Supported Education - An Innovation in Psychiatric Rehabilitation Practice: Results from the United States and The Netherlands

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Abstract

Psychiatric rehabilitation (PSR) addresses global needs for community-based services for individuals with psychiatric disabilities. This article describes one of the newest PSR innovations – supported education. Implementation of the program in the US and the Netherlands is described. Program differences are contrasted and related to the context of service delivery and the circumstances surrounding implementation. Many similarities are identified, suggesting that this innovation has the potential for successful utilization in many different locations. The article also demonstrates the benefits of international collaborations in terms of model improvements.

> "Education...becomes the practice of freedom, the means by which men and women deal critically and creatively with reality and discover how to participate in the transformation of their world."
>
> Shaull, in Freire (1968)

Deinstitutionalization (DI) in the United States began in the late 1950's and peaked in the mid 1970s (Grob, 1991; Kiesler & Sibulkin, 1987; Mowbray & Moxley, 2000). Following DI, alternative services and settings have been developed for individuals with serious mental illness, who are now living in communities rather than isolated in institutions. Deinstitutionalization is a global issue – occurring at different times and with more or less controversy around the world. Prior to DI in the US, in the 1940s and 1950s, both Britain and Norway initiated consumer-centered, community integration efforts: therapeutic communities, sheltered workshops, and comprehensive treatment programs. As deinstitutionalization has been international in scope, so too, services utilizing psychiatric rehabilitation principles and methods have expanded globally, evidenced by representation beyond the US and Canada in IAPSRS and the development of the World Rehabilitation Association, with regular biennial conferences. People with mental illness are now provided programs designed to maximize their potential, thus revitalizing hope.

This article describes one of the newest psychiatric rehabilitation (PSR) innovations–supported education (SEd)–and its development and operation in the United States and the Netherlands. Supported education provides preparation, assistance, and support to adults with psychiatric disabilities, who wish to pursue post-secondary education. In both countries, SEd was initiated through similar methods. However, implementation varied, reflecting adaptation to particular national circumstances and local needs. Nonetheless, the similarities between the two programs indicate the robustness of supported education across varying contexts and populations, suggesting that it may be a model worth replicating in many different locations and cultures, demonstrating the value and the power of education.

History of Supported Education in the US

In the US, in the mid-1970's, deinstitutionalization treatment failures were apparent; it became clear that new service models were needed. As physical rehabilitation methods had successfully addressed chronic physical illnesses and conditions, it was reasoned that a similar approach--psychiatric rehabilitation--could be used with long-term, persistent mental illnesses. "Rehabilitation focuses on the reduction of disability and the promotion of more effective adaptation in the individual's environment" (Silverstein, 2000, p. 228); individuals acquire skills and knowledge to minimize their disability and environmental supports to assist

them in carrying out their rehabilitation plans. Recognition of the need for rehabilitative and support services as critical supplements to mental health treatment led to the development of the Community Support Program (CSP) in the 1970s. The CSP movement launched several innovative models for rehabilitation including supported employment (Tice, 1994) and supported housing (Ogilvie, 1997). These approaches use normal, community settings (competitive employment and independent living) congruent with individual preferences, adding appropriate supports to achieve self-determined rehabilitation goals. Research has shown that supportive rehabilitation services for people with psychiatric disabilities are effective, producing more normalized role functioning for the majority of service recipients (Barton, 1999).

Psychiatric rehabilitation practice expanded into the educational arena in the 1980's, with a federal grant to the Boston University Center for Psychiatric Rehabilitation for a supported education program. The Center received additional federal funding to replicate SEd at seven sites nationwide. Subsequently the Massachusetts Department of Mental Health provided support for SEd in a variety of locations within that state. In California, its community college system elevated the visibility of psychological disabilities in a mandate to disabled student programs; four sites were chosen to implement supported education services to adults with psychiatric disabilities (Mowbray & Collins, 2002; Parten, 1993; Unger 1993). Since that time, supported education programs have been initiated in colleges and universities, mental health agencies, and PSR settings in North America and Europe.

The Rationale and Global Need for Supported Education

Across the industrialized world, success in the marketplace and in obtaining jobs with stability, benefits, and career potential requires advanced training and education. But, despite the importance of higher education and the increased openness of colleges and universities to disabilities, people with psychiatric disabilities are frequently unable to access educational resources or maintain their involvement with educational institutions (Cheney, Martin & Rodriguez, 2000). However, the need is there. Recent developments have increased not just the need, but also the demand for higher education access among consumers with serious mental illnesses. In the 1990's, the consumer movement created a new sense of hope with the recognition that recovery from serious mental illness is definitely possible. Recovery potentials have been enhanced by the development and utilization of new psychotherapeutic medications combined with psychiatric rehabilitation models having demonstrated effectiveness. Recovery paradigms provide

further motivation for consumers to pursue their goals, and not just settle for "stabilization" or staying out of the hospital. Participating in higher education can now be seen as a more feasible and desirable endeavor. Another rationale for SEd services is that higher education and increased knowledge have long been recognized for their empowerment potential – knowledge is power and can lead to improved self-perceptions, increased confidence, a greater sense of self-efficacy, and improved rehabilitation outcomes. Thus, advanced education offers greater potential for recovery as well as for empowerment, contributing to consumerism overall. These trends and conditions affecting mental illness treatment go beyond the borders of the US and certainly North America.

Supported Education Mission, Values and Models

The supported education program model follows the Boston University PSR model of "choose-get-keep" -- assisting individuals to make choices as to needed paths for education and training, helping them to get (access) an appropriate education or training program, and assisting them to keep (retain) their student status within that program until their goals are achieved. SEd programs accomplish these ends by providing individuals with the knowledge and skills they need to help them achieve success, by offering assistance and support to them in their interactions with postsecondary educational settings (including coping and problem-solving abilities), and by intervening in these settings and with ancillary support services to change how systems interact with and support these individuals (Mowbray, Szilvagyi & Brown, 2002). "The philosophy and principles of supported education emphasize the values of individualization, self-determination, and support. Program operations embody these critical factors, and throughout the process build in dignity and hope" (Soydan, 2002).

SEd programs differ, but most offer these core services (Brown, 2002):

- *Career planning*: instruction and assistance with vocational self-assessment, support and counseling, career exploration, developing an educational plan, and course selection.
- *Academic survival skills*: strengthening basic educational competencies, information on college/training program enrollment, time and stress management, developing social support for educational pursuits, tutoring and mentoring services, and providing opportunities for confidence building and for social development within a normalized setting.
- *Outreach to services and resources*: facilitated referrals and contacts with resources on campus (e.g., the computing center) and/or relevant human service agencies, like vocational rehabilitation, assistance with the college enrollment process, education on rights and

resources for people with disabilities, assistance in obtaining financial aid and resolving past educational debts, and availability of contingency funds.

Additionally, for SEd to promote "normalization" and role transformation from "psychiatric patient" to student, some significant part of the services should be located on a college campus (Cheney et al., 2000).

The core SEd services have translated into three general models (Unger, 1990), distinguished by the degree to which participants are integrated into campus life and by the agency providing the support services (Mowbray, Moxley, & Brown, 1993):

The self-contained classroom model
- structured curriculum, utilized with a group of students
- time-limited and usually delivered on a college campus
- strong vocational focus (developing career goals)
- academic skill-building and practice
- supportive relationships with staff

The on-site model
- generally sponsored by a college/university
- individual not group-based
- utilizes on-campus services for all students with disabilities, rather than special programming
- existing disabled student support services are enhanced to be more relevant and accessible, e.g., through the addition of specialized mental health staff or a peer support group

The mobile supported education model
- services provided through a larger psychosocial rehabilitation agency
- students select their own post-secondary educational site
- workers from a PSR agency provide support, assistance, and/or trouble-shooting to students on-site in an individualized and flexible manner

A review of published reports indicates that supported education programs are well-utilized, with participation rates ranging from 57% to 90% (Mowbray & Collins, 2002). Evaluations have shown significant increases in participants' college enrollment (Cook & Solomon, 1993; Dougherty et al., 1992; Hoffmann & Mastrianni, 1993; Wolf & DiPietro, 1992), competitive employment and self-esteem, and decreases in hospitalization (Cook & Solomon, 1993; Unger, Anthony, Sciarappa, & Rogers, 1991). There are currently about 120 supported education programs in the US and Canada, based in settings ranging from universities and community colleges, to PSR clubhouses, community mental health agencies, consumer/advocacy groups, inpatient psychiatric hospitals, and grass-roots/mutual support organizations (Megivern & Holter, 2000; Mowbray, Brown, Furlong-Norman, & Sullivan-Soyden, 2002).

The Michigan Supported Education Program (MSEP)

In Michigan, interest in supported education first came from middle and upper income parents of young adults with serious mental illnesses. Typically children in these families graduate from college and go into business or professional occupations. However, adult children with mental illness could not obtain support or assistance for career or higher education goals–instead, vocational rehabilitation and mental health workers expected them to pursue non-skilled jobs in service or industry settings ("hash or trash"). Families responded by demanding a supported education initiative similar to that of Boston University. Since there was no new program money available in the state, an application for federal funds for a demonstration project was submitted, having broad support (Mowbray, 1999). The proposal was to utilize an experimental design with random assignment to a control group or to supported education services. To assure enough eligible individuals for the research design and to meet the federal funding expectations, a large urban area was selected as the recruitment site. The program was thus regional, not local, creating transportation and other issues for many participants. The research requirements did prove beneficial: MSEP became the first supported education program to demonstrate the effectiveness of SEd services, because of its strong experimental design.

Target Group

Program staff used extensive outreach, publicity and recruitment to distribute applications for the program (Frankie et al., 1996). Applicants were primarily individuals receiving services from the public mental health system. They were screened in person or by phone vis a vis eligibility, which required: 1) psychiatric disability of at least one year duration; 2) high school diploma or GED obtained or near completion; 3) interest in pursuing post secondary education; and 4) willingness to utilize mental health services, if needed, during participation. The program has been serving about 200 students a year.

Table 1 presents information on the demographics of the students served in the research phase (N=397). There was a slightly higher percentage of females than males and most were non-white. The average age was 36.9, but ranged from 17 to 75 years old. On average, participants had experienced mental illness for more than 14 years. The vast majority received Social Security Income (SSI or SSDI). About a quarter had a high school diploma or GED and a quarter had not completed high school. Nearly half had some post high-school education. Participants resided in Detroit as well as the outlying areas of the county and their distribution generally resembled that of the Community Mental Health Board's overall clientele.

Setting

The Michigan Supported Education Program has utilized two college campuses -- in downtown Detroit and in western Wayne County. Each campus site provided a classroom plus one staff office with phone, fax and copying facilities. The provision of opportunities and assistance in a campus setting, conducive to the exercise of consumer empowerment, is a central component of the rehabilitation process in MSEP. The program also has a business office, housing a resource room with computers and software for developing or renewing skills in math, reading, writing, computer literacy, or typing; tutors are also available. The services are open to individuals currently or previously enrolled in the program.

The Program

The mission of Michigan Supported Education is to prepare adults with serious mental illness for post-secondary education. This is accomplished by helping participants to choose career and educational goals, acquire the skills necessary to achieve these goals, and facilitate goal attainment. To promote skill acquisition, most services are provided in a classroom format. Non-credit classes meet twice a week in two and a half hour sessions for two 14-week semesters.

The classes provide opportunities to develop and practice skills by using a set of curriculum modules adapted from the B.U. program (Unger et al., 1987). The curriculum uses small group exercises and experiential learning, organized around three topics: coping with the academic environment, stress management, and developing career choices. The curriculum seeks to develop academic and social skills and utilizes verbal and written assignments focused on the use of the library, the career laboratory, and other campus resources. The curriculum covers career planning and vocational assessments, information on college or training program enrollment, assistance in obtaining financial aid, problem-solving and academic trouble-shooting, stress management, time management, information on rights and resources for disabled students, and facilitated contacts with campus special student services offices and with vocational rehabilitation (as a source of financial support for educational and vocational plans) (Frankie et al., 1996). Follow-up services are available and include individual counseling and scheduled group sessions to help students carry out their educational plans. Students can also participate in an alumni group that provides continuing peer support. All students are encouraged to follow up with their case managers to discuss

progress on their educational plans and also to attend periodic refresher sessions and educational field trips, particularly during the summer, when schools are not in session.

The full-time director of the program is a master's-level social worker with extensive experience in psychiatric rehabilitation. The direct-service staff includes three full-time employees (at least one of whom is a mental health consumer) for the classroom groups, plus a tutoring coordinator, a full-time administrative assistant and part-time clerical support. The program budget contains flexible funds to meet a wide range of student needs, such as for transportation, childcare, and academic supplies.

Research

To determine the effects of MSEP on personal outcomes and academic/employment achievements, two "active" conditions where services were delivered in a classroom or group format were compared to a control condition, providing no group services, only information about higher education and referrals on request. Median attendance rate in the active conditions was 12 sessions (out of 28). At the one year follow-up assessment, outcomes for the active interventions differed significantly from the control condition in showing higher Quality of Life, Self-Esteem, and Social Adjustment scores. Participation in college/ vocational training increased three-fold, from less than 9% to about 25%. Outcomes were also assessed qualitatively through focus group sessions. Analyses of themes that emerged from these sessions showed that participants experienced many benefits associated with MSEP and that the changes which participants described were congruent with an empowerment process (Bellamy & Mowbray, 1998).

Case Vignette:

John was a successful systems operator in the graphic arts industry until a series of crises started him on a slow spiral into depression. He was referred to the local mental health center, given medication for depression, and counseling to start him on the road to recovery. John clearly wanted to resume working, but not in his prior career. The Department of Vocational Rehabilitation was of no assistance. John's case manager heard about MSEP and told John, "This would be perfect for you." John contacted MSEP: "The MSEP staff were the first people who took an interest in my *life*, not just my illness." At MSEP, John learned more about his disorder, and he learned that *he* could be an active participant in his treatment planning. The MSEP classes helped him relearn how to take notes, how to study, and how to take tests. But more than these concrete skills, John said that the staff of MSEP gave him respect and kindness and helped him improve his self-esteem. Using the skills and knowledge he developed during his MSEP experience, John found a technical school he wanted to attend and lined up funding to finance his education. John aims for certification as a Microsoft engineer. He plans to work as a systems administrator and, in the future, wants to have his own business installing cabling for information technology use. John has also helped friends and relatives with mental illness-- sharing information about the importance of medication, the need to maintain stable sleep patterns, and how to find funding for college. John is a great recruiter for MSEP. He also stays in touch with fellow MSEP graduates--"We help each other."

Barriers

At the 12-month follow-up, while many students were pursuing educational goals, others reported continuing barriers to education: about 40% cited financial need and/or their own mental illness; 20-25% indicated physical illness and/or fears of dealing with college; one in six mentioned lack of academic skills; and one in seven identified family crisis as a difficulty. Analyses also showed that relatively few participants were getting follow-up support from any source for their educational activities. However, receiving follow-up support (from MSEP, families, or mental health workers) was a significant predictor of enrollment in college or vocational training. Interestingly, the direction of causality in this relationship was reciprocal: having contacts with others concerning educational plans affected enrollment and, in turn, being enrolled in college or training produced more extensive contacts with others about education.

The Rotterdam Supported Education Project

Until 1999, there was no structural interest in the Netherlands in applying psychiatric rehabilitation to the life area of learning (compared to life areas of living, working or socializing). Nor was there in the field of education any interest in serving students with psychiatric disabilities. However, a study on rehabilitation and care programs for young adults with schizophrenia demonstrated the importance of education for this population (Van Weeghel & Ketelaars, 1997). The study further showed that there were no Supported Education programs or rehabilitation activities on learning currently available.

A deinstitutionalization movement is now going on in the Netherlands, and the importance of education for (young) people with psychiatric disabilities has been recognized by mental health and educational organizations. In 1999, GGZ Nederland, the national umbrella organization for mental health and addiction agencies, and the Trimbos Institute, the national research institute for mental health and addiction, joined hands and organized two national conferences in Amsterdam to publicize psychiatric rehabilitation and education.

Very important to the success of these conferences was the willingness of the different organizations to work together on this topic. Each conference was well attended by about 200 from mental health and educational settings. Specialists in Supported Education from the US and from England were invited as keynote speakers. That April, the Rotterdam Supported Education Project began through a grant from the Department of Health, as a three year collaboration between the Rehabilitation 92 Foundation, the ROC Zadkine, and the Trimbos Institute[1]. The project developed, implemented, and evaluated a Supported

Education program within the ROC Zadkine in Rotterdam, based on the Choose-Get-Keep model, developed by the Center for Psychiatric Rehabilitation at Boston University (Sullivan et al, 1993) and adapted to the Dutch situation.

Target Group

Project participants were recruited from mental health sites in Rotterdam as well as from the GOAL-project[2]. Applicants were required to be 16 years of age or over, be willing to use an educational (group) environment, to develop and utilize an educational plan, and to have experienced a severe disability due to mental illness of at least one year. If students were already attending college or had moved on to regular classes, documentation of acceptance as a matriculated student was required in order to receive services. Current students of the ROC Zadkine with psychiatric problems could apply through the college's internal support service. (See Table 2 for demographic and clinical data on participants).

Setting

The Supported Education program is situated at one of the ROC Zadkine campuses. ROC Zadkine has about 33,000 students, 1800 teachers and more then 30 locations in the Rotterdam area. It is a comprehensive, post-secondary educational institution for high quality vocational education, adult education, and training for all people over the age of 16, irrespective of background or social position. The educational programs that the college offers aim to:

- qualify people for the demands of the labor market, thus enhancing their opportunities for a better position in society;
- contribute to people's personal development;
- prepare people to function better in a multicultural, diverse and complex society.

The Supported Education Project is part of the Health and Welfare division of the College, but the participants are free to choose another field of interest (Technical, Health and Welfare, Economy (administration, business, tourism), or Adult Education) or even another college.

The Program

The mission of the Rotterdam Supported Education program is to help students with psychiatric disabilities to choose, get and keep an educational environment of choice so they can be successful and satisfied in this environment with the least amount of professional intervention, congruent with the Boston University model. The goal of "choosing" is to select an educational or training site compatible with the

participant's values, skills, and learning needs. The goal of "getting" is to secure admission to a preferred educational program or training site. The goal of "keeping" is to sustain enrollment and increase success and satisfaction through development of participant skills and external supports. The Choose-Get-Keep model has been operationalized through two services. The first is a preparation class, named Impulse, based on the self-contained classroom model (Anthony & Unger, 1991); the second provides internal and external support, based on the On-site and Mobile support models (Anthony & Unger, 1991). (See Korevaar, 2001, for additional details.) The program is staffed by three part-time teachers/supported education counselors (5 days/week), one teacher for the preparation class (2 days/week for four months), two part-time (1½ day per week) project directors (one from education and one from mental health), and a part-time researcher.

The Preparation Class: The aim of the preparation class is to help students with psychiatric disabilities choose and get their own educational goals, but also to help them feel comfortable in the post-secondary educational environment, to help them utilize educational services such as the library, to build confidence, and to get used to the role of student instead of the role of patient. The class is located on the campus of the community college and not at a mental health agency, so that students can participate in normal educational experiences in an integrated setting. The subjects of the class include: orientation to college locations and services; assistance with meeting requirements in a major field of study, course selection and registration; academic skills building; and development of coping strategies. Classes meet two times per week for 5½ hours per day for 16 weeks from January until April (since May is when Dutch students usually apply for admission to college). Most college courses start in September, after a two month school holiday. To keep SEd students occupied in the summer period, there are one-day sessions at the end of May, June, and August. Because the project was externally funded, there were no fees associated with attending the program. After completing the class, students may move on to other courses at ROC Zadkine, courses at another college, or other education or training programs.

Case Vignette:

Kathryn is now 27 years of age. She was diagnosed with ADHD at age 19; and at that moment stopped her study of Social Work at a four year College. She became very depressed and has been in day treatment for several years. She was put on medication that helped her a lot and that she is still using. Three years ago, she started volunteer work two days a week at a Day Activity Center for people with psychiatric disabilities. In the fall of 1999 her supervisor told her about the preparation class at the ROC Zadkine. She requested an application and was called in for an interview. She was accepted and started the 16 week class in January 2000. At the beginning of the class, Kathryn was very impatient and became agitated by its slow pace. After discussing these problems with one of the teachers and doing the exercises, she became aware that she had problems with the ordering of her thoughts. Because of this, most of the time she wanted to

go too fast. In the Impulse class, she learned to think about her future preferences in a very detailed and concrete manner. She said about the class: "Because you have to go out and do research on educational options, you get a clear picture of the different courses and their locations. The comparison of the different options with each other makes it clear which option does meet your preferences the most." The class helped increase her self -confidence and self-esteem. In September 2000, Kathryn returned to college to finish her study in Social Work. She has also been a paid co-presentor in workshops about the Supported Education Project.

Internal (On-site) and External (Mobile) Support Services: Dependent on whether students move on to courses at ROC Zadkine or another college, they can get internal or external support to help them maintain their educational plans. The internal support is provided by staff from the ROC Zadkine who are members of the Supported Education Project team. The external support is provided by staff from a community-based Psychiatric Rehabilitation Center. This center is part of the Bavo RNO Group, a large mental health organization in the Rotterdam area. One of the teachers of the Impulse preparation class works as a psychiatric rehabilitation counselor in this center. The aim of the on-site and mobile services is to provide the necessary academic and emotional support needed by individual students as they pursue their educational plans. The support, provided as long as needed and wanted, includes academic and emotional skills teaching; assistance with financial aid applications; linkage with tutors, treatment, etc.; advocacy with faculty for accommodations, such as untimed tests and assignment alternatives; peer group support; and emotional support.

Preliminary Research Results

Preparation class: Of 39 students accepted to date, 14 were in the first class, 15 in the second, and 10 in the third. Twenty-six students (67%) completed the Impulse class. The reasons for stopping were very diverse; e.g., needed a more individual process of choosing, personal problems, moving to another city, physical illness, different expectations from the class, the time for transport, or not qualified for the course of preference. In general, the students were positive about the support received in making course choices, the clear picture they got of the schools they visited, the positive atmosphere, the support of the teachers, their own growing self esteem, the role of student (not patient), and the experience of going to school again. The students were more negative about the pace of the class and being able to pay for future courses. Students also complained about Social Security Services, which had to approve their educational course selection and authorize payments. The agency's bureaucracy often made it difficult to get permission for a course without losing a financial grant, or took too long before giving permission. Students who completed the SEd class and moved on to regular courses were obviously satisfied over their achievements, but students who did not

move on were also satisfied. Impulse helped them to begin a process of choice and to look more to the future instead of the past (Korevaar et al, 2000).

Onsite and mobile support services: 25 students attending regular classes also receive onsite (20) or mobile (5) support. As of January 2001, eight students and three SEd specialists were interviewed as part of the program's evaluation (Van Erp et al, 2001). According to specialists, support services address multiple topics: insecurity about the class and functioning in class; insecurity about social intercourse with fellow-students and teachers; problems with planning tasks (for example, because his teacher had been ill for a long time, one student had a lot of tasks to catch up on); learning problems (e.g., attention); problems collaborating with fellow-students; disclosure of psychiatric history; and problems with internships.

Five female and three male students were interviewed. Seven were single and one was married. Three students lived with their parents, two lived on their own, one lived with a partner, one lived with her child, and one student lived in a supervised house. Four students had never finished high school; two were high school graduates; and one had finished post-secondary education (one was unknown). Of six students who knew their psychiatric diagnosis, four reported schizophrenia, one affective disorder, and one personality disorder. The mean contact with mental health services was 3.5 years (1 to 7 years). Six students were still at school, but two had dropped out. In general, all of them were very satisfied with the support (on-site and mobile) provided by the program. The element identified as most important was the knowledge that there was a person they could rely on, someone available should they have the need. Topics addressed with their support person were problems with planning, collaboration with fellow-students, internships, self disclosure of psychiatric problems, and social skills. These early evaluation results show high satisfaction with the on-site and mobile support services. Students have a need for someone who will be there for them if they have problems, providing emotional support as well as information on managing problem situations. The support received and their relationship with the SEd specialists seemed to have met their expectations.

Conclusions

Supported Education for people with psychiatric disabilities in the Netherlands is still in its infancy. From a psychiatric rehabilitation point of view, a lot can be learned from the experiences in the United States, but not all of that knowledge can be utilized. Educational support services must be adapted to the Dutch mental health and educational systems. For the success of these services, it is very important that the

world of education and the world of mental health come to know each other better and have the willingness to collaborate with psychiatric rehabilitation as the crucial link (see Figure 1). In the coming years, new Supported Education programs hope to start in other regions of the Netherlands. The Rotterdam Supported Education Project is participating in these initiatives. ROC Zadkine plans to continue Supported Education as one of the structural services the college provides for students. To conclude, not all students with psychiatric disabilities are in a need of support. Some will manage on their own. But for many others, chances would be missed and talents wasted if efficient support was not organized and offered to them.

Discussion

Mental health and educational systems in the US and in the Netherlands are quite different. Goodwin (1997) characterized the US as a liberal regime, in which maintenance of market relationships in economic and social affairs is emphasized. In the mental health arena of liberal regimes, deinstitutionalization started early and community-based services focus on individuals regaining independence within market conditions. On the other hand, the Netherlands represents a social democratic regime which emphasizes the social and economic rights of citizens. Deinstitutionalization in the Netherlands was implemented later and more slowly, but development of alternative services has proceeded rapidly since the early 1980s. In terms of educational systems, the US has public education from kindergarten to grade 12 (usually age 18). Following high school graduation, education is optional, competitive and privately financed, for the most part. In the Netherlands**,** schools are public and private, but 65% of children attend the latter. Education is mandated full-time to age 16 and part-time through age 18. Secondary education, starting at age 12, is divided into prevocational education, general secondary education, and pre-university education. Following completion of these programs, students either enter secondary vocational training (4 levels, ranging from 6 months to 4 years), higher education (professional, university, or open distance education), or opt for day release (1 day/week classroom along with practical training by an employer) (Netherlands Ministry of Education, Culture and Science, 1998).

These system variations may account for some of the differences in the Rotterdam versus Michigan supported education programs—for example, the characteristics of participants. In the Dutch program, supported education students were much younger, on average (about age 30), compared to Michigan participants (average age 37). It seems likely that this age difference reflects the fact that the Rotterdam

project recruited more students from the ROC Zadkine and from mental health facilities for adolescents and that adolescents can begin secondary vocational education at the age of 16 in the Netherlands.

In terms of programmatic differences, the Dutch program represents much more of a partnership with the academic sector, probably reflecting its original auspices as an educational and mental health collaboration, beginning with the two conferences in Amsterdam. This partnership approach appears to have helped minimize the implementation problems experienced in Michigan–that is, getting a community college site that was willing and able to house the on-campus part of the program. The partnership approach has also shaped the services delivered in the Rotterdam supported education project, which cover the spectrum from recruitment through post-secondary educational enrollment and completion, and include on-site and mobile support components. The Rotterdam program focuses equally on access to and retention in higher education settings, while the Michigan program focuses primarily on access. MSEP provides services, when requested, by students who complete the program, but is not structured for tracking and follow-up of its graduates.

This program difference may reflect the Dutch emphasis on social and economic rights of citizens (to higher education, even though they have a mental illness) vs. the US focus on market positions (the community college's ability to attract customers by excluding the stigmatized). The program difference may also stem from how the Michigan project was originally organized on a regional basis, in order to generate sufficient enrollment for an effectiveness study and a true experimental design. In Michigan, providing on site or mobile support services to address retention would require visiting a huge number of post-secondary educational sites over a large geographic area, which is not logistically or economically feasible. In the Dutch program, students are in the Rotterdam area, at several campuses of the ROC Zadkine, all in close proximity. But more than logistics and costs and variations in service philosophy, the difference in the programs probably represents increased experience with supported education and a greater understanding of the fact that students with psychiatric disabilities need support throughout their post-secondary educational careers–not just when they are planning or starting them. The support may not need to be continuous, but it needs to be regularly available and structured. As in other areas of psychiatric rehabilitation (vocational, housing), support that is not built into a system is usually either not used or not effective. This is a lesson to which newly developing and existing programs in many different locations should attend. The SEd programs

in Michigan and Rotterdam are a good example of how the mutual/reciprocal influences of innovation can improve the overall quality of programs.

The curriculum content for the two programs is similar, except that in Michigan classes run for two semesters, while in Rotterdam, the class is only one semester long. Ostensibly this reflects differences in the educational calendars of the two countries. However, the Michigan program found that many of its students prefer a reduction in the length of preparation time, attending for only one semester. The Michigan program has accommodated the need for varying lengths of preparation by letting each cohort enrolled determine the sequencing of topics from the curriculum. In some cohorts, many of those enrolled have college experiences and want to consider more practical topics like arranging financing, getting admitted, accessing resources, rights of disabled students, etc. In other cohorts, there is less prior experience with higher education, so students want to focus on vocational planning and academic skill development. The need for variety in academic preparation and support, in terms of breadth and depth, may also be a universal lesson for SEd programs. Indeed, in Chicago, the SEd program run by Thresholds, a large PSR agency, offers multiple classes in which students can enroll, depending on their needs, before they seek education or training in integrated settings. Boston University's Psychiatric Rehabilitation Center now operates "The Recovery Center," which offers academic preparation and other classes (similar to community education) on personal development and practical skills.

Student heterogeneity and the need for variety probably explain one of the few complaints voiced by students and staff in the Rotterdam Supported Education Project–concerning the curriculum. In developing the Michigan program, staff reviewed curricula from Boston University and Thresholds. But once the program started, staff discovered that students in the Detroit area had other educational needs, which were not being covered. Some of these were emergent–for instance, information about rights under the Americans with Disabilities Act, or the need for information about how to access Internet resources. Others appear to reflect circumstances unique to the local area; for example, the need for more information on psychotherapeutic medications and on how to manage psychiatric disability, topics which were not being covered by many mental health providers. SEd programs probably should expect that the process of developing and implementing a curriculum is multi-stage. It is wise to obtain curricula from as many other programs as possible and to survey students about specific needs. However, even with such preparation,

program administrators should expect that curriculum development will be an ongoing activity–as is the case in any quality educational endeavor. The Rotterdam Project should be able to rapidly improve its classroom material, though, because there are now many different modules for SEd available through BU, Thresholds, Michigan, and other sites.

In Michigan, but apparently not in the Netherlands, SEd students experienced barriers due to the attitudes of mental health workers – who failed to support a recovery and rehabilitation philosophy for their clients and saw post-secondary education and training as beyond the possible reach of someone with a "chronic" mental illness. These workers would not refer clients to the program, nor did they become educated about what SEd programs could do. When their clients enrolled in SEd anyway, they often failed to provide the support and encouragement clients needed to go on. Such attitudes reflect the stigma and discrimination associated with mental illness that is very prevalent in the US, even among mental health professionals. Unfortunately, this stigma is internalized by many consumers, who themselves are reluctant to enroll in SEd, or, when enrolled, have such ambivalence that they attend half or less of the sessions–fearing failure if they really try hard, or perhaps fearing a success which could not be repeated. Oftentimes fears were not acknowledged by students (except with extended dialogue), who, instead, cited transportation or personal problems for non-participation, as in the Rotterdam Project (Bybee, Bellamy & Mowbray, 2000).

Similarities

Despite structural differences in mental health and educational systems in the two countries, there are many similarities in the SEd programs. Both have been viewed extremely positively by students and staff and have been continued through their host agencies. In both sets of evaluations, consumers noted the value of receiving support and individualized assistance from the SEd staff-–people who care about consumers' goals, take educational goals seriously, and help consumers successfully pursue them. Feedback about the US program has emphasized the value of the group–peers sharing information and providing support to each other. This may be because the US students were older, the program was structured more around the group, or the group component lasted longer. We recommend that SEd programs do as much as possible to enable consumers to build on and use the positive support and problem-solving strategies to be gained from their peers; oftentimes many participants have tried attending college before and have valuable experiences to

share. The MSEP follow-up data show that the more support individuals receive, the more likely they are to successfully pursue plans.

Another similarity is that in both countries a national authority was needed to institute and fund SEd program development. It is probably the case that SEd programming is not something that a grass-roots constituency (a group of parents or one college campus) could have started up on their own. Barriers to full implementation and utilization of supported education services in the Netherlands and in Michigan are also, unfortunately, similar. In both locations, there were major barriers attributed to governmental bureaucracies. In Rotterdam, this involved procedures for the Social Security system to approve and pay for eligible students' course selections. Unfortunately, the system did not have sufficient flexibility or timeliness to accommodate the new innovation of higher education as a rehabilitation tool. Likewise, in Michigan, the state Vocational Rehabilitation (VR) agency was often an impediment; while VR would pay for "training," it would often not approve or pay for post-secondary classes in liberal arts or basic academic preparation that were needed before an individual could take specific skills or para-professional training courses. Furthermore, sometimes variations in processing and granting VR approvals were more reflective of the proclivities or biases of individual counselors or regional offices than of state policies.

Summary

Program development based on a common model or framework can offer much to participating sites. The benefits of international collaboration are clear. In this case, the US offers a well-developed curriculum and larger number of modules for use; the Rotterdam program is an innovation in that it combines the classroom model with on-site and mobile services–-in a fully developed partnership with academic institutions–-which makes a significant contribution to the more limited model now in use in Michigan. International relationships also provide many possibilities for research collaboration as well as for answering important questions about what makes SEd. That is, multiple sites of SEd have naturally varying program components which can be studied separately and analyzed on the extent to which each contributes to SEd outcomes. In the future, hopefully, with SEd replications in many different locations, we may have some answers to the perennial question as to what works for whom, and under what circumstances—at least for supported education.

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Table 1
Selected Demographics of Participants in the Michigan Supported Education Program

	N	%
Sex		
Male	189	47.6
Female	208	52.4
Ethnicity		
White	150	37.8
Non-White	245	61.6
Educational background		
Some grade school	17	4.3
Some high school	82	20.7
High school grad/GED	100	25.2
Vocational training	22	5.5
Some college	131	33.0
Associate's degree	20	5.0
Bachelor's degree	22	5.5
Master's degree	3	.8
Living situation		
Alone	83	20.9
With family	156	39.3
With friends/roommates	41	10.3
Supervised setting	116	29.2
Type of income		
SSI/SSDI	331	83.4
Other	54	13.6
Unknown	12	3.0
Age at enrollment	36.9 $\pm$ 9.40 (SD)	
Age of onset of mental illness	22.09 $\pm$ 9.91 (SD)	

Total N=379
SD=Standard Deviation

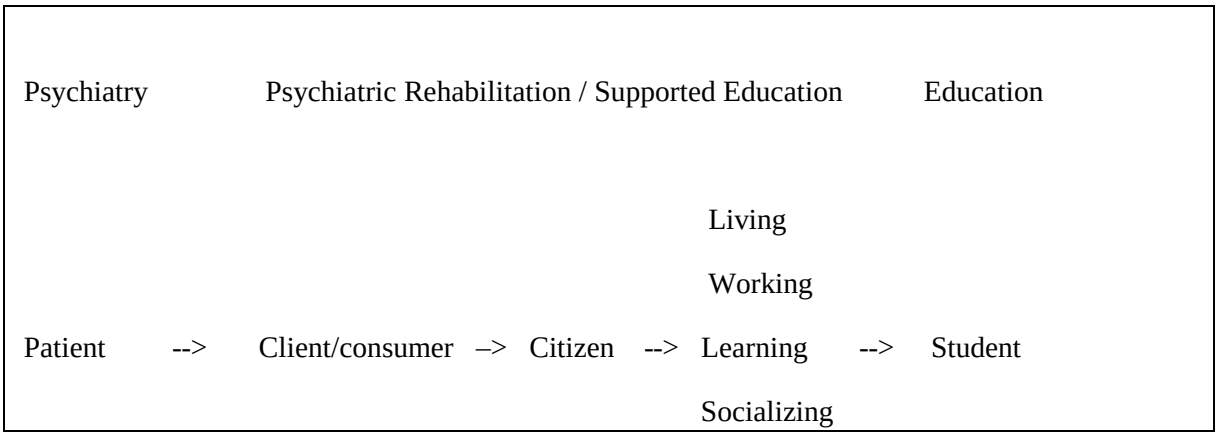
Table 2

Demographic and clinical characteristics of 39 participants in the Rotterdam Supported Education Project

	N	%
Sex		
Male	18	46
Female	21	54
Age (years)		
Mean	29.9	
Range	17 - 45	
Living situation		
Alone	22	56
With family	8	21
In a supervised setting	9	23
Vocational status		
Ever worked		
Yes	14	36
No	25	64
Diagnosis category		
Schizophrenia	12	30.5
Affective disorder	12	30.5
Personality disorder	8	21
Other or missing	7	18
On psychotropic medication?		
Yes	35	90
No	4	10
Years of contact with mental health		
Mean	6.5	
Range	1 - 24	

Figure 1.

Psychiatric Rehabilitation/Supported Education as the link between psychiatry and community



Notes

[1]. The aim of the Rehabilitation 92 Foundation in Rotterdam is to introduce and implement the psychiatric rehabilitation approach of the Center for Psychiatric Rehabilitation of Boston University in the Dutch Mental Health Care System. One of the activities of the foundation is the Supported Education project. The Trimbos Institute is the Netherlands' Institute of Mental Health and Addiction. The aim of the institute is to promote mental health in the broadest sense of the term.

[2] The GOAL-project is a one year course for consumers to become providers in mental health (assistant mental health worker).