

Supported Education Toolkit

Tools and guidelines for organizations and professionals
working with students with psychiatric disabilities



Jacomijn Hofstra & Lies Korevaar (Eds.)

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Research and Innovation Center for Rehabilitation,
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Colophon

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Foreword

People with psychiatric disabilities frequently experience difficulties in pursuing higher education. For instance, the nature of their disability and its treatment, stigmatization and discrimination can be overwhelming obstacles. These difficulties can eventually lead to early school leaving and consequently to un- or underemployment. Unfortunately, support services for (future) students with psychiatric disabilities are often not available at colleges and universities or at mental health organizations.

For the social inclusion and (future) labor opportunities of people with psychiatric disabilities it is of the utmost importance that they have better access to higher education, and are able to complete such study successfully. Supported Education is a means to reach these goals. Supported Education is defined as the provision of individualized, practical support and instruction to assist people with psychiatric disabilities to achieve their educational goals (Anthony, Cohen, Farkas, & Gagne, 2002).

The main aim of the ImpulSE project (see Appendix 1 for information about the project's organization) was the development of a toolkit for Supported Education services for (future) students with psychiatric disabilities. The toolkit is based upon needs and resources assessments from the four participating countries, as well as good practices from these. Secondly, a European network of Supported Education (ENSEd) is initiated, starting with a first International Conference on Supported Education. The aim of ENSEd is to raise awareness in the EU about the educational needs of (future) students with psychiatric disabilities and for services that help to remove the barriers for this target group.

The toolkit is aimed at students' counselors, trainers, teachers and tutors, mental health managers and workers, and local authority officials involved in policymaking concerning people with psychiatric disabilities. It enables field workers to improve guidance and counseling to (future) students with psychiatric disabilities, supporting them in their educational careers.

In the Netherlands alone, it is estimated that six per cent of the total student population suffers from a psychiatric disability—that is, a total of 40,000 students. On a European scale, the number of students with a psychiatric disability is therefore considerably high. We hope that through the project these students will be better empowered to be successful in their educational careers and that their chances in the labor market and their participation in society at large will be improved.

Please visit www.supportededucation.eu to view the toolkit online and to become a member of ENSEd.

Groningen, January 2016

Jacomijn Hofstra, PhD, project coordinator

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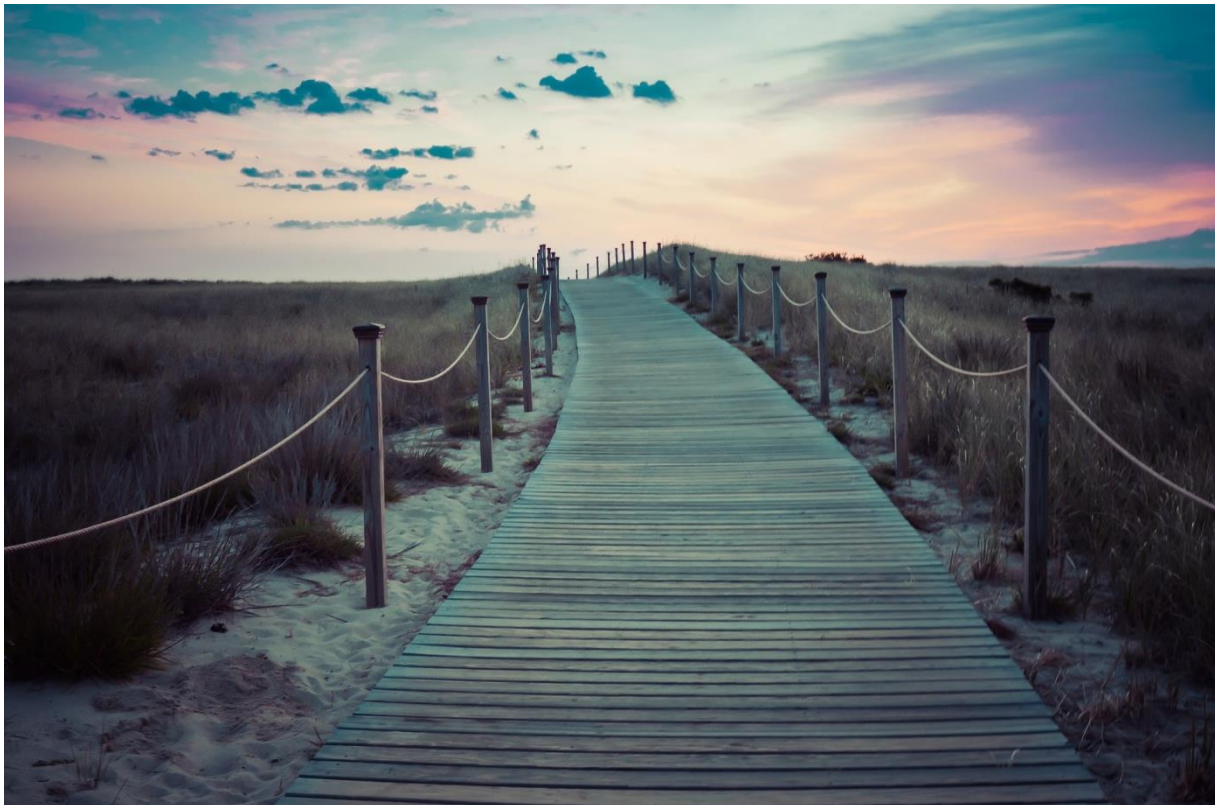
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Section 1

Introduction to the toolkit



1.1 Myths, Facts and Figures

In this paragraph we describe some existing myths about studying with a psychiatric disability followed by the related facts. Also we provide the available information (figures) about the prevalence of mental health problems among students in the four involved countries.

1.1.1 Myths and facts about students with psychiatric disabilities¹

MYTH 1: People with psychiatric disabilities can't meet the demands of college.

FACT 1: With support and reasonable accommodations, people with psychiatric disabilities who choose college can be successful in school.

MYTH 2: People with psychiatric disabilities are disruptive in an academic setting.

FACT 2: People with psychiatric disabilities are no more disruptive than other students.

MYTH 3: People with psychiatric disabilities aren't interested in pursuing higher education.

FACT 3: When offered the opportunity to experience college, many individuals with psychiatric disabilities respond positively.

MYTH 4: People with psychiatric disabilities can't take the stress of college.

FACT 4: Recovery helps people to adapt to a level of stress of their own choice: having meaningful choices can actually reduce stress.

MYTH 5: Equal opportunity means everyone should be treated the same.

FACT 5: Equal opportunity does not mean that everyone should be treated the same. Rather, it recognizes that people may experience disadvantage for a range of reasons and need support to enable them to achieve their potential.

MYTH 6: Students with disabilities are too time consuming and their needs are too difficult to cater for in a college/university environment.

FACT 6: Many students with disabilities are highly motivated to attend college/university and do well when provided with appropriate support. While a problem may seem daunting to staff, it is quite likely the student has faced something similar before and can readily identify either a solution or an alternative.

MYTH 7: Psychology, medical work, social work and nursing courses are not suitable for students with psychiatric disabilities.

FACT 7: Students with psychiatric disabilities have the same rights as other students to aim for careers consistent with their goals, interests and abilities. In some courses, reasonable adjustments can be made to ensure that students with psychiatric disabilities are able to meet the academic requirements. It is not the institution's responsibility/right to decide whether a student will reach employment, based on the course of study.

MYTH 8: Students with disabilities incur substantial costs through the provision of extra equipment and additional staff time.

FACT 8: It is impossible to generalize. Some students with psychiatric disabilities require special equipment or additional learning support from staff; others require none. Adaptations may be one-off and low cost.

¹ Revised from *Inclusive Practices for University Students with Disabilities: A Guide for Academic Staff* (Lawrence, Alsop, Flood, & Wibberley, 2000), University of New South Wales, and from *The Supported Education Program Manual* (2004), The Supported Education Community Action Group, University of Michigan School of Social Work.

MYTH 9: Students with disabilities would be better off studying through external or distance-learning courses.

FACT 9: There are advantages and disadvantages to external study. Many students with psychiatric disabilities prefer on-campus study so they can enjoy the stimulating social and intellectual interaction with other students and staff. Others prefer distance learning, or a mix of distance learning and on campus study. This is a personal choice, and people with psychiatric disabilities should be free to make that choice for themselves based on their own circumstances, personality and preferences. Flexible learning may suit some students with psychiatric disabilities, as it would any other student.

1.1.2 Figures

Our literature review shows that there is little information available about the prevalence of mental health problems among students in the four countries. We only found this information for Norway and the Netherlands. For Portugal and the Czech Republic, we have made estimations based on other data sources.

Portugal

According to the Base de Dados Portugal Contemporâneo, estimates are that in 2013, 371,000 students were enrolled in higher education. A study on psychotropic drug use among higher education students by Correia, Nunes, Barros, and Penas (2010) showed that 11.9 per cent of the 352 students that were part of the sample used some kind of psychotropic drug. If we standardize this percentage to the general student population, 12 per cent corresponds to 44,520 higher education students in Portugal that may be using psychotropic drugs, which represents a large proportion of the student population that experiences mental health problems.

The Czech Republic

The number of contacts with psychiatric emergency services involving children has increased by 60 per cent over the last 20 years in the Czech Republic; however, the number of children and young people receiving psychiatric treatment has not increased significantly over the past five years, perhaps because of the lack of psychiatrists specialized in the treatment of children and young people (Institute of Health Information and Statistics of the Czech Republic, 2013). It is estimated that 200 to 300 children drop out of secondary education in the Plzen region (0.5 million inhabitants), many of whom drop out because of mental health problems. The Ledovec SE helping net estimates that a similar number of students with mental health problems manage to continue their studies, sometimes after changing school or repeating a year. The drop-out rate for post-secondary education is much higher, but many students, especially university students, start a course with no intention of completing it (Ministry of Labour and Social Affairs of the Czech Republic, 2014).

Norway

In 2010, three major student welfare organizations catering for the three largest student populations in Norway, Oslo, Bergen and Trondheim respectively, cooperated in funding a large student survey called the Student Health and Satisfaction Survey (Nedregård & Olsen, 2010). In total, 23,000 of the 100,000 students participated in the study. Results were that students as a whole reported having higher levels of “mental health symptoms” than cohorts in the civic population as a whole. Fourteen per cent reported experiencing permeating mental health symptoms, of whom 22 per cent reported a causal link between emotional and mental health problems and the capacity to fulfill student workloads. Of the students reporting “serious mental health symptoms”, only one third sought psychiatric help for their problems during the school year. TNS Gallop, the organization conducting the survey, postulates an inferred estimate as high as 9 per cent of the student population in need of some sort of mental health support system yet to be provided. Taken together with the percentage of students with serious mental health symptoms actually seeking help, either within the student welfare organization or outside it, we have a total of around 12–13 per cent

of the student population experiencing serious mental health issues that lead to problems in workload progression.

The Netherlands

In the school year of 2012–2013 in the Netherlands, 662,800 students were studying at a university (421,500 at a university for applied sciences and 241,300 at a university) (DUO, 2013). Research has shown that about six per cent of students in higher education experience mental health problems (Broenink & Gorter, 2001). More than half (55 per cent) of this group of students is (severely) hindered by their psychiatric problems during college (Plemper, 2005). That would mean that in the Netherlands, almost 22,000 students experience problems with their study caused by their mental health problems. This number of students is at risk for early school leaving, which has far reaching consequences: the chance of isolation, problems with integration, crime, radicalization and unemployment is higher. Next to the consequences for the person himself, premature school leaving leads to a financial burden for society as a whole, in the form of social benefits (Cuelenaere, van Zutphen, van der Aa, Willemsen & Wilkens, 2009).

Conclusion

Remarkably, there is little information available about this topic, except for the Netherlands and Norway. In these countries, there seems to be a greater focus on students with psychiatric disabilities than in Portugal and in the Czech Republic. Overall, the percentage of students in higher education experiencing problems with their study due to mental health problems varies between six and thirteen per cent. In order to make sure that students with psychiatric problems in the future have a better chance of successfully finishing their study and of a paid job, extra research and support is needed. This way, the students will receive the support they need, college dropout will be reduced and their position in the labor market will be improved.

1.2 Supported Education

The onset of psychiatric disability generally occurs between the ages of 17 and 25—the years in which young adults follow higher education (including advanced vocational education), which is a major channel in our society to prepare for a career and enhance life goals. Yet for people with psychiatric disabilities, this resource is largely unavailable.

Although people with psychiatric disabilities often attempt higher education, they are frequently unable to complete their studies because of the nature of their illness and its treatment. They often meet with overwhelming obstacles, including stigmatization and discrimination. In an economy that requires (higher) education for upward occupational mobility, people who are unable to succeed in postsecondary/higher education or training may find themselves ultimately underemployed or unemployed (Cook, 2006; De Klerk, 2000; Rudnick & Gover, 2009).

For other disability groups, such as people with physical disabilities, learning disabilities or acquired brain injury, student services are available on most campuses, while people with psychiatric disabilities have not been included in these services; this is also because student services staff have limited knowledge about (students with) psychiatric disabilities.

Therefore, it is of the utmost importance for the social inclusion and future (labor) opportunities of (young) adults with psychiatric disabilities that they have better access to higher education, and are able to complete such a study successfully. The ImpulSE project will contribute to empowering these young adults to do so by developing and implementing Supported Education services (toolkit) in European countries. Supported Education (SEd) is defined as the provision of individualized, practical support and instruction to assist people with psychiatric disabilities to achieve their educational goals (Anthony et al., 2002).

1.2.1 Pillars

The pillars of Supported Education are formed by:

1. The Universal Declaration of Human Rights
2. Inclusive education
3. Recovery
4. Psychiatric rehabilitation

Ad 1. The Universal Declaration of Human Rights

The UN High Commissioner defines human rights as: 'rights inherent to all human beings, whatever our nationality, place of residence, sex, national or ethnic origin, color, religion, language, or any other status. We are all equally entitled to our human rights without discrimination. These rights are all interrelated, interdependent and indivisible (United Nations Office of the High Commissioner of Human Rights, 2015). All basic human rights presuppose a measure of freedom and autonomy for the individual in expressing— simply by existing and/or through acts of active promotion—his or her own values as long as these do not impinge on others' human rights.

SEd services are perfectly aligned with autonomy and freedom as outlined in the tenets of basic human rights, and they constitute the natural extension and expression of the intentions outlined in Article 26 of the Universal Declaration of Human Rights (United Nations General Assembly, 1948):

Everyone has the right to education [...] and higher education shall be equally accessible to all on the basis of merit. Education shall be directed to the full development of the human personality and to the strengthening of respect for human rights and fundamental freedoms. (p.7)

The focus of SEd is always on students' (higher) educational goals, and conceptually we find a similarity between SEd services for our target group and existing student counseling services available to the general student population. The differences emanate, of course, as a consequence of the needs of our target group, and a major distinction is that SEd services have a greater range of help to give and such help is also often available for longer periods.

Ad 2. Inclusive education

In 1993, UN directives on equal opportunities for people with disabilities stated that not only should equal rights on education for all children, youths and adults with disabilities be assured, but it should also be guaranteed that education occurs in educational settings and in regular schools. Therefore, inclusive education means that all students should learn together, regardless of each one's difficulties and differences. Universities must meet the diverse needs of their students, adapting to the various styles and rhythms of learning, in order to ensure more effective education for all.

An education that guarantees the principles of equity and quality while promoting educational projects based on inclusion should bring together all stakeholders (teachers, students, families and the community). Educational settings should develop access for all and a support system, internal or external, in order for the school to make a more effective response to the diversity of students. Universities must promote the participation of all students, valuing the knowledge and experiences acquired by all, as well as developing educational processes by school and community resource mobilization.

The principles and practices of inclusive education can help overcome more effectively the barriers opposed to the educational success of students for more effective educational progress (Bénard da Costa, Leitão, Morgado, & Vaz Pinto, 2006).

Assumptions of inclusive education

- Inclusion is an effort to make sure that diverse learners—those with disabilities, different languages and cultures, different homes and family lives, different interests and ways of learning—are exposed to teaching strategies that reach them as individual learners.
- Inclusive schools ask teachers to provide appropriate individualized support and services to all students without the stigmatization that comes with separation.
- Teachers in inclusive classrooms vary their styles to enhance learning for all students.

According to inclusive education, every student should receive proper education—i.e., have a suitable study place, including students who need extra support. Supported Education fits into the ideas of inclusive education, as the objective of Supported Education is to provide support services to students with psychiatric disabilities in order to support them with choosing, getting and keeping a regular education of their choice.

Ad 3. Recovery

Human rights based services, ones that secure a close adherence to the central tenets of autonomy and freedom, are most easily manifested by following each individual's own goals and methods towards obtaining those goals. This is in essence recovery.

Recovery: a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful and contributing life even with the limitations caused by illness.

Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness (Anthony, 1993).

Recovery is not the direct answer to an illness, to psychopathology; rather it represents an answer to the crippling or destruction caused by the illness. Because the goals of recovery are obtainable without eradicating the illness itself, its expression and process must nurture inclusion, cooperation and dignity. Movement away from a focus on the illness and from the perspective of the service provider means we need not seek compliance or even a common definition of underlying causality in working with service users. The focus is now on user goals and, following a holistic approach, we allow ourselves to get involved with personal recovery goals lying traditionally outside the domain of psychiatry.

We see Supported Education as a role recovery-oriented service and, to insure empowerment and ownership, we also help people with their educational plans when they are making mistakes. We motivate them to take risks, we help them up when they fall down or make inevitable mistakes: we build resilience instead of instilling fear of failure. As we will see later, the boundaries between the professional and the service user are lowered, enabling a level of normalcy between partners in a more reciprocal relationship. Ethical considerations are perhaps even more relevant here than in traditional therapist-patient discussions, however, because the leveling of the playing field makes for less than clear distinctions between provider and user.

Ad 4. Psychiatric rehabilitation

What is not researchable is whether or not rehabilitation services should be offered to people with psychiatric disabilities. Either we as a people value and believe in the opportunity for rehabilitation for people with psychiatric disabilities or we do not. That is a question of humanism and not empiricism (Anthony et al., 2002).

Psychiatric rehabilitation promotes recovery, full community integration, and improved quality of life for persons who have been diagnosed with any mental health condition that seriously impairs their ability to lead meaningful lives. Psychiatric rehabilitation services are collaborative, person directed, and individualized. These services are an essential element of the health care and human services spectrum, and should be evidence-based. They focus on helping individuals develop skills and access resources needed to increase their capacity to be successful and satisfied in the living, working, learning, and social environments of their choice (United States Psychiatric Rehabilitation Association, 2007).

Supported Education is that part of psychiatric rehabilitation with a focus on the life area of learning, and is defined as the provision of individualized, practical support and instruction to assist people with psychiatric disabilities to achieve their educational goals (Anthony et al., 2002). The mission of Supported Education is to help (young) people with psychiatric disabilities to choose, get and keep regular education of their own preference.

1.2.2 Specific information for mental health practitioners

1. Academic failure is often seen as a major sign of psychiatric illness. In psychiatry, academic failure is sometimes the only 'visible' sign of an ongoing and persistent psychiatric condition in contrast to other non-psychiatric medical conditions. Therefore we presume that academic failure has an important role in diagnostic assessment in psychiatry.
2. Supported Education and the concept of recovery probably have a therapeutic potential. Academic improvement is again a 'visible' sign of an improvement in young psychiatric patients.
3. A modern knowledge-based society has a large proportion of teenagers and young adults in secondary and postsecondary education. In fact, the majority of people in the second and third decades of their life attend some regular education. That is the reason why we believe that Supported Education is very useful for many people in our society.

1.2.3 Supported Education research

Many of our efforts revolve around gathering and analyzing existing practice from the four partner countries. At the moment, SEd is a promising practice (SAMHSA, 2011). A promising practice is an action, program, or process that leads to an effective and productive result in a situation (Fels Institute of Government, 2009). At the most basic level, a promising practice must have measurable results that demonstrate success over time. Stronger promising practices are reviewed by experts or academics, are successfully replicated, and provide reliable cost information. If SEd is to become an evidence-based practice (EBP), more effectiveness research on SEd models is critically needed (Rogers, Kash-MacDonald, Bruker, & Maru, 2010).

1.2.4 Mission and principles

The mission of Supported Education is to help (young) people with psychiatric disabilities to choose, get and keep regular education of their own preference.

Supported Education is based on the following principles:

- Improvement of the educational outcome for persons with psychiatric disabilities.
- Hope—an essential ingredient of the Supported Education process.
- Self-determination: a focus on students making choices (setting their own educational goals) and accepting responsibility for their educational process.
- Students are actively involved in all phases of their Supported Education process, determining the criteria for success and satisfaction, as well as in evaluating progress toward meeting their goals.
- Partnership between participant and Supported Education professional.
- Services match participant's preferences.
- Equal/fair access for everybody.
- Development of participant skills and of environmental support.
- Bridging with mental health services.
- Support as long as needed.

1.2.5 Target group

The SEd target group consists of (young) people with psychiatric disabilities, who experience difficulties with returning to and/or remaining at school due to their disabilities and to environmental obstacles. The approach is also applicable to people with cognitive impairments, mild intellectual disabilities and physical disabilities. It could be necessary to make (mild) adjustments to the Supported Education services.

Psychiatric disabilities and related educational limitations

The term psychiatric disability is used to describe a psychological and emotional state of mind that influences one's thoughts, emotions and behavior in such a way that one cannot optimally function in daily life. The most common psychiatric conditions are the following:

- Anxiety and panic disorders (e.g., phobias, obsessive-compulsive disorders and post-traumatic stress disorders).
- Mood disorders (e.g., depression and bipolar disorder).
- Personality disorders (e.g., borderline personality disorder; anti-social personality disorder).
- Psychotic disorders (e.g., schizophrenia).
- Addiction (e.g., alcohol and drugs).
- Eating disorders (e.g., anorexia nervosa and bulimia).
- Autism spectrum disorder (e.g., Asperger's syndrome and PDD-NOS).
- ADHD.

About six per cent of students in higher education experience psychiatric problems (Broenink & Gorter, 2001). More than half (55 per cent) of this group of students is (severely) hindered by their psychiatric problems during college (Plemper, 2005). This hindrance negatively influences the study results. Research has shown that students with psychiatric problems on average study more but get lower grades and fewer credits than students without psychiatric problems (van den Broek, Muskens, & Winkels, 2013). Besides, this group appears to have an increased risk of early school leaving. Many problems are experienced with cognitive functioning (Kidd, Kaur-Bajwa, & Haji-Khamneh, 2012; Megivern, Pellegrito, & Mowbray, 2003; Pratt, Gill, Barrett, & Roberts, 2007), as for instance problems with:

- Attention
- Concentration
- Memory
- Planning
- Motivation
- Organization

Several studies have shown that many people with psychiatric conditions want to study but also want and need support with that (Gilbert, Heximer, & Walker, 1997; McLean & Andrews, 1999; Unger, 1998; Wertheimer, 1997). In order to know what kind of Supported Education services are needed the most and thus have to be included in the toolkit, we wanted to identify the specific barriers that people with psychiatric disabilities face whilst studying (again). These barriers are discussed in the next paragraph.

1.2.6 Barriers to choosing, getting and keeping a study

The four ImpulSE project partners used the same research methods and procedures so the outcomes could be compared. We have conducted a literature review (both peer reviewed and gray publications), and have analyzed 30 questionnaires that were sent to experts in SEd and/or mental healthcare. In addition, we have organized focus group interviews with 27 people with mental health problems who want to go (back) to school. (For more details about the method and procedures, see Appendix 2).

Interestingly, in all four countries the answers to our questions about the barriers could roughly be divided into three categories: personal barriers, barriers in the educational environment, and barriers in the social environment. We have used these categories to organize our results. In Table 1.1 below, the most frequently mentioned barriers (in at least two countries) are summarized.²

Barriers related to personal factors

In all four countries experts and (aspirant) students themselves frequently mentioned lack of self-esteem and fear of being stigmatized as barriers in choosing a study and also in choosing to go back to school in general. Regarding lack of self-esteem, one participant (NL) stated that her fear of failure hinders her in actually making a choice: “Am I able to do this?” Also, many experts mentioned that people with psychiatric disabilities are often convinced of the fact that ‘they just cannot do it’. Previous negative experiences with going to school hinder people with psychiatric problems in their choice to go back to school. For some participants, these negative experiences originate from their time at elementary school. One participant said:

At elementary school, the focus is on the future. But you don’t think about the future, you are trying to survive physically and mentally. At school, there is no attention or room for that. When you’re trying to survive, the future is not important at all. So, school is future oriented and if you put your achievements next to that, then you totally fail. The aversion I felt for school only disappeared after 21 years. So, now I am ready to think about going to school again.

Self-stigma (that is, one starts to believe the negative stereotypes that exist about people with psychiatric disabilities and act upon them) was also seen as a barrier in choosing to go back to school: for instance, they believe that they are not intelligent and withdraw themselves from the school system. The (aspirant) students mentioned difficulties with

² In Appendices 3-5, you will find tables with all the barriers that were identified by the experts, focus groups and through the literature review in the four countries.

choosing a study as another hindrance. There are too many studies that they like, or they do not know what they want. Finally, lack of financial means is another barrier to choosing to back to school.

Table 1.1 Most frequently mentioned barriers in the four countries to choosing, getting and keeping a regular (vocational) education.

	Personal barriers	Barriers in educational environment	Barriers in social environment
Choose	<p>Earlier negative experiences with going to school</p> <p>Lack of self-esteem</p> <p>Fear of being stigmatized</p> <p>Self-stigma</p> <p>Difficulties with choosing</p> <p>Lack of financial means</p>	<p>Lack of support/clear information at the school</p> <p>No match between educational offer and student's needs</p> <p>Lack of information about support services</p> <p>Unfamiliarity with support services among staff</p> <p>Unclear and vague information about support services</p>	<p>Lack of financial, emotional and practical support from family</p> <p>Lack of emotional and practical support from mental health professionals</p> <p>Stigmatization by mental health professionals</p> <p>Lack of cooperation among educational, medical and social services</p>
Get	<p>Presence of (residual) symptoms and side effects of medication</p> <p>Fear of failure</p>	<p>Difficulties with application procedure</p> <p>Several institutions involved and no communication between them</p>	<p>Fear of being stigmatized</p> <p>Lack of knowledge about rights of people with psychiatric disabilities</p>
Keep	<p>Direct consequences of psychiatric disability</p> <p>Difficulties with executive functioning skills</p> <p>Lack of self-esteem</p> <p>Dilemma of disclosure</p> <p>Feeling of stigmatization</p>	<p>Lack of support</p> <p>Inflexible structure of the school system</p> <p>Lack of understanding, expertise and empathy of staff</p>	<p>Little or no support from family/ fellow students/ mental health professionals</p> <p>Stigmatization/ discrimination by fellow-students and teachers</p>

Regarding getting a study, there was only one barrier that came up in at least two of the four countries: the presence of (residual) symptoms and side effects of medication. As one Portuguese student stated: "...when I started to take medications I had my admission exam and I didn't do it so well. I wasn't able to follow the college of my first choice." A barrier that was mentioned by students in the Netherlands was fear of failure. According to some participants, it is of course possible to get all the information needed, it is not that difficult, but it touches a kind of vulnerability. As one participant puts it, "It's not difficult, that is the stupid thing. It's not difficult, but when you fail, another piece of your self-esteem is gone: it wasn't difficult, yet I failed." This fear of failure reduces the chance that people with psychiatric disabilities apply for a study.

The most frequently mentioned personal factor that hinders the participants in keeping their study, is the direct consequences of the psychiatric disability, such as problems with

concentration ("I can read the same page more than 85 times, yet I don't actually read it, very frustrating"); fatigue ("Travelling from where I live to school and back is extremely tiring. So, a full time study will exhaust me. The longer I have to travel by bus, the less energy I've got"); psychoses; apathy and (re)-hospitalization. Also side effects of medication are seen as a barrier: some students said that when they had an increase in medication, their academic results got worse: "medication made me slower, and I had difficulty in reading; when finally I reduced the medication, I got better results." This barrier was named in all countries. A related barrier that was also frequently mentioned was difficulty with executive functioning skills. They lack competencies such as planning or structuring, or they do not structure in the right way. An example: "People with a disability do know that structure is important. Many people know how to do it. I also have a structure for myself, a very clear structure. I just do not adapt my structure and planning to the situation. So many people know how to deal with structure, yet they do not do it in the right way." Lack of self-esteem is also indicated as a barrier in maintaining a study: "I thought I wouldn't make it."

Another difficulty faced by students is the dilemma of whether to disclose or hide their mental health problems at school. If they decide to disclose, there is a risk of being stigmatized; yet if they decide to hide their problems, there is a risk of not getting the support needed. The feeling of being stigmatized also makes it more difficult to keep on studying. Students do not seek professional help because of this feeling of stigmatization and try to solve their problems on their own. Oftentimes, this doesn't work and worsens the situation. Finally, lack of financial means was mentioned again: "Now that I am older than 21, I am facing extra barriers. I do not get financial support from the government anymore. That is a barrier"; and, "Well, you do have to fill the refrigerator."

Barriers related to the educational environment

Lack of support at school during the 'choose' phase was mentioned in all four countries by experts, participants of the focus groups and in the literature. There is little or no extra support for people with psychiatric disabilities in this phase; also, the information that is given about the different studies is often unclear. Most of the time, the information is given during an open door day; personal contact with staff members is often not possible. A second important factor that was frequently mentioned, is the fact that the educational offer doesn't match the student's needs. For instance, there are few studies that can be done part time or in one year. In the Netherlands, all participants of the focus group stated that lack of (or too little) information about available support services at school is a major barrier in choosing a study. Participants cannot find the information: "There is a lot of bureaucracy, they send you from pillar to post"; staff members are unfamiliar with existing support services at their school:

I asked the receptionist of a certain faculty the name of the staff member to whom students with psychiatric disabilities can go to with their questions. The answer was that such a person does not exist and I received a brochure about the general support service of the university. But each faculty is more or less obliged to have such a specialized staff member! Then I think, 'Okay, so I cannot take this service seriously because no one knows about it.

Furthermore, the information that is available is oftentimes unclear and vague. All participants agree that clear information about available support services is crucially important to make the right choice, as their choice depends on the expected chance of keeping the study. That chance of keeping the study largely depends on the available support at school. Another remarkable finding was that in Portugal alone the most stated educational factor that hindered people in making a choice was the high cost of tuition: "...if I didn't have financial aid, I wouldn't choose to go to college."

In terms of the question, 'what hindered you in getting a study?', the barrier that was mentioned in all four countries was the difficulty that the aspirant students experience with the application procedure. Examples that were given of these difficulties are no support with filling out difficult application forms and making the payment (Portugal); difficulties with getting accepted at a school because schools nowadays use strict selection procedures and more easily reject prospective students (NL); and problems with the form of assessment, as there was only one opportunity to sit the admission exam and there was no adaptation of the examination procedure (Czech Republic). In the Netherlands, the participants of the focus group mentioned that it hindered them that they had to go to several institutions to get the information they needed for applying for a school—"The course that I wanted to take was already over by the time we had all the information we needed"—and that these institutions (e.g., schools and governmental institutions) do not communicate and oftentimes contradict one another—"These institutions, yeah, they do not communicate for a bit."

The most frequently mentioned barrier related to the educational environment in keeping the study is lack of support. Often because of a lack of means or expertise of the staff members there is too little time and support for people with psychiatric disabilities, whilst this is often the most crucial factor in successfully carrying on with a study and finishing it. The experts in the Czech Republic cited the lack of coordination and cooperation between, for instance, the educational consultant, tutor, school psychologist and the student as the main problem. The inflexible structure of the school system is another factor that was mentioned in all four countries as hindering students in completing their education. For instance, in the Netherlands nowadays, the education is focused on competencies. This kind of education has a less clear framework (i.e., students have to prove by building up a portfolio that they possess a certain competence), which can lead to problems for disabled students. Also, the difficulties with getting tailor-made exams are seen as a barrier. Examples of this inflexible structure of the school system were: "closed and streamlined system, unwelcoming of students with psychiatric disabilities"; a "rigid structure in faculties that doesn't allow for alternative forms of student assessment" (here referring to lack of alternatives to oral exams, presentations, and fieldtrips); "existing student services don't feel a responsibility for this group"; and "schools don't allow a reduced study progression to match the student's capacity." A final frequently mentioned barrier to keeping the study is the lack of understanding, expertise and empathy of staff. A student from the Czech Republic said: "When I wanted to explain my problems, nobody listened." Another example in this regard comes from a Dutch prospective student: "There was no involvement at all at my former school. Not even from my tutor. I'd already quit school for three months when my tutor found out.... There was no social awareness at all."

Participants also mentioned that sometimes staff members think that they know how to deal with persons with a certain disability because they've met a person with that kind of disability before. They then tend to ignore all distinctions between people with the same disability and behave in the same way towards them. This can lead to a misfit. One of the participants experienced this and had to quit his study. Some experts that were interviewed in the Netherlands stated that the lack of understanding, expertise and empathy of staff members is sometimes caused by the fact that these students with a psychiatric background do not disclose their problems, and therefore the staff members do not know about these problems.

Barriers related to the social environment

The lack of social support on a financial, practical and emotional level from family and mental health professionals is seen as the major barrier in the social environment of the prospective student in choosing a study. As a Dutch participant of the focus group puts it: "The belief of the people around you is important. The social network influences making a choice. Am I able to do this? Am I ready for it? Where am I in the process?" The social environment can influence the self-esteem of the prospective student in a positive or negative way, and self-esteem is needed to eventually choose a study. It was also mentioned (in more countries)

that parents sometimes discourage the prospective student because they under- or overestimate their child. The mental health practitioner is sometimes too much focused on medical treatment, and not so much on the participation of their client. A rather shocking factor that was mentioned in Norway and the Netherlands is the stigmatization by mental health professionals that is experienced by the prospective students as a barrier in actually choosing a study. Some of these students responded that their psychologist or psychiatrist actively warned against studies ('wait until you are well enough to start studying')—"They didn't realize that it was studying that made me well." In the Czech Republic, the lack of cooperation among different services was mentioned by the experts as an important barrier. Educational, medical and social services do not work together to manage individual cases; there is no networking.

Remarkably, not many factors in the social environment were mentioned as barriers to getting a study. In Portugal, prospective students mentioned the fear of being stigmatized/labelled as a hindrance in this phase. Experts from Norway cited lack of knowledge about the rights of people with psychiatric disabilities. This lack of knowledge (of staff members at schools or at social services/ student loan departments) can often result in the retraction of rights, either in the form of financial support or with respect to the length of support offered: "They showed no understanding that my illness made it difficult to make full progress."

Two factors seem to be major hindrances for students in keeping their study: little or no support from the family, co-students, and/or mental health professionals, and a related factor of stigmatization/discrimination by co-students and/or teachers. It was mentioned that family members often do not know much about (the content of) the study and sometimes underestimate or even discourage the student. Furthermore, sometimes mental health professionals do not provide support with, for instance, arranging adjustments and making agreements with the school. Regarding stigmatization and discrimination, one participant of the focus group in the Netherlands indicated that he has been terrorized because of his disability by his fellow students, which eventually led to a psychosis. Another participant said: "I felt alone. Shut out. I did not feel I was part of them."

Conclusion

When we take a look at the barriers mentioned in the four countries, we can conclude that there are more similarities than differences. Notably, in Portugal the financial situation is more often mentioned as a hindrance in going (back) to school than in the other countries. In fact, in Norway this factor has not been mentioned at all. Nowadays, in Portugal, financial difficulties are a main problem and hindrance for many families that have to set priorities, and in numerous cases paying for college tuition becomes less important compared to more basic needs. Another noticeable difference is that in the Netherlands, lack of information about support services was mentioned more often than in the other countries. It seems that there are several support services available, but they are not available and visible enough for students with psychiatric disabilities.

Important barriers that were mentioned frequently across countries and across the phases of choosing, getting and keeping a study are fear of failure of the (prospective) student; stigmatization by staff members, mental health professionals and co-students; problems caused by the mental illness itself and medication; and lack of support (social, practical, financial) from family, co-students, staff members and mental health professionals. This brings us to the question of what helps (prospective) students with psychiatric disabilities choose, get and keep a study. The answers to this question will be discussed in part 1.2.7 of the toolkit.

1.2.7 Facilitators in choosing, getting and keeping a study

In order to find out what is helpful for (prospective) students, we asked the 27 participants (young adults with psychiatric disabilities) of the focus groups in the four countries what helps, helped or would help them with choosing, getting and keeping a study. Below, we will discuss the most frequently mentioned facilitators (see Table 1.2) and some remarkable findings. Appendix 6 presents all the results.

Table 1.2: Most frequently mentioned facilitators in the four countries in choosing, getting and keeping regular (vocational) education.

Choose	<ul style="list-style-type: none"> • Clear information about available support services at school • A decision making course • Support from social environment
Get	<ul style="list-style-type: none"> • Support from mental health professional with the application procedure and with finding special arrangements • Information about what to do, where to find information and where to go with questions
Keep	<ul style="list-style-type: none"> • Frequent personal contact about study related issues with professional • Flexible school system • Peer support group • Support with disclosing ones psychiatric background

In the choose phase, clear information about available support services (on a website or through personal contact with a staff member) is helpful. Also, a decision making course and support from family, friends and mental health professionals would facilitate in making a choice.

Regarding getting a study, the students frequently mentioned that it would be helpful if their mental health professional could support them with the application and with finding special arrangements that are available to them. In this phase, it seems really helpful that the (prospective) student knows what to do, where to find information and where to go with questions.

Most facilitating factors were mentioned for the 'keep' phase. Frequent personal contact about study related issues with a staff member/professional with expertise was mentioned a lot by the participants—"the practitioner's support in organizing a study plan, doing homework, having a good place to study and guidance to goals." Preferably, this professional coordinates/cooperates with all stakeholders (for instance, mental health professionals, educational organizations, welfare functionaries). Also, a more flexible educational system would be helpful—for instance, optional attendance in class and possible adaptations during exams (oral instead of written exam, more time, other location, etc.). A peer support group was also mentioned. In such a group, one has the opportunity to speak freely about the challenges one faces with people who have the same experience. As one student from Norway stated, "The only place where I talk about my illness and how it affects my daily life is in this group. None of my fellow students at university knows about my illness."

Another facilitator that was mentioned is a course in study skills, such as planning, structuring, and time management. In this phase, support from family and friends is also important to be able to finish the study. Finally, it was mentioned that support with disclosing one's psychiatric background would also be helpful. Disclosure can be important, as it might eventually lead to more support from staff members, fellow students and friends. Participants would find it helpful to receive support with the decision to disclose and with how, what and to whom to disclose.

1.2.8 General Conclusion

In parts 1.2.6 and 1.2.7, barriers and facilitators of going (back) to school have been discussed. The findings of our research in the four partner countries give us input for the contents of the toolkit. With the barriers and facilitators in mind, we decided to put the following topics into the toolkit for professionals.

- A decision making course, to help prospective students with choosing and getting a study.
- Skills and resources: which skills and resources are important in an educational setting and how to assess and improve the skills and resources of students with psychiatric disabilities?
- Disclosure: an intervention to help students with the decision to disclose or not, and also with how and what to disclose.
- Peer support group: information about what peer support is, what the benefits are and how to organize it.
- Advice, consultation and coordination: support for educational staff. Information about where staff members can go to with questions related to studying with mental illness; how they can set up a network of professionals who are working with a specific student, etc.

Section 2

Choose-Get-Keep interventions



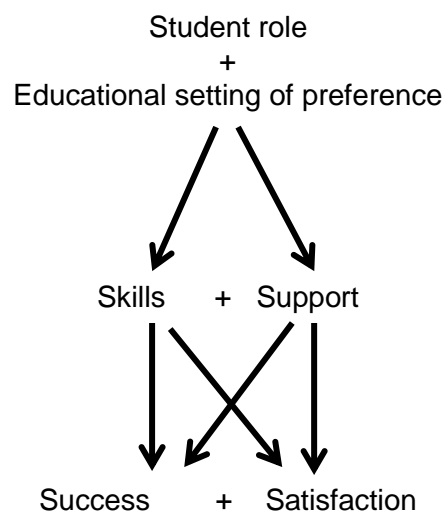
2.1 Introduction

Supported Education is an individualized instruction and support program which assists (young) people with psychiatric disabilities to obtain educational goals. The goal of these services is to help participants choose, get and keep enrollment in an educational or vocational training program of their choice. Supported Education is not therapy or mental health counseling.

The goal of choosing is to select an educational or training program compatible with the participant's values, skills and learning needs. The goal of getting is to secure admission to a preferred educational and vocational training program. The goal of keeping is to remain at school and increase student success and satisfaction through development of participant skills and support.

Supported Education is the process of assisting students/clients to acquire and to use, the internal and external skills, supports, and resources necessary to be successful and satisfied in the educational environment of their choice (see Figure 2.1). At its most basic level, Supported Education seeks to help students/clients to determine and prioritize their educational goal, to identify paths for achieving this goal, and to develop the needed skills and supports to achieve this goal (Anthony, Cohen, Farkas & Gagne, 2002).

Figure 2.1: The Supported Education Process



2.2 Supporting and Communication Skills

Any helping relationship presupposes a minimum of agreement between participants. A Supported Education role recovery-oriented process has as its central organizing theme a focus on the student's/client's own goals and aspirations. We have stated that unless the student/client has very specific needs, ones not essentially dependent on prolonged interpersonal contact, then the relationship itself functions as the vehicle for furthering empowerment—autonomy, freedom and self-authorization of own experience. Of course, we need not complicate matters and/or elevate ourselves to omnipotent partners in all cases, since many students/clients do perfectly well with temporally delimited services and specific and pragmatic interventions void of intimate personal needs. Nonetheless, an overwhelming percentage of students/clients articulate the importance of that accepting, non-judgmental important other as they embark upon the recovery process. Recovery processes on the

whole necessitate time. At a minimum, then, a helping relationship must allocate enough time—as judged by the student/client—to allow for new growth and the necessary accommodation to new and desired functional levels. In this paragraph we describe the supporting and communication skills that can help the professional to build a helping relationship with the student/client.

2.2.1 Aspects of helping relationships

If user and provider can agree on the most basic of consensual foundations, we can look more closely at what defines a good helping relationship. The concept of a working alliance is often central when identifying helpful relationships. Rogers (1951) outlined a half century ago factors that today stand as prerequisites for helping relationships. The following are deemed as minimum in our approach.

- Students/clients are free to determine their own agenda for their (educational) life and support and to describe their own subjective experience in their own way.
- They are in a relationship with someone who has faith in them, who listens empathetically and accurately for the deeper meanings of what they are communicating, and who deals with them honestly without roles or manipulation.
- The relationship is as egalitarian as possible without a "power-over" authoritarian posture.

A number of authors (e.g. Egan, 1975; Culley & Bond, 2004; Ross, 2003) choose to frame helping relationships as involving specific stages. For our purposes, it is enough to cite a bare minimum of general stages thought to derive from clients' perspectives (Egan, 2002):

- (1) What is going on? Helping students/clients to clarify and identify key issues calling for change.
- (2) Which solutions make sense for me? Helping students/clients see various possible outcomes from which to choose.
- (3) What do I have to do to get what I want? Helping students/clients develop strategies for accomplishing goals.

Although proponents of stage models often posit a linear progression moving from attending, exploration, understanding, and action, and culminating in termination, without underlining the ebb and flow of truly reciprocal helping relationships, we posit that recovery relationships are fluid, moving freely back and forth between presupposed stages. Keeping a focus on the three client-centered perspectives ensures fidelity to the student/client experience.

2.2.2 Interpersonal communication and fostering helping relationships

The field of interpersonal communication and interpersonal skills has wide-ranging applications. For our purposes, we need only emphasize those aspects pertaining to recovery-oriented helping relationships. Recovery-oriented helping relationships rest on "choosing, getting and keeping" reciprocally negotiated successful communication. We understand relationships in this context to be constituted by two equally valued participants, while accepting an asymmetry wherein focus is on the student's/client's goals. Staying close (by showing respect and understanding) to the student's/client's experience, thoughts and feelings, even and perhaps especially when they deviate from one's own, necessitates a decentering of one's own perspective, one that furthers respect and a sense of security in the face of inevitable tension.

Acknowledging that most students/clients have the capacity to help themselves is of equal importance to the practitioner's willingness to help. SEd counselors presumably enter into helping relationships with a genuine wish to assist the student in unlocking latent capacities. Wanting to help is a minimum, though we know that some people are naturally better helpers than others.

We should note that a recovery-oriented service should be able to offer at least one alternative helper if interpersonal communication breaks down beyond repair. We know that some people just can't seem to work together. It is also advisable to have both genders in staff so that users can choose accordingly. Furthermore, SEd services must regularly allow for internal evaluation and mutually reinforcing supervision for its staff, possibly from outside expertise when necessary. A safe and trusted arena for assessing both successful and unsuccessful experiences is an absolute minimum.

We cannot do justice to the topics of interpersonal communication and interpersonal skill in this toolkit. We can, however, recommend as a thorough reference text *Interpersonal Communication: Relating to Others* (Beebe, Beebe, & Redmond, 2010). The book breaks down communication into logical components and argues that skills can be learned and enhanced. What we want to point out here is that the maintenance of the helping relationship requires continual reevaluation of the working alliance with the student's/client's goals and aspirations as the guiding light. Any SEd service should, from its initiation, plan to allocate both time and expertise to the dilemmas and intricacies inherent in communication wherein individuals must relate to one another over time and with a wide platform of reciprocal determination.

Supporting and communication skills

The most critical communication and supporting skills in the Supported Education process are detailed in Figure 2.2 below.

Figure 2.2: Critical communication and supporting skills in the SEd process

Supported Education Task	Relevant Practitioner Competencies
Connecting	Orienting Demonstrating understanding Self-disclosing Inspiring hope Requesting information
Personal Support	Encouraging Advocating Inspiring hope Confronting Directing

Adapted from: Anthony et al. (2002). *Psychiatric Rehabilitation*. Boston, MA: Boston University, Center for Psychiatric Rehabilitation

2.2.3 Conclusion

Following the foundation of recovery outlined above, we do not make judgments about student choices; we are not "gate-keepers". Students are expected to follow and pass normal educational institution demands, though we often assist students in collaborating with said institutions so that each student's knowledge is best evaluated whether such knowledge is presented orally or written or as consequence of group presentations.

SEd counselors will experience the tensions surrounding the provision of role recovery (Supported Education) services and risk aversion. As an example, the following fictional anecdote is offered.

A young man seeks inclusion in SEd services after many years of treatment at a large mental institution. At 19, as he is finishing his high school degree, he is stricken with a serious psychotic episode leading to a prolonged in-house treatment regime assuming near total control over his life. Before this “life-threatening” experience, he harbored a dream to become a doctor and his academic achievements supported this dream. A well-meaning case-management team had throughout his time in the institution made decisions for him, and they advised strongly against his aspirations. In fact, as he reported on completion of his treatment, this advice took on the form of admonition wherein his dreams, if pursued, were framed as certain failure scenarios and even as a possible cause for regression into further psychosis. A confrontational relationship developed and his persistence in and of itself was considered evidence of a continued state of delusion.

This student nonetheless approaches SEd services with the hope that he will receive assistance in achieving his long-held dream of becoming a doctor. The initial interview leaves SEd counselors worried that his dreams may be unattainable. Nonetheless, and with the recovery model as a guiding force, SEd services are instigated to follow his plans. These entail helping to structure studies and skills-attainment of study techniques, gaining access to student welfare services, and ongoing discussions with medical school personnel. This student expresses gratitude for the help provided, citing specifically the respect and validation inherent in the relationship with the SEd counselor as an absolute necessary factor in furthering his own capacity to attempt a reintegration into what he defined as his natural place in society.

After three months of extensive exertion, and although his intellectual capacity was still capable of attaining knowledge as required by the institution, he approaches the SEd counselor with the wish to change his subject of study to “medical assistant”. His reasoning for this is that he has come to the conclusion that the total amount of work involved in combination with the future work and responsibility envisioned would tax his resources so much as to lower his long-term quality of life. He has now finished his degree and is in full employment.

He states in his final SEd session that he would never have been able to come to this conclusion without having had the support to try, and hence “own” his narrative and subsequent trajectory. Had we advised against medical school, he would not have accepted SEd services, nor experienced the personal development allowing for a new and for him more appropriate equilibrium. He explains that SEd support was like having a trusted accomplice walk beside him rather than in front of him. With this support, he was able to change direction without feeling shame or animosity and he was thus capable of accepting help from the same SEd counselor toward obtaining new goals.

His story is one of many supporting what we reported earlier from the independent national evaluation of SEd services in Norway and expressed here by Anthony et al. (2002):

Seemingly universal in the recovery concept is the notion that critical to one’s recovery is a person or persons in whom one can trust to “be there” in times of need.

2.3 Choose and Get

In this part of the toolkit, the focus is on the choose and get phases of the model, operationalized through a preparation course manual—the Impuls career guidance course—that helps dropped out (young) adults with psychiatric disabilities to return to school/university. Although the course has been developed for groups, the content is also applicable for individuals following a personalized choose and get process.

2.3.1 The Impuls career guidance course

What?

Description of the career guidance course: contents and organization.

Why?

To support (young) adults who do not exactly know what they want and what their educational options are; who have difficulties with making choices in this area; or who doubt their academic skills.

Who?

(Young) adults from 16 years of age and older, who receive treatment or have received treatment because of a severe mental illness and who are interested in going (back) to school in the near future.

When?

The course needs to begin a few months before the application forms for community colleges and universities have to be handed in, so the participants have enough time to, for example, visit open door days and make an informed choice.

Where?

A location of a regular educational organization, so the participants are able to make use of the available facilities and follow the course in a regular class room.

How?

Twelve weekly sessions of 5.5 hours.

A career guiding course named Impuls has been developed in 1999 at a community college in Rotterdam as part of the first Supported Education project in the Netherlands. The Impuls course focuses on supporting -in groups- (young) adults with psychiatric disabilities in choosing and getting a regular (vocational) education.

The course is based on the psychiatric rehabilitation approach of the Center for Psychiatric Rehabilitation of the University of Boston (Korevaar, 2005; Unger, 1998). The aim of the psychiatric rehabilitation approach is to help people with psychiatric disabilities from a client perspective to take up their self-chosen citizen role. That role can be related to one of four areas of life: living, working, learning and socializing. The Impuls course is derived from Supported Education, a program developed by the Center for Psychiatric Rehabilitation of the University of Boston for the life area of learning.

Next to the psychiatric rehabilitation approach, the concept of recovery is also related to Supported Education. Recovery can be seen as an individual process in which a person learns to live with the radical consequences of a psychiatric disability and can give meaning again to life (Korevaar, 2005). Supported Education shows that participation in regular education can contribute to (role) recovery and as such can give an impulse to personal growth and meaning.

Based on the Impuls course, the next paragraphs describe how to organize such a career guiding course and what the contents of such a course could be. In the last paragraph, some experiences with the Impuls course in the Netherlands will be discussed.

Organization

Participants

The career guidance course aims at (young) adults from 16 years of age and older, who receive treatment or have received treatment because of a severe mental illness and who are interested in going (back) to school in the near future. The participants do not exactly know what they want and what their educational options are; they have difficulties with making choices in this area, or doubt their academic skills. For these reasons, they need support in the form of a career guidance course.

In order to recruit the participants for the career guidance course, an information brochure for possible participants and an information brochure for referrers could be sent to mental health organizations, social benefit agencies, employment agencies, vocational rehabilitation agencies, business associations and reintegration agencies, for example.

It is important that the (young) adults who are interested in the course register themselves personally. When organizations/referrers register these (young) adults, they need to be requested to ask the (young) adult to do this himself. A basic principle of Supported Education is that people with psychiatric disabilities work on their own needs and goals and not on those of others (e.g. social workers, social benefit employees and family members).

After registration, the (young) adults are invited for an interview to discuss their expectations, motivation and goals. If the Supported Education professionals think that the (young) adult is suitable for the Impuls course, the registration for the course is final. The number of participants should preferably be between eight and twelve.

Costs/fees

The costs of the career guidance course will differ per country/organization, so it is hard to give exact figures. One should take into account that there will be costs for personnel (e.g., teachers and coordinator), materials (brochures/literature/homework, etc.), rooms, and catering.

Location of the course

The goal of the career guidance course is of course to help participants with choosing and getting regular (vocational) education. Besides, the course also helps with the orientation toward and the use of educational facilities and with gaining educational experience and rhythm. Therefore, it is preferable that the participants follow the course at a location of a regular educational organization so the participants are able to make use of the available facilities and follow the course in a regular classroom (with a computer and beamer, etc.). This also prevents the course from becoming a supportive or therapy group.

Start and duration of the course

The course needs to begin a few months before the application forms for community colleges and universities have to be handed in, so the participants have enough time to visit open door days, for example, and make an informed choice. The course often lasts twelve weeks, with one course meeting of 5.5 hours per week.

Supervision within the course

It is important here to stress that the participants do not attend the course as a patient/client, but as a student. Within that structure, one can work with the questions, needs and educational preferences of the participants. The structure of the program is meant to give some grip on that. The influx of participants is (as far as background and educational experience are concerned) very diverse. This calls for a very flexible attitude in the teacher/Supported Education specialist (and the participants) with regard to the content and pace of the program. Important is that the underlying structure of the program—exploring, choosing, getting and keeping—remains present.

Participants often have the following expectation about the course: 'In the course, I will hear which study is best for me.' Therefore, from the start, but certainly also during the course, it is important to mention that the participants have to take action themselves in order to get a positive result.

Preferably, the course is given by a pair of teachers: one who is educated in the psychiatric rehabilitation approach and who monitors the aim of the program, helping with choosing and getting a study; and one who is an expert by experience and maybe has been a participant on the Impuls course himself. This co-teacher assists with activities in subgroups and with supervising the group process. He might also teach a few theme lessons individually such as time management, stress and coping, and group processes.

Most activities take place as a whole group. Participants receive an introduction to a certain theme and have to elaborate this theme individually or in a subgroup through an assignment. Afterwards, the assignment is discussed with the entire group. The teachers are available to support the individual participants with the assignments.

At the start of the course, each participant will be assigned a mentor (being one of the two teachers). During individual coaching, participants can discuss what is difficult for them during the course, but they can also discuss what goes well. Often themes like current expectations about a study, self-esteem and support, one's experiences, or whether the supervision is in line with one's personal needs are discussed. Also, more personal themes such as how to subsume a difficult situation at home into your new study or how to cope with the change from being a client to being a student might be topics that are addressed during coaching. The individual coaching often takes place during breaks or at the end of the day.

Contents of the course

Structure

The contents of the decision making course can be divided into two parts:

1. Setting an educational goal
 - describing educational alternatives
 - identifying personal preferences
 - choosing an educational goal
2. Getting and preparing for a study of one's own choice
 - applying for a college or university
 - listing and practicing critical competencies
 - listing and organizing critical resources

Ad 1. Setting an educational goal

During the first part of the course, a list of studies in which the participant is interested is composed. Books and brochures that the teachers have collected can be used in this activity, as well as an internet search. Further information is gathered by attending open door days of colleges and universities. After a list of possible options has been made, a second list is composed that contains personal preferences—for instance, whether a study is directly focused on work or not—that the participant considers important when choosing a study. Subsequently, these two lists are put together and the study that mostly fulfills the personal preferences of the participant is chosen. Subsequently, an educational goal can be set. Such a goal describes when the participant wants to go to what particular study at what particular school. An example of such a goal is: "In September 2015 I want to start the information technology course at level 4 at the Alfa College in Groningen".

Ad 2. Getting and preparing for a study of one's own choice

After the educational goal has been set, a plan is made in which it is written what needs to be done in order to be able to start with the study. One has to register at the particular college or

university and sometimes one needs to work on getting financial support from a social benefit agency. When one is eligible for financial support, one has to apply for a student grant.

There are two other things that need to be considered before starting with a study: these are skills and support. During the course, one explores which skills are critical to start and maintain a study. This does not include the skills one gets taught during the study, but it includes skills one does not get taught there. These skills can vary from person to person. For instance, one participant has difficulty planning his homework, and another participant finds it hard to give a presentation in front of his classmates. However, it could also be a skill that is not directly linked to achievement at school—for instance, talking to a classmate in the canteen, or getting up on time in the morning. Critical skills can be practiced.

As far as support is concerned, the same procedure is followed. One explores what kind of support is critical in order to study successfully and it is ensured that this kind of support is actually available. This support can be given by a person, but also things, activities and places can be important resources. Examples of resources are a person who helps with homework, a relaxation exercise, or a room to which one can go and relax for a while. Although the necessary skills and support are different for all participants, they are discussed in the group. Consequently, people can help each other and practice together. To summarize, during the decision making course the participants work on four things: choosing a study; arranging things in order to be able to start with the study (registration, finances, permission, etc.); listing and practicing critical skills; and finally listing and organizing critical support.

Homework

After each course meeting, the participant receives a homework assignment(s). This way, he can get even more out of the course and also practice the critical academic skills at home.

Portfolio

During the course, the participant collects all the theory and all the assignments in a portfolio, together with the description of the personal goals of the participants. A portfolio is a map in which the participant describes what he is working on and which development he is going through. The portfolio can be taken to the intake/interview for the new study. Often the enrollment officer of a course of study appreciates this, as a portfolio gives a good impression of the needs, qualities and learning needs of the participant.

Topics

In twelve weeks, all of the above are addressed in the following topics:

1. Identifying personal interests and capacities
2. Researching educational environments
3. Setting an educational goal
4. Listing one's own (central) qualities
5. Information about learning styles and working in groups
6. Learning personal (academic) skills
7. Learning communication skills
8. Determination of and practicing personal learning goals
9. Organizing the support needed for getting a study
10. Keeping the study of preference

Evaluation of the decision making course in the Netherlands

In the Netherlands, we have evaluated eight Impuls courses using evaluation forms that the participants fill out after the course and group interviews with the participants. Evaluation forms of 74 participants have been analyzed. This analysis shows the following picture.

The participants appreciated the Impuls course, with a mean score of 4.2 on a five point Likert scale (range 3.9–4.2). They were particularly positive about the fact that the course gives tools for and support with choosing a study. Also, they appreciated that the course gave hope and that it was clear and goal-oriented. Some participants were less positive about the diversity of the group (participants with autism were found to be difficult to deal with); the information about the different studies (they would like to have received more information); and about the fact that there was a large portion of self-study in the course. A suggestion for improvement was to learn more about the experiences of students with psychiatric disabilities. In addition, more attention could be paid to time management and to how to work efficiently. Finally, a better balance between theory and practice would be appreciated. From the 74 participants, 63.5 percent had chosen a study after completing the ImpulSE course. Unfortunately, we do not know whether the participants maintained and completed their studies. It is therefore recommended to stay in touch with the participants in order to follow their academic careers and hence to get a glimpse of how effective the career guidance course is. We conclude with the description of the experiences of two former participants of the ImpulSE course in Groningen, the Netherlands.

Case 1

Peter is a young man who is 26 years of age. During his higher general secondary education, he experienced his first psychotic episode. Several times, he was hospitalized for several months. He was diagnosed with schizophrenia. After his last hospitalization, he remained in day treatment for two years. He lives with his parents and sister. He finished his higher general secondary education, but after his graduation he did not go on to another type of education. His case manager told him about the ImpulSE course. He enrolled, got accepted and finished the course. After he finished, he said that the course helped him to get insight into his preferences and possibilities. He thinks the study of his choice is the right one: a three year full time course in information technology. He is happy with the Impuls course: "Without Impuls, I don't think I would have started with a new study." Besides the support he gets within the course, he gets a lot of support from his parents, friends with whom he was in treatment and from a fellow student at the Impuls course.

Case 2

Karen is a woman who is 27 years of age. She was diagnosed with ADHD when she was 19 and she quit her social work course at a university of applied sciences. She became severely depressed and went to day treatment for a couple of years. She received medication that helped her well and that she still uses. Three years ago she started working as a volunteer at a day activity center for people with psychiatric disabilities. Her mental health practitioner pointed her toward the decision making course Impuls at the Hanze University, Groningen. Karen requested an information and intake brochure and she was called for an interview. She got accepted and started the course. At the beginning of the course, she was very impatient and got annoyed by the slow pace of the course. Through discussing these problems with one of her teachers and doing the exercises, she discovered that she had difficulties with organizing her thoughts. This is why she often goes too fast. By means of the course, she learned to think about her future wishes in a very detailed and concrete way. About the course, she said: "Because you are forced to go and explore several educational options, you get a clear view of the different studies and their locations. Comparing several options makes clear which study mostly fits your own preferences and capacities." She also said that through the course, her self-confidence and self-esteem were enhanced. Eventually, she chose to start again with her social work study, but now part-time. She has already started studying again.

2.4 Keep: On Site and Mobile Support Services

In this part of the toolkit, the focus is on the keep phase of the model, operationalized through on site and mobile support services to support students with psychiatric disabilities to remain at school/university, and continue and complete their studies.

2.4.1 Functional assessment: functional assessment tool and skills inventory educational setting (SIES)

What?

It is an assessment of the critical skills needed to be successful and satisfied in the educational setting of preference.

Why?

To understand which critical skills are needed to be successful and satisfied in the educational setting of preference and which skills are already present and which skills have to be learned.

Who?

Supported Education professional together with the student with psychiatric disabilities.

When?

In the phase of getting and/or keeping his/her educational setting of preference. After the student has set his overall educational goal, the Supported Education professional starts, together with the student, listing the critical skills. If needed and wanted, the Supported Education professional teaches the student the skill and/or helps the student to utilize the skill. Helping the student to perform the necessary critical skills makes the student more independent of people or other resources. Only when it is not possible for the student to learn or utilize the needed skill (for example, making an appointment) or when skills alone are not sufficient to solve the problem (for example, lack of transport to get to school), do we start listing resources.

Where?

In a place chosen by the student.

How?

Using the functional assessment tool and/or skills inventory educational setting (SIES).

The goal of a Supported Education program is to support access to schools and improve the maintenance within schools of people with psychiatric disabilities, helping schools become settings which are more respectful of diversity. In order to assist students in perceiving how their functioning may affect the achievement of their educational objectives, Supported Education professionals, in collaboration with the student, should do a functional assessment.

A functional assessment consists of supporting students to understand their functioning in the use of those critical skills needed to be successful and satisfied in a chosen educational setting. The success is to participate in all activities in the educational program in colleagues/universities and to learn all aspects of the curriculum necessities to obtain their goal.³

A functional assessment should be organic. This means, to understand the student in their educational setting, the assessment should not only focus on students' characteristics, but also on what skills the student has to develop to deal with the educational setting limitations. In the end, the functional assessment will help understand which skills are necessary to develop or unlock in order to achieve educational goals.

³ Based on WHO (2004). Disability and Health. ICF (International Classification of Functioning)

For a student to be able to identify which critical skills are needed to achieve his/her overall educational goal, he/she must be integrated in the chosen educational setting; only then can the student understand what skills he/she needs to develop or which school barriers the student must overcome.

This leads us to functional assessment, where the use of two tools , the functional assessment tool and the skills inventory educational setting, will help the student to recognize their functioning in the use of those critical skills needed to achieve success in the educational setting.

Functional assessment tool

*Instructions*⁴

a. Support the student to identify which critical skills he/she considers to be the most important to achieve his/her educational goal. The critical skills assessment allows the student to evaluate his/her functioning as well as the school functioning through an analysis of the necessary goals related to educational settings and the defined important goals by the student. Start a dialogue with the student about the critical skills needed or, if this is not possible or too difficult, use the skills inventory educational setting (see SIES below) to choose which skills can be helpful to meet the student’s needs. Write the outcome down in the functional assessment chart (see Figure 2.3).

b. Following the definition of which skills are critical to achieve a specific overall educational goal, the student must define actions to be able to perform a skill that goes towards the goal needed. Then it is necessary to define in which settings they will take place and finally to establish their regularity, taking into consideration and valuing the student’s experience.

c. In order to evaluate the process, indicators need to be defined jointly between the student and the professional. This makes it easier to monitor the application of such skills in the educational setting. Also, it allows us to identify the skills that need development or the necessary skill needed to overcome a school barrier, generating the required evaluation instruments to contribute to the next step.

d. In functional assessment, students may need professional support to have greater involvement in the assessment activities. Information may be necessary to clear the students’ doubts; this information can come from professionals as well as other students that share the experience, encouraging the student to talk about a specific subject. Students’ experience must be valued in order to facilitate knowledge sharing; this will lead to a sometimes necessary negotiation between the student perspective and the professional perspective related to the assessment and the necessary support to achieve goals. Finally, the students and professional agree upon how the progress of the student will be evaluated.

Figure 2.3: Functional assessment chart ⁵

Required Skill Goal	Critical Skills *	Activities and settings	Indicators	Support		Evaluation
				Professional	Peer	

* This column is for the student’s or the school’s required critical skills.

⁴ Adapted from the Center for Psychiatric Rehabilitation, Boston University

⁵ Adapted from Center for Psychiatric Rehabilitation, Boston University

Examples

John is very motivated with his law study, but it seems that he is having some problems being on time for classes, due to difficulties in adapting to new routines. Therefore, he asked the Supported Education professional to help him solve this problem.

Required Skill Goal	Critical Skills	Activities and settings	Indicators	Support		Evaluation
				Professional	Peer	
Be on time for classes	Managing time: following schedules	Have a schedule with all class hours	How many times per week arrived on time to classes	Help create a schedule plan	_____	Weekly meeting with professional to evaluate if schedule is kept or if it is necessary to reassess
	Coordination schedule with roommates	Establish a schedule for using bathroom in the house	How many times per week used the bathroom according to schedule	Strategies to negotiate the use of the bathroom	Help to follow schedule	

Mary is currently studying architecture. When she is in class she sometimes needs to close her eyes because she is tired due to her mental illness. Her professor thinks that she goes to bed too late or that she is using alcohol and he approaches her accordingly in front of the class.

Required Skill Goal	Critical Skills	Activities and settings	Indicators	Support		Evaluation
				Professional	Peer	
Teacher managing diversity	Help the student to learn how to negotiate with the teacher	Set up a meeting to explain the situation to the professor	If reprimanding stops	Attend the meeting and help student	-----	Weekly meeting with SEd professional to evaluate if the professor has changed his behavior

Skills inventory educational setting (SIES)

Instructions

- a. Review the chosen overall educational goal with the student/consumer. Discuss with him/her if this is the education of his/her own preference and if he/she owns the educational goal him/herself (not the family, the mental health practitioner or the educational staff). Use the SIES, Figure 2.4.
- b. Review the requirements of the (community) college/university and the related skills in the skills inventory with the student/consumer.
- c. Assess the student's/consumer's ability to perform each of the listed skills by exploring with the student/consumer his/her impression of whether he/she can do the skills (strengths) or needs help (deficits).
- d. Explore the student's/consumer's feelings about the skill strengths and deficits and what it may take to achieve his/her educational goal.
- e. Ask the student/consumer to select which skills he/she thinks are most critical in relation to his/her educational goal.
- f. If the student/consumer is able to perform the skill (after teaching the skill lesson), but not as often or as well as needed, assess the barriers that hinder the student from performing the skill, and then assist the student/consumer to overcome the barriers so he/she can perform the skill as needed (skill programming).
- g. If the student/consumer cannot perform the skill and has little or no knowledge of the skill, then develop a lesson plan to teach the student how to perform the skill and afterwards help the student to perform the skill as often as needed (skill programming).

Figure 2.4: Skills Inventory Education Setting (SIES)

Skills Inventory Educational Setting⁶				
Student/consumer:				
Supported Education professional:				
Overall educational goal:				
A.	Environmental Skills	Can do	Needs help	Explanation
1.	Commuting to campus			
2.	Maneuvering around campus			
3.	Using administrative services			
4.	Applying for educational finances			
5.	Selecting classes			
6.	Registering for classes			
B.	Academic Skills	Can do	Needs help	Explanation
1.	Utilizing college resources (library, learning center, etc.)			
2.	Clarifying assignments			
3.	Managing time: scheduling			
4.	Managing time: following schedules			
5.	Taking notes			
6.	Completing assignments			
7.	Preparing for tests			
8.	Taking tests			
9.	In-class participation: asking questions			
10.	In-class participation: answering questions			
11.	In-class participation: working in small groups (in class)			
12.	In-class participation: working in small groups (outside class)			
13.	In-class participation: managing internal distractions			
14.	Meeting with professor/adviser/ other college staff			

⁶ Revised from Sharac (1997). *Opening doors: College and you*. Worcester: Quinsigamond Community College, Supported Education Services

C.	Emotional Skills	Can do	Needs help	Explanation
1.	Managing emotions			
2.	Managing emotional themes			
3.	Responding to feelings			
4.	Coping strategies			
5.	Responding to feedback			
D.	Social Skills	Can do	Needs help	Explanation
1.	Meeting people			
2.	Making small talk			
3.	Listening			
4.	Demonstrating understanding			
5.	Managing free time on campus			
6.	Participating in on-campus groups			
7.	Utilizing campus social places			
8.	Researching social activity listings			
E.	Personal Coping Skills	Can do	Needs help	Explanation
1.	Adhering to medication regime			
2.	Remembering			
3.	Utilizing support			
	Utilizing resources			
	Determining barriers			
F.	Dorming Living Skills	Can do	Needs help	Explanation
1.	Sharing living space			
2.	Coordinating schedules with roommate(s)			
3.	Resolving conflicts			
4.	Volunteering for dorm responsibilities			
5.	Maintaining quiet hours			

2.4.2 Resource assessment: resource assessment tool and resource inventory educational setting (RIES)

What?

It is an assessment of the critical resources (people, things, places and activities) needed to be successful and satisfied in the educational setting of preference.

Why?

To understand which critical resources are needed to be successful and satisfied in the educational setting of preference, which skills are already present, and which skills have to be learned.

Who?

Supported Education professional together with the student with psychiatric disabilities.

When?

In the phase of getting and/or keeping his/her educational setting of preference.

Where?

In a place chosen by the student, inside or outside the educational setting.

How?

Using the resource assessment tool and/or resource inventory educational setting (RIES).

One of the goals of Supported Education programs is to facilitate community integration, offering educational services to people with psychiatric disabilities so they can have access to resources in order to successfully remain in schools and complete their studies, as well as supporting educational settings to develop the necessary school accommodations.

Resource assessment assists the SEd professional and the student in defining together which are the critical resources needed to be successful and satisfied in their overall educational goal in the chosen environment. This assessment allows the student to determine the type, intensity and frequency of the resource use.

While conducting a resource assessment, always keep in mind that the services should meet the unique needs of each student as well as providing an environment that assures individual privacy and enhances personal dignity. The services should promote access to non-stigmatizing resources that are consistent with the student's choice as well with the typical routines of a student's life. Coordinating with the different types of resources needed is necessary to help the student meet his/her overall educational goal.

In order to conduct a resource assessment it is fundamental to identify the resources needed using the tools described below, the resource inventory and the resource assessment chart; to describe the resource use; and to determine its availability. Throughout the process it is essential to respect the student's wishes and allow him/her to control and fully participate in determining the criteria for success and evaluating his/her own progress.

Resource assessment tool

Instructions

a. Start a dialogue with the student about the critical resources needed or, if this is not possible or is too difficult, use the resources inventory educational setting (see RIES below) along with the student to identify which resources he/she considers critical to achieving his/her educational goal. Write the outcome down in the resources assessment chart (see Figure 2.5).

b. After identifying the critical resources, analyze with the student what is the support (people) or use (tools) needed from each critical resource, in order to establish the intensity and frequency of the resource use.

c. In this final stage, support the student to plan how to connect with the chosen resources. If the student already uses the resource, help negotiate the necessary support or use. If the resource is needed but is not present, establish with the student how to find it.

Figure 2.5: Resources assessment chart⁷

Critical Resource	Resource Use or Support	Availability		
		Needed	Present	Alternative Resource

Example

Mary recently enrolled in an art history course of study. The university to which she applied has a monthly tuition fee of €200. She herself does not have the money to pay for attending this course, so she needs help in finding available resources to help overcome the financial barrier to accomplish her educational goal.

Critical Resource	Resource Use or Support	Availability		
		Needed	Present	Alternative Resource
Tuition money	Monthly payment of €200 for school tuition fees	€200 / month	€100 / month from parents	Bursary

Resource inventory educational setting (RIES)

The result of the inventory (list of resources) is different for each student and depends very much on the educational environment the student is in. Resources are people, places, activities or things that are critical for remaining at school, according to the student and other people. Resource assessment is an instrument for the professional to help the student to determine which resources are critical in order to achieve his/her educational goal. It is essential for the use of the resource that the student acknowledges the importance of the resource (support and/or tool).

Instructions

- a. Review the chosen overall educational goal with the student/consumer. Discuss with him/her if this is the education of his/her own preference and if he/she owns the educational goal him/herself (not the family, the mental health practitioner or the educational staff). Use the RIES, Figure 2.6.
- b. Review the requirements of the (community) college/university and the related resources in the resource inventory with the student/consumer.
- c. Assess the student's/consumer's ability to realize each of the listed resources by exploring with the student/consumer his/her impression of whether the resource is needed and present.
- d. Explore the student's/consumer's feelings about the needed and present resources and what it may take to achieve his/her educational goal.
- e. Ask the student/consumer to select which resources he/she thinks are most critical in relation to his/her educational goal.

⁷ Revised from Unger, K. (1998). *Handbook on supported education: Providing services to students with psychiatric disabilities*. Portland, OR: Rehabilitation through Education.

f. If the resource is not present and the student/consumer cannot realize the resource him/herself and has little or no knowledge of the resource, then develop a resource intervention plan to help the student/consumer realize the resource.

g. If the resource is present, but the student/consumer does not use the resource as often or as well as needed, then assist the student/consumer to use the resource as needed.

Figure 2.6: Resource Inventory Educational Setting (RIES).

Resource Inventory Educational Setting				
Student/consumer:				
Supported Education professional:				
Overall educational goal:				
A.	People	Needed	Present	Explanation
1.	Teacher			
2.	Tutor			
3.	Fellow student			
4.	Brother			
5.	Friend			
6.	Study advisor			
7.				
8.				
B.	Places	Needed	Present	
1.	Library			
2.	A study room			
3.	Open learning center			
4.	Canteen			
5.	Schoolyard			
6.				
7.				
C.	Activities	Needed	Present	
1.	Appointments			
2.	Discussion			
3.	Role plays			
4.	Breaks			
5.	Supervision			
6.	Supervision at internship			
7.	Relaxation			
8.				
9.				
D.	Things	Needed	Present	
1.	Calculator			
2.	Study book			
3.	Notepad			
4.	Student loan			
5.	Social benefit			
6.	Recording device			
7.	Desk			
8.	Alarm clock			
9.	Drinks			
10.	Travel expenses			
11.	Money for books			
12.				

2.4.3 'To tell or not to tell': Disclosing a psychiatric disability in the educational setting

Susan

Susan is 23 years old and a first year psychology student. At the age of 19, Susan became very depressed. She attempted suicide and was admitted to a mental hospital for some time. She has been in day treatment at the same mental health organization for the past two years. Over the last year Susan has been doing very well and she went back to study psychology again (at a different university). In an introductory meeting with the lecturer and other students, the lecturer asks Susan, "Susan, what have you done before?" Susan is surprised by the question and doesn't know what to say.

Peter

Peter is 22 years old and at the point in his study at the university where he is to start a period of internship. He has an interview with a supervisor of the company where he wishes to do his internship. During the interview, the supervisor asks Peter why one year in his curriculum vitae is blank. Peter tells the supervisor that three years ago he was treated for a year because of a psychosis. The supervisor ends the interview quickly. Peter never heard from the company again.

The stories of Susan and Peter are good examples of a very common dilemma for students with psychiatric disabilities: the decision to tell or not to tell about their psychiatric disability. Disclosure can have benefits, but some students tend not to disclose their psychiatric disability because they fear being discriminated against or because they are able to manage their study on their own. However, every student's situation can change for a variety of reasons and this may have an impact on their decision to disclose. In the next paragraphs, we present an intervention that is intended to support students with psychiatric disabilities in making informed decisions about whether or not to disclose. Students can follow the steps individually, therefore we wrote the text from the student's perspective. However, the student can also carry out the intervention together with a student counsellor or other relevant professional. The information we present in the following paragraphs is based on the current literature about disclosure and on the experiences with the tool of students and professionals from Norway, Portugal, the Czech Republic and the Netherlands.

Disclosing your psychiatric disability

The decision to be open about a psychiatric disability is a personal one, and your own situation and circumstances play an important role in making this decision. Below, you'll find some aspects that may help you with your decision.

- Do I benefit from disclosure?
- Whom do I tell and why?
- How will teaching staff respond to students with psychiatric disabilities?
- Will I get better support if I disclose?
- What are the risks of disclosure?
- Will I be carrying the continuous stigma of having a psychiatric disability ("being mad")?
- What happens if people find out?
- What will people think of me?

Disclosing your psychiatric disability means that you tell someone about your psychiatric past or present. To decide whether to tell about your psychiatric disability or not, you could consider the following steps:

Determine:

- 1 **Whether** to tell
- 2 **What** to tell
- 3 **Who** to tell
- 4 **When** to tell
- 5 **How** to tell

It is important to note that you do not need to follow the steps in a specific order. You can start with the step you prefer. However, we recommend that you do consider all five steps to come to a well informed decision. For each of the five steps there is an accompanying worksheet. These worksheets can be found in Appendix 7.

1. Whether to tell

The decision to disclose is a difficult one. The choice will be different for everyone because everyone has different experiences and different needs. Disclosing is a personal decision—you are the only one who can make it. Don't give in to pressure to disclose for the sake of other people: you are the one who has to live with the positive and negative outcomes.

A psychiatric disability is often not visible and manifests itself differently and in its own, unique way in each person. Disclosing your psychiatric disability can be necessary to get access to the accommodations and support the faculty offers to students with psychiatric disabilities. Disclosure can also be related to the decision to tell other students, in case of a friendship, or when you have to work together with others.

Unfortunately many myths and wrong information still exist regarding psychiatric illnesses. Disclosure can sometimes result in being stigmatized, with people treating you differently or viewing you as your illness, especially if they don't know anybody themselves with a psychiatric disability.

So, there are positives and negatives to disclosing your psychiatric disability. The decision to disclose or not is often not a final decision but one that can be re-evaluated over time, based on the student's circumstances. It is important that the factors that determine whether disclosure occurs or not be explored before a decision is made. In determining whether disclosure should occur or not, you could consider the following aspects.

Benefits of disclosing

- Better support
- Adjustments can be negotiated and implemented
- If staff respond positively, you may feel more confident about your studies.
- You might meet other people with similar experiences through disclosure
- If people you trust know more about who you are, you may have better relationships with them
- Making your needs known will help ensure that the university is responsive to the needs of other students with psychiatric disabilities
- More interest, care and support from teaching staff
- Staff will be able to respond appropriately and sensitively when difficult situations occur
- Having access to the same rights and entitlements as everybody else
- Not being seen as a troublesome student
- Being able to receive support and advice

Disadvantages of disclosing

- Others may feel threatened, due to ignorance and personal experience
- The burden of having to explain your disability
- The fear of discrimination
- Feelings of rejection
- The fear of being singled out in class
- Misunderstanding by others of the disability's impact
- The belief that you may be denied opportunities, such as a place on the course you wish to undertake
- The fear that the disability may provoke curiosity or unnecessary concern in others
- Fear that the disability instead of the academic capacity of the person will become the central focus
- Fear that you will be treated differently from other students

You may also choose NOT to disclose your psychiatric disability

You may have several reasons for not disclosing, including:

- You may not require any additional support or services, because your disability does not influence your capacity to study at college
- You may be uncertain about contacting disability support services at this time
- You may not know who will have access to your personal information
- You may have developed strategies for managing your psychiatric disability and would not benefit from disclosing your disability
- You have an expectation that equity and access are in place, thus eliminating the need to seek education related adjustments

If you do not require any accommodations to perform your study, there is no reason to inform a college that you have a psychiatric disability.

Try to find a balance for yourself between the advantages and disadvantages about disclosure. You should be clear about why it is you want to disclose, what your goal is. It is important that you make up your own mind and decide for yourself what is best for you.

2. What to tell

In every situation, with every person and at every moment, you have to ask yourself what you want to tell. You could have a fixed story that you tell every time again, but that story may not always be adequate.

According to the situation, you have to decide whether you want to tell about:

- Having a psychiatric disability
- Aspects of your psychiatric disability

What you tell can also vary depending on the person to whom you disclose. It could be that:

- You want to educate that person about your psychiatric disability
- You want to tell how your psychiatric disability impacts your study
- You want to explain that you have a certain learning style
- You want to provide the other person with information about your psychiatric disability
- You like to talk with a fellow student about your psychiatric disability

It is also possible that someone asks questions about your psychiatric disability—for example, a professor who asks what your diagnosis is when you ask him/her for support. What to do? In this situation, you are still the one who decides what and how much you tell about your disability. If you do not want to tell more than necessary, you could say, for example, the following:

'The Disability Support Service has all the information. I would rather not discuss the details of my problems with you (alternative: I prefer to keep the details of my illness to myself), but my disability means that I have problems with (mention the study activity). Regarding this activity, the accommodation or support that helps me a lot is (mention the accommodation and/or support). I am happy to discuss with you how to realize this'.

Explain your situation to your professor in such a way that he or she understands what the impact is of your disability on your study. Most importantly, keep the disclosure conversation focused on your abilities, not on your disability. It is not always essential to disclose specific personal information about a disability. What is most important and helpful is to provide information about how the disability impacts your capacity to study and what support you need in order to study in an optimal environment.

3. Who to tell

Besides the decision whether and what to tell, it is also important to think about who to tell. Below you'll find a list of persons to whom you possibly want to disclose your psychiatric disability.

- *Academic advisor or counsellor.* He or she is there to help you to arrange things or refer you to the right services.
- *Special disability support staff.* The staff of disability support service is specialized in helping to arrange accommodations and to provide support.
- *Teaching staff,* because the accommodation or support you need is directly related to their course.
- *Fellow students,* so they understand why you are receiving accommodations or extra support and they can support you.
- *Faculty administrative staff,* because they can assist you with processing information or applications
- *Equity staff,* because they will assist you if you are being discriminated against or if you are not receiving the support to which you are entitled. They can also assist you if you are not sure to what support you are entitled.
- *Housemates,* so they understand for example why you use medication, why you go to bed so early or why you are feeling not so well.

Before you decide to disclose, often you want to know if the person will treat your information as confidential. Important in this decision are your experiences with earlier disclosures. If your trust has been abused in the past, you will think twice before you disclose again. This is discussed elsewhere in this brochure.

4. When to tell

Most educational programs have a time span of several years. In those years, many changes can occur. You'll find yourself in new situations, meet new people; there are changes in your circumstances, but also your study load at college could increase. All or any of these situations might be a catalyst to you needing to consider whether or not you disclose your psychiatric disability while studying. Below you'll find a description of some of these situations.

Prior to enrollment

Your choice of a course of study at a certain college could be dependent on the support that the college offers to students with psychiatric disabilities, especially when you know that your psychiatric disabilities have influenced your prior study performances and that support is needed. To find out if the college provides academic and personal support, it is often necessary to disclose your psychiatric disability.

Therefore, it is necessary to decide whether you will need an accommodation or extra support to perform the study to which you are applying. The best way to do this is to find out what duties are required, and consider how you can fulfill them with or without an accommodation or extra support. This allows you to confidently decide whether or not to disclose your psychiatric disability. If you choose to be open because you need an accommodation or extra support, discuss the needed accommodation or support as soon as possible with disability service staff, because the process of enrolling can be exhausting with forms to complete, payments to be arranged, and venues to be located. Requesting support at an early stage can help you to start your study more relaxed and successfully.

At the time of enrollment

Students with a disability are also faced with the choice of whether or not to disclose their disability at the time of enrollment. At the time of enrollment, often students have an opportunity to disclose their disability on the enrollment form. It is unlawful to use the disclosed information against you. The information is meant to discuss possible negative influences of your psychiatric disability on your study performance and/or to find solutions for these problems. If students choose not to disclose their disability on the enrollment form, they still have the option of contacting the disability support service staff at any time for advice or practical support.

During your study

Some students tend not to disclose their psychiatric disability in the early stages of their study, sometimes out of fear of discrimination, and sometimes because they are able to manage their workload. However, every student's situation can change for a variety of reasons and this may influence their decision to disclose. It is also possible that during their studies, students unexpectedly acquire a psychiatric disability or experience a deterioration in an existing disability. This may result in the student needing to disclose the disability to seek support to continue the study. As these are unexpected circumstances, students may require disability support to be put in place quite quickly, to ensure that their studies are not negatively influenced. This may or may not be possible depending on the level of support required.

You may choose to disclose your disability at any time during your study because:

- Your personal circumstances may change—for example, you acquire a psychiatric disability.
- Your disability may progress and its impact on daily living may also increase.
- You may feel more confident that disclosing at this time will not lead to discrimination.
- You may have identified specific support that will enable you to participate in the course on an equal basis with other students.

In addition, in the following situations you may decide to disclose during your study:

- Before a specific exam.
- When you have to participate in a course in which a specific didactic method—for example, a role-play or working together in subgroups—is used.
- When you meet new people at the beginning of a new course.
- When you meet fellow students.
- When you become a member of a student group or student sports club.
- When you make new friends.

Internship or fieldwork

Most studies require an internship or fieldwork. Being an intern or working in the field often requires other skills, knowledge and attitudes than being a student at college. Most of the time you are seen as an employee and colleague instead of a student. It is possible that this new role asks for other accommodations and support. Also in this situation you will have to decide why, what and to whom you disclose your psychiatric disability in order to get the

necessary accommodations and support. So, there are many moments and situations during your study in which you have to decide to disclose or not. It is and will always be your own decision to determine whether it is the right moment, the right situation and the right person, and how much information you wish to tell.

5. How to tell?

Disclosing your psychiatric disability is not a one-off event. Often, in every new situation (when), or with every new person you meet (who) you have to decide whether and what you want to tell about your psychiatric disability. Moreover, it is also important how you tell it. To prepare yourself for how to tell about your psychiatric disabilities, consider the following.

- Know yourself and your psychiatric disability.
- Identify your strengths.
- Identify areas where you may need assistance.
- Plan ahead and practice what you might say.
- Know the resources available to you.
- Know what you want to discuss with a disability liaison officer or counsellor.
- Become familiar with the equity policies and procedures of the school/university.
- Consider possible prejudices you may encounter and how to deal with them.
- Be prepared to deal with insensitive questions.

If you tell:

- Be brief.
- Relate what you tell to your study.
- Be assertive and enthusiastic.
- Be familiar with the topic and course requirements.
- Describe the way you learn most effectively.
- Discuss the reasonable adjustments you are requesting on the basis of your psychiatric disability.
- Describe how you overcome difficulties that the other person could see as problems.
- Be prepared to deal with insensitive questions.
- Before the meeting, determine a good time and place that you both agree on, to discuss your psychiatric disability.
- Depending on your preference, you can visit staff at their student consulting times, phone them, or e-mail them.
- Note that less effective or appropriate times and places are after lectures with other students listening, in the cafeteria, in a corridor, in the break of a lecture, etc.
- Find out as much as possible about how you are able to function and what the trigger points are to becoming unwell.
- Know about positive and adverse reactions to medicines, how they affect you and how this can influence your ability to study or enjoy being a student.

Sometimes you find it hard to be open about your psychiatric disability because you are still struggling to accept your situation. Also, when symptoms of your psychiatric problems occur (like depression, anxiety, fear or stress), it is often harder to be open about your psychiatric disability. In these situations, it is good to talk with someone you trust and to consult him about whether to tell or not.

Confidentiality

An important consideration for you in your decision to disclose or not might be the issue of confidentiality, for example: 'If I disclose, then what will happen with this personal information?' If you want to disclose for academic or support purposes, it could be good to know if there are confidentiality policies at school/university about what happens with your personal information. You may want to find out about these policies before you decide to

disclose. It is important to discuss what you and the other person mean by the term confidentiality.

In most circumstances, it is best practice that you are asked to give permission to pass the information to other persons or agencies. It may be necessary for you to notify tutors of the arrangements you have made with disability support staff. You may like to discuss with your disability support worker whether you feel comfortable with your tutors knowing about your psychiatric disability.

In case disclosure of a disability becomes a matter of duty of care, because your safety or that of others is at stake, then people who need to know may be informed without your permission. What if you are not in a position to speak for yourself? Do you carry appropriate information, such as a medic alert bracelet or similar?

If you are disclosing to a friend or another student, you may want to ensure that they understand that you want to keep the information private. You will have to make a decision about trust in the relationship.

Discrimination

If you feel you have been discriminated against because of disclosing your psychiatric disability, you have the legal right to object. Please contact:

- The disability liaison officer at your institution
- The equity representative for your organization
- The discrimination advisor
- The student union
- The institution's grievance procedures
- The Equal Opportunity Commission
- The Human Rights and Equal Opportunity Commission

Further information

On campus

- Disability liaison officer.
- Counsellors—self-confidence and esteem; talking about yourself and your learning needs; assertive communication.
- Disability contact officers—for the program/course/unit or schools/departments.
- Discrimination advisors.

Websites

Interesting information about studying for persons with psychiatric disabilities can be found on the websites below:

www.begeleidieren.nl (in Dutch, with a page with information in English): an informative site with e.g. brochures about studying with psychiatric disabilities; information about projects on Supported Education; information about national and regional resources for students in the Netherlands.

<http://cpr.bu.edu/resources/reasonable-accommodations/jobschool>: an informative site with issues about work and school. The site is developed by the Centre for Psychiatric Rehabilitation of Boston University.

<http://www.cmha.ca/youreducation/introduction.html>: information about studying with a psychiatric disability in higher education in Canada, with a special page on disclosure.

<http://www.hindawi.com/journals/edri/2014/295814/>: this is an article from the Latrobe University in Melbourne, Australia, about the role of university support services on academic outcomes for students with mental illness.

[Oxford Student Mental Health Network](#): this is a comprehensive site with information about mental health issues in Oxford, for students, teaching staff and mental health workers.

2.4.4 Peer support group

What?

This toolkit chapter is an introduction to the peer support group.

Why?

The purpose of the peer support group is to help the students help each other.

Who?

The peer support group can be organized by students or by SED employees.

When?

For a given time period—for instance, over the course of a semester. Alternatively, the time for the group meetings can be fixed, and the group can be open to anyone wishing to attend.

Where?

It can be done wherever needed.

How?

This chapter gives you some examples on how to organize a peer support group.

A peer support group is an arrangement in which students who have experienced mental illness first-hand can gather in a group, organized either by SED or by the students themselves. The group's purpose is to help the students help each other, as well as themselves; students who have experience with the various challenges that arise for a student with mental illness can help other students in the same situation. Peer support groups can be organized in various ways. They can be organized on the students' own initiative, or they can be organized by SED employees, for instance. The group can be fixed, in the sense that the same group of students may attend the group for a given time period, such as over the course of a semester. Alternatively, the time for the group meetings can be fixed, and the group can be open to anyone wishing to attend.

There may be various expenses related to a peer support group, such as rental of premises and other meeting expenses, expenses for food, or related to the group's attendance at various social events. It should always be clarified in advance who will be responsible for such expenses, so that the students can consider whether they can afford to attend.

Content of a peer support group

All groups start with the participants presenting themselves one by one, by first name as well as what they study. This round of presentations may take some time, as the students often take the opportunity to ask questions about various possibilities regarding subject combinations and the like. The further course of the meeting depends on whether a topic for the meeting has been given in advance (for instance, there might be a guest who is there to talk about a given topic) or whether the meeting is open for dialogue between the students. Oral participation from the participants is very individual and situational, depending both on the topic and on the participants. Some people like to talk, while others wish to participate in silence. As an alternative outcome of a group offering, students can also cooperate on other levels. For instance, providing each other academic assistance outside the peer support group.

Often a peer support group is a loosely composed group where students connected with SED meet each other. The main rule is that SED organizes the meetings, but the group always discusses their own needs and wishes. The support from the group meetings may be of an academic or more social nature. A peer support group is a sort of respite in students' lives, where they can relax and take a break from worrying about exposing their mental illness to their surroundings.

Part of the strength of the peer support group is the fact that the group participants have experienced first-hand what it is to be a student with mental illness, and that the challenges and problems that other participants struggle with are recognizable. However, this can also

be a weakness for this type of support; other people's challenges and worries can bring back painful memories about self-experienced challenges and worries.

Topics that can be discussed in a peer support group

- Dealing with exam stress
- Guided relaxation
- Study techniques
- Self-disclosure
- Mindfulness
- Film meetings
- Social security rights

Recruitment

There are different ways of composing the groups. One may choose an open group, where anyone can participate on the scheduled dates. This is a loose and low threshold way of organizing the peer support group. This type of peer support group entails a certain degree of unpredictability, for the group supervisors as well as for the participants. As there is no requirement to sign up for the groups, there is no way of knowing who will participate, or how many participants there will be for each meeting. A benefit of this type of group is that the meetings are similar to other social settings and less like a treatment program in the clinical sense. This gives the group a safe environment to explore their experience and discover what is important and what works when you are a student with mental illness. It is also possible to organize groups by diagnosis (such as a group for students diagnosed with Asperger's syndrome, as described below). Inclusion criteria of the group are identical to the inclusion criteria at SEd. As such, the participants must fulfill the university's admission requirements, must receive treatment from specialist health services, and must have a moderate to serious mental illness.

The group processes use the individual participants' resources—their values and thoughts about themselves—as a starting point before considering what the participants have in common and what opportunities there are for them to gain something from each other's experiences. When activities are organized outside the student service offices, where the students will need to sign up, the students have to do so by email. Notices and information about the groups are also sent by mailing lists, where the recipients all receive blind carbon copies. All students have agreed to be on the mailing list.

Positive norms and rules: Instructions for group supervisors

Establishing positive rules and norms for the peer group has been identified by service providers as a critical ingredient for creating and maintaining a safe space, as well as a way of influencing positive behaviors and attitudes within the peer group such as positive conflict resolution strategies, social skills and a focus on the positives.

Group rules/norms may include having respect for one another, not being judgmental, being inclusive, no bullying, harassment or violence, and no alcohol or drug use. Peer-based programs use positive peer and social influence to establish and maintain positive peer group rules/norms. Positive peer influences encourage imitation of positive behaviors which receive social validation by the peer group and are therefore more likely to be repeated (My-Peer Toolkit, 2010).

The group supervisor or leader must always adhere to the needs and wishes of the participants. The supervisor or leader role is also dependent on whether the meeting or group is of a social or a more subject specific nature. The purpose of the group meetings must be clarified with the participating students through dialogue. The group supervisor or leader also adheres to a confidentiality statement, and should inform the group that not all participating students that are associated with SEd wish for this association, nor their

association with this group, to be public knowledge. The group supervisor should also have a partnership attitude: effectively, 'nothing about us without us'. They should promote participation in all processes, and focus on independence, proactive and process-oriented. A group supervisor also needs to ask questions, listen and respond accordingly without delay, collaborate, share power and connect with others, and share experiences with open communication.

It would also be favorable if the supervisor had knowledge of the educational system, and the welfare and healthcare systems, and also knew coaching and counseling techniques. A key element would be that the supervisor holds SEd attitudes—hope inducing, respectful, with the language of empowerment and a solution-oriented pragmatism, along with patience, tolerance and empathy.

Experiences with peer support groups in Norway

Bergen

In Bergen, there have been fixed peer support groups since the inception in 2006. The group has monthly meetings: dates are announced by email and there is no requirement to sign up. Some of the topics dealt with have been mindfulness, guided relaxation, study techniques, film meetings, and information meetings where an employee from the Norwegian Labor and Welfare Administration informs the attendants about various social security rights. There are also political, philosophical and ethical discussions, based on things like newspaper articles or happenings in society.

Tromsø

In Tromsø, there are two groups. One of these has been operational since 2010. There have been some changes in its participants, but some students have participated since the beginning. For a number of reasons, the group took a break during the fall semester of 2014, but it has now been started up again. The group has about nine participating students that meet every two weeks. Usually, between five and seven students attend each meeting. This is a closed group, but students are informed about the possibility of joining the group when they join SEd. The focus for the group meetings is to be a social meeting place for students associated with SEd. At the start of the meeting, the group always orders food and the participants eat together. The topics are not decided in advance, but rather there and then, based on the participants' present situation. The feedback from the students suggests that they appreciate having a place where they know that they are not alone in struggling with their life as a student. This is not so much a topic as a sort of backdrop for the meetings. The importance of these groups for the students was clear during the break last fall semester: the demand for the groups soon rose again.

The other group in Tromsø is a group meeting for SEd students diagnosed with Asperger's syndrome or other autistic conditions. At present, there are four or five participating students. They meet every two weeks at lunchtime. As in the other group, they order food and focus on the social aspect. The participants are students who have a difficult time socializing at university, and it appears that these group meetings are of great importance to them. The topics are not decided in advance, but rather arise from everyday experiences or other events that come up at the meetings. As the participants have come to know each other more closely, they have also started meeting outside the group premises on campus. One of the participants has shown a lot of initiative in including new members in the group and inviting new members to activities that he attends outside the group. This has been important to the students, who otherwise spend a lot of time on their own and express a wish to participate more in social situations. A topic that the group has discussed lately has been how one may appear to others socially in terms of clothes, style, hair, etc., and it has become possible to talk about the challenges that the students experience in this area.

Grimstad

In Grimstad, a peer support has been organized for approximately every two weeks for the past four years. Their meetings take place in a café on a fixed weekday evening. The group is on offer to all students associated with SEd, and it is solely a social offering. There is no set topic; they talk about whatever is on their minds. The students receive a text message reminder one day prior to the meeting, and there is no other form of signing up. Some arrive late, some leave early, but in general, the group meetings last for two to three hours. The number of participating students varies from meeting to meeting, but is usually somewhere between six and twelve. SEd employees use project funds to buy drinks and snacks for the participants, so that it never becomes an issue that some students may not be able to afford to participate. Sometimes, SEd employees may assist students with transport if there are students who find it difficult to get there on their own.

The demand for these meetings is often evident from early on in each semester, and the positive outcome is clear in that the participants get out and meet other students in similar situations, form friendships and make arrangements to study together. For some of the students, this is the only leisure activity that they have, or that they can manage to maintain.

In Grimstad, there are also two daytime group meetings over the course of a semester. This is for everyone associated with SEd; the meetings are held on campus and the topic is decided in advance, based on the wishes expressed by the students. Relevant topics can be exam stress management, humor and mood, how to write a CV, how to handle job interviews, visits from mental health workers, and more. For these meetings, it is often requested that students sign up in advance. The meetings last about two hours.

Section 3

Implementation Manual



3.1 Introduction

Supported Education (SEd) helps (young) people with psychiatric disabilities to choose, get and keep their regular postsecondary education of choice. This implementation manual aims to assist the management of colleges, mental health agencies, national and regional mental health departments, consumer organizations and other stakeholders in mental health systems who want to develop and implement a SEd program that enables students with psychiatric disabilities to meet their educational goals. This manual provides relevant practical information and is divided into several parts:

- Involvement of stakeholders
- Needs assessment
- List of available/required resources inside and outside the Higher Education institutions: resource scan and social map
- Good practices (from Norway, Portugal, the Czech Republic and the Netherlands)
- Communication plan
- Information brochures (for Students; Consumers; Family members; Educational staff; Policy makers -management colleges and universities; Mental health practitioners; Policy makers-management mental health organizations)
- Practitioner's competencies
- Staff training
- Support for educational staff: advice, consultation and coordination
- Sustainability (quality, evaluation, finances)

The manual is based on the experience of developing and implementing the SEd programs of the ImpulSE project team in the Czech Republic, the Netherlands, Norway and Portugal. For some professionals, the information provided in this implementation manual will be supplementary. You may have already developed an effective intervention for supporting students with psychiatric disabilities to choose, get and keep their educational goals. For others less familiar with SEd, this information might be new and you may find it helpful to go through each part. Those professionals might quickly obtain a working knowledge by reviewing the first two sections of the toolkit (Introduction to the Toolkit and Choose-Get-Keep Interventions). In addition to this manual, the ImpulSE project provides training to professionals to acquire the needed SEd competencies and the technical assistance for the development and implementation of SEd programs.

3.2 Involvement of Stakeholders

Implementing a Supported Education program must be an effort made by the educational staff, mental health practitioners, consumers and families, but for its success the program must be developed in the community. To this end, creating a clear vision of the SEd principles and goals is essential, as well as the involvement of stakeholders and partners. Most often, there is no need to develop new resources because each organization, entity or agency has a personal line of intervention: the involvement of stakeholders and creating partnerships can pull out the talents and resources of many consumers, experts and staff, using the existing resources to implement a Supported Education program (Unger, 1998). It is more important to do a resource assessment, to list all the available resources and to determine if required resources are missing (see resource scan in paragraph 3.4 below).

The involvement of stakeholders can start while implementing the SEd program—the creation of advisory board meetings can be a good first step. A community partnership setting involves the promotion of trading mutually beneficial information and resources and joint efforts to resolve a common problem. In this section, we will address the importance of involving stakeholders and creating community partnerships for the success of a SEd

program (Ornelas & Vargas-Moniz, 2011; Wolff, 2010).

A stakeholder can be defined as someone who can be or is already involved with the success of a SEd program and of its consumers, including school administrators, teachers, mental health practitioners, students, family members, schools board members, city councilors, state representatives and mental health experts. Stakeholders may also be organizations, initiatives, committees, media outlets and cultural institutions. They have a personal, professional, civic or financial interest or concern in the SEd program and consumers (Wolff, 2010).

The following is a list of stakeholders from whom SEd program developers are encouraged to seek information.

- Consumer organizations
- Student unions
- Family organizations
- Peer support services
- Day activity centers / Clubhouses
- Vocational rehabilitation agencies
- Local social service agencies
- Student disability services at educational institutions
- Key informants (i.e., parents, mental health professionals, current students with disabilities)
-

To identify the stakeholders that are relevant for your SEd program, you can do a stakeholders analysis (see Figure 3.1) or you can make a resource scan (see paragraph 3.4).

A community partnership setting usually occurs when searching for answers to identified social problems; financial opportunities for a SEd program; or a group, organization, or community perception in relation to a problem or a crisis situation. Therefore, in the development of a partnership, sharing resources usually forms its basis, since the success of a partnership resides in its ability to obtain beneficial results for the different groups involved in the community and in its development process (Ornelas & Vargas-Moniz, 2011).

3.2.1 Stakeholders analysis

When engaging stakeholders or possible partners, always pay attention to the following assumptions.

- The community is central to the implementation of a SEd program.
- Learn about Supported Education.
- Learn about community settings.
- Share power and resources.
- Do “with” as opposed to doing “for”.
- Honor consumers’/ students’ knowledge and experience.

Key questions

- Who might you invite?
- Who else is also involved in supporting students with psychiatric disabilities?
- What are the resources and strengths of my organization?
- Which are the resources we need to implement a SEd program?

Formal and informal stakeholders/partners

Formal stakeholders or partners of the community are those organizations, groups, or agencies that represent the major institutions such as government, education, health and business. Informal stakeholders or partners of the community are those parts of the community best connected to consumers/students, such as associations, families, etc.

Figure 3.1 Stakeholders analysis chart

Stakeholders/Partners	Formal	Informal
Which groups, organizations, entities are related to Supported Education?		
What role can they play?		
What benefit do they gain from joining?		
What barriers exist?		
Which are their strategies or programs?		
What resources can they provide?		
How to reach them?		

(Ornelas & Vargas-Moniz, 2011; Wolff, 2010)

3.3 Needs Assessment

While implementing a Supported Education program, it is essential to perform a needs assessment if you want to design relevant interventions for a specific population. Making sure consumers have a say in services that will affect their future is fundamental. A needs assessment can be defined as a methodical and in progress process offering useful information and knowledge about the needs—in this case, about the needs of students with psychiatric disabilities (Unger, 1998; Mowbray et al., 2006).

The first goal of a needs assessment is to understand what the target group already knows and thinks so you can determine what educational services are required. The second goal is to establish how your SEd program can be more useful for and accessible to consumers (McCawley, 2009).

Performing a needs assessment can provide benefits for your program (Mowbray et al., 2006), such as:

- Decisive information on areas that need intervention
- Effectiveness in program planning
- Help with funding for a new program
- Priority analysis regarding needs
- Students' personal stories can be powerful advocacy testimonies
- Can have political implications

We recommend that before you conduct a needs assessment you develop a plan and determine the what, why, when, who, where and how of your program (see Figure 3.2; McCawley, 2009):

- Define your goals: What do you want to obtain from the needs assessment?
- Choose a target group and stakeholders: For whom is your program and which stakeholders is it also important to involve?
- Method of collecting information: How will you collect data and who will be the respondents?
- Analyze that collected information: How will you analyze it?
- Make decisions: What will you do with the information you gathered?

While conducting a needs assessment, you can collect information directly from the consumers/students and complement this with information that has already been collected. To collect information regarding the students'/consumers' needs, you can use quantitative methods such as a survey applied to students, consumers, families or different stakeholders; or use qualitative methods such as a focus group or open interviewing. Always keep in mind while conducting a needs assessment that the people involved are answering according to their needs and creating the expectation that this program will exist (Mowbray et al., 2006). Other beneficial results can be achieved by applying a needs assessment concerning the development of a SEd program (Mowbray et al., 2006):

- Ascertain who are the people interested in being part of a SEd program.
- Describe what will be the success factors for each of the different stakeholders, especially to consumers.
- Make clear what the specific characteristics of the community are in which your program will be implemented.

Needs assessment can address the following questions. To understand to whom your services will be provided, it is important to define your target group. Socio-demographic information is required, as well as their specific needs.

- What are the needs or problems in this community or of these students?
- How many consumers with educational goals exist in this community or setting? What services do they benefit from?
- How many of these consumers are still in college/university or have dropped out? Other questions to take into consideration (Nelson & Prilleltensky, 2005) could be:
- What are the resources and strengths available that can be used to resolve these needs or problems?
- What can we do to address the problems and meet the needs?

To complete the process of a needs assessment, consider that all stakeholders should have the opportunity to give feedback about the identified needs, so that you may define what are the priority needs and the barriers to implementation of a successful SEd program. To conclude the process of needs assessment, you should make a list of needs, concerns or barriers that will affect the implementation of your SEd program (Mowbray et al., 2006).

Figure 3.2: Checklist for needs assessment

Steps in the Needs Assessment Process	Completion Date
Step 1. Define your goals: What do you want to obtain from the needs assessment?	
Step 2. Choose a target group and stakeholders: For whom is your program designed and which stakeholders is it also important to involve?	
Step 3. Create your list of questions.	
Step 4. Select your method(s) of collecting information: How will you collect data and who will be the respondents? (Consider surveys, record reviews, focus groups, individual expert interviews.)	
Step 5. Analyze that collected information: How you will analyze it?	
Step 6. Make decisions: What will you do with the information you gathered? Prioritize needs and propose solutions to needs and barriers.	

Based on McCawley, P. (2009). *Methods for conducting an educational needs assessment: Guidelines for cooperative extension system professionals*. University of Idaho Extension. Retrieved from <http://www.cals.uidaho.edu/edcomm/pdf/BUL/BUL0870.pdf>

3.4 Resource scan: List of available/required Resources inside and outside Educational Organizations

What?

Inventory of the available support (services) inside and outside the educational organization, both formal and informal.

Why?

To have an overview of all available support, so the Supported Education professional can help the student with psychiatric problems find the support (services) he/she is in need of to remain at school.

Who?

The Supported Education staff list and all available support (services).

When?

At the start of a Supported Education program. Updates should be made on a regular basis.

Where?

Supported Education office.

How?

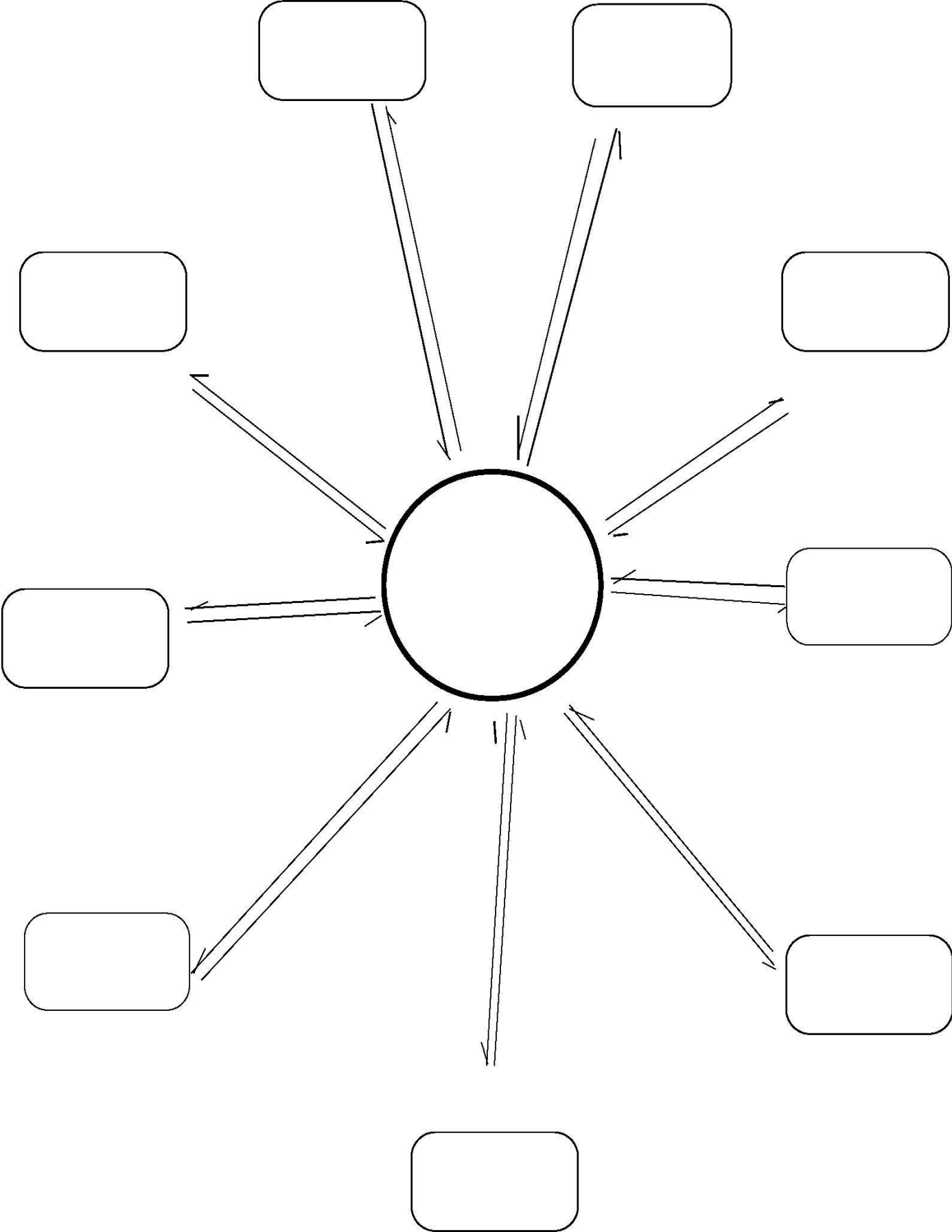
To help students with psychiatric problems to find the support services they are in need of to remain at school, we have developed a tool, the resource scan. The resource scan can help you to list possible forms of support, inside and outside the educational organization, both formal and informal.

In this document you will also find the outcome of a European resource scan conducted by the four partners of the ImpulSE project. It is an overview of general types of support. Per country there will be specific resources

This is an exercise to introduce you to concepts essential to the resource scan. Just as this has been adapted from other uses (i.e., SECAG), you may use the ideas behind it for any planning process. Please feel free to abbreviate as necessary. In the context of developing a Supported Education program, these are the instructions:

- a. The students with psychiatric disabilities you are serving have to be at the center of the scan. Write this in the circle (see Figure 3.3).
- b. Each of the boxes around the page indicates an organization, service, program, agency, individual or entity which is or could be supportive to students with psychiatric disabilities.
- c. Those who are or could be supportive are known as resources. Please write their names in the boxes.
- d. Mark the most critical resources (top three to five).
- e. Write on the incoming (towards you) arrows what you could reasonably expect to receive from each critical resource. If you are extremely persuasive, write what you hope to receive.
- f. Write on the outgoing (towards the resources) arrows what you expect the students with psychiatric disabilities will have to do to get access to this resource.
- g. After you have done this by yourself, repeat the process, but this time, talk to each of the potential resources to find out if your assumptions were accurate. Update your resource scan.
- h. If you discover additional resources, add them to the process.
- i. List and describe the resources in more detail. You can find examples of resources inside and outside education in paragraphs 3.4.1 and 3.4.2

Figure 3.3: Resource map



3.4.1 Resources within education⁸

Figure 3.4: Overview of resources

	Within education	Outside education
Formal	<ul style="list-style-type: none"> • Supportive educational staff members • Teachers/tutors • Student psychologist • Information outlet • Disability services • Student union • Study advisor • Remedial teaching 	<ul style="list-style-type: none"> • Supported Education center of expertise • Telephone helpdesk • General practitioner (GP)/school doctor • Self-employed psychologists • Mental health services • National disability organizations • Finances
Informal	<ul style="list-style-type: none"> • Fellow students • Peer support group 	<ul style="list-style-type: none"> • Self-help groups • Family • Friends • Study buddy project • Patient and consumer organizations

Formal resources

Supportive educational staff members

Secretarial staff, library staff, and administrative staff often know students quite well. The contact with these staff members is often different from contact with teachers or tutors. The degree to which supportive educational staff members have contact with students depends on their task interpretation and their personality. Friendly support from these people can help you to feel better, but when you experience severe psychiatric problems, contact with a doctor or specialized social worker might be necessary.

Teachers/lecturers/tutors

Besides an academic role, teachers and tutors also have a more general supporting role. Many students discuss their personal problems with them. This can be helpful because it can be good to talk to someone, but also because the teacher or tutor can give advice concerning the consequences of the problem for their study. However, students do have to realize that teachers and tutors are not mental health practitioners. Moreover, they are often very busy, so the degree to which they can give support with severe psychiatric problems is limited. Nevertheless, it can be helpful if a student keeps his teacher/tutor informed about the situation. They can give suggestions about other support services or even arrange appointments straight away.

Student psychologist

When less specialized forms of support are insufficiently helpful, it might be good to get help from a psychologist who is connected to the educational organization (not every educational organization has a student psychologist). This psychologist can often do a lot himself, but he can also refer the student to other social workers as necessary.

Disability services

Some educational institutions have student disability services in place. At first, these services

⁸ The situation and existence of listed resources may differ in particular countries.

were aimed more at physical disabilities than at psychiatric disabilities. Slowly, the focus on the latter is growing. Usually, a disability service does not offer therapy, but more practical help with the solution of problems. The focus of this help is on:

- support for the individual
- realization of adjustments to the educational environment

Support for the individual might consist of discussing problems; the availability of a computer to ease the application of study competencies; someone to take notes during class; someone to help the student to actually go to school; or someone to negotiate with teachers in order to achieve that the student gets more time for his exam, for instance.

Changes in the educational environment might be the availability of a quiet environment; the possibility of a part time study; or the availability of a silent room to take an exam.

Student union

Student unions often offer students confidential and free advice about, for instance, debts, housing, and problems related to study and administration. Often, students can come to a student union any day during office hours. Students get help with exploring the possible support services and information about other resources that are available to them. Some student unions have a special workgroup of students with a disability.

Study advisor

At many schools, study advisors are present who give support when there are problems during the study. Often there is a study advisor who specializes in students with a disability. With certain matters, one can also go to a study advisor or tutor. If possible, it is wise to get in touch with these staff members prior to the start of the study.

Remedial teaching (organized, or by a classmate)

Remedial teaching tailors remedial intervention plans to a student's specific needs. It makes use of one-on-one instruction, small group instruction, written work, verbal work and computer-based work. Help is offered to students who need (pedagogical/didactic) assistance.

Informal resources

Fellow students

Support from fellow students, whether they are friends or not, might help. It might concern students who go to the same classes or who live in the same house and have probably already noticed that something is going on. It is possible that a fellow student has his own thoughts about what you should do in order to solve your problems. Sometimes, this opinion contradicts your own. It can also be that you don't want to share certain things (disclose) with an interested fellow student. Confidentiality is not guaranteed. Sometimes a student with problems is afraid to burden a fellow student because he thinks that the other has enough problems on his mind. Sometimes, fellow students spontaneously make themselves available as supportive volunteers. They can offer valuable support; however, when the need is too great, specialized help is needed.

Peer support group

A peer support group offers mutual support when studying with psychiatric problems through, for instance, the exchange of experiences and study tips. Reciprocal contact is often a source of recognition, acknowledgement, support and information for many students with psychiatric problems. A peer support group is a place where understanding and support, on top of the daily hassles, are central. By exchanging experiences and supporting and advising each other, you help yourself and each other to become stronger and more resilient for the future and to leave the past behind you. A peer support group helps because:

- you often have questions and insecurities that you wish to discuss with peers.
- you experience in the peer support group that you are not alone.

3.4.2 Resources outside education

Formal resources

Telephone helpdesk

Telephone helplines offer the possibility of having a confidential conversation with someone when other services are not available (at night and during weekends). If desired, the caller can remain anonymous. Sometimes it can help to discuss your problems in this way. The helpline can also give you information and advice about other support services.

Self-help groups

Self-help groups are organizations in which people who are experienced with similar problems offer help. The support can be related to depression, sexual abuse, addiction, eating disorders, etc. You can discuss your problem and learn how others have coped with a similar problem.

General practitioner (GP)/school doctor

The GP or school doctor is not only there for severe physical or psychiatric problems. They are open to other life problems as well. Most doctors are willing to discuss any problem a patient brings to the table. Most of the time, you can see a doctor at short notice. Everything you discuss is, of course, confidential. A possible advantage might be that this professional has nothing to do with school.

Students are sometimes afraid that, when they go to a doctor with their problems, they are left with a file that says that they have a psychiatric disability. Yet even when such a diagnosis is made, there are sufficient safeguards that this information remains confidential.

It is likely that much suffering can be prevented by calling for help quickly when in psychiatric need. When more specialized psychological or psychiatric help is needed, the doctor can make a referral to other professionals. Doctors can also give general information and referrals to self-help groups. Besides, a doctor can prescribe medication to counteract fear, depression, insomnia, etc.

Mental health services

Mental health services support and treat people with mental disorders (mental illness or mental health difficulties) in the community, if possible, or in a psychiatric clinic or hospital if necessary. The array of (community) mental health services varies depending on the country in which the services are provided. The services may be provided by government organizations and mental health professionals in the form of psychiatrists, psychologists, psychotherapists, psychiatric nurses, social workers and occupational therapists.

Self-employed psychologists and other practitioners

Self-employed practitioners are not free, but sometimes they are partially or totally reimbursed through health insurance. These practitioners operate following different approaches. The focus might be on:

- connecting experiences from the past with current experiences.
- giving attention to established thought and behavior patterns.
- working with problem solving techniques.

Sometimes a practitioner might combine several approaches. Often, the relationship between the client and the practitioner determines the success. So, if you are not satisfied with the approach of a practitioner, don't be afraid to try another one. Among the social practitioners there are, unfortunately, some with spurious qualifications: it is a good idea to ensure that the professional is professionally recognized.

National disability organizations

These are centers of expertise supporting and stimulating the community integration of people with disabilities. There are specific disability organizations supporting young adults with a disability to study successfully in postsecondary education at the study of their choice. They signal what is important to the students, translating their questions into possibilities that an educational institution might offer in order to bring about a change in mentality. They develop instruments to help both students and educational institutions to solve problems. They are also a service and information point for educational institutions. Such an organization answers questions about support from the educational institutions and provides courses to enhance the expertise at the institutions.

Finances

Students with a disability can apply for many benefits. Does a student have a study delay because of incapacity to work or special circumstances? In some cases, this student might apply for a special benefit, a student loan. Usually, the student has to apply for this benefit together with and after consultation with the student advisor.

The Disablement Assistance Act for Handicapped Young Persons is an act for people who became handicapped or chronically ill at a young age and who need help with finding and keeping a paid job. In different countries, this Act has different names. Disabled young persons can apply for a benefit if they are not able to work or do not earn enough money with their job. The focus of such an Act is mostly on finding and keeping a job, not on education. Legislation and regulation concerning studying with a disability changes on a regular basis.

NGO (social services)

NGOs provide individualized long-term help or support in the form of Supported Education, social rehabilitation, supported employment, sheltered housing, meaningful day activities and information. Concerning education, NGOs could provide general support to help students reach their goals—dealing with practical issues, assistance and escort, negotiating with institutions, the daily regime, study, living, finances, coordination of other resources, recommendation of subsequent services, support to family and relatives, feedback, and psychological support.

Peer support

Peer support refers to initiatives where colleagues, members of self-help organizations and others meet as equals to give each other support on a reciprocal basis. Peer support is distinct from other forms of social support in that the source of support is a peer, a person who is similar in fundamental ways to the recipient of the support; their relationship is therefore one of equality. A peer is in a position to offer support by virtue of relevant experience: he or she has "been there, done that" and can relate to others who are now in a similar situation. Peer support is a key concept in the recovery approach and in consumer-operated service programs. Peer support in education refers to students with psychiatric disabilities supporting each other and challenges the associated stigma and discrimination in educational institutes.

Informal resources

Family

For support with their psychiatric problems, students often go to their family first. Family members know you well, are interested, can show empathy and understanding, and can reassure you. However, they can also have an opinion with which you disagree. It is also possible that you do not want to share everything with your family.

Sometimes one's problem is related to the family situation and therefore it might be better to talk to an outsider about this. You have to decide for yourself what your family can offer you in your specific situation.

Friends

When students go through difficult times, friends form a valuable and frequently used source of support. They know the student and his situation, and they can reassure him and show understanding. However, sometimes you need more than your friends can offer. They might be too closely involved and have their own opinion about what you should do. Sometimes you do not want to tell everything to your friends, and confidentiality is not guaranteed. Sometimes one is afraid to ask too much from friends, and sometimes one's friends have enough of their own problems on their minds.

The above certainly does not mean that you ought not to go to your friends for advice. Research has shown that openness in friendships has a positive effect on your psychological health. However, you need to consider what you discuss with your friends (disclose) and to what degree you want to make use of their support.

Study buddy project

A study buddy project uses volunteers (students) who want to be a buddy for (future) students who, for whatever reason, cannot make it on their own. A study buddy is a student who likes to help a fellow student with his study for one part of one day each week. It is about studying together, discussing together how best to plan the study, and drinking coffee together in the canteen. It is important that both parties like to be together and find it useful.

Patient and consumer organizations

In most countries, there are national and regional patient/consumer platforms (RPCPs). These regional platforms consist of local patient/consumer organizations and departments from national patient/consumer organizations. These platforms aim at the representation of interests, providing information for consumers, offering a complaints service, and promoting quality.

Mental health care client platforms are part of these RPCPs. These client platforms are a bundle of interest groups of and for people who are hindered or limited in their everyday social functioning due to psychiatric, psychosocial and/or addiction problems. In a client platform, client organizations, family organizations and client councils in mental health care work together to improve the position of the person who asks for help and his social environment. One section of these client platforms is a question and health information point on mental health: this is a central information outlet with a broad spectrum of information about mental health. Students with psychiatric problems can also make use of this information to find their way through the many available services and possibilities. A client platform serves a broad target group—that is, with their activities and work, they do not make a distinction according to what psychiatric complaint, problem, illness, diagnosis, disability or handicap a person has.

3.5 Good Practices

In the next sections, descriptions of four good practices are given. Each of the ImpulSE project partners has described their own good practice regarding Supported Education services. The good practice needs to be worth transferring and exploiting in different contexts and environments by new users. We hope that professionals wanting to provide a Supported Education service to students with psychiatric disabilities become inspired by these good practices and find these descriptions useful for the development of their own SEd program.

In the good practice descriptions, the following topics are discussed:

- Collaborating organizations
- History
- Philosophy, mission and principles
- Participants
- Services/activities
- Evaluation (experiences and results)
- Success factors
- Risk factors
- Future

The Supported Education program “*Studier Med Støtte*” (SMS) in Bergen, Norway, is described in section 3.5.1. This is followed in 3.5.2 by AEIPS’s Supported Education program in Lisbon, Portugal. In 3.5.3, the Czech Supported Education services are discussed, and finally, a description of the Dutch career guidance course entitled Impuls is given in 3.5.4.

3.5.1 “Studier Med Støtte” (SMS) in Bergen, Norway

Collaborating Organizations

Supported Education in Bergen (SEd), or Studier Med Støtte (SMS) in Norwegian, is currently housed in the Student Welfare Organization in Bergen (SiB), which is a private, yet publicly subsidized, nonprofit organization with a long history of providing various services to university and college students in the city of Bergen. SEd is organizationally situated under the superordinate “Health and Counseling Services” branch of SiB. SEd Bergen is financed by the Hordaland regional branch of the Norwegian Labor and Welfare Administration (NAV), the bureaucratic entity executing legislative directives under the Norwegian Ministry of Labor and Social Inclusion, and the Norwegian Ministry of Health and Care Services. These two partners constitute the formal and minimum collaborating requirements for SEd operation in Bergen.

History of the Program

In 2006, Norwegian cities were successful in lobbying for earmarked government funds designed to help alleviate the extra costs said cities incurred as a result of a proportionately exaggerated number of psychiatric patients finding permanent residence in cities where treatment services were available. Patients with psychiatric disabilities from rural areas would end up in the cities after long treatment regimes. This temporary redistribution of centralized funds was called the “Big City Push,” and a condition for the provision of these funds was that said cities designed projects to cater specifically to this target group. This legislation set the stage for numerous pilot projects working with this target group, though the implementation of Bergen SEd did not materialize out of thin air.

Two years before this “Big City Push,” in 2004, the city of Bergen hosted an international conference on psychiatric rehabilitation. The city of Bergen’s “senior advisor on mental health issues,” Audun Pederson, who held official responsibility for creating the project profile of the Big City Push, had in advance the opportunity to see Professor Lies Korevaar of the Netherlands speak on SEd. This coincided advantageously with an internal evaluation undertaken in 2004–2005 by Bergen’s first psychiatric rehabilitation outpatient clinic, Solheimsviken Psykiatrisk Poliklinikk, wherein 156 long-term patients were asked whether they would like to pursue a degree in higher education. Eight percent expressed a wish to study, though almost all felt too “weak, afraid or stigmatized” to begin studies on their own.

Originally germinated in Bergen as a locally planned municipal aspiration, SEd soon came under the lens of the central government agency, the Norwegian Labor and Welfare Administration (NAV). In 2006, a formal collaboration was established between NAV and SiB

and two “project leader” positions were provisioned at 50%, one held by a clinical psychologist with experience with the target group across a range of public health institutions and one held by a nurse with a master’s degree in Health Promotion. This initial enterprise was part of a larger campaign called “The Will Leads the Way,” which was an amalgam of projects geared towards assisting young people with psychiatric disability in their attempts at reintegration into society, both with regard to supported employment and self-governed “meaningful activity.” Under these auspices a two-year mandate was allocated as a trial period.

Student welfare organizations in Norway have a long and strong tradition in providing various low-threshold services to students. NAV approached the student welfare organization in Bergen, Student Samskipnaden I Bergen (SiB), via one of Bergen municipality’s collaborating organizations catering to psychiatric disabilities. This organization, the Center for Training for Work Employment (ALF), functioned as the initial project overseer. ALF then formally transferred management of SEd responsibilities to SiB, which since 2006 has housed SEd and functioned as employer and professional caretaker of the “pilot project.”

SEd Bergen thus had its target group and one additional criterion was added: All students had to have “external therapists.” It was thought that this stipulation would ensure that SEd avoided becoming an additional partner in a health service treatment regime. SEd services would focus on the student role. Two 50% positions were funded, with one being extended to a full 100% position a few months into the first phase.

NAV was simultaneously gearing up to address the rising number of permanently disabled, with a special look at young people with psychiatric disabilities, and SEd looked to be a well-thought-out project with some clout from successful projects in the USA and the Netherlands. Preliminary evaluations of SEd during 2006 were positive and under the umbrella of the “National Strategic Plan for Work and Mental health 2007–2012,” NAV decided to continue funding SEd and other projects beyond the initial two-year mandate.

So without an existing academic milieu, or even an interested organization lobbying for such a service, SEd was initiated in April 2006, in Bergen, Norway. All this was accomplished without specific competence or extensive preexisting knowledge of the field, whether by a bureaucratic official or newly appointed project employee.

The above-mentioned sequence of events, or “serendipity,” indicates that it was by no means a given that SEd would arise in Bergen, and were it not for these specific events/conditions/engaged persons, we would most likely not have seen SEd on the scene for years to come. However, though it is now eight years since SEd began servicing psychiatrically disabled students, there is to this day no final adjudication as to who shall fund SEd, where SEd should be embedded, or even, indeed, if SEd services will exist beyond 2015.

A truncated history of SEd in Bergen includes the following relevant factors:

- 1.5 SEd positions hired in 2006 to adapt principles to a small target group in Bergen.
- Organized within Student Welfare Organization independent of university.
- Trip to the Netherlands. Professor Lies Korevaar host and consultant.
- No unique central government administrative provisions. Lumped together with “Work and Mental Health” programs as tiny adjunct project.
- Coincided in 2007 with national push to address increasing levels of permanent disability among young adults in the work force with psychiatric disabilities.
- Formally accepted as desired “developmental goal” under the auspices of the “National Strategic Plan for Work and Mental Health 2007–2012 ” of the Ministry of Labor and Social Inclusion.

- In 2007, Bergen SEd is formally asked by NAV to function as consultant in the service of establishing SEd projects around the country where large student populations indicate a need for local SEd program placement.
- By 2012, eight SEd sister projects are provisionally established at either/both university or/and college locations. Each project is adapted to local conditions. Various models of cooperation and organization have thus far functioned successfully.
- NAV commissions in 2012 a large independent evaluation/study of seven SEd projects in Norway (results to be looked at in section 6, "Evaluation (experiences and results)."
- 2012–2014: still awaiting central government adjudication. Year to year existence.

Social, cultural, historical variables impacting SEd implementation in Norway:

- Longstanding egalitarian society with modern/"imported" monarchy/aristocracy. Historically narrow gap between the rich and poor. Class awareness, workers' rights understood and integrated in society. Oil found in 60s–70s. Per capita wealth near top in the world.
- Preconceptions about chronic psychiatric disability, color awareness and inclusion. Physical disabilities traditionally addressed according to European standards.
- Academic affiliation with West. Psychiatry traditionally a biological-medical monopoly administered by doctors. Latency in adapting psychosocial rehabilitation from outside sources. High levels of forced medical treatment and hospitalization.
- Growing realization of the significance of psychiatric disability as economic burden on state. "Work" and mental illness becomes focus.
- Elementary and secondary school health services guarantee physical and mental health services. Contemporary focus on workplace inclusion.
- No focus on "chronic" psychiatric disability at tertiary/higher educational levels. Student welfare organizations provide short-term counseling and treatment for students with lighter, transient psychological challenges. Moderate to serious disabilities are referred to state-run institutions.
- 2009 – Law Against Discrimination Based on Disability. Physical and mental disability equated. Responsibilities for support fall on workplace and educational institution.
- Despite law of 2009, no facilities or support for psychiatric disability in place for tertiary education in 2014. Problem of definition, culture and division of labor. Health services expected to cure first then leave student to move on alone.
- Local student services run almost entirely by student welfare organizations.
- SEd projects financed and run by labor/welfare system. Few places available. "Eye of needle" principle. No rights-based service.
- Public services huddled under "Supported Employment" administration. Three-year support limit.

Philosophy, Mission and Principles

SEd in Bergen draws upon central humanistic principles in general, and specifically upon the foundations built by the psychosocial/psychiatric rehabilitation movement for people with psychiatric disabilities. More recently, SEd Bergen has adopted a recovery-oriented stance, and to the degree one can clearly define the concept of "recovery," we feel this stance more accurately places the center of movement and change within our clients, thereby aiding the delineation of our role vis-à-vis our clients' own goals and aspirations. We understand our role in this partnership as a natural evolution of any secular state welfare provision in parity with any rehabilitation service catering to physical disability. In both cases, rehabilitation, or "recovery," is a specific health-promoting process based entirely on the client's factual condition, accessible resources, personal aspirations and hence unique trajectory. We do not possess blueprints that all clients must follow. They are antithetical to our approach.

As a minimum, the following constitute basic tenants of this “philosophy” or ideology:

- People with psychiatric disability can recover from their illnesses, but often recovery entails recovering from the destruction caused by their illnesses.
- We help people with their plans instead of making plans for them – even when they make mistakes.
- We work on life goals, not just illness treatment goals.
- We motivate and excite them to take chances and try new things even when they may fail – “bumbling side by side” (Ragins, 2012).
- We build them up so they will be resilient when things go wrong instead of shielding them from things that may go wrong.
- Recovery services are relationship based, constantly changing and evolving.
- Recovery in the face of chronic illness is not about the “cure,” but rather about maintaining self-image and hope, maintaining wellness and responsibility for self-care, participating in meaningful activities, and ultimately replacing professional support with natural support.

These basic tenants emanate from the humanistic principle forwarding the idea that “authoring” one’s own experience is a basic human right; that in a moral world, no one but the person in question has the status, the authority, under normal conditions, to decide what his/her experience means to them.

Our specific recovery-oriented endeavor in Bergen adopted Unger’s (1991) definition of SEd and our mission is outlined as follows: Education in integrated settings for people with severe psychiatric disabilities for whom postsecondary education has been interrupted or intermittent as a result of a severe psychiatric disability, and who, because of their handicap, need ongoing support services to be successful in the education environment.

We understand SEd services as ideally situated recovery-oriented services wherein student goals and aspirations take a front seat in defining what, when, where and how we provide individualized support. Furthermore, we subscribe to Article 26 of the Universal Declaration of Human Rights, stipulating that “Everyone has the right to education.... and higher education shall be equally accessible to all on the basis of merit.”

Furthermore, Norway passed the Law Against Discrimination Based on Disability in 2009, wherein physical and mental disability are equated. The law states that the responsibilities for support fall on the workplace and educational institutions. Although we have yet to see the practical implementation of this law across society as stipulated by the law, we operate in accordance with the intentions posited therein. In the same way that physically disabled students receive support in educational settings, we provide relevant support for the psychiatrically disabled. For many, such support will need to be provided throughout the course of higher education.

The counselor-student relationship is at the outset defined to a large degree by the student’s educational goals and the educational landscape, and the temporal aspects of higher education define the extent of our involvement in the student’s life goals. Though the individual student’s educational goals are the obvious focus for our collaboration, we adjust our support according to each individual’s needs during the course of his/her education. Our focus is not on pathology – a severe deviation from a hypothetical mean – but rather on challenges presented by students, ones that they outline as obstacles to goal achievement. We are thus flexible and attend to a wide range of presenting problems. We do not provide treatment per se, though we engage in client-centered dialogue revolving around student disabilities as these impact study capacity.

Participants

As mentioned in the section on the “history of the program,” the target group for SEd services in Bergen was defined at the outset as “persons with moderate to serious psychiatric disability who are qualified for higher education and who maintain an ongoing relationship with an external therapist.” Moderate to serious psychiatric disability entails for us a level of functional disability as opposed to the traditional biomedical definition of serious psychiatric disability. Hence, any given student with, say, a diagnosis of one of the psychoses may present better functioning than a student with complicated anxiety.

Recruiting participants to SEd Bergen was not difficult, since we had an existing network of health professionals placed in psychiatric institutions and community-based services. We approached these connections with our pilot project outline and soon we had more willing participants than we did available resources. Since the autumn of 2006 we have had a long waiting list, with an average wait of over 1.5 years.

The majority of our students in 2006 had experienced truncated educational careers years earlier as a consequence of budding psychiatric disease. All but one or two had particular educational goals and all of these were interested in individualized support. In fact, many expressed a dislike of participating in group activities or classroom-oriented support. The average age was 33 in 2006, though that age has since been lowered to approximately 29–30. During the eight years we have provided this service, we have seen on average a 60–40 % female to male ratio among our participants.

Applying for inclusion in SEd Bergen is done by the student, based on the student’s own motivation. We do not maintain records or journals from mental health institutions, nor do we need their evaluations of any one student’s prospects. However, if the student himself/herself wishes to provide this information initially, or if he/she wishes to be accompanied by mental health professionals, we welcome this as long as the student’s own presenting reality is central.

The majority of our students receive funding from the superordinate administrative provisions in NAV called “Supported Employment.” Though NAV did entertain the idea of developing a support system funding category designed specifically to cater to students – for example SEd – this was abandoned when the future of SEd and its eventual place in a permanent budgetary hierarchy became an issue at the end of the National Strategic Plan funding period. We await SEd’s final placement, a permanent embedment in Norway, and we have been informed that as of spring 2014 a central government committee composed of bureaucrats across the directorates of health, education and welfare was appointed to address this situation. We are in favor of the national implementation of SEd at all levels of higher education, with primary responsibility situated in the Ministry of Education.

Though we see a need for collaboration across directorates, our stance is that an unequivocal placement within the sphere of education both secures the rights of the student as stipulated under the law of 2009, and furthers the superordinate responsibility of society in reducing stigma in general. Students with documented psychiatric disability will then enjoy the same “rights-based” support as those with physical disability.

Services/Activities

SEd Bergen is based to a large degree on SEd theory and practice developed earlier in the USA and the Netherlands, and we adhere to what is now known as the “Choose – Get – Keep” model. Our services and activities are therefore designed to help any student in our target group with choosing a desired educational path, getting access to such an education and thereafter maintaining the process of completing the desired education. Because the majority of our students are automatically qualified in terms of academic requirements, and because most of these choose their direction before they come to us, most of our services

have been developed to help students maintain their educational careers (“Keep”).

SEd Bergen has been operating since 2006 with a long waiting list. Students simply complete our application form, a form found both on the SiB homepage and NAV’s homepage. We respond to all applications within approximately one week, informing the student about the waiting list. When a spot opens up, we contact the student for an interview where we explain our services in depth, while also inviting the student to elaborate on his/her wishes. If the student is within our target group and he/she still wants to receive our support, we offer initial consultations wherein the student’s particular challenges are discussed.

SEd Bergen is located centrally on campus, inhabiting offices within the university-owned, SiB-used “Student Center”. Our offices are to be found alongside other health and counseling services – student advisors, psychologists and career consultants – and this is conducive to relevant cooperation when students present problems spanning these services. The Student Center also houses a swimming pool, weight rooms and a variety of workout opportunities. There is also a large cafeteria, a small restaurant, student bookstore, newspaper, radio station, conference rooms and offices for student democracy. The Student Center is thus the heart of student activity in Bergen.

Inhabiting this centralized position, and being integrated within health and counseling services in general, which are open to any student, seems thus far to be advantageous in lowering thresholds for our students. Most of our students have long histories in dealing with mental health institutions, personnel, government offices and case workers, etc., who focus on pathology/deviation and hence view the students as needing particular guidance above and beyond what “normal” students need. Having these services situated together, services students can access without a referral from a doctor or mental health professional, helps solidify students’ identity as “owners” of student services on a par with any other student. We will come back to this in the section on “Success Factors,” but for now we can state that many students have expressed relief at finding our services on campus and integrated within the Student Center.

As mentioned above, most of our students are looking for “Keep” service help. We do, nonetheless, have a few students who want help with “Choose” and “Get” services. Roughly speaking, we can outline our services as follows:

Choose: Help establish educational goals, find the correct educational institution for such goals, and choose – sometimes as a consequence of trial and error – the correct academic load for each individual.

Get: We help students with forms, interview preparation, deadlines, telephone calls, on-campus tours, sifting through student handbooks, etc. Here we are hands-on, practical and pragmatic according to very specific needs.

Keep: Our primary goal is to assist with whatever the student presents as a hindrance to his or her education. This often includes a number of the following services:

- In keeping alive and enhancing the educational process, we often focus on study skills and techniques and the structuring of study schedules.
- We communicate with, and refer to, our educational experts in neighboring offices so that our students can benefit from their expertise in study technique, exam anxiety reduction and social skills building.
- We are keenly aware that students in our target group have, on the whole, poorer physical health and we thus spend some time helping our students get acquainted with training facilities. In fact, we offer our students free access to five major gyms run by Sib, and we often accompany our students ourselves to these facilities so that they may feel more comfortable accessing what other students take for granted. One student who has now graduated has expertise in physical fitness and outdoor recreation. We have, as of spring 2014, hired him to structure and provide training sessions, both in the gyms and in and around the city of Bergen (mountain climbing,

- jogging/running and cabin trips).
- Some students request help in communicating with relevant institutes/faculties when planning the curriculum, working out special needs etc. We ask to be included in such meetings with student advisors and for many this helps to build confidence and a sense of security about their progression. Student advisors are, on the whole, positive about our presence, and both parties (student and educational institution) solidify a common understanding of the situation.
- We help students apply for specific exam support, such as extra time, single rooms or exchanging oral for written exam formats. These provisions have thus been given without question as long as applications are on time.
- We take tours of the city and campus in order to help students build cognitive maps of their educational environment (much of the university and parts of colleges are in the downtown area). We help students find student services, from cafeterias, offices, student organizations etc.
- We arrange for monthly social gatherings with food and drink. Though most of our students ask for individual support, many enjoy meeting others in open social gatherings. Meeting other students in the same situation builds a sense of community. We sometimes use these gatherings to invite outside experts, relevant bureaucrats who may have important information for our students.
- We arrange for Christmas dinners, a tradition in Norway, either locally organized here at the Student Center or at restaurants serving traditional Norwegian Christmas foods.
- Most students ask for “support consultations” on a regular basis during the course of their education, and these consultations constitute our primary function.

Evaluation (Experiences and Results)

Any evaluation of our SEd service must focus on whether or not students receive services that assist them in attaining their own goals. We do not dictate or even suggest specific educational paths for a student unless he/she asks for guidance. Though SEd still falls technically under the administrative rubric of Supported Employment, we are not concerned directly with what the student decides to do with their education upon completion. We do, however, assist any student for a period of six months after he/she obtains a degree in finding appropriate job placement services. We adhere to Unger’s definition of SEd outlined earlier, and with that as backdrop, we ask ourselves if we are able to help the student get to where he/she wants to go, be it enrollment in a few courses chosen purely out of interest, or a formal vocational degree at master’s or PhD. level. We do not, therefore, function as a gatekeeper or monitoring control unit vis-à-vis educational institutions.

SEd Bergen has, from the outset in 2006, been a “popular” service, with demand outweighing supply. We noticed early on that our students were keen to maintain their slots in our SEd program, and this tendency seemed to exceed retention rates for other programs who dealt with young people exhibiting psychiatric disability. In order to assess SEd services beyond anecdotal evidence, we undertook in 2010 a so-called “internal evaluation.” We asked four simple questions, two regarding personal information and two of which are relevant here: (1) What does your higher education mean to you? and (2) What does SEd mean to you? Two thirds of our students responded. The following is a sample of responses from this initial internal evaluation:

- Man, 33 years of age, who studies Biology at University of Bergen (UiB)
 - (1) My education represents one of the few positive activities in my life. Successfully learning new things helps me to believe in a brighter future.
 - (2) SEd lowers the threshold for my participation in higher education by stimulating belief in myself which strengthens my motivation to succeed.

- Woman, 35, Nursing School, Bergen College

(1) Education gives me the chance to move on in life and ultimately free myself from dependency on the state. Studying is inherently meaningful and this increases my quality of life and nurtures my self-esteem.

(2) SEd provides the security I need to persevere when I doubt myself. Emotional support and help to focus on academic activity.

- Man, 31, Master of Physics at UiB

(1) My studies give me a longer horizon and a meaningful daily life. Without a long-term goal my days blur and time loses its meaning.

(2) SEd offers understanding and help in dealing with aspects of my condition that rarely get attention. The best part about SEd for me is their patience and capacity to empathize with my problems. They treat me like a fellow human being.

- Man, 32, Bachelor in Biology

(1) My education is important to me. Because of deep depression and anxiety I could not continue with my schooling as planned after high school. I tried to work for a while but had to quit eventually. At 29 I heard about SEd. Now I'm committed to fulfilling my Master's Degree in Biology, though it may take a little longer than is the norm.

(2) SEd means a lot to me. My contact with SEd gives me a feeling of security in my daily struggle. My counselor understands my problems and his support has been crucial in dealing with difficult times. The conversations we've had have given me more insight into the nature of my problems, and I feel strengthened for the future. I have also received help in finding relevant services, and even help to fill out forms so that I may get special services around exam time. My future now looks better and SEd is largely responsible for that.

- Woman, 32, Master in History

(1) Higher education is my window to the rest of the world. I am challenged and must relate to other human beings beyond those in my closest family. I am much less isolated now. I'm able to study something inherently interesting to me and this will hopefully move me in the direction of a normal job. The Supported Employment services I tried earlier only found positions for me that do not take into consideration my interests or skills.

(2) SEd gives me the motivation to try one more time. My conversations with my counselor are extremely helpful and I am treated like an equal. I have felt a renewed desire to better myself. On occasion I have needed practical help and my counselor will gladly help me, even outside of his office.

- Woman, 29, Master's in Information Technology

(1) I am finally beginning to hope that my education will result in a job of my choosing.

(2) I would not have been able to restart my education without SEd.

Evaluations like these illustrate the importance of the process of higher education, both as a "window" to the future, or more expansive "horizon," and as an opportunity to rebuild/acquire self-confidence in a normal non-stigmatizing environment. As an arena for Recovery, we see here that individuals rekindle hope and envision their lives after education. So even though we do not provide supported employment services per se, we see that students naturally make the connection between self-development and an expressed wish to participate in society after completing their degrees – like other students.

SEd Bergen had, by the time of this internal evaluation, helped initiate six other sister projects across Norway where student populations were large. We functioned as consultants and advised them to execute their own internal evaluations. The findings from their evaluations mirror our own results.

In 2012, when the National Strategic Plan was nearing its completion, the Norwegian Directorate for Labor and Social Inclusion (NAV) wanted an independent evaluation spanning the country as a whole. The independent research center, UniHelse & Uni Rokkansnetet, provided the best proposal for this endeavor and they completed their report, Supported Education: An Evaluation Commissioned by NAV, in 2012 (Haugland, Ravneberg, Ludvigsen & Lie, 2012). Seven existing SEd projects in varying degrees of development in seven urban sites with student populations were evaluated with respect to models of organization, service provision content and student satisfaction. The main findings of this national evaluation can be summarized as follows:

- SEd in Norway should be made permanent and available to a greater number of students.
- Preliminary evaluation results indicate that SEd actually frees up resources from other health and social services. Many students reduce their use of other services as they gradually master their student roles, become confident and experience self-efficacy/self-esteem. This finding would point to a joint economic cooperation between departments of education, health and labor.
- Experiences with SEd thus far in Norway overlap with research from other countries, suggesting that students with psychiatric disorders can complete their studies when guaranteed the right for support and the right kind of support.
- Students express the importance of SEd counselor relational competence and stability/availability over time. Student formulations appear akin to what research in psychotherapy refers to as “interpersonal skills.”

These results, from both the internal and independent evaluations, reveal – at the very least – a large unmet existing need among students and potential students who would profit from SEd services. SEd has a short history in Norway, with only a few people at all levels engaged in its inner workings and administrative anchoring. The overwhelmingly positive results of the independent evaluation seem to simultaneously complicate the solidification and development of SEd simply because issues of ownership, bureaucratic responsibility and professional leadership come into play the moment a service of this kind is expected to expand and become permanently embedded within a government department/directorate. Thus we await final adjudication from the newly formed committee spanning the fields of health, education and labour.

Success Factors

From what we’ve experienced thus far, “success” can mean many things to many people, and organizational factors, social/society factors and personal factors all play a role (these were covered in the section on expert and student interviews, “What hinders and what helps”). SEd Bergen, as a Recovery-oriented service, came into being through a series of events, brought forth by enthusiastic individuals at an opportune moment within the larger context of society’s need to deal with rising numbers of permanently disabled young people.

To the extent SEd assists students in a “non-stigmatizing environment,” we have evidence that our localization on campus, within existing student welfare services, has furthered this particular cause. Students express an increased ability to participate in student life in general, they are more inclined to know about and use services, and this helps inform, build and nurture a budding identity as a student on a par with other students. The majority of SEd students have histories of collaboration in health institutions or welfare offices wherein their disability alone is the leverage for some intervention thought best for them, but authored by others. Students feel our services break with this pattern and they feel more at ease and empowered when they are encouraged to self-direct any intervention we can offer. They feel less shame coming into our office building.

Though we are a “campus model” SEd service, we also consider ourselves to be a “mobile model” service because we participate, in line with student wishes, both in meetings

throughout the educational institution and in meetings with health institutions, NAV caseworker meetings, etc.

If we first take students' responses to our services as reliable sources of information, we see that students express a need for relational stability and connectedness during the course of their higher education. Some will need the support of the counselor throughout their education, while others may need help sporadically. Flexibility, emotional availability and knowledge of psychiatric disability are minimum requirements outlined as essential SEd counselors traits. We have made individual service provision the central element of SEd Bergen, as this was both asked for by our students at the outset and is underlined as salient in the literature on both SEd and recovery.

Studies on the efficacy of SEd often cite the problem of "attrition," that is, the disturbingly high number of students who drop out of higher education during the course of the research paradigm. Attrition percentages as high as 40% for our target group are not uncommon. SEd Bergen is not at this time equipped to undertake research responsibilities as our staff is already running at full throttle, with daily support services monopolizing all work hours. Although we do not have quantitative data at this time to support our hypotheses in this regard, we do feel that attending to the individual's particular needs and relational capacity strengthens resolve and hence buffers against despondency. We have a very low attrition rate, and we like to think this is because we emphasize from top to bottom the importance of the relational bond in maintaining faith in the future, and hope for better times to come. We cite Anthony et al. (2002): "Seemingly universal in the Recovery concept is the notion that critical to one's recovery is a person or persons in whom one can trust to 'be there' in times of need." This "axiom" is mirrored in the responses we accumulated from our students. It seems to be the most important supportive factor for the students.

To maintain our acuity in this regard, we conduct internal supervision sessions with a self-critical eye to how we impact upon our students' progressions, and in times of turbulence for the individual we look to "operationalize" our input in whatever way it may or may not have impacted relevant events.

Our students battle continually with the dilemma of disclosure. Stigma is a very real phenomenon for our target group, and despite some legislative progress during these last decades, stigma permeates the psyche of our Western societies. In fact, the fear of disclosure is often in and of itself a barrier in terms of accessing available resources. Success for some entails working through or dismantling the fear and shame associated with the condition. Having our services integrated within existing student welfare services, both physically and administratively, helps to normalize and lower the threshold for asking for assistance.

Identifying what works and what doesn't in this field is a difficult task. Evidence-based practice (EBP) is the expected norm, while much of our daily activity resists the operationalization of variables conducive to statistical analysis – though we could no doubt quantify many of the results of our practice with greater resources, something we look forward to doing on a national level sometime in the future. So what we now posit here as success factors represents in fact what we like to call "practice-based evidence" (PBE).

Particular organizational/environmental factors can in retrospect be identified as allowing for a successful early phase of SEd Bergen. Prominent among these were (1) a number of engaged individuals promoting SEd for our target group, many with experience, and hence networks, spanning the spheres of healthcare provision, higher education counseling, health promotion and municipal primary care services, (2) a national focus looking for new, yet "proven," services for our target group that could be quickly initiated as trial projects, (3) immediate administrative and physical integration in existing low-threshold student welfare

services on campus, (4) the development of a network of SEd sister projects throughout Norway that created a necessary network of professionals who met annually to reinforce and develop SEd as a legitimate student service, (5) positive media coverage, in national and local newspapers, student newspapers and radio interviews, and (6) professional autonomy allowing for a local adaptation of SEd principles that were thought most applicable for students of higher education in Norway in general and Bergen in particular.

Risk Factors

Risk factors for the individual student have been outlined in earlier sections. Fear of stigmatization, lack of inclusion within the educational setting and any number of symptoms associated with psychiatric disability itself (anhedonia, cognitive impairment, side effects of medicines, etc.), together or combined, can derail academic progress.

In terms of risk factors for SEd Bergen as a service, ones that ultimately impact the viability of the service, we find political/economic/societal factors. Without a supportive environment in all necessary reverberating contexts, from the local project arena to the highest ministerial/bureaucratic levels of national responsibility, SEd services will not flourish. Though we owe our start-up to all those involved in making SEd a reality at the outset, the fact that none of the successful SEd projects in Norway have yet to be permanently anchored must be seen as a risk factor at this stage. Higher education is a long process for any student. Funding for SEd services has been a budget to budget ordeal. If we give credence to what our students are telling us about what they view as essential for them, namely the confidence in a stable relational connectedness throughout their studies, then we must also be able to assure them of our existence for whatever time they need. Not knowing whether or not we will “survive” from year to year is detrimental to the trust we so desperately need to convey. Without it, many will shy away from taking the risk of rekindling truncated educational aspirations. Furthermore, and equally important, the SEd counselor should also have enough job security to invest his/her time in this new endeavor. Building a new field of knowledge and a service around this knowledge cannot be done efficiently if carriers of the culture lose faith and seek employment elsewhere. We have, contrary to other healthcare vocations, no academic educational/vocational institutions providing SEd workers for the job market. The few SEd counselors who thus far have invested their time and energy need to be nurtured further if these services are to consistently induce trust and a level of professionalism.

Another risk factor, assuming a paradoxical character, is that SEd Bergen is now so sought after that we cannot provide the services for those who ask for them. In fact, we now have a waiting list of between one and two years, an untenable situation for the individual for whom immediate help may be alpha and omega. This is frustrating for the student in question, for us and for our network collaborators. We have become too popular, at least gauged against the backdrop of the resources allocated, ones allocated for a “pilot project” with a clientele of around 18 participants. We are currently operating with 38 participants.

Any official person inhabiting a critical position vis-à-vis the student may constitute a risk factor. Though the university environment, with its teachers, fellow students and administrative staff, more often than not is well-meaning and very helpful, we do come across those who do not understand how to collaborate with our students. At some of these junctures we meet persons of position who exhibit stigmatizing attitudes and behavior towards our students, be it consciously or not. Case workers at NAV, the caretakers of citizens' rights, will from time to time behave in an inexplicable manner, furthering the insecurity of the student with regard to self-respect and economic security. Different case workers inhabiting the same position can come to widely varying conclusions. Currently there are no specific legislative provisions for SEd in Norway. There are provisions for Supported Employment, and here we find ourselves operating more or less in accordance with these regulations. We see this as a risk factor simply because, although the

theoretical/ideological foundations are the same, completing a higher education and finding a job through job placement and counseling are two different things, with different temporal trajectories and different associated challenges. As mentioned earlier, we hope in the future to be anchored firmly in the Ministry of Education, a permanent service catering to students as indicated by the law of 2009.

Future

SEd Bergen has been given a funding guarantee throughout 2015, the length of the ImpulSE project. Technically, no other SEd project in Norway has a funding guarantee beyond 2014. We have therefore only tentative plans for the future. SEd Norway has done a commendable job in building a field. Numerous projects have been conceived to further this development, but we simply cannot take on, say, developing standardized cataloging/assessment tools, to name one project, without assurances of our continued existence and without the necessary resources to adequately cater to our existing student loads.

We hope the ImpulSE project will function as a "success factor" for the anchoring, expansion and development of SEd services in Norway. We cite Anthony et al. (2002) once more: "What is not researchable is whether or not rehabilitation services should be offered to people with psychiatric disabilities. Either we as a people value and believe in the opportunity for rehabilitation for people with psychiatric disabilities or we do not. That is a question of humanism and not empiricism."

3.5.2 Associação para o Estudo e Integração Psicossocial (AEIPS) – Supported Education Program

Introduction and collaborating organizations

In Portugal there is no specific governmental program or legislation about Supported Education for people with mental illness and no specific funding for Supported Education programs. In 2008, a law was approved that promotes equal opportunities and values education as well as an inclusive and democratic school oriented to the academic success of children and young people. This law (3/2008 of 07 January) puts into place the Student with Educational Special Needs status (SESN) to be applied at primary and secondary levels of education. This status provides specialized support, which can imply adapting strategies, resources, contents, procedures and instruments as well as using support technologies. There's no specific legislation for students with special needs in higher education, so this status is adapted by universities with different interpretations and forms.

Due to the lack of specific programs to support people with mental illness in accessing education, AEIPS (Associação para o Estudo e Integração Psicossocial), a private nonprofit organization created in 1987 by a group of professionals, families and people with mental illness, implemented in 2001 the first Supported Education program for people with mental illness.

This program provides a set of support services through choosing, getting and keeping educational projects at all levels of education (literacy courses, elementary and secondary education, higher education – undergraduate, master's and PhD), creating links to the community as well as social and school integration. With the right support, students are able to complete their educational goals (Unger, 1998).

History of the Program

After the creation in 2001 of the Supported Education program whose goal was to allow access to schools in the community to all participants who wished to improve their academic level of education, AEIPS established several protocols with education and training centers as well as schools and universities, providing support to students and acting as a consultant

to teachers and schools in order to ensure students' academic success.

There were two key moments in divulging Supported Education in Portugal: The first was in 2004 when AEIPS organized the international conference "Participation and Empowerment of People with Mental Illness and their Families," which included a presentation by Lies Korevaar entitled "The Supported Education Program in Rotterdam" and another by Ana Franco and Fatima Freitas entitled "Uma oportunidade para voltar a estudar: modelo de educação apoiada para pessoas com doença mental." The second one was in 2007 when AEIPS organized a Supported Education conference entitled "Educação Apoiada: Suportes educativos para jovens e adultos com doença mental no ensino básico, secundário e superior," with the participation as keynote speakers of Steve Szivalgyi and Judith Cook.

Philosophy, Mission & Principles

Educational support programs are an important support resource for people with mental illness facilitating going back to school and supporting their school projects in formal and natural settings. Supported Education programs consist of the promotion of integration in schools and universities and are based on an empowerment perspective (Ornelas, 2008).

The acquisition of new knowledge and the improvement of academic qualifications are fundamental factors for increasing job opportunities and career development. Other positive consequences of participating in natural educational environments are the development of new social relations with colleagues and teachers, the increase of self-confidence and personal strength and developing a new personal identity (from a role of patient to a role of student), thereby contributing to the recovery process (Frado, 1993; Ornelas, 2008; Pomeroy & Pape, 1999).

The Supported Education model aims to support the integration of people with mental illness that wish to proceed with their studies in an educational setting where they may experience life as students and not as psychiatric patients (Bellamy & Mowbray, 1998).

Supported Education is defined as education in integrated settings for people with mental illness that want to go back to school requiring ongoing support services to be successful in the educational environment (Unger, 1991).

AEIPS's Supported Education program has the mission to increase the academic qualification of people with mental illness at all levels of education and in regular educational environments. Increasing candidates' qualifications improves their access to better jobs in the open labor market.

The program's goals are: to foster participants' enrollment in educational projects; to support participants' access to schools and universities in the community; and to provide a support service that contributes to successful educational projects.

The values of the program include domains such as: the use of natural resources, for instance access to libraries, study rooms etc.; a continued support that may be provided within or out of the school setting through support meetings, support in filling out forms for application/registration, etc.; individualization of support taking into consideration students' needs and skills; accessibility to schools and training settings through sharing information about educational opportunities; and service coordination to improve natural support and academic success.

Participants

Supported Education participants are people with mental illness and who are enrolled in AEIPS, are over 18 years old and intend to pursue an educational goal. In 2013, the Supported Education program gave support to 16 students in choosing, getting and keeping

educational projects: nine students in higher education, one student in secondary education, four students in basic education and two students in short-term educational courses.

Services and Activities

This program provides three types of support:

- A. Individual educational program;
- B. Students group and a college students group;
- C. Free study and supported study.

Ad. A. Individual educational program

Corresponds to the support provided individually in order to ensure access to and maintenance of the educational project of students' choice and interest. This support is provided at several levels:

- The choice of the educational project, analyzing the previous school career, the clarification of educational goals and outlining the individual educational plan;
- Access to school: promoting the relationship between the student and the school, support in the enrollment and application process, applications for scholarships, the choice of routes and transport to school;
- Coordination of resources and maintenance of the educational project: a set of brackets provided within the school (with the consent or request of the student) and out of the school.

Ad. B. Students group and college students group

This weekly meeting was established in order to respond to supporting the needs of students. In collaboration with the participants, several goals for this group were defined:

- Sharing and reflecting on the school experience and training;
- Learning to take and organize notes and information;
- Developing skills and study methods;
- Establishing goals and how to reach them;
- Discussing ways to handle the pressure of exams and assessments;
- Discussing the relationship with peers and teachers;
- Providing effective support among group members in carrying out work.

Ad. C. Free study and supported study

Our community center provides study rooms, as well as resource materials such as computer equipment, Internet access and photocopying. Each student can use these spaces as previously planned.

Monitoring also includes a study plan and an individualized support program, and provides information for accessing other resources in the community (libraries, conferences, study places, etc.). Examples of services and activities that we provide are:

At school:

- support with filling out forms for application/registration
- getting information about, and making applications for financial aid for students
- helping students to discover and use school resources (library, cafeteria, academic tutor)
- speaking with teachers and negotiating reasonable accommodation
- linking with student support office

Outside school:

- organizing time and study methods
- providing resources (study rooms, Internet, computers)
- use of community resources (libraries, conferences)
- student support group (weekly meeting established in order to respond to students' needs: sharing experiences and peer support; time management; developing study methods; selecting classes; test preparation; homework; relationships (peers and teachers; problem solving).

An example of a Supported Education plan for a student to access and maintain a graduate course in geography:

1. Definition of a general schedule with classes, study time and sports (jogging on the university campus);
2. Individual weekly meetings – “we spoke about everything, integration difficulties, my successes and less good moments”;
3. Support and monitoring in the application for a scholarship;
4. Collaboration with the head of the University Students' Support Office to access Students' Special Needs Status, which offers some of the following possibilities:
 - a. Changes in the timelines for assignments;
 - b. Taking the exams in a separate room;
 - c. Part-time status: “It is important to note that I did not need these services because the main support was given by the Supported Education program.”
5. Students Support Group – “The participation in the students group was essential for sharing experiences and defining strategies.”

Evaluation

In 2011, a program evaluation was carried out to evaluate the level of satisfaction of students regarding the service provided by the Supported Education program. All students (N=20) enrolled in the program filled out a questionnaire, “Qualitative Indicators for Supported Education Service Users,” which was adapted from “Qualitative Indicators for Supported Employment Service Users,” developed under the Supported Employment Project of the EU Equal Program. It used a Likert scale ranging from 1 (never) to 5 (always) with five factors: Welcoming, Self-determination, School Integration, Support in Maintenance, Rights and Duties. The mean of the results in all factors was 4 or above 4, which means that there was an overall satisfaction with the program quality.

Success Factors

These types of programs that promote community integration through participation in natural educational settings allow the acquisition of new social roles: From the stigmatized role of mental patient to the valued role of student, this way education provides a sense of accomplishment and purpose (Unger, 1998).

Another success factor relates to the student's active participation in the development and structuring of his/her educational project, since the student makes all decisions regarding his/her project.

The support provided according to individual needs is also fundamental to the success of the program as well as the student's opportunity to increase his/her social network. This promotes a feeling of hope towards the future that contributes to the recovery process.

Risk Factors

1. Lack of funding for Supported Education programs
2. Students' financial difficulties
3. Lack of services that promote the integration of students within the school setting
4. Lack of effective accommodation

Future

In Portugal, Supported Education for people with mental illness has a long way to go in order to be a mainstream solution to preventing school dropout of students with mental health problems. There's still little or no communication between mental health providers and educational settings, however with the ImpulSE project we intend that more students may be able to access schools through supported education programs. Also, the creation of a national and international network of Supported Education will make it possible to disseminate and advocate the right of everyone to access education in regular schools and universities. "Supported Education enhances career opportunities and promotes independence and recovery, and should be a service option available for all who are interested" (Unger, 1998). These programs allow the increase of opportunities for participation and success in schools and university settings, contributing to a more inclusive society that understands, respects and values diversity (Ornelas, 2008).

3.5.3 Czech Supported Education Services: Ledovec, Práh and Baobab

Collaborating Organizations and Description of Situation

At this moment in the Czech Republic the entire service of Supported Education (SEd) provides no organization. The reason for this situation is that there is no systematic and financial support from any state department (Ministry of Social Issues, Ministry of Health or Ministry of Education) or other civil or local administration. Requests for EU grants have not been granted to any of the projects written and repeatedly proposed by SE providers.

Some basic and reduced SEd services are currently provided by three nonprofit nongovernmental organizations (NGOs) – Ledovec in the Pilsner region, Práh in Brno and surrounding areas, and Baobab in Prague; all of them occupy themselves with providing social services to people with mental illness. SEd is offered according to their current concrete circumstances, (financial) sources, strong points and legislative options. None of these NGOs report the SEd services for official purposes, they are included in other provided (i.e. legally possible registered) services – usually social rehabilitation and counseling.

Also, most of the colleges and universities have already established some programs of general support for disabled students and started to understand that there are also mentally ill students among them. Nevertheless, the schools still do not have much experience of their concrete support.

So, currently SEd services operate in some kind of run-down or "underground" environment. The topic of SEd does not exist on a systematic and state level, so the question of who should primarily provide the SEd services – NGOs as up to now or schools and educational institutions in cooperation with NGO social services – or whether SEd should be one of the official social services or an educational service integrated in the educational system, has not yet been resolved.

History of the SEd Program

- 2004 – the idea of SEd is expressed in discussion between the directors of Ledovec and Práh (both former high school teachers)
- 2005 – first SEd part-time job in Ledovec; source mapping, contact with Prof. Korevaar
- 10/2006 – 6/2008 SEd pilot project in Ledovec (financed by EU grant) – first team, principles, mission, unifying of definitions, clients, seminars, courses...
- 1/2010 – 6/2012 regional SEd project in Pilsner region by Ledovec, within EU grant again
- 1/2011 – 6/2012 SE project funded by EU grant started by Práh in Brno (based on

- methodology and under the supervision of Ledovec)
- 3/2011 – application of Ledovec into ImpulSE project
- 2012--2013 – one full-time SEd job under the scope of the Social Rehabilitation service of Ledovec, one part-time job in Práh until now
- 4/2012 – visit of Prof. Korevaar to Czech Republic
- 9/2013 – 6/2015 partnership of Ledovec in project ROPOV of West Bohemian University – support for disadvantaged students
- 10/2013 – start of ImpulSE project in Ledovec

There is a service called the “Student under the Scope of Social Rehabilitation Service” in Baobab. It has been provided and developed on the basis of Canadian methodology since 2010. It is currently getting closer to the SEd approach.

Philosophy, Mission and Principles

SEd is a service for people with psychological problems or mental illness, their close relatives and friends and pedagogical staff. The service is provided by means of a supportive network of health, social and pedagogical institutions.

The mission and goals of SEd-providing NGOs can generally be summarized by these words: the provision of support and help to people with mental illness to maintain and improve the quality of their lives in society. The aim is for these people to have the skills and abilities they need to live an individual life in their natural environment.

The three organizations all share the notion that the services are “client-oriented”, That means their activities are based on clients' wishes and needs, helping them to achieve their goals, trying to lead them to the most effective use of resources in their surroundings and also handling their illness to prevent deterioration. The principles of client-oriented access (“not to at students but WITH students”) are:

- In cooperation the client is an equal partner
- During the whole time of the cooperation period the clients decide freely and bear the responsibility for their decisions
- The cooperation with the clients is based on their own wishes and motivation
- Each client is a unique individual with his/her own feelings, opinions and experiences
- The services are provided with emphasis on the client’s development opportunities and his/her integration in ordinary life.

SEd providers use the Choose – Get – Keep model in full in their access and perform in both individual and group form. The model can be used as a help to individuals to decide and choose the appropriate direction for their further education, facilitation of their access to it and gaining it, and from this point on a support in keeping the student status until the chosen goals of cooperation are accomplished.

The supportive network is a consequence of multidisciplinary effort, which is the next important element of SEd provision in the Czech Republic. It is not possible to support a student enough without functioning health – pedagogic – social cooperation. It is essential to mention an important role of peer consultants and their readiness to share their own experiences with mental illness and study.

Finally, within Ledovec, there is an effort to take advantage of opportunities given by the principle of “Recovery” from mental disease. Recovery is a way to live a satisfied, hopeful and beneficial life despite the limitations caused by the illness. Recovery builds a new meaning and purpose to a person’s life by overcoming disastrous consequences caused by mental illness. The model (Dr. Ragins, MHS Village, Los Angeles, USA) terms that are used following the phases of recovery are as follows:

- Hope – confidence that it will be better. Without hope there is nothing to look forward to. This is no false daydream but a reasonably based vision of how things may develop.
- Autonomy a sense of one's own abilities and possibilities; confidence that I can handle what I have; opportunity to make decisions by myself.
- Responsibility – realization of having one's life in one's own hands; bearing the risks and learning from one's own mistakes; cut off the "caretakers."
- Meaningful role in life – it is not the role of the victim of mental illness, a chronic patient ... it is a normal life role unrelated to the disease: employee, son, mother, neighbor, volunteer, specialist on something...

The framework of SEd service consists of three basic activities:

- Prevention – creating general awareness of mental illness and its prevalence in society, destigmatizing activities, informational and educational programs and courses for students and teachers.
- Direct support – individual work with clients (student, teacher, family and close friends) at their request, one-time or short-term consultancy in the field of study, individual supportive student program. Further comprising and offering educational and preparing courses, psychosocial rehabilitation, regular therapeutic meetings, peer consultancy, group support (supportive group for students, group for parents and other close people).
- Work of supportive network – includes cooperation of various parties, organizations and institutions concerned, which is coordinated in the same way as the goal of support for students and elimination of stigma is pursued.

Participants

The following participants are involved in SEd services: clients, SEd provider (coordinator), members of supportive network, eventually other involved persons or institutions ready to cooperate.

Clients

In spite of the fact that the services of SEd are now provided within other social services, the student must usually reach the target group of the service (e.g. diagnosis) of the organization. Other set criteria are usually age over 15, socially unfavorable situation, motivation to study and contract in the field of study. SEd services are provided to students of all educational levels. The reason is that secondary school in the Czech Republic ends at about the age of 20, which means many students fall ill in the course of their studies in high school, and after overcoming all the obstacles to its completion it is hard to find the motivation for further studies. When aged over 20 they often require shorter and more focused educational forms.

SEd service provider (coordinator)

At this time there are three service coordinators – the three NGOs providing a wide spectrum of social services for people with mental illness. SEd service demand at the moment exceeds supply because of the low capacity (financial reason). That is the reason why SEd services are not offered much in public. The time of service provision to a student is not set, it is individual according to the chosen form of cooperation and the client's needs. Services are provided on an outpatient basis and in the field.

SEd supportive network

Apart from the client and coordinator the SEd network includes the client's family, the psychiatrist, counseling centers of colleges and universities, educational consultants of secondary schools, peer consultants, social workers from other services, school psychologist, special pedagogic-psychological centers, and eventually other interested people or institutions with whom cooperation is established (physician, classmates and

friends, employer, psychologist, psychotherapist, psychiatric hospitals ...). It is the first considerable attempt at a systematic interconnection and cooperation in a climate of trust, which is entirely dependent on the willingness of its individual segments to cooperate. Membership in the network is completely voluntary, financially unvalued and contractually unfounded.

The expert system of mental health care in the Czech Republic is quite rich (there is a certain lack only in the case of child psychiatrists), but its individual parts do not cooperate together, sometimes quite the opposite. From the negative manifestations of relations it is necessary to mention first of all the general mistrust between institutions. Also significant is the distrust of patients/parents toward institutions. It is necessary to mention the rivalry of psychiatric wards of general hospitals and specialized psychiatric hospitals. At present, this is enhanced by the uncertainty and fear of impending transformation of psychiatric care and the changes that will bring.

Among the positive signs, it is the competition between individual schools for students (read money) that ensures their survival and therefore the effort to enable and facilitate the study also for handicapped students. Finally, there is a significant increase in the number of specialists whose education has already taken place in the post-communist period and who have experience from abroad.

As for the societal atmosphere, the stigmatization of mentally ill persons, which is gratefully encouraged by some media, is worth mentioning. On the other hand, people who have adapted their own experience of mental illness tend to be very open and willing to help others.

Services and Activities

SEd services generally include:

- support for student in achieving study goals before the beginning, or over the period of, the study
- support for family and loved ones, who are the natural background of the student
- support for teachers in working with students with mental health problems or mental illness.

Specific activities are as follows:

- Individual student support program that includes:
- Mapping the client's abilities and study opportunities
- Support in choosing a suitable school, in preparing for study, for entrance examination, in study or returning to study (Choose – Get – Keep)
- Help with planning, orientation and coping with ordinary school duties
- Support in coping with stress and crisis situations related to studies and in everyday life
- Mediation of tutoring
- Support in negotiations with teachers and other school staff (study dept., counselling dept.)
- Help in the implementation of rights and legitimate personal interests at school
- Support in relationships with classmates, family and loved ones
- Assistance (e.g. escort to school, etc.)
- Preparing for the transition from school to work environment
- Long-term individual psychosocial rehabilitation for people with mental health and psychiatric problems, based on their personal needs and offering support in several areas
- Educational and preparatory courses (training and practice of specific skills important for studying and learning in the groups: training of cognitive functions, work with stress, study skills, social skills)

- Counseling for students with mental and psychiatric problems, counseling for teachers and persons close to such a student
- Support in job search and mediation of other related follow-up services
- Supportive groups
- Peer consultations
- Seminars: “How Do I Know That I Am/He Is Going Crazy?” and “The Blind Leading The Blind – On Mental Health in The Education System” and other (custom-made) preventive and destigmatizing actions and activities
- Building and coordination of SE supportive network
- Collaboration with university counseling centers and high school counselors to develop kinds of support for with mental illness in their schools

Evaluation (Experience and Results)

Due to the aforementioned considerable stigmatization of students with mental health problems and lack of information about mental disorders in schools we decided to put a strong emphasis on prevention, and in addition to direct support for students, two basic variants of information seminars for students and teachers were created. We also responded flexibly to the demand for tailored seminars or programs. In addition to students, we also offered general support to teachers and family members and other persons close to the student.

Mutual distrust, a lack of communication and lack of cooperation between experts, and a lack of and unsystematic coordination of activities in for clients resulted in the decision to try to interconnect professionals and establish a supportive network for mentally ill students. As part of the SEd program (at the time of the projects funded by EU grants) we managed to build a fairly wide support network of professionals throughout the region. The SEd service provider and coordinator of the network was at the same time trying to carry out the role of case manager in individual cases.

The majority of schools, as well as universities, expressed their willingness to cooperate. The quality of cooperation was very different, and only particular schools went in for active cooperation (search for individuals and presenting contacts of service). Gradually we managed to convince the Pedagogic-Psychological Counseling Center that SEd does not only substitute their work and to initiate an effective cooperation.

The program was open to all students with mental health difficulties. Most of the clients were from secondary schools. Clients learned about the service from both the teaching staff of cooperating schools and collaborating (child) psychiatrists and other members of the built supportive network. A total of 2533 students or pupils were in some way supported during the two years of the last EU project in Ledovec.

Success Factors

The growing number of people with mental health problems in society is slowly leading to the opening up of the topic and hence to the increase of awareness and reduction of stigma. All of the aforementioned organizations, which initiated an SEd network in their regions, primarily adapt their work to the needs of the client. Not only are SEd services offered, but also overall support for clients with mental illness, including related services or referrals to other resources. Psychosocial rehabilitation, which combines the medical and educational environment, is the method used for working with all clients.

Sharing and mutual exchange of knowledge in the education and mental health care environment amongst SEd workers is natural. All the organizations employ social workers, psychotherapists and persons with pedagogic education in their teams. They work together very closely. In the broader SEd team, medical practitioners and direct teaching staff meet with each other.

The reluctance of a number of teaching staff to continue mandatory education even in their own field, much less in such a “distant” one, is well known. In health care we can say it is similar. Since in their work other disciplines significantly overlap, social workers are the most open group towards continuing their education. The willingness and initiation of cooperation also derive from this model. Even within the broader SEd teams the willingness to listen, to be informed, to discuss and solve concrete problems is quite apparent before getting educated “officially.”

People working in circumstances of Czech NGOs mostly like to do their job and are recognized for it. The attitude of employees in the mentioned NGOs and their approach to work are enough for them to be called loyal devotees. The current situation of the stagnation of SE services is not so much an expression of the indifference of management and a reluctance to seek finances, it seems it rather hinges on the reluctance of political representation to support the trend. The willingness to cooperate and the amount of work done by other members of the SE network hinge on the activity of the key coordinator (NGO).

Informal contacts and respectful communication are, in a narrower group of the SEd network, a matter of course. Because of the size of the cities and regions where the services are provided, it is, of course, not possible to make do with a limited number of SEd members and with communication with persons unfamiliar with SEd. Therefore it has been suggested that specialized SEd centers should also be set up in schools and university counselling centers, which may employ their own specialists in the field of mental health. That would allow more intensive contact, cooperation, understanding and, last but not least, mutual learning, and the students would move in a safe and familiar environment of one organization.

At present, all the organizations lack the continuous collection and analysis of feedback, evaluation of the progress of the service and its adaptation to the new conditions. The situation is caused by minimum SEd service levels, where mostly one or two people working part-time within one NGO are devoted to the service. At the moment there are basically no functioning teams and no functioning network. But these principles are common in other services of the mentioned organizations and during the SE project implementation they were also well established, so it can be assumed that the organizations are able to learn from their own experience.

How to present the service, and how to let people know about it, depends largely on the coordinating institution: It is difficult to admit students from other educational institutions to the service in the case of universities. In the case of NGOs, it becomes an obstacle to persuade schools and psychiatrists to promote the service enough, because their mutual cooperation just adds to their work. An offer of cooperation and assistance in the implementation of new trends, and an offer of attractive services for cooperating subjects, must be an essential part of an NGO's activities as well as creating a good reputation in the public consciousness.

Risk Factors

An essential element of good practice is the sustainability of SEd in the regular structures of the health, educational and social system in the Czech Republic (independent of EU grants). The question of Supported Education is currently a subject for “disabled” students, social workers providing SEd and some enlightened pedagogic workers or staff of university counselling centers. The success is built on the willingness of individuals (teachers, principals, educational workers, psychiatrists ...) to cooperate, on their will, time and ability to help the student to graduate, and then on the activities, offers and possibilities of the coordinator.

As has been mentioned in many places in the text, long-term financial security is the most important risk factor for the SEd service in the country. In the Czech Republic, the private funds and donations are not yet developed enough to fully secure the provision of some “marginal” social service either in a region or in a city, much less nationwide.

The upcoming transformation of psychiatric care is another present topic and also a risk factor for SEd services. In the psychiatric care environment, the uncertainty of what the transformation will bring, and political maneuvering about possible ways to take a stand in time, shows a lot. This situation contributes to the extension of the unanchoring of the SEd theme, including financial issues.

Future

It is necessary to put great emphasis on prevention in the Czech environment. The lack of information and the prevailing stigmatization of people with mental health problems in society are the main target of changes not only in the SE but among the whole range of helping professionals working with people with mental illness. Teachers and educational institutions in general (including universities) still do not have sufficient knowledge, experience or skills in how to interact with and teach students with mental illness or psychiatric problems. They lack the realization that it makes sense and is possible to support and educate these people through the normal institutions. Due to the lack of information, even the students themselves often have no idea where their problem lies and where they can turn.

The effort for a multidisciplinary approach and collaboration helps to prevent “damages” caused by the insensitive attitude of doctors and health professionals (i.e. iatrogenic stigmata) and other situations, where clients or their families are given contradictory information and instructions by professionals of various disciplines. From another point of view, this is an effort to prevent situations that deepen confusion, helplessness, deprivation and closure.

In the Czech environment it is still normal that the so-called helping network of professionals and experts in mental health care is completely unconnected – e.g. a psychiatrist does not communicate with a pedagogical psycho-diagnostics counseling or social therapist, a psychiatric hospital does not cope with the fact that their patient is also a student, and parents in an atmosphere of distrust strategically decide whether to admit the illness of a child at school. Confusion among families and clients from contradictory conclusions and recommendations of the various institutions is quite normal. Case management in social work in the Czech Republic is missing.

SEd needs to be opened up as a nationwide theme of pedagogy or at least social services and integrated into the structure of the health, educational and social system of the country.

3.5.4 Supported Education at the Hanze University of Applied Sciences Groningen: the Impuls Course

Collaborating Organizations

The Supported Education Center of Expertise was officially launched in Groningen in November 2010 at the Hanze University Groningen (University of Applied Sciences). This Center of Expertise is a partnership between the Research and Innovation Center for Rehabilitation of the Hanze University Groningen and Rehabilitatie '92 in Utrecht. The Center of Expertise also works closely together with mental health institutions such as Lentis, GGz Drenthe, Promens Care, Accare youth psychiatry, Elker youth care and GGz Friesland, with community colleges such as the Alfa College and the Menso Alting College, and with social benefit agencies such as the UWV.

The Center of Expertise develops products and services for, and gives information to, students, clients, family members, teachers and social workers about studying with a psychiatric disability. One of the products/services is the career guidance course Impuls.

History of the Program

In 1999, the career guidance course named Impuls was developed at the community college ROC Zadkine in Rotterdam, as part of the first Supported Education project in the Netherlands. The Impuls course is aimed at helping people with a psychiatric disability to choose and get regular (vocational) education. The Supported Education Center of Expertise modified the Rotterdam Impulse course and in 2009 the first Impuls course started in Groningen.

Philosophy, Mission, Principles and Values

Philosophy

The Impuls course focuses on the support -in groups- of (young) adults with psychiatric disabilities in choosing and getting a regular (vocational) education. The course is based on the Individual Rehabilitation Approach. This approach is in turn based on the psychiatric rehabilitation approach of the Center for Psychiatric Rehabilitation of the University of Boston (Korevaar, 2005; Unger, 1998), and has the goal of helping people with psychiatric disabilities from a client perspective in taking up their self-chosen citizen role. That role can be related to one of four areas of life: living, working, learning and socializing.

The Impuls course is derived from “Supported Education,” a program that is developed by the Center for Psychiatric Rehabilitation of the University of Boston for the life area of learning. A concept related to Supported Education is “Recovery”. Recovery can be seen as an individual process in which a person learns to live with the radical consequences of a psychiatric disability and can give meaning again to life (Korevaar, 2005). Supported Education shows that participation in regular education can contribute to (social) recovery and as such can give an impulse to personal growth and meaning.

Mission

The mission of the Impuls course is:

“The support -in groups- of (young) adults with psychiatric disabilities in choosing and getting regular education.”

Basic Principles of Supported Education

- Improvement of the educational outcome for persons with psychiatric disabilities
- Hope is an essential ingredient of the Supported Education process
- Self-determination: a focus on students making choices (setting their own educational goals) and accepting responsibility for their educational process
- Students are actively involved in all phases of their Supported Education process, determining the criteria for success and satisfaction, as well as evaluating their progress toward meeting their goals
- Partnership between participant and Supported Education professional
- Services match participant's preferences
- Equal/fair access for everybody
- Development of participant skills and of environmental support
- Bridging with mental health services
- Support as long as needed

Values

The values are as follows (Anthony et al., 2002):

- Person orientation
- Functioning
- Support
- Environmental specificity
- Involvement
- Choice
- Outcome orientation
- Hope

Each of these values is reflected in Supported Education practices. The value of person orientation underscores the importance of personalizing the relationship with potential students, seeing each as unique. The value of functioning is evidenced in SEd by the practical skills taught to help someone complete a course; or to teach someone how to respond to negative feedback instead of delving into the root cause of his/her low self-esteem. The value of support is similar: providing practical assistance as long as needed. The need for a morning phone call on the day of an exam may decline over the semester, while the need for an inspirational pep talk may be ongoing.

Environmental specificity reminds us that people differ in their level of functioning across settings. Supported Education assessment should focus on the educational skills and support needed in the school environment, recognizing that the same person who can excel in a math class may have difficulty living on his/her own. A case in point is the Supported Education doctoral student who could barely stay out of the hospital for longer than two weeks yet all the while was completing her Ph.D. dissertation in chemistry at Harvard.

The fifth value, involvement, is self-explanatory, but crucial; the student must be an active participant who drives the rehabilitation process. She or he is the one to set goals, evaluate progress toward those goals, and, with assistance, take responsibility for the many choices that present themselves throughout the Supported Education process. In accordance with this philosophy, SEd embraces the value of choice. When students choose their own school/classes/course of study, they are much more likely to strive to succeed. Shedding the role of patient to take responsibility for choices and decision-making is terrifying. The shift from “patient” to “student” is a powerful one, fraught with the fear of failure, and for many, the equally terrifying fear of success. Yet it is critical that Supported Education be conducted with students, and not to students (Anthony et al., 2002). As in all rehabilitation interventions, students must be “active and courageous participants in their own rehabilitation” (Deegan, 1988, p. 12).

Outcome orientation is the seventh value espoused by psychiatric rehabilitation, and speaks of the importance of assessing not only a student’s grades or attendance, but his/her satisfaction with the entire experience. Finally, belief in growth underscores the importance of hope in the process of returning to school.

Hope has long been recognized as an essential ingredient in rehabilitation, psychotherapy and recovery processes (Anthony et al., 2002; Deegan, 1988). Education in and of itself creates hope; using the intellect creates hope; attending classes on a college campus with other students creates hope; the adoption of the role of student creates hope. Following is a table summarizing the values of psychiatric rehabilitation with examples from an educational setting.

Participants

The Impuls course is accessible for people of 16 years of age and older, who are (ex-)clients of mental health care and want support with choosing and getting (again) a regular (vocational) education and who do not yet know which study they want to pursue and/or doubt their study competencies.

Services/Activities

The (young) adults (hereafter called “participants”) follow the course at a location of a regular educational organization, together with other participants with psychiatric disabilities. The curriculum is fixed and all participants within one group receive the same teaching. During the course, the participants make use of the available facilities at the educational organization. After the Impulse course, the participants can go to a study of their choice and further support is taken care of.

The goal of the career guidance course is to help participants with choosing and getting a (vocational) education. The course also helps with the orientation to, and use of, educational facilities and with gaining educational experience and rhythm.

The course takes place at a location of a regular educational organization from January until April. During that period, there are 12 teaching days (one per week) that last 5.5 hours.

The career guidance course includes the phases of choosing and getting, preceded by a phase of recruitment and selection:

- A. Recruitment and selection:
 - recruitment
- B. Setting an educational goal
 - describing educational opportunities
 - identifying personal criteria
 - choosing an educational goal
- C. Getting and preparing for a study of one’s own choice
 - organizing the registration
 - mapping and practicing critical competencies
 - mapping and organizing critical resources

Ad. A: Recruitment and selection

In order to recruit the participants for the career guidance course, an information brochure for possible participants and an information brochure for referrers have been composed. These information brochures are sent to, for example, mental health institutions, social benefit agencies, employment agencies, business associations and reintegration agencies.

The career guidance course is aimed at (young) adults from 16 years of age and older, who receive treatment, or have received treatment because of psychiatric problems and who are interested in going to school in the near future. These (young) adults do not (exactly) know what they want and what the educational opportunities are; they have difficulties with making choices in this area; or doubt their study competencies. For these reasons, they need support in the form of a career guidance course.

These (young) adults can be pointed toward the Impuls course by a mental health institution, yet they need to register themselves personally. When institutions register these (young) adults, they are requested to ask the (young) adult to do this himself/herself. A basic principle of Supported Education is that people with psychiatric disabilities work on their own needs and goals and not on those of others (e.g. social workers, social benefit employees and family members).

Ad. B: Setting an educational goal

During the first part of the course, a list with studies in which the participant is interested is composed. Books and brochures that the teachers have collected can be used with this activity. Further information is gathered by attending open-door days of colleges and universities. After a list with possible options has been made, a second list is composed that contains personal criteria that the participant considers important for choosing a study: for instance, whether an education is directly focused on work or not. Subsequently, these two lists are put together and the education that most fulfills the personal criteria of the participant is chosen. Then an educational goal can be set when the participant wants to go to a particular study at a particular school. An example of such a goal is: "In September 2015 I want to start at the Alfa College in Groningen."

Ad. C. Getting and preparing for a study of one's own choice

After the educational goal has been set, a plan is made in which it is written what needs to be done in order to be able to start with the study. One has to register at the particular school or university and sometimes one needs to work on getting financial support from a social benefit agency. When one is eligible for financial support, one has to apply for a student grant.

In the second part of the course, two other things that need to be considered before starting with a study are worked on. These are skills and support. During the course, one explores which skills are critical to start and maintain a study. These do not include the skills one is taught during the study, yet they include skills one is not taught there. These skills can vary from person to person. For instance, one participant has difficulties with planning his homework and another finds it hard to give a presentation in front of his classmates. However, it could also be a skill that is not directly linked to achievement at school: for instance, talking to a classmate in the canteen or getting up on time in the morning. Important skills can be practiced.

As far as support is concerned, roughly the same procedure is followed. One explores what kind of support is critical in order to study successfully and it is ensured that this kind of support is actually available. This support can be given by a person, but also things, activities and places can be important. For instance, one could think of a person who helps with homework or with a bicycle to come to school, a relaxation exercise or a room to which one can go and relax a bit for a while. Although the necessary skills and support are different for all participants, they are discussed in the group. Consequently, participants can help each other and practice together. To summarize, during the career guidance course the participants work on four things:

- choosing a study,
- arranging things in order to be able to start with the study (registration, finances, permission, etc.)
- listing and practicing critical skills
- listing and organizing critical support

Portfolio

The participant collects all the theory of the course and all of his assignments in a portfolio. A portfolio is a map in which the participant describes what he is working on and which development he is going through. The portfolio can be taken to the intake/interview for the new study. Often the enrollment officer of a study appreciates this, as a portfolio gives a good impression of the wishes, qualities and learning points of the participant.

Homework

After each course day, the participants have to do homework. This way, they can take even more out of the course and also practice important study competencies.

In 12 weeks all of the above is addressed in the following topics:

1. - identifying personal interests and possibilities
2. - researching educational environments
3. - setting an educational goal
4. - listing own (central) qualities
5. - learning information about learning styles and working in groups
6. - learning personal (study) skills
7. - learning communication skills
8. - determining and practicing personal learning goals
9. - organizing the support needed with getting and
10. - keeping the study of one's own choice

Case 1

Karen is a woman of 27 years of age. She was diagnosed with ADHD when she was 19 and she quit her Social Work study at a university of applied sciences. She became severely depressed and went to day treatment for a couple of years. She got medication that helped her a lot and that she still uses. Three years ago she started working as a volunteer at a day activity center for people with psychiatric problems. Her mental health practitioner pointed her toward the career guidance course Impulse at the Hanze University of Groningen. Karen requested an information and intake brochure and she was called for an interview. She got accepted and started the course. At the beginning of the course she was very impatient and became annoyed by the slow pace of the course. Through discussing these problems with one of her teachers and doing the exercises she discovered that she had difficulties with organizing her thoughts. This is why she often goes too fast. Through the course, she learned to think about her future wishes in a very detailed and concrete way. About the course she said: "Because you are forced to go and explore the educational possibilities, you get a clear view of the different studies and their locations. Comparing several options makes clear which study most fits your own preferences and possibilities." She also said that through the course, her self-confidence and self-esteem were enhanced. Eventually, she chose to start again with her Social Work study, but part-time. She has already started studying again.

Supervision within the course

The participants of the course are not there as a patient/client, but as a student. Within that structure, one can work with the questions, needs and educational preferences of the participants. The structure of the program is meant to give some grip on that. The inflow of students is (as far as background and educational experience are concerned) very diverse. This requires a very flexible attitude from the teacher (and the participants) towards the content and pace of the program. It is important that the underlying structure of the program – exploring, choosing, getting and keeping– remains present!

Participants often have the following expectation of the course: "I will hear which study suits me." Therefore it is important from the start, but certainly also during the course, to mention briefly that the participants have to take action themselves in order to obtain a positive result.

The course is given by a permanent teacher who monitors the mainstream of the program: helping with choosing and getting a study. This teacher is educated in the Individual Rehabilitation Approach at expert level at least and is specialized in Supported Education. He receives assistance from a co-teacher who is expert by experience and who has been a participant of the Impulse course himself. The co-teacher teaches several parts of the course, supervises the group process and assists with activities in subgroups. He also teaches a few theme lessons individually, such as time management, stress and coping and group processes. Most activities take place in the entire group. Participants receive an introduction to a certain theme and have to elaborate this theme individually or in a subgroup through an assignment. Afterwards, the assignment is discussed with the entire group. The

teachers are available to support the individual participants with the assignments.

At the start of the course, a mentor/teacher is assigned to each participant. During individual coaching, participants can discuss what is difficult for them during the course, but they can also discuss what goes well. Often, themes such as current expectations about a study, self-esteem, the support one experiences or whether the supervision is in line with one's personal needs are discussed. Also, more personal themes can be discussed: for instance, how to adapt a difficult situation at home into your new study or how to cope with changing from being a client into being a student. The individual coaching often takes place during breaks or at the end of the day.

Case 2

Peter is a young man of 26 years of age. During his higher general secondary education he experienced his first psychotic episode. Several times he has been hospitalized for several months. He was diagnosed with schizophrenia. After his last hospitalization he remained in day treatment for two years. He lives with his parents and sister. He finished his higher general secondary education, but after his graduation he did not move on to another type of education. His case manager told him about the Impulse course. He enrolled, got accepted and finished the course. After he finished, he said that the course helped him to gain insight into his preferences and possibilities. He thinks his choice of study is the right one: a three-year-long full-time education in information technology. He is happy with the Impuls course: "Without Impuls I don't think I would have started with a new study." Besides the support he gets within the project, he receives a lot of support from his parents, friends he was in treatment with and from a fellow student on the Impulse course.

Evaluation (Experiences and Results)

After each course, the course is evaluated using an evaluation form and a group interview. The evaluations of the first four Impuls courses (41 participants) show the following image:

Personalia (n = 41)

- 23 men; 18 women
- Ages ranged between 17 and 37 years
- Living conditions: living alone, living together, living with family, assisted living, living at a crisis department of a clinic or in a therapeutic setting
- Pre-education: varying from secondary school to university (2 years)
- Great diversity in diagnoses
- Contact with mental health care: 1–16 years
- 70% use psychotropic medication

Of the 41 participants, 27 successfully completed the course (= 61%). A total of 22 of these 27 participants have formulated a goal (21 have set an educational goal; one participant decided to get a job). Five participants have not made a choice (yet).

Nineteen of the 21 who have set an educational goal have started with a regular study. The outflow to regular studies is very diverse and individually determined, despite the fact that the course is being delivered in a group. There are no indications that the choice is (co-) determined by the group or other group members.

The studies that the participants chose are:

- Higher general secondary education (HAVO; 2x)

At community college level:

- Beautician
- Training to become a nursing aid
- Training to become a cook
- Social pedagogical work

At the level of university of applied sciences:

- Medical laboratory assistant (2x)
- Physiotherapy
- Human resource management
- Applied psychology
- Law
- Business management
- Social work
- Medical imaging and radio therapeutic techniques
- Animal management
- Hotel management school

Reasons to quit:

The 14 participants who quit the Impuls course prematurely mentioned the following reasons:

- One participant started an individual rehabilitation trajectory and subsequently went to the REA college (a school for young people with a psychiatric disability)
- One participant will soon start with an individual rehabilitation trajectory
- One participant started an education during the course (outdoors)
- One participant has made a choice for a particular study during the course and left the course early (after the eighth meeting)
- One participant was not able to follow the course completely because of physical and psychiatric problems (he was off and on present, and did not make a choice for an education)
- Nine students stopped without making a choice (three after the first meeting and the other six after four to six meetings)

Success Factors

Based on the opinions expressed in the interviews, ten essential determinants for successful Supported Education programs were formulated. Eight determine success and two determine risk.

A. Psychiatric rehabilitation technology as the connecting link

The five practices show that it is possible to have organizations with widely differing missions, cultures and employees cooperate in a common Supported Education initiative. For a large part this can be attributed to the unifying properties of psychiatric rehabilitation. In this approach the focus is on students with psychiatric disabilities realizing their education goals. Support is aimed at functioning well in the student roll. This mission creates a bridge between mental health and education.

B. Joining expertise in mental health and education

In four of the five initiatives professionals in mental health and education work closely together, mental health professionals share their knowledge of rehabilitation and approaching mental illness and their colleagues in education share their pedagogical expertise. This results in mutual inspiration and increases commitment.

C. Educating staff

In order to work together efficiently a shared frame of reference for professionals from the fields of education and mental health is required, in this case the technology of psychiatric rehabilitation. Usually the mental health professionals were educated in psychiatric rehabilitation, but the education professionals not necessarily. The former thought it important for the latter to be trained in the field of psychiatric rehabilitation to facilitate cooperation.

A shared frame of reference for the Supported Education team is offered by a detailed manual. In this respect the experiences of a group approach to psychiatric rehabilitation in so-called IPRT (Intensive Psychiatric Rehabilitation Treatment) centers in New York state can be useful (Buccifero, Sheets, & O'Brien, et al., 1991a, 1991b; Grossman & Owens, 1994).

D. Commitment of staff and management

In all good practices the commitment of staff is mentioned as a determinant of success. This commitment should be safeguarded by management. That was not the case with all initiatives. When management commitment is insufficient an initiative may get stuck at the project level because of lacking finances and too little effort to acquire them.

E. Short lines of communication and informal contacts

Short lines of communication and informal contacts bring flexibility to a Supported Education project and facilitate cooperation. Although it helps when prior to implementation mental health and education staff have been working together, this is not a requirement.

Short lines and informal contacts can be achieved more easily when a project is situated in a relatively small division of a community college. Not only can staff profit from a small scale, but participants too can appreciate a safe and small building.

F. Learnability of the organization

For long-term success it is important that an organization is able to learn from its experiences. According to the INK model of quality care, learnability is an important characteristic of an organization (Van de Lindt et al., 2002). It fits in the values of psychiatric rehabilitation to have input from participants when setting up a Supported Education initiative. In four of these five practices this sort of input was lacking (it was only evident in Apeldoorn/Deventer in public relations). However, courses, group meetings and individual support were thoroughly evaluated and adapted when necessary. In this respect it can be said that the practices had learnability.

G. Admission policy

In all five practices admission was limited. Most participants were referred by mental health professionals. Referrals from school were fewer (except in Rotterdam). The project proved unable to attract students that might be interested. To a degree this can be explained by the fact that students with hidden psychiatric problems are not easily identified. Wider publicity could possibly lead to higher participation.

H. Customization

Participants consider a Supported Education project successful when it caters to their individual needs, or put differently, when it is customized. Classroom support or group support can be helpful for shaping one's point of view, enhances mutual recognition and

enables one to put one's problems in perspective. Of all the Supported Education elements, however, individual counseling is valued most by the participants. For that reason several practices decided to offer individual counseling during classroom or group activities such as choosing and getting an education environment. Participants consider it a big drawback when there is no individual counseling available.

Risk Factors

A. Financing

All five good practices have problems with financing. Not one succeeded in procuring long-term financial security. They depend on temporary grant subsidies to individual participants and payments by participants. The most stable source of income is the national health insurance. Payment is only made, however, when a participant is officially diagnosed with mental illness. Students with relatively mild mental problems are often reluctant to seek such a diagnosis with the stigma attached. The financial aspect makes Supported Education less accessible for students with relatively mild psychiatric problems. An obvious source of finance for classroom support in choosing and getting an educational environment would be the regular national education budget. For organizational reasons this doesn't work, however. A possible temporary way out can be found in means earmarked to prevent dropout. Besides the national health insurance and the national education budget, local means could be used. Unfortunately this is complicated by a lack of transparency. Clear and up-to-date financial guidelines would therefore be useful.

B. Timing of courses

Courses at community colleges start at the beginning of the academic calendar. Graduates of an introductory Supported Education course find it disappointing when they have to wait for their elected studies to begin. Most community colleges don't offer the possibility of starting studies at a time preferred by the student. It is therefore important to ensure that an introductory Supported Education course ends not long before follow-up studies start.

Supported Education offers counseling in which psychiatric rehabilitation is applied in the life domain of education. When students graduate the process ends. At that moment in most cases the search for a job begins. Without ongoing support this can be very hard for graduates with serious mental disabilities. It is remarkable that none of the good practices have tried to connect Supported Education to the life domain of work. A logical next step, therefore, would be to extend the Supported Education model with a stage in which graduates are assisted in finding work.

Future

The support of (young) adults with psychiatric disabilities is becoming a more and more relevant theme in the Netherlands, and linked to this, also Supported Education as an intervention. This can be concluded from a very recent report from the Board of Health about the "Participation of youth with psychiatric problems" (Gezondheidsraad, juli 2014). The Board of Health recommends investing in the development and application of Supported Education in education. The knowledge base of this rehabilitation method, which is based on the Individual Rehabilitation Approach, is still relatively small, but since the inability of educational professionals to provide adequate educational support to young adults with psychiatric problems is large, the Board considers a recommendation for further development justified. The government should stimulate this through pilot testing, accompanied by effectiveness research (Gezondheidsraad, 2014, pp. 64–65).

3.6 Communication Plan: Guidelines for Networking and Communication about Supported Education

For the continued spread of Supported Education, it is not only important that participants of the ImpulSE project explore the ideas presented here: equally important is that Supported Education can count on sufficient support within and outside its own organization. This applies not only to professionals and management, but also to students/clients, the social network, volunteers and other relevant organizations.

It is important that all these groups work well in collaboration with Supported Education and to implement and secure it within an organization. To inform the stakeholders about Supported Education, communication about the topic is necessary, as what is unknown cannot be appreciated. A communication matrix is a tool to address communication systematically. Such a matrix indicates:

- Which target groups/stakeholders are important for Supported Education.
- How important these target groups/stakeholders are.
- What their current knowledge, attitude and behavior is toward Supported Education.
- What needs to be changed in that.
- How that can be achieved.

To complete a communication matrix use the worksheets in Appendix 8 and proceed as follows.

1. Enumerate on worksheet 1 all the target groups/stakeholders that are important for Supported Education. Think about internal target groups as well as external target groups.

2a. Select on worksheet 2 the six most important target groups/stakeholders and describe the frame of reference of these groups.

2b. Try, as much as possible, to estimate the current knowledge (k), the attitude (a) and the behavior (b) of a target group with respect to Supported Education. Use worksheet 2.

KNOWLEDGE

- | | |
|---------|--|
| k = - | target group has no knowledge of Supported Education |
| k = -/+ | target group has general knowledge |
| k = + | target group has detailed knowledge |

ATTITUDE

- | | |
|---------|---|
| a = - | target group has a negative attitude toward Supported Education |
| a = -/+ | target group has a neutral attitude |
| a = + | target group has a positive attitude |

BEHAVIOR

- | | |
|---------|--|
| b = - | target group tries to prevent Supported Education |
| b = -/+ | target group behaves in a neutral way with regard to Supported Education |
| b = + | target group is actively involved in Supported Education |

3. Now estimate, in the same way as you did before, the knowledge (k), attitude (a) and behavior (b) that you wish to achieve in a target group with respect to Supported Education. This is a 'goal' in the communication matrix (worksheet 3).

4. Write your message for the target group on worksheet 3. Make a list of the topics that the different target groups:

- * should have more knowledge about
- * should have a (more) positive attitude towards
- * should be actively involved with.

For instance, you could think about the following topics.

- a. Why Supported Education?
- b. What is the goal of Supported Education?
- c. Who is involved with (our) Supported Education services?
- d. How does Supported Education work?
- e. How can we establish Supported Education?
- f. What is the result of Supported Education?
- g.and so on.

5. Do this for each target group separately.

6. Indicate in the matrix on worksheet 3 for each target group what means you can use to achieve the communication goals.

For instance:

- written means
- oral means
- audio-visual means

(See Appendix 9 for a description of the purpose and use of these particular means)

7. For the implementation of communication activities about Supported Education, it is also important to determine the frequency, timing and place (use worksheet 3):

- When?
- How often?
- Where?

8. Write down on worksheet 3 who the sender is of the message.

For instance:

- Manager
- Professional

9. Finally indicate on worksheet 3 what feedback options there are for the receiver(s) of the message.

With this systematic approach you can keep your communication well in hand.

3.7 Information Brochures

The information brochures provide Supported Education information relevant to the particular stakeholder being addressed. The brochures give answers to the question: why should I, as a student, consumer, family member, teacher/educational staff, policy maker, mental health practitioner, be interested in Supported Education?

Below, the brochure for students is presented. You can find this and the other brochures on www.supportededucation.eu.

Information for students

What is Supported Education?

Supported Education is the provision of individualized, practical support and instruction to assist people with psychiatric disabilities to achieve their educational goals

What are the principles of Supported Education?

Supported Education is based on the following principles:

- Improvement in educational outcome for persons with psychiatric disabilities
- Hope is an essential ingredient of the Supported Education process
- Self-determination: a focus on students making choices (setting their own educational goals) and accepting responsibility for their educational process
- Students are actively involved in all phases of their Supported Education process, determining the criteria for success and satisfaction, as well as evaluating their progress toward meeting their goals
- Partnership between participant and Supported Education professional
- Services match participant's preferences
- Equal/fair access for everybody
- Development of participant skills and of environmental support
- Bridging with mental health services
- Support as long as needed

What are the essential components of Supported Education?

Supported Education is based on the choose-get-keep model of the Center for Psychiatric Rehabilitation of Boston University.

- *Choose*: to select an educational or training course compatible with the participant's values, skills, aptitudes, career interests, finances and learning objectives.
- *Get*: to secure enrollment in a preferred course.
- *Keep*: to sustain enrollment and maintain an acceptable level of success and satisfaction until completion, through skills and support development.

What can you do yourself to remain at college or university?

Obtain an overview of all relevant resources catering to your needs, both those geared toward special needs and those designed to help all students in the educational setting. It is also advisable to evaluate to what degree you may want to disclose your situation and disability to key people at your institution. This may allow for individually designed support, both socially and with respect to taking exams and participation in mandatory seminars.

Resources: Who and what will support you in your educational process?

First and foremost, check to see if your educational institution or other collaborating institution provides a Supported Education program. In addition, higher educational institutions have a duty to help students with special needs aspire to their own educational goals.

Student counseling offices are to be found on most campuses and here you will find professionals with local knowledge about student services and you may also qualify for individual and sustained help. It is also advisable to speak with your teachers and/or tutors if you have thought through the possibility of disclosing your situation. Friends and family, mental health practitioners and community health personnel can function positively as a team to help you with your higher educational degree. Many urban environments have user-driven organizations with resources over a wide range of support, and many students find validation in an environment where others have similar challenges. (Fountain House is an example of such an organization). Financial support, housing and collaboration with trusted mental health practitioners are all central to obtaining the stability needed to achieve a degree. Many local communities provide services catering for those with a psychiatric disability, and there you may find both users and competent mental health professionals who can function as supports.

More information

Information about Supported Education can be found at www.supportededucation.eu

3.8 Practitioners' Competencies

What makes a good SEd counselor? Can we isolate and/or quantify the necessary elements? What would constitute a minimum of formal qualifications? The ImpulSE project consortium has not focused on identifying necessary formal qualifications for SEd employment.

SEd counselors in the consortium member countries come from a wide range of vocations and training. Although we may see a formalization of SEd competence education in the future, we forge ahead under the assumption that recovery-oriented helping relationships can be created and maintained by counselors from wide-ranging backgrounds. It is advantageous for the SEd service in question to have members in the organization who can wield a significant amount of professional authority, since this authority is often essential in collaboration with partners and with respect to negotiating SEd service identity with legislators.

The consortium has been interested in these questions from the beginning of the ImpulSE project and conducted a brainstorming exercise with the object of defining SEd counselor attributes. The following breakdown resulted.

- Partnership attitudes
 - (1) "Nothing about us without us." Promotes participation in all processes.
 - (2) Focuses on independence; is proactive and process-oriented.
 - (3) Dares to be informal/self-disclosing, with self-irony and personable language use.
 - (4) Has emotional availability.
- Partnership skills
 - (1) Asks questions, listens and responds accordingly without delay.
 - (2) Collaborates, shares power.
 - (3) Connects/relates to, and shares experiences with open communication.
 - (4) Is comprehensive in approach; does not ignore subjects students want to discuss.

- Knowledge of:
 - (1) Educational system.
 - (2) Welfare and healthcare systems.
 - (3) Coaching/counseling techniques.
 - (4) Tools/instruments for enhancing studies.
 - (5) Community integration opportunities.
 - (6) Mental health care resources beyond traditional treatment regimes.
 - (7) Target group disability.
 - (8) SEd research.

- Collaborative skills
 - (1) Bridge building for community integration.
 - (2) Networking skills.
 - (3) Advocacy and negotiating skills.

- SEd attitudes
 - (1) Hope inducing.
 - (2) Respectful.
 - (3) Makes use of empowerment language and solution-oriented pragmatism.
 - (4) Has patience, tolerance and empathic supportiveness.

- SEd skills
 - (1) Helps with choosing the educational goal of preference.
 - (2) Helps with getting the educational goal of preference.
 - (3) Helps with keeping the educational goal of preference.
 - (4) Recognizes vulnerabilities and signs of relapse.

We make an argument for Supported Education as a human rights based role recovery-oriented service. Paramount to a successful Supported Education process is the relationship between the practitioner and the student/consumer. Part of the efficacy of various SEd interventions is the relationship that develops between the practitioner and the individual receiving help. The practitioner can facilitate the process by being a skilled listener who is empathic and respectful. By engaging or connecting with the student/consumer, the practitioner increases the chances of the SEd process helping the student/consumer to achieve the desired educational goals. The findings with respect to the importance of the relationship in leading to successful helping and learning outcomes is perhaps the most researched topic in all of behavioral science. The implementation of the Supported Education process demands an interpersonally skilled practitioner (Anthony & Farkas, 2009, p. 13, adapted to Supported Education).

3.9 Staff Training

The ImpulSE project has developed a series of one day training courses on a range of topics covering Supported Education:

1. Introduction to Supported Education
2. Choosing and getting regular education: The preparation course
3. Keeping regular education: Skills and support
4. Disclosure: To tell or not to tell
5. Implementation of Supported Education

Our objective is to familiarize participants with Supported Education and to offer them high quality training courses in the main topics of Supported Education as part of the implementation of a Supported Education program. Below, general information about the training courses is given. See www.supportededducation.eu for a description of the five training courses.

General information

Target group

The training courses are targeted at professionals who may wish to learn more about Supported Education, professionals working in a Supported Education program and for those working with youths with psychiatric disabilities who want to return to school or to remain at school.

Time and duration

Six contact hours and one hour lunch. The training course will start at 9.30am and finish at 4.30pm.

Location

The training courses will be held at the location of the organization that asked for the training or with open enrollment at a location of one of the ImpulSE partners in the Czech Republic, the Netherlands, Norway or Portugal.

Presenter profile

All training courses will be hosted by Supported Education experts who work on a daily basis in the field of mental health care and/or education, thus providing a practical and hands-on perspective.

Language

Training courses organized in the Czech Republic, the Netherlands, Norway or Portugal are respectively in Czech, Dutch, Norwegian or Portuguese. Training courses organized in other countries will be held in English.

Fees

By appointment, depending on the organizing country. For in company training courses, the organizer is responsible for the lecture room, the equipment, and lunch/tea and coffee. The organizer also pays for the travel and accommodation costs of the trainer.

3.10 Support for Educational Staff: Advice, Consultation and Coordination

What?

Information about support, cooperation and training of educational staff.

Why?

Educational staff have a significant role in creating school environments and can be very useful for students; they can also (even unconsciously) form barriers.

Who?

Every employee at school/university who comes into direct contact with students as part of his/her job duties.

When?

On request, according to arrangement.

Where?

According to arrangement. At school or in a consultation room of the SEd workplace.

How?

Education and training, counseling, consultation and support, coordination of different activities.

Support for educational staff is considered to be an essential and self-evident part of the Supported Education service. The reason is that the staff constitute the basic determining element of the study environment and school atmosphere, influencing the approach to students with disabilities. A person who is acquainted with the sphere of mental health awareness, knowing where to seek advice or help, can cope with persistent prejudice or his/her own fears more easily and shall also be ready to act on behalf of a student with mental health problems.

3.10.1 Who are educational staff?

Educational staff are every employee of a school/university who comes into direct contact with students as part of his/her job duties. Therefore the term pertains to the immediate surroundings of the student—ranging from teachers, tutors, supervisors, leaders of study circles, academic advisors, "study-buddies" (other students helping students with special needs with studying and orientation at the school), to official persons (e.g., vice deans or deputies), to administrative staff (assistants, secretaries of departments, personnel of study department, and so on). They all have their role in creating the school environment and can either be very useful for students or can (even unconsciously) form barriers. All these persons should have, besides other things, basic awareness on topics surrounding mental illnesses. That way, the wrong approach to students so burdened should be reduced, and the provision of appropriate means of support encouraged.

For this reason, we also consider educational staff to be another target group of Supported Education services. If a student is to be helped, it is necessary to work with those in their immediate environment (such as family and friends), including teachers. They spend a lot of time together and education is the point, so the educational staff should be involved and feel supported. Educated, oriented, and supported staff improve the school environment and conditions for students with mental disorders a great deal.

In the context of Supported Education, the educational staff comprise the key partner. The will, willingness, support, responsiveness and effort of the staff in understanding the student's situation and their knowledge of the possibilities that didactics and psychology and school offer in education are the most important resource for students with altered learning abilities or special needs. If the school is not willing to accommodate these students, the default position of other supporting segments of the Supported Education service is significantly weakened and the potential for a student to complete their study decreases.

In order to help bear this responsibility for educational staff faced with a specific problem, the Supported Education workers are here for educational staff as well as for students. They provide them with information and support, and they can manage the situation or, if necessary, mediate with other services or forms of support and manage the mutual cooperation of all those involved by so-called case management.

3.10.2 What should educational staff know and be able to do?

The educational staff should have basic mental health awareness and know how this topic is related to working with students. The staff also should know their personal limits and capabilities and the facilities of the institution/school.

Educational staff should neither encourage by their own behavior nor tolerate biased opinions about mental illness which often persist in society, and should respect and promote the rights of students, as provided for in the Convention on the Rights of Persons with Disabilities, Article 24 (United Nations, 2015) in particular. Educational staff should know that, in addition to students with physical disabilities or learning disabilities, there are students with limitations caused by mental illness. These students have the same rights as others, the same equal opportunities, and often the same ability to study, but their needs may be different. In order to meet the necessary conditions for study, schools should provide maximum support for students with altered study capabilities and needs (e.g., attendance, grading rules, length of study, ways to be excused from lessons, etc.) and be prepared to deal with alternatives.

The form of support should be based on the specific needs of the student. This does not mean being excused from study requirements, just a reasonable adjustment—for example, in the case of a student with problems of fatigue, which can be caused by medication, not to insist on attendance; negotiating terms for testing and presentations at a time when the student is able to focus; adjusting the time for test processing, etc. The school should make it possible to even up the conditions under which the student has the opportunity to fulfill their study obligations. This should be done in a way that will be useful and meaningful to the specific student: an individual approach is required. Equalizing of conditions only moderates the handicap which the afflicted student has in comparison to ordinary students. The criterion of required knowledge does not change for the student with a mental illness. It is important to distinguish between the content and the form of the curriculum, to discern what it is important for the student to know and not to be attached to a particular way of finding it out. The educational staff should respect the fundamental rights and basic needs of students and not give preference to routine, prejudice and generalized solutions.

Educational and administrative staff should acquire the basic ability to communicate with students about their problems relating to the situation to be resolved, including the topic of mental health. Staff should not be afraid, not dodge, not reject a student's claim for support; they should be specific and not ask for things unrelated to the topic (no snooping); they should hold a positive attitude and offer support; they should be aware of their options and the possibilities of the school, and know to whom to turn for consultation or cooperation.

Basic perceptiveness of the mental health of students (and one's own) is essential. It is important that teachers—and especially key educators (class teachers, supervisors, tutors, etc.)—are attentive to their students, paying attention to unsubstantiated/unexpected/strange transformations or changes in their behavior—for example, a usually cheerful and active student keeps themselves in seclusion and has a high percentage of absenteeism; increased paranoia; distractions from the subject or entering into it with ideas that lack continuity; an otherwise calm student is suddenly lively and brimming with ideas, etc. They should be ready to take the possibility of mental illness into consideration and not be bashful about sensitively asking the student about the changes and offering support or help. They may be one of the first people to point out the changes and give impetus to solving the student's problem.

Educational staff should have clarified how they and their educational institution can accommodate students with difficulties in the area of mental health, and should be aware that they do not have to take care of it all by themselves. They should have a basic knowledge of the services or institutions that could be helpful to students with mental health problems and to which they may refer students. This could be a service inside the school—such as a school counsellor for students with special needs, a school psychologist, a legal or educational counsellor, etc.—or outside—a psychologist or psychiatrist, social services, NGOs, etc. Where a Supported Education service is available, this should be the teacher's first choice, because it does not provide a service only to the students: the teachers and other educational staff may contact it themselves to ask for information or help. In addition to direct support to students with mental health problems, it is equally important for educational staff not to be afraid to consult on the situation discreetly and seek advice, especially at moments of uncertainty or when not feeling safe in the situation. When a person is not certain about what to do, they cannot be helpful or supportive in the right way, if at all.

3.10.3 What Supported Education services offer to educational staff

Students have the possibility of requiring from the teacher or study counsellor:

- Support with any difficulties they are experiencing and that affect their performance in school—this may be in the form of mediation of other services, providing contacts for a psychologist, drug counsellor, etc.
- Support in inclusion in the class (e.g. when returning after hospitalization, or when transferring into a new class/school). This includes assistance in coping with the situation and tactfully informing classmates about the illness (but only with the permission of the student).
- Individual support in studying and defining new rules—i.e. discussing the obstacles and limitations caused by the student's mental illness (deteriorated concentration, sleepiness caused by medication, great mental strain during testing, etc.) and setting rules that help to overcome such difficulties (allowing short breaks during the lesson, a different method of testing, etc.). The teacher should discuss these new rules with the school study counsellor and also inform other teachers or classmates, if necessary.
- Help with securing and forming an individual education plan which should enable the fulfillment of school duties, including in the situation when the student's ability to prepare and the performance of school duties are disrupted to a large extent.

Supported Education services offer educational staff education and training in the sphere of mental health, counseling, consultation and support in specific situations, arranging the coordination of experts and their work with the student.

Education and training

A Ledovec course (*The Minimum about Mental Health*) is available for schools and teachers dealing with basic questions and problems related to mental health and oriented to the educational environment and the role of the teacher. At the same time, the course introduces the Supported Education service and cooperating supportive network of experts from the fields of health, social services and the educational system, outlining their roles and capabilities, and how, when and whom to contact. A similar course given on the topic of mental health intended for students may assist the teacher to broach this topic in a group or just help to educate the students in this area (primary prevention).

A seminar or training takes place according to demand, in the school space, in a timeframe offered or agreed upon. The recommended minimum duration is two hours. Increasing the length of training also requires increasing the rate of active involvement of the participants. It is necessary to keep enough time for questions at the end and to encourage participants to

ask questions throughout the seminar. If the organization has a (student) peer-worker, it is possible to offer their first-hand experience during the seminar.

The basic themes that the seminar should cover are as follows.

- Mental health and modern society.
- Statistics of incidence of mental illness in the current (European) population among students, putting emphasis on the age range when mental illness most often occurs.
- Basic overview of the most common and serious mental illnesses.
- Signs and symptoms of psychological problems or mental illness and how it is possible to recognize them in students in the school environment.
- Problems that persons with mental illness struggle with (health, social, or personal problems).
- Problems that a mentally ill student faces and what impact on the study they may have.
- What the school and the educational staff can do for such a student and how.
- Who can be contacted and under what circumstances.
- Where to seek information and support as a teacher of a student with mental health problems.

Case 1

A school teacher contacted the Supported Education service asking for support when a student with a known diagnosis of schizophrenia returned to his class. His last contact with the class was a few months ago during the presence of his psychotic symptoms (an acute manifestation of the illness). The class teacher expressed concern about the atmosphere in class and lessons after the student's return. The students were exposed to the unfamiliar anxiety of what attitude to take toward the classmate: Help him? Ignore him? Avoid burdening him with shared topics? Workers from the Supported Education service visited the class and organized a seminar with discussion; they handed over basic information on the general perspective and the needs of people with schizophrenia in relation to the outside world. The student agreed with the actions taken.

Counseling

Counseling is a low threshold way to obtain necessary information in the field of Supported Education when a teacher feels the lack thereof. The service can be contacted by telephone, online (email, etc.), or personally.

Short-term counseling is a service whereby the user is provided with basic support and information that enables them to handle their situation. Counseling takes the form of a non-binding single or repeated dialogue between the user and a Supported Education worker. Counseling can be anonymous: the user need not disclose any information about him/herself. The service is provided in person at a meeting, by telephone, or in writing (email, letter, SMS), and can be used repeatedly.

Counseling can offer, for example:

- Support in finding solutions to specific situations—consultation on the case of a student with mental health problems or mental illness; dealing with stressful situations; communication with students with mental health problems; mental hygiene rules.
- Provision of information and contacts to support programs and services in the locality or region.
- Information about mental disorders and mental illness.
- Organization of a prevention program or seminar for students focused on the issue of mental health or a specific situation (similar to a seminar for teachers).

It is appropriate to set aside specific times and human resources for counseling (e.g., Counseling provided on Monday and Thursday from 9am to 4pm, or other times according to prior arrangement). At these times a specific employee who is in charge of counseling is allocated to consult newcomers, answer phone calls, handle correspondence and arrange appointments.

Case 2

At the request of an educator, the Supported Education service provided basic counseling when looking for possible solutions to difficulties the educator was experiencing with a student with a psychiatric disability. The student did not behave well at school, shouting at fellow students and teachers. The school was on the verge of sending him away from school. The teacher was informed about different ways of dealing with the situation, especially how to teach the student the critical skills required in dealing with the requirements of the school.

Consultation and support

Supportive consultation provides an opportunity to discuss the specific situation of a teacher, a class or a student with a specialist, focusing directly on the teacher's personal role. It is possible to establish long-term cooperation on the case, using group consultation (e.g., Balint group, supervision, training, etc.) or consultation within the school. Consultations within the school are particularly suitable for the clarification of possibilities when a student asks for adaptation of conditions of study, or he/she is simply "causing trouble" and there is a need to diagnose the situation.

Educational staff in all the above-mentioned challenging situations can consult gradually, plan, and find solutions in cooperation with a SEd worker. Furthermore, they can expect support when they cannot cope with the demands placed on them (time, energy, one's own strength, risk of exceeding the professional role) or are uncertain about their behavior, opportunities, rights and responsibilities. A SEd worker can serve as a counselor or mediator in communication with the school management, parents, psychiatrist, or Child Protection Office to develop a joint plan to work with the student. A SEd worker can also provide or arrange psychological support for the teacher (supervision, training, Balint group, expert advice) or support in managing stressful/crisis situations. It is also possible to arrange crisis intervention for the teacher and the group which was impacted by the crisis situation.

SEd worker and teacher meetings are based on individual needs and possibilities within the service in order to find a solution to the teacher's specific customized needs. Cooperation can be long-term and may include follow-up.

Case 3

A teacher contacted the Supported Education service with a request for help concerning a student with mental health problems who couldn't decide whether or not to disclose her mental health problems to her classmates. He didn't know what advice to give. The teacher was informed about the existing disclosure brochure and that the ultimate decision of telling or not telling was up the student herself. The teacher discussed the topic of disclosure with the student with the help of the brochure.

Coordination

Coordination of work with a student with mental health problems is based on the possibility of interconnection of experts concerned with the case. Supported Education can offer case management and can also facilitate a student's access to the supportive network of SEd. The existence of the SEd supportive network of educational counselors, psychologists, psychiatrists, social counselors, therapists and psychotherapists in connection with the student, his/her teachers and family or intimates creates several opportunities to grasp the situation and direct it to the benefit of the student in such a way that all the participants feel confident and safe, and are also pulling in the same direction as the student. Interconnection,

education and communication among these experts prevents situations where, for example, a psychiatrist, therapist, or teacher—as well as sometimes the student him/herself—have different ideas, take contradictory steps, or make recommendations that cause uncertainty, confusion or conditions that do not allow the student to manage the demands of his study.

Resolving the client's situation often requires the cooperation of several institutions (organizations) whose services need to be coordinated. As a tool for more effective teamwork in solving clients' problems, case management is used. A SEd worker leads the client's case and, together with the client, chooses when and which social service, institution or organization should be involved in addressing the client's situation.

In resolving the client's situation, several services within one organization can participate, but also other entities that constitute a team may have varying degrees of involvement. The team can function passively—the members know about each other; they jointly seek solutions to the client's situation; they share information about the steps taken; their services do not overlap; they meet minimally or not at all, communicating with each other via phone or e-mail. Or the team can be active—regular staff gatherings; managed seeking of ways to solve the client's problem. The client must be invited to these meetings, proposals for solutions must be in consultation with them, and they must choose whether the proposed process will be used or not.

In all cases, it is necessary to determine who is the so-called key worker in the process (usually a SEd worker, but possibly an employee of the Child Protection Office). The key worker has an overview of all activities and actions in the client's case and coordinates the process of providing services to the client.

A case conference is used as a tool for an active case management team. A meeting of at least three sides is called for the above purpose, which is managed by an independent moderator (facilitator). The facilitator must be an impartial and disinterested person who works directly with the client. It is important that all parties already be previously acquainted with the client's case.

Case 4

The Supported Education service was contacted by the school with a request for support in a case where the teaching staff became concerned about the mental health of a student with a psychiatric disability. After several consultations, the supportive network of the Supported Education service was used and several specialized sides were engaged. The Supported Education service coordinated the entire process between the student, family, school, and experts from the supportive network (psychiatrist, psychologist, peer support group of the Supported Education service, etc.).

3.11 Sustainability (Conditions, Quality, Evaluation and Finances)

We do not develop Supported Education (SEd) because it is currently trendy now, but as a lifeline and support for educational and mental health organizations to provide quality education to all people despite their possible disabilities. Important elements of the sustainability of a Supported Education program are the conditions, the quality, the evaluation and the finances of the program. In this paragraph we briefly describe those elements.

3.11.1 Conditions of sustainability of Supported Education

1. There has to be a continuing need for SEd in society. As documented elsewhere in this toolkit, the number of young people with mental illness in many European countries is rising, while in others it remains at a constant level. Little effort was put into developing support for students with mental illness in schools over the last century. Nowadays, the situation is different. The majority of countries have signed the UN Convention on the Rights of Persons with Disabilities which proclaims that people with disabilities must have the same resources as others. Students with a disability have a right to get the support they need to study. This is why we see SEd as a very important service.

2. SEd is recognized as a unique and independent service. It is not special education, treatment of mental illness or case management. SEd is a multidisciplinary service. It stays at the border of mental health care, education and social care, and some would say that SEd does not specifically belong to any of those branches. Thanks to the clear definition of its aims, target group and methods, it is an independent and unique service. We do not see any healthcare, social or educational spheres struggling to absorb SEd—in fact, mostly we see exactly opposite process. This is why we consider SEd to be an independent service and we are building its independent existence by choosing the name, editing its toolkit, calling conferences on SEd, and so on.

3. SEd is a progressive, self-developing, quality focused, effective service, whose results can be substantiated. This can be either evidence based or practice based.

4. SEd is adequately funded. If these conditions are met, than there is a good chance that the SEd program will be sustained. In the following paragraphs, the latter two conditions will be explained in more detail.

3.11.2 Quality and evaluation of a Supported Education program

Supported Education programs are all presumably acting in the best interests of their clients, namely the students. Programs are constructed according to student needs as these are understood by the providers, both with regard to established universal evidence and also according to and influenced by local contexts. Key stakeholders will need to make thorough evaluations of their programs on a regular basis to ensure the best possible services for their students. Implementing, maintaining and further developing any SEd program is best seen as a continual process, a never-ending incremental process of improvement. To this end, quality and evaluation are two overlapping constructs needing periodic attention from all important stakeholders.

At its most fundamental level, programs need to ask themselves basic questions about both process and content. Examples of such basic questions are, has the SEd program been implemented as planned? Is the program serving the intended target group according to plan? Are interdependent parties functioning properly according to the initial plans, and are they satisfied? Once established, and once enough time has elapsed, can it be said that the SEd programs' goals are being fulfilled—i.e., do we see satisfactory results?

We think that any evaluation of SEd services should focus on whether or not students receive services that assist them in attaining their own goals. Questions to be asked are:

- What does (higher) education mean to you?
- What helped you to remain at school?
- What hindered you from remaining at school?
- How do you value the support from the Supported Education service/professional?
- How can we improve our Supported Education service?

In short, we need to know both how things are being done and what comes out of the process. This entails developing and collecting process measures and outcome measures. Process measures will help provide structured and objective guidelines by which stakeholders can implement and/or improve practices currently deemed both valid and reliable. Together, these measures will constitute a norm from which evaluators can measure fidelity to said norm. We also need to collect outcomes, and in this context we are actually evaluating whether or not the SEd program succeeds in helping the student attain his/her educational goal(s). Goals can be long term or short term and both can be translated into specific measures. Processes and outcomes make up the evidence from which stakeholders can evaluate SEd programs locally, and the aggregation of such evidence helps to build the field of Supported Education as a specific and worthwhile service as a whole, above and beyond local contexts. It behooves all SEd program stakeholders to assign weighted and structured attention to these issues on a regular basis.

Stakeholders may harbor differing ideas about how goals are to be understood. Though we have emphasized throughout our consortium collaboration the importance of a human rights based service provision, one wherein the value orientation supersedes economic considerations, we must also attend to economic realities and the goals of SEd program funders. More often than not, a funder will be heavily invested in outcomes, as these are reflected in student goal attainment and subsequent movement towards employment. These are ultimately macro goals with ramifications for unemployment rates and socio-economic inclusion in the greater society. More often than not, these goals mirror the goals of the individual student.

There will, however, be students who seek support for no other reason than to obtain higher education for and in and of itself, without any concrete aspiration to qualify for a particular vocation or future employment. Our stance towards these students is the same as it is to those seeking specific education for specific employment-related reasons. Therefore, although we do want to collect outcome measures, such measures should be collected and evaluated according to student educational goals.

The ImpulSE consortium collaboration functions to enhance each member's understanding of the SEd program in general and also to help consolidate the burgeoning practiced based evidence (PBE) not yet systematized and validated against the principles of evidence based practice (EBP). One shared and salient piece of PBE across all consortium national lines was the reported importance of the student's evaluation of the specific relationship with the SEd worker. In other words, the student's themselves point to and emphasize what we may call a basic requirement for any constructive process leading toward a desired outcome. The positive relationship with the SEd worker is seen as necessary in maintaining hope and stamina throughout the higher education process. These results further emphasize the existing recovery research, wherein service users evaluate the fundamental requirements of recovery processes. This is discussed at length elsewhere in this manual.

There are various accomplished sources in the literature covering the topics of evaluation and quality for developing evidence based practices in the field of human service. We lean heavily on one specifically geared for SEd, *Supported Education: A Promising Practice. Evaluating Your Program*, provided by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, and available online at

www.samhsa.gov. We strongly recommend that stakeholders at any stage of assessment review this excellent work in order to evaluate their own practices against these helpful suggestions.

3.11.3 Finances

Money is somehow always important. As has been said in many places within this document, the point of Supported Education is to help fulfill the educational aspirations of people with mental health problems. Since the right to education is one of the fundamental human rights according to the UN, thus compliance becomes the responsibility of individual states. From this general point of view, we consider it essential to say that Supported Education should be financially secured from state resources.

Returning to the practical level of funding: if we want to establish Supported Education as an independent service, it is difficult to build only on voluntary work or work in addition to the main work arrangements. Rather, it is necessary to budget cost as for any regular service of this type.

The costs of a SEd service can vary widely, but the main component is always the personnel costs—the SEd professionals. Furthermore, there are operational rooms and facilities, offices, telephones, internet, travel expenses, training and education of workers, supervision, printing, promotion. Acquisition costs are for computers, phones, perhaps a car (depending on the area of service provision—whether housed at the university, where university campuses are, or, alternatively, if it's an independent agency and works for multiple institutions in multiple locations).

Sources of financing

Generally, the basic rule applies that where the service can ask for money, it will be inclined to do so. Due to the Europe-wide impact of the toolkit, it is difficult to offer clear and specific financial resources that could be used throughout Europe.

Similar types of new service usually start as a small volunteer project or an initiative of individuals or institutions which are later supported by grants from ministries (education, healthcare, social affairs) and governments, or from EU structural funds (as this project).

Moving on from the immediate type of financing, it is necessary to search for ways to finance permanently.

Non-governmental organizations sometimes follow the path of building a network of regular donors. This is a tradition in the U.S., but it is not a typical means of sustainable funding on the European continent. It is preferable rather to seek connections to the budgets of larger organizations, or state (regional, municipal, etc.) departments. SEd can become a part of the information and counseling centers (or other student welfare centers) at universities. In some countries, SEd is provided within the framework of psychosocial rehabilitation and is financed in a similar way to supported employment and related services, through government subsidies or payments of health insurance or welfare benefits. To become a part of the state budget is the target level for sustainable financing of this service. In the countries where SEd has been developed, experience shows that no ministry has been willing to give SEd a clear sign of independence, but rather the between-departments status of the service has been seen as an opportunity to shift the burden of responsibility to another area.

Full recognition of the uniqueness and effectiveness of SEd by governments is yet to come. We are not aware that SEd has been systematically funded from the state budget of any state. We cannot therefore recommend any guaranteed right way to procure sustainable financing for the SEd. However, experience has taught us that a way to maintain the SEd service is always somehow found, and this feeds us with hope for further consolidation of SEd services in the systems of our countries.

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Appendices

Appendix 1: Project organization

Participating Organizations

The Czech Republic	Ledovec (www.ledovec.cz)
The Netherlands	Hanze University of Applied Sciences Groningen (www.hanze.nl)
Norway	Studentsamskipnaden I Bergen (SIB) (www.sib.no)
Portugal	Associação Para o Estudo e Integração Psicossocial (AEIPS) (http://www.aeips.pt)

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Project coordinator	Jacomijn Hofstra, Hanze University of Applied Sciences, Groningen

Meeting Venues

October 2013	Groningen, The Netherlands
May, 2014	Plzen, Czech Republic
November, 2014	Lisbon, Portugal
May, 2015	Bergen, Norway
November, 2015	Groningen, The Netherlands

Advisory Board Members

Bénard da Costa, Ana Maria	Educational specialist and policy maker (retired), Portugal
Bogarve, Camilla	Rehabilitation specialist, Sweden
Podlipny, Jiří	Psychiatrist, Czech Republic
Zijlstra, Annemarie	Director of the Rehabilitation '92 Foundation, The Netherlands

Appendix 2: Methods used to identify barriers to choosing, getting and keeping a study

A. Literature review

Both peer reviewed and gray publications were used to get information about the hindrances that people with psychiatric problems encounter when going (back) to school. Publications were included when they described the situation in the specific country. Key terms including 'students with psychiatric disabilities', 'mental health problems and students', 'psychiatric disabilities and (higher) education', and 'students with special educational needs' were used in search engines for Google Scholar and several literature databases such as WorldCat and PsycINFO. As can be read in the four separate reports about the results of the research in the four countries, in the Czech Republic and Portugal especially very few publications were found. Of the four countries, the Netherlands is the country with most publications concerning our topic.

B. Questionnaires from experts in Supported Education/mental health care

Next, we were interested in what experts on Supported Education and/or on students with mental health problems consider to be barriers to going (back) to school for young people with psychiatric disabilities. Therefore, all partners sent the following two questions to several experts by e-mail/letter: "What hinders young people with psychiatric disabilities in going (back) to school?" and "What hinders young people with psychiatric disabilities in keeping their study?"

The experts all came from the social networks of the partners, and were all working in education or in mental health care. In total, 30 experts sent back their answers to the questions.

All partners used the same coding system to analyze the answers. For each question, all the answers were put together into one file. Next, all answers with more or less the same content were marked in the same color. For instance, all answers about 'lack of self-esteem' were coded in red. By coding the answers with colors, one can more easily distinguish categories in the answers.

C. Focus group interview with people with mental health problems wanting to go (back) to school

Besides asking experts in the field of Supported Education about the barriers people with a psychiatric background face when going (back) to school, we also asked people with a disability themselves about their experiences with going (returning) to school. We did this in a focus group meeting. A total of 27 participants joined the group interviews that were organized by the four partners. The participants were all part of the networks of the partners—for instance, because they were participating in a course on SEd that was organized by the partner. The age of the participants ranged from 17 to 60 years. Of the participants, 13 were male and 14 female. All participants had dropped out of school once or twice before. Psychiatric diagnoses were, amongst others, depression, schizophrenia, PTSS, anxiety disorder and autism.

The procedure was roughly the same in the four partner countries. The interview was led by one or two interviewers (at least one partner working on the ImpulSE project took part in the interview). Before the interview began, the purpose and plan of the group meeting was discussed. We mentioned that the interview would be audio and/or videotaped and that the recordings would be destroyed after the analysis. Also, we guaranteed that the reporting about the group interview would be anonymous. Finally, we told the participants that we were going to ask them about what hinders and what helps them in choosing, getting and keeping a study. The actual interview lasted between 75 minutes and two hours. In general, the participants appreciated having the opportunity to tell about their problems related to

studying. They felt heard.

The interviews were transcribed and the answers subsequently analyzed using the same color coding system as was used to analyze the answers of the experts. That is, answers with more or less the same content or meaning were given the same color: for instance, all answers about 'lack of information about available support services' were marked in blue. By coding the answers in different colors, one can more easily distinguish categories in the answers. After we finished the report about the focus group meeting, the report was sent to the participants for feedback.

Appendix 3: Barriers related to personal factors as identified in Portugal, the Czech Republic, Norway and the Netherlands.

Between brackets, the method of research is given (L = literature review; E = questionnaire to experts; F = focus group interview).

	Portugal	Czech Republic	Norway	The Netherlands
Choose*		Difficulties with choosing a study (F)		Difficulties with choosing a study (E, F)
	Earlier negative experiences with going to school (F)	Earlier negative experiences with going to school (E, F)		Earlier negative experiences with going to school (E, F)
	Lack of self-esteem (F)	Lack of self-esteem (E, F)	Lack of self-esteem (E)	Lack of self-esteem (E, F)
	Fear of being stigmatized (E)	Fear of being stigmatized (E)	Fear of being stigmatized (E, F)	Fear of being stigmatized (E)
		Self-stigma (E)		Self-stigma (E)
				Difficulty accepting own disability (E)
				Difficulty estimating the study load and the own capacity (E)
				Fear of dropping out because of relapse (E)
				Concentration problems (E)
	Lack of financial means (E, F)			Lack of financial means (E)
				Pressure on executive functioning skills (E)
				Letting go of the secure base one has created for oneself (F)
Get				Fear of failure (F)
	Difficulties with executive functioning skills (E)			
	Lack of financial means (F)			

			Difficulty enrolling because of stigma about mental illness (F)	
	Presence of (residual) symptoms and side effects of medication (F)	Presence of (residual) symptoms and side effects of medication (F)		
	Fear of stigma (F)			
Keep	Difficulties with executive functioning skills (L, E, F)		Difficulties with executive functioning skills (E)	Difficulties with executive functioning skills (L, E, F)
	Lack of self-esteem (F)	Lack of self-esteem (E)		Lack of self-esteem (E, F)
	Direct consequences of the psychiatric disability (F)	Direct consequences of the psychiatric disability (E, F)	Direct consequences of the psychiatric disability (E, F)	Direct consequences of the psychiatric disability (L, E, F)
	Difficulty with choice to disclose or not (E)			Difficulty with choice to disclose or not (L, E)
	Lack of financial means (E)			Lack of financial means (E, F)
	Impact of being stigmatized (E)	Impact of being stigmatized (E, F)		
			Not fitting in (F)	

*Note that with this phase we mean the choice of a certain study, but also the choice to start studying again.

Appendix 4: Barriers related to educational environment as identified in Portugal, the Czech Republic, Norway and the Netherlands.

Between brackets the method of research is given (L = literature review; E = questionnaire to experts; F = focus group interview). *Note that with this phase we mean the choice of a certain study, but also the choice to start studying again.

	Portugal	Czech Republic	Norway	The Netherlands
*Choose	Lack of support (E)	Lack of support at school (F)	Lack of support at school (E)	Lack of support at school (L, E)
	Educational offer doesn't match with student's needs (F)	Educational offer doesn't match with student's needs (F)		Educational offer doesn't match with student's needs (E)
				Difficulty with educational methods (E)
				Lack of (or too little) information about available support services (L, F)
				Uncertainty about promises that the school makes (F)
	High study tuition fees (F)			
Get	Difficulties with application procedure (E, F)	Difficulties with application procedures (F)	Difficulties with application procedures (E)	Difficulties with application procedures (E, F)
				Information to be received from several institutions (F)
				The institutions do not communicate (F)
	Lack of information about the school (F)			
Keep	Lack of support (L, E,F)	Lack of support (E, F)	Lack of support (E)	Lack of support (L, E)
		Lack of understanding, expertise and empathy of staff (E, F)	Lack of understanding, expertise and empathy of staff (E)	Lack of understanding, expertise and empathy of staff (L, E, F)
	Structure of educational system (F)	(Inflexible) Structure of educational system (E, F)	(Inflexible) Structure of educational system (E)	(Inflexible) Structure of educational system (L, E, F)
				Lack of information about available support services (L, E)
	Lack of mentor/ or peer(E)			

Appendix 5: Barriers related to social environment as identified in Portugal, the Czech Republic, Norway and the Netherlands.

Between brackets the method of research is given (L = literature review; E = questionnaire to experts; F = focus group interview). *Note that with this phase we mean the choice of a certain study, but also the choice to start studying again.

	Portugal	Czech Republic	Norway	The Netherlands
Choose*	Lack of social support (financial, practical and emotional level) from family and mental health professionals (F)	Lack of social support (financial, practical and emotional level) from family and mental health professionals (E, F)	Lack of social support (financial, practical and emotional level) from family and mental health professionals (E)	Lack of social support (financial, practical and emotional level) from family and mental health professionals (E, F)
			Stigmatization by mental health professionals (F)	Stigmatization by mental health professionals (E)
	Stigmatization/discrimination by co-students (E, F)			
		No cooperation between mental health professionals, family, educators (E)		
		Stigmatization in society (E)		
Get			Lack of knowledge of staff members about rights of people with psychiatric disability (E)	
	Fear of being stigmatized (F)			
Keep	Little or no support from the family, co-students, and/or mental health professionals (F)	Little or no support from the family, co-students, and/or mental health professionals (E)	Little or no support from the family, co-students, and/or mental health professionals (E)	Little or no support from the family, co-students, and/or mental health professionals (E)
	Stigmatization/discrimination by co-students and/or teachers (E, F)	Stigmatization/discrimination by co-students and teachers (F)		Stigmatization/discrimination by co-students and/or teachers (L, F)
			Lack of knowledge of staff about rights of people with psychiatric problems (E)	

Appendix 6: Facilitators of choosing, getting and keeping a study as identified in Portugal, the Czech Republic, Norway and the Netherlands.

	Portugal	Czech Republic	Norway	The Netherlands
Choose*				Clear information about the available support services: website
				Personal meeting with staff member about support services
				A supportive course that helps with choosing, identifying competencies, qualities
	Support from practitioners/ family/ peers			
Get				To do list on the school website
				Reception desk at school, specifically for questions about application
	Support from mental health professionals with applying and finding arrangements	Support from mental health professionals with applying and finding arrangements		Support from mental health professionals with applying and finding arrangements
		Information about system of student and health disability benefits		
				ImpulSE course
Keep	Frequent personal contact with staff member/practitioner with expertise	Frequent personal contact with staff member with expertise		Frequent personal contact with staff member with expertise
				Clear information about support services
		Course in time management, study skills		A course in planning and structuring

		Learning how to manage illness/ medication in context of studying		
		Venting one's educational frustrations by transforming them into poems or by talking to someone		
		Studying something the students really enjoys		
		Smaller classes		
		Familiarity with system of student and health disability benefits		
	Flexible educational system (optional attendance)	Flexible educational system (optional attendance)	Flexible educational system (optional attendance)	
		More understanding staff		
		Some kind of professional service that coordinates/ cooperates with all stakeholders	Existing cooperative meeting between stakeholders	
		Support with disclosure		
			Physical exercise	
	Peer support group		Peer support group	
	Support from family and friends		Support from family and friends	
	Feeling of social integration			
			Supported Education program	

Appendix 7: Worksheets Disclosing your psychiatric disability

Worksheet 1 Whether to tell

Instructions: Determine whether you want to tell about your psychiatric disability

- Remember to:
- a. Identify benefits
 - b. Identify risks
 - c. Compare balance

Identify Whether to Tell	
A. What are the benefits of disclosing?	B. What are the disadvantages of disclosing?
C. Compare the benefits and the disadvantages. Which are most important to you? Rank the benefits and disadvantages of disclosing from most important to least important.	

Worksheet 2: What to tell

Instructions: Think about your situation and decide what you want to tell.

Remember to:

- a. Assess your situation
- b. Determine what you want to tell

Formulate What to Say
a. Assess your situation
I have the following psychiatric disability/disabilities.
This manifests itself in the following way.
I find it hard to/ I have problems with (related to your study performance):
I tell you this because:
What would help me is:
b. Determine what you want to tell
Is everything that you wrote down under A relevant for the person you'd like to disclose to?
Do you want to tell everything or only parts of it?
Write down exactly what you want to tell.

Worksheet 3: Who to tell

Instructions: Think about your own situation and identify who to tell.

Remember to:

- a. Brainstorm relevant people
- b. Select the best choice

Identify Who to Tell
a. Brainstorm relevant people
b. Select best choice (and your reasons)

Worksheet 4: When to tell

Instructions: Think about your own situation and decide when to tell.

Remember to:

- a. Identify times
- b. Choose the best time

Decide When to Tell
A. Identify appropriate times and places
B. Choose the best time and place (and your reasons)

Worksheet 5: How to tell

Instructions: Think about your own situation and formulate how to tell.

Remember to:

- a. Determine the means of communication (face to face, email, phone call)
- b. Determine your tone of voice

Formulate How to Tell
A. How are you going to communicate your message (e.g., by phone, email or face to face) and why?
B. What is going to be your tone of voice (e.g., (in)formal, neutral, happy, etc.)? Take the goal of your message into consideration.

Worksheet 6: Checklist

Instructions: You could use this checklist when you are practicing disclosing, or when disclosing your psychiatric disability did not go well, in order to identify what went wrong or could go better. You can indicate which steps and behaviors you have performed, and you can reflect on this in the right column (comments). Discuss your performance, if needed, with, for instance, your disability specialist.

Disclosing your psychiatric disability	Yes	No	Partial	Comments
1. Choose whether to tell				
a. Identify benefits b. Identify disadvantages c. Compare and rank benefits and disadvantages				
2. Identify what you want to tell				
a. Assess your situation b. Determine what you want to tell				
3. Identify who to tell				
a. Brainstorm relevant people b. Select best choice				
4. Identify when to tell				
a. Identify times and places b. Choose best time and place				
5. Formulate how to tell				
a. Means of communication b. Tone of voice				

Appendix 8: Worksheets Communication Matrix

Worksheet 1: Target group inventory (national and international)

Number	Target group /Stakeholder
1.	Organization: Contact person: E-mail:
2.	Organization: Contact person: E-mail:
3.	Organization: Contact person: E-mail:
4.	Organization: Contact person: E-mail:
5.	Organization: Contact person: E-mail:
6.	Organization: Contact person: E-mail:
7.	Organization: Contact person: E-mail:
8.	Organization: Contact person: E-mail:
9.	Organization: Contact person: E-mail:
10.	Organization: Contact person: E-mail:
11.	Organization: Contact person: E-mail:
12.	Organization: Contact person: E-mail:
13.	Organization: Contact person: E-mail:

Worksheet 2: Frame of reference of the six most important national target groups and international target groups

Target group	Description of frame of reference + current knowledge, attitude and behavior
1.	
2.	
3.	
4.	
5.	
6.	

Worksheet 3: Communication matrix

Target group	
Goal (required knowledge, attitude and behavior)	
Message	
Means of communication	
Frequency + Timing (when) + Where	
Sender	
Feedback options	

Appendix 9: The purpose and use of oral, written and audio-visual means

Oral means

Means	Information	Attitude change	Behavior change
Work meeting		X	X
Presentation	X	X	
Large gathering	X	X	
Consultation hour		X	X
Face-to-face contact		X	X
Meeting		X	X
Helpdesk		X	X
Roadshow		X	
Course/training			X
Cafeteria talk		X	
Workshop			X

Written means

Means	Information	Attitude change	Behavior change
Memo	X	X	
Bulletin/newsletter	X	X	
Letter	X	X	
Staff journal	X	X	
Brochure	X	X	
Newspaper	X		
Report	X		
Manual	X		
Notes	X		
E-mails	X		

Audio-visual means

Means	Information	Attitude change	Behavior change
Telephone consultation		X	X
DVD	X	X	
Film	X	X	
TV news	X	X	
Facebook	X	X	
Twitter	X	X	
LinkedIn group	X	X	
Intranet	X	X	

