
| – Depression with psychotic features | 3 |
| Illness duration (mean years, SD) | 4.28 (2.56) |
| BPRS total score (mean, SD)[1] | 34.30 (5.92) |
| Education (secondary)[2] | |
| – Less than Year 10 | 1 |
| – Year 10 | 5 |
| – Year 12 | 14 |
| Education (tertiary)[2] | |
| – Certificate I or II | 5 |
| – Certificate III or IV | 0 |
| – Undergraduate diploma or equivalent | 1 |
| – Bachelor degree or higher including postgraduate diploma | 2 |
| Vocational goals | |
| – Vocational education | 12 |
| – University qualifications | 8 |
| – Education plus employment | 10 |

Notes: 1. BPRS (Brief Psychiatric Rating Scale) total score is the sum of 24 symptom constructs, each with a 7-point scale of severity from 1 = not present to 7 = extremely severe (Ventura et al 1993). 2. Education classification according to Australian Bureau of Statistics (2001).

From a client perspective, the common principles enabled clients to predict the nature of the services that they would receive in both programmes.

### Education outcomes

Twenty clients received assistance to enrol in tertiary education in the period from January 2007 to July 2008. The duration of supported education assistance averaged 8 months, with a range of 1-20 months. Twelve (60%) clients enrolled in courses at a local university, 6 (30%) in TAFE courses at various campuses throughout the area and 2 (10%) in courses at private education institutions. University courses included a wide range of bachelor's degrees. TAFE courses included vocational certificates in six different vocational areas. Several service users enrolled in tertiary preparation courses at TAFE or university.

By the end of the evaluation period, 14 students (70%) completed their course of study or were continuing with their studies. Of the six students who did not complete, the reasons were unable to manage work and study commitments concurrently (two students); experiencing an increase in symptoms or requiring a hospital admission (two students); difficulty in managing the workload (one student); or moving away (one student). Three students who ceased studying were enrolled in tertiary preparation courses at TAFE or at the university. Two other students did not complete vocational certificate level courses. Student feedback from a brief satisfaction survey consistently highlighted, first, the benefits of studying in mainstream education and, second, the direct benefits of the individual support provided by the programme. For instance, one student commented:

> Just because you have a mental illness doesn't mean you don't have the same aspirations as everyone else. You need to have these aspirations, and you need to have support around those aspirations to get you through the hard times.

Given that some courses require a minimum of 4 years full-time study, these 18 month results are considered preliminary. Furthermore, since this type of programme has not been previously reported in Australia to the authors' knowledge, there are no established benchmarks for results. In general population terms, the TAFE New South Wales module completion rate was reported to be 79.1% for 2007-2008 (NSW Department of Education and Training 2008). Similarly, there is little information available on university completion rates for people with severe mental illness. Mainstream estimates for Australian undergraduate completions range from 70% to 85% (Marks 2007).

## Discussion

Australia has an education-rich environment, where access to vocational education is widely available at relatively low cost and university course costs can be met through a national student loans scheme linked, through the taxation system, to automatic repayments from future earnings. Yet a rich environment is not sufficient. It was found that individuals with severe mental illness may need many different forms of individual support to get established. This depends on both their personal circumstances and the characteristics of the course and the education institution selected. It is believed that the individualised nature of the support combined with the option of attending a peer support group, where both continue to be available throughout the course, are key ingredients of success. This is supported by feedback from individuals. For instance one student commented:

> I found the group discussions really helpful … just sharing ideas and giving others advice about what helps with studying.

It is also felt that it is an advantage for the support providers to have no affiliation with any particular education institution. This ensures that clients are not guided into courses preferred by the support provider or a particular institution and enables clients to select courses from the widest range of options available.

The potentially promising outcomes suggest that the IPS principles make a suitable starting point for providing supported education to people with psychiatric disabilities. The optional student support group is an enhancing feature to these principles. This is consistent with the conclusions of Nuechterlein et al (2008), who found that for people with a recent-onset schizophrenia, IPS principles can be successfully extended to integrate supported education with supported employment. This approach also fits with the occupational therapy philosophy of client-centred care (Sumsion and Law 2006) and is consistent with a recovery-based approach to service delivery. For young people in particular, offering both supported employment and supported education may also increase engagement in mental health services (Porteous and Waghorn 2007).

Establishing communication between the mental health service and the educational institution enabled relevant clinical information to be used effectively with students' consent; that is, to maintain enrolment, negotiate reasonable accommodations and minimise disruption to the education programme. Close links between the present supported education and supported employment programmes encouraged service users to consider their longer-term career goals. Clients were asked to consider their medium-term to long-term career choices and whether their current skills and qualifications restricted their employment to entry-level positions.

Providing educational assistance alongside supported employment promises to counter two challenges to supported employment programmes, namely short job tenure and entry-level status (Bond et al 2001, Murphy et al 2005). The potential benefits of higher education and vocational education provide the rationale for leading supported employment programmes designed specifically for young people with severe mental illness in Australia and New Zealand (for example, Killackey et al 2008, Porteous and Waghorn 2009).

## Limitations of the study

These results represent a small sample in a non-controlled trial of relatively short duration. Hence, these results may not generalise to all community residents with severe mental illness in all developed countries. However, this limitation is typical of previous studies in this field owing to the many practical constraints on this type of research. Unlike supported employment (Bond 2004, Bond et al 2008), there is not yet a large evidence base of controlled trials from which the most effective ingredients of supported education can be determined. Furthermore, every country has different health, welfare, labour market and education systems, so it is unclear whether education performance benchmarks established in one country can be attained in another.

# Conclusions

These preliminary results show that individualised support for the education goals of people with severe mental illness is promising even in long duration courses of study. The principles derived from supported employment were a good starting point for this approach, particularly when both supported education and supported employment programmes are provided. Occupational therapists can take a leading role in the development and implementation of supported education and supported employment programmes as potentially valuable adjuncts to recovery-oriented mental health services.

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*Conflict of interest:* None.

**Key findings**

- Supported education and supported employment programmes when provided together, have the potential to enhance the career prospects of young people with severe mental illness.
- The principles of IPS supported employment were a good basis for designing a supported education programme.
- More research based on longitudinal and experimental designs is urgently needed.

**What the study has added**

This study shows how an individualised supported education programme can be successfully integrated with a supported employment programme delivered from within a community mental health service.

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