DEVELOPING SUPPORTED EDUCATION PROGRAMS AT CALIFORNIA UNIVERSITIES :

A TOOL KIT OF POSSIBILITIES

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Overview

Supported education programs for students in the process of recovering from mental illness exist in California primarily at our community colleges. Programs vary in size, focus, types of supports that are offered and measured success. The target population for these programs has been students with temporary or long term disabilities which inhibit a major life activity, although many of the supports and services are also made available to students experiencing less severe emotional difficulties. Services provided by supported education programs are over and above existing supports for students provided by colleges. Program strategies are aimed at outreach, filling service gaps, service coordination, employment and transfer support, providing peer support and infusing recovery principles into the environment.

Considerations

When considering the development of supported education programs at the university level, unique applications of supported education principles will need to be created. Thus this document is called a "*Tool Kit of Possibilities".* However, much of the general program structure, components and the collaborative process used to develop the community college programs are applicable.

What is supported education?

Supported education programs are partnerships made up of mental health consumers, family members, service providers, advocacy groups and colleges pooling resources to maximize educational and career outcomes for persons recovering from mental illness. **Link 1: Supported Education Program, Link 2: Supported Education Facts**

What are the goals of supported education?

In addition to providing access to educational and career opportunities, other goals of supported education are numerous and include: access to the normalized rehabilitation and recovery opportunities offered by the college environment, improved quality of life, empowerment associated with education and the reduction of internal and external stigma. **Link 3: Goals of Supported Education**

What are the values and principles of supported education?

The values and principles put forth by supported educational providers are based on and similar to those of Psychosocial Rehabilitation and Recovery and focused on flexibility, treating students with dignity, offering hope, building on student strengths, coordinating services, providing individualized supports and services, supporting empowerment and self-determination through active involvement by students. **Link 4: The Principles of Supported Education, Link 5: Philosophy and Core Values of Supported Education. Link 6: SAMHSA's National Consensus Statement on Mental Health Recovery**

What is the relationship of supported education to mental health workforce development?

Since the passage of the Mental Health Services Act (MHSA) in 2004, supported education is being viewed as a potentially powerful tool to meet state and local mental health workforce development goals and the mandate of the MHSA to integrate mental health consumers into the workforce at all levels. For this reason, numerous California counties have included supported education projects that are linked to human services degree programs at local community colleges as part of their MHSA Workforce Education and Training (WET) plans. Most recently, San Francisco County Behavioral Health has issued an RFP for a supported education at a four year university as part of its WET plan. San Francisco State University, College of Health and Human Services has answered this RFP. **Link 7 SF State proposal summary**

Why is supported education needed at our universities?

There are many reasons why supported education is needed at our California universities. The most prominent are the college-age onset of mental illness, inadequate Disabled Student Service staffing, difficulty experienced by persons with psychiatric disabilities at career transition points, the effects of the

stressful academic environment, stigma and prejudice on the college campus, lack of service coordination between college student services units and community mental health and providers and the need for improved educational and professional employment outcomes for persons recovering from mental illness.
Link 8: Why Supported Education is needed at our Universities and Article:
Kessler, R. C., Foster, C. L., Saunders, W. B., & Stang, P. E. (1995). Social consequences of psychiatric disorders, I: Educational attainment. *American Journal of Psychiatry*, 152(7), 1026-1032.

What is the relationship of supported education to the legal mandates of the ADA and Section 504? Postsecondary institutions are charged with protecting the rights of disabled students. Section 504 of the Rehabilitation Act of 1973 and Title II of the Americans with Disabilities Act of 1990, prohibit discrimination on the basis of disability. Basically these laws govern admission, re-admission, and accommodations. Supported education is a service delivery model that goes beyond the mandates of the ADA but insures that the spirit of the law is carried out by facilitating greater access to education and its benefits to the individual.

What are the educational accommodations that are offered to students under Section 504 the ADA? Typically, accommodations are provided to ensure equal access and are arranged through the Office of Disabled Student Services. For psychiatric disabilities these may include: changes in instructional strategies, individual tutoring and increased time for assignments and exams, change of location of exams, use of technology such as recording devices or computer enhanced note taking, alternate testing methods, and personal support staff assigned to individual students or peer support groups on or off campus. **Links 9, 10 and Article**: **Salzer, M. S., Wick, L. C., & Rogers, J. A.** (2008). Familiarity with and use of accommodations and supports among postsecondary students with mental illnesses. Psychiatric Services, 59(4), 370-375.

What are the key areas of focus for supported education?
Supported education services are over and above existing educational supports provided by the college. Traditionally these supports and services have focused on three key areas of concentration**.** These are:

1. **Access**: How to effectively link persons recovering from mental illness to our colleges and universities by creating an atmosphere that is welcoming, receptive, encouraging and hopeful.
2. **Retention**: How to support students recovering from mental illness to stay in college and complete their degree by creating a campus environment that promotes wellness and offers the availability of a wide range of supports.
3. **Career outcomes**: How to facilitate successful career outcomes for students recovering from mental illness by creating a field placement and employment culture that is flexible, supportive and empowering.

What types of supports and services are provided in supported education programs to promote access, retention and career outcomes?
Access supports would usually are related to outreach and orientation; Retention supports and services usually include assessment, planning, service coordination, educational accommodations, wellness instruction, disability related counseling, peer support and outcome supports include career mentoring, job placement, job coaching, benefits counseling and program evaluation. **Link 11: Examples of Supported Education Supports and Services that could be provided in the university setting.**

How are supported education services provided at California community colleges?
Supported education services at California community colleges have primarily been provided by professional and peer staff funded by community mental health. Rehabilitation agencies, employment providers, peer organizations and advocacy groups also participate as key stakeholders in a collaboratively steered program and contribute various essential resources to the program. Depending upon resources available, supported education staff is either full or part-time working in campus office space provided by the college. In addition, they perform outreach to community housing and recovery centers. Colleges also reassign staff time to supported education, usually from Disabled Student Services, to work collaboratively with community providers and peers. Together they provide services in one-to-one, group and classroom venues. **Link 12: College of San Mateo Transition to College Program Description**

How will supported education services at California universities be provided?
Since supported education programs are yet to be developed at California Universities, exactly how supported education services will be provided and by who will be determined as programs evolve. It could occur that the role played by local mental health may not be as large as it is at the community college programs because universities serve students from all counties in the state and most students needing services would not qualify or apply for local services. DSS offices may also not play as large a role in university supported education because many of these same students will not register with DSS.

What are the steps in developing supported education programs?

Step 1: Form a stakeholders' collaborative
A suggested first step in the development of a supported education program is to identify the key partners or stakeholders. At the university this will likely consist of groups from on and off campus. The on-campus stakeholders may include all student service units, instructional programs, campus organizations and student groups. The off-campus stakeholders include: community mental health agencies, organizations, consumer groups, social services, and employers who will be hiring graduates and/or providing intern sites. A recommended process would be to convene two separate meetings of potential partners to assess the general interest in developing a supported program and securing initial buy-in from participants; one for on-campus stakeholders and another for off-campus stakeholders. With the help of those in attendance, additional stakeholders can be identified and invited to subsequent meetings. At some point, representatives from each group can be joined together to become the one collaborative for the project. **Link 13: Example of University Supported Education collaborative Partners**

Why is a stakeholders collaborative necessary?
At present, supported education programs and services overlap the missions of the universities, community colleges, high schools, community mental health, the Department of Rehabilitation, local Work Force Investment Boards, consumer groups and civil rights organizations, peer empowerment programs, student groups, foster care and transition age youth agencies, independent living centers, student rights organizations, numerous health focused foundations and community foundation alcohol and other drug recovery centers and many more stakeholders. Because of this overlapping mission and no clear designated single responsible party all of these stakeholders need to be involved.

Step 2: Identify common values and goals
After collaborative membership is established, subsequent meetings can be held to identify and agree upon common values, principles, goals and program objectives. Program goals and objectives will vary according to the uniqueness of the university, its community and the availability of resources.

Step 3: Redirect staff and reallocate resources
The next step in supported education program development is for the collaborative to undertake an inventory of their collective resources and staffing that could be directed toward the program to meet identified goals and objectives. Most supported education programs have been started though the reallocation of existing resources and partial reassignment of existing staff. It is advisable that, at some point in the programs development, memorandums of understanding are created between participating partners to define the role of the each of the various stakeholders in the maintenance of the program and the delivery of services. **Link 14: Some examples of resource reallocation and staff reassignment possibilities. Link 15: Example of a Community College/Community Mental Health Memorandum of Understanding**

Step 4: Identify funding sources to fill service gaps
In addition to pooling resources and staff time, the second main function of a supported education advisory committee is to seek new funding to fill service gaps not covered by stakeholder contributions. A major strength of supported education programs is that they are built by active community collaboration, a process that is highly valued by funders. And, as discussed above, one of the strengths specific to university-based supported education is that many faculty who may be involved in the program will be experienced in applying for funding, administering grants, evaluating and conducting research.

Link 16: Examples of funding sources for supported education programs

When new funds have not been available, many California community colleges and their local county community partners have established modest programs requiring less coordination, and one-to-one service provision. These programs usually maintain a primary focus on increasing access since most retention and outcome supports require designated staffing and service coordination. Many new programs have started with this limited type model and expanded as the relationships between the partners solidified and new funds or full-time commitments were made available.

Link 17: Examples of supported education program options that require no new funds or significant staff reassignment

What is the relationship of instructional programs to supported education?

This tool kit has been focused on the development of supported education programs that serve the entire university community. One reason for this is that the numbers of students recovering from mental illness enrolled in any individual instructional program are usually too small to sustain an intra-departmental program. Individual instructional programs can, however, be key players and leaders, especially when program mission and values align with those of supported education and supported education practices are infused into the program culture. At the community colleges, Human Services Certificate and Degree programs are being successfully linked to supported education programs as part of county mental health workforce development efforts. Through their commitment to supported education principles and practices, instructional programs can create an academic culture of receptivity, safety, support and flexibility. This can result in successful careers for students recovering from mental illness and in needed professional workforce development outcomes. **Link 18: Examples of supported education applications infused into instructional program cultures**

What is the relationship of schools of social work to supported education?

California's university schools of social work show great promise for achieving greater success with students in recovery from mental illness through involvement with supported education. Their commitment to social justice and responsibility for administering MHSA career stipend programs has placed them in a central leadership position in the effort to establish supported education practices and programs at California universities. The California Social Work Education Center (CalSWEC) and its member faculty and administrators, are beginning to explore the implementation of better supports and flexible policies for university students with recovering from mental illness by convening a statewide symposium on supported education for which this tool kit was created. Some of these supports and policy modifications will be unique to their programs and others will be linked to a campus-wide supported education effort. The result will be movement toward a more skilled, experienced and diverse mental health workforce.

What does the research reveal about supported education?

There are 18 studies of the effectiveness of supported education, including one with a randomized control design. Most of the studies are small with pre-post designs. However, the intervention has been found effective in virtually all studies despite encompassing a wide range of models, settings and client subgroups.

Some studies have investigated predictors of success. In Unger's [1] three-site study, predictors of lack of success were number of previous hospitalizations and not having a car. Diagnosis, gender, previous schooling, type of institution, and previous jobs were unrelated to success. In Mowbray's[2] randomized control study, predictors of success in a multivariate model were productive activity at baseline or having

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[1] Unger, K.V. & Pardee, R. (2002). Outcome measures across program sites for postsecondary supported education programs. Psychiatric Rehabilitatio Journal 25(3), 299-303.

[2] Mowbry, C.T (2004)). Supported education: Diversity, essential ingredients, and future directions. American Journal of Psychiatric Rehabilitation, 7(3), 248-254

a partner. Having problems performing housework or high levels of family encouragement for education were negatively associated with productive activity. Again, mental health related variables (diagnosis, symptoms, duration of illness) were not related to success.

Existing studies include many persons who were enrolled in four-year institutions but does not describe intervention models specific to that type of institution. Other weaknesses in the literature are a lack of long-term follow-up and use of objective measures rather than self report. A major omission is any study that focuses on students who first experience a serious psychiatric problem while in college; all studies have as participants persons who have been out of school, usually for several years, and are returning.
Link 19: Summaries of research findings and issues for evaluating supported education programs

What are potential "pit falls" and barriers that could interrupt the development or success of the program?

Barriers: The main barrier to the development of supported education programs is the fact that at present is not seen or legislated as the responsibility of either the universities' or public mental health and rehabilitation departments. This has resulted in a lack of a clear funding stream. The second significant potential barrier is stigma and prejudice toward persons with mental illness which is still very strong in our society.

"Pit falls": Because the successful development of supported education programs relies on the creation and maintenance of a strong coalition of stakeholders who are actively involved in the oversight and delivery of the program, most "pit falls" are related to attempts by organizers to shorten the collaborative process. The most common are listed below:

- Creating weak collaborative/advisory group that is not representative or only partially representative of the program's stakeholders
- Holding irregular and infrequent stakeholder meetings
- Developing a program that does not involve all stakeholders in some form in-kind, staff or resource contribution
- Failing to develop clear goals, objectives and value statement
- Waiting too long to develop a memorandum of understanding between the main partners signed by high level college and mental health and employer administration
- Failing to develop and maintain a strong partnership with DSS, Psychological Services and Health Services
- Failing to achieve college faculty and student service buy-in and participation that is reinforced by regular communication
- Not including campus anti-stigma education as part of the program design
- Not including participating students in the planning and oversight of the program
- Not including a research and evaluation component at the start of the program
- Failure to seek outside funding
- Forgetting to celebrate and honor student and program success

Link 1

SUPPORTED EDUCATION PROGRAMS

Supported Education Programs are community partnerships made up of mental health consumers, family members, agencies providers and colleges with the intention of pooling resources to maximize educational opportunities and employment outcomes for persons with psychiatric disabilities. Supported Education programs modify existing educational environments by making them more receptive, supportive and encouraging to students with psychiatric disabilities.

These modifications are over and above existing educational supports, services and accommodations for students with disabilities and may include:

- Outreach and Recruitment
- Special orientations
- Specialized transitional classes
- Identified counselors and instructors familiar with psychiatric disabilities
- Educational coaching
- Liaison and service coordination between the college and mental health and rehabilitation providers
- Special crisis intervention procedures
- Peer counseling
- Support groups
- Clubs and social activities
- Award ceremonies
- Newsletters and communications
- Book and scholarship funds
- Research and evaluation

Every Supported education program will vary in structure according to the unique needs and assets of each community and the participating partnership organizations and colleges.

Link 2

SUPPORTED EDUCATION FACTS

What is it? Supported education is providing services to people who have a mental illness so they can have access to and utilize resources that will help them succeed in a college, university or technical training setting.

What services are provided? College personnel provide, in addition to academic counseling, accommodations to address problems in functioning that students may have as a result of their psychological disabilities. Mental health staff provides information about educational services, advocacy, and case management services.

Who returns to school? The average supported education student is about 34 years of age and has a diagnosis of schizophrenia, major depression or bipolar disorder. Since the usual onset of psychiatric illness is 20 years of age, most supported education students have been hospitalized an average of seven times and have spent approximately 11 months in the hospital prior to returning to school.

What accommodations are necessary? The most common accommodations needed by people with mental illness are assistance with registration and financial aid. They also may need extended time for exams, changes in format or time frames for exams or assignments, tutoring, note taking assistance or tape recorders. Research has shown they do not need more accommodations than other disability groups.

What is the greatest challenge? Stigma is the greatest challenge students face. Many people still believe that mental illness is a debilitating life-long disease and that people with a mental illness are dangerous. Research has shown that the majority of people with mental illness do recover. Research has also shown that people with mental illness do not commit more crimes than others. They are, however, often the victims of crime.

Do people with a mental illness disrupt the learning environment? Research has shown that students with a mental illness are no more disruptive than other students.

Can students recovering from mental illness be successful in school? According to a nation wide study, students in supported education programs complete 90 percent of the courses for which they enroll with an average grade point average of 3.3.

What are the positive benefits of supported education? A national research study reveals that supported education students report a significantly greater level of satisfaction with their quality of life than people with a mental illness who are not enrolled in school. They report higher levels of satisfaction with their living situation, finances, daily activities, social relations and family contacts than those who are not going to school. People who are enrolled in a supported education program have had decreased incidence of hospitalization and more than them are employed.

Karen Unger 1998

Link3

Goals of Supported Education

Individuals with psychiatric disabilities increasingly recognize that education can play a significant role in enhancing their recovery and reintegration process. To support them in reclaiming the valued role of the "student", the practice of supported education has evolved.

Supported education involves the provision of ongoing supports to assist people with psychiatric disabilities to take advantage of skill, career, education and interpersonal development opportunities within a normalizing academic environment.

Supported Education has the following goals:

- Provide opportunities to explore individual interests relating to career development and vocational choice.
- Provide opportunities to strengthen basic competencies necessary to succeed in school and competitive employment.
- Provide opportunities to earn degrees, certificates, or vocational training that will lead to employment and careers.
- Provide access to a normalizing environment within which individuals with psychiatric disabilities can experience a wide range of people and social situations that allow for an alternate means of self-definition, from patient to student.
- Provide access to the cultural and recreational resources available in educational settings.

Adapted from "An Overview of Supported Education", *Moving Ahead*, Summer 1993, Michigan Supported Education Project, Wayne State University and "Reclaiming Rightful Roles: Supported Education for Young Adults with Psychiatric Disabilities," Karen Unger, MSW, Ed.D, Center for Psychiatric Rehabilitation, Boston University

Link 4

Principles, Philosophy and Values of Supported Education

Guiding Principles of Supported Education

The common thread to supported education is an adherence to principles grounded in those of psychiatric rehabilitation. Below is a description of key principles drawn from Carol Mowbray (2002) and Ann Soydan (2004), leading practitioners in the field.

Normalization: All program participants are called "students," not patients or clients. Services are consistent with the normal routines of life within the educational community. The most non-stigmatizing and integrated settings and methods should be used, including campus settings for at least some of the services.

Self-determination: The involvement and empowerment of the student is essential. Students participate in all aspects of the program, including serving on a program board, as peer mentors, paid staff, tutors or research assistants. Students retain as much control as possible over their own lives, including setting goals and evaluating progress toward them. The program provides knowledge essential to *success in the educational environment. Choices are offered regarding many aspects of services*

Support, skills, and relationships: Learning skills for success is a critical part of the program, both explicit (such as how to take notes) and implicit (such as managing symptoms). Supports should be available long-term, whenever students want or need them. One-on-one counseling must be available. Resources need to be available to overcome barriers (such as transportation, child care, and need for financial aid). An important element is assisting students to develop their own informal support networks.

Hope and recovery: Every student is treated with respect and dignity and as a developing person capable of growth, positive change, and recovery from mental illness. An underlying assumption is that academic participation promotes a transformation from "mental patient" to "college student." Persons are not excluded based on diagnosis or mental health history.

Systems change: Problems which need to be addressed in achieving individual goals and objectives do not reside solely within the individual. Programs must support needed accommodations for students with psychiatric disabilities, address stigma and discrimination, and confront other barriers. Programs promote both individual empowerment and group empowerment for all those with disabilities (M. Becker, Martin, Wajeeh, Ward, & Shern, 2002; Bellamy & Mowbray, 1998).

Settings and program models: Supported education has been offered in a variety of settings (Mowbray, 2004) including campuses, club-houses, consumer self-help groups or agencies, mental health agencies, and through mobile programs serving participants on multiple campuses. Perhaps most common is a program in a mental health agency linked to a campus program. There is indication the settings may be becoming more diverse (Mowbray, Megivern, & Holter, 2003).

Link 5

Philosophy of Supported Education

- Students take control - of their disability, of their environment, and of their future.
- Choice is fundamental. Students identify and explore their career interests and, in return, receive support in acquiring the skills and resources to meet their career goals
- Many supports are necessary for learning. Students are encouraged to maintain relationships with the supported education staff, special student services on campus, CMH case managers, peers, families, and residential providers.
- Students are involved in the implementation of the program. Students can serve as staff, peer mentors, tutors, and/or as board members.
- Supported education programs incorporate empowerment strategies.

Core Values of Supported Education

- Flexibility: Services are evaluated on an ongoing basis
- Dignity: Services are provided in a manner and in an environment that protects privacy, enhances personal dignity and respects cultural diversity.
- Coordination: The resources are brought together to work for the benefit of the students.
- Individualization: Services are tailored to meet the unique and changing needs of each student. Services build on the individual strengths of participants.
- Self-determination: Students set their own goals.
- Active involvement: Students participate in all aspects of the program from planning to implementation to evaluation.
- Strengths: Services are built on the unique strengths of students.
- Hope: Participants are treated as developing persons, capable of growth and change.
- Advocacy: Participants are supported to advocate on their own behalf.

Kessler, R., Foster, C., Saunders, W. and Stang. P (1995), Social consequences of psychiatric disorders. Educational attainment. *American Journal of Psychiatry*, 152 (7), 1026-1033.

Unger, K (1993), Creating supported education programs, utilizing existing community resources. *Psychosocial Rehabilitation Journal*, 17(1), 11-2

Link 6

SAMHSA's National Consensus Statement on Mental Health Recovery

Mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential.

The 10 Fundamental Components of Recovery

As Amended by the CA Association of Social Rehabilitation Agencies

January 2008

A Culture-Centered Approach: A culture centered approach to recovery posits that culture is central – not peripheral – to recovery. A culture-centered approach seeks to understand a person in recovery in their cultural context (Pedersen, P, 1996). This approach seeks to focus on both culture and context, and to provide an integrative framework with which to better understand the critical role which culture play in the recovery process.

A culture- centered approach to recovery begins with the culture of origin of the person in recovery and their individual lens or Worldview, a unique personal mix of values, beliefs, perceptions, and language. As persons in recovery participate in client culture and professional culture, recovery comes to mean involvement in creating "cultures of recovery", places of change and growth, as they begin to experience themselves as a "person in recovery" rather than as a "person with a mental illness". Through their involvement in these "cultures of recovery", persons in recovery encounter "cultural teachers" – persons who engage with them in mutually interdependent relationships - collaborative and empowering relationships that assist persons in recovery to locate sources of strength and resilience for the journey that is recovery. Recovery comes to be experienced and understood as a change in one's Worldview, including one's sense of self, and a change in one's cultural identity – a non-linear process which continues to create a "self in recovery".

Self-Direction: Because all persons grow up in a cultural context which is unique to them, consumers lead, control, exercise choice over, and determine their own path of recovery in accordance with values, beliefs, and perceptions in their Worldview. This individual cultural context provides the frame in which individuals optimize their autonomy, independence, and control of resources to achieve a self-determined life. By definition, the recovery process must be self-directed by the individual who defines his or her own life goals and designs a unique path towards those goals in alignment with their cultural expectations.

Individualized and Person-Centered: Since culture is central – not peripheral- to recovery, the family unit and community play crucial roles in mediating cultural norms and values to the individual in recovery. The multiple pathways to recovery are based on an individual's unique cultural heritage, including strengths and resiliencies as well as his or her needs, preferences, and experiences (including past trauma). Individuals also identify recovery as being an ongoing journey and an end result as well as an overall paradigm for achieving wellness and optimal mental health.

Empowerment: Consumers have the authority to choose from a range of options and to participate in all decisions—including the allocation of resources—that will affect their lives, and are educated and supported in so doing. For consumers who grew up in conditions and cultures of oppression and disempowerment, this will require education and advocacy to equip them with the ability to join with other consumers to collectively and effectively speak for themselves about their needs, wants, desires, and aspirations. Through empowerment, an individual gains control of his or her own destiny and influences the organizational and societal structures in his or her life, in accordance with their changing Worldview and sense of self.

Holistic: Recovery encompasses an individual's whole life, including mind, body, spirit, and community within their cultural expectations as to what constitutes wholeness and wellness. Recovery embraces all

aspects of life, including housing, employment, education, mental health and healthcare treatment and services, complementary and naturalistic services, addictions treatment, spirituality, creativity, social networks, community participation, and family supports as determined by the person. Families, providers, organizations, systems, communities, and society play crucial roles in creating and maintaining meaningful opportunities for consumer access to these supports.

Non-Linear: Recovery is not a step-by-step process but one based on continual growth, occasional setbacks, and learning from experience. Changes in one's sense of self and one's cultural identity as a person in recovery begin with an initial stage of awareness in which a person recognizes that positive change is possible. This awareness enables the consumer to move on to fully engage in the work of recovery.

Strengths-Based: Recovery focuses on valuing and building on the multiple capacities, resiliencies, talents, coping abilities, and inherent worth of individuals within the cultural contexts they grew up in and those which they have adopted. While manifested in particular individual qualities, resilience is a product of culture as learned by the individual in life and throughout their recovery. By building on these strengths, consumers leave stymied life roles behind and engage in new life roles (e.g., partner, caregiver, friend, student, and employee). The process of recovery moves forward through interaction with others in supportive, trust-based relationships which are mutually interdependent – i.e. collaborative and mutually empowering.

Peer Support: Mutual support—including the sharing of experiential knowledge and skills and social learning—plays an invaluable role in recovery. Consumers create "cultures of recovery," places where the norms of recovery encourage and engage other consumers in recovery and provide each other with a sense of belonging, supportive relationships, valued roles, and community.

Respect: Community, systems, and societal acceptance and appreciation of consumers —including protecting their rights and eliminating discrimination and stigma—are crucial in achieving recovery. Since all recovery involves a change in one's sense of self and one's cultural identity, the shift from being a person with a mental illness to a person in recovery involves at least two crucial aspects of self-hood: self-acceptance and regaining belief in one's self. Respect ensures the inclusion and full participation of consumers in all aspects of their lives.

Responsibility: Consumers have a personal responsibility for their own self-care and journeys of recovery. Taking steps towards their goals may require great courage and must be in harmony with the consumers existing cultural values and strategies. Consumers must strive to understand and give meaning to their experiences and identify coping strategies and healing processes that are **culturally syntonic** to promote their own wellness.

Hope: Recovery provides the essential and motivating message of a better future - that people can and do overcome the barriers and obstacles that confront them. Hope is internalized, but can be fostered by peers, families, friends, providers, and others. Hope is the catalyst of the recovery process. It is shaped by the cultural background of the person in recovery and is expressed according to the tenets of their Worldview. Mental health recovery not only benefits individuals with mental health disabilities by focusing on their abilities to live, work, learn, and fully participate in our society, but also enriches the texture of community life in the United States. The **nation** reaps the benefits of the contributions individuals with mental disabilities can make, ultimately becoming a stronger and healthier entity.

Link 7

EXECUTIVE SUMMARY: San Francisco State University Student Resource Center

The College of Health and Human Services at San Francisco State University is seeking funding through the RFP “Supportive Services for Consumers Enrolled in Public or Private Universities or Colleges” for an innovative new program at its Student Resource Center (SRC). The goals of the program are to increase access and enrollment, enhance retention, and maximize graduation rates among consumers, family members, and members of underserved and underrepresented communities who are preparing for careers in the public behavioral health field. These services would expand workforce penetration by the target populations and provide career ladders to all levels of the system. The SRC will use the research-tested, evidence-based model of supported education. Over the last two decades, supported education has proven successful at community colleges across the United States; however, similar programs have yet to be implemented at the four-year universities.

The SRC will employ a wrap-around, multidisciplinary, and culturally sensitive approach, conducting comprehensive outreach to underserved communities and providing students with personalized educational and career planning. In addition, community building and socialization will be furnished through peer-provided support. The Center will offer direct intervention when educational problems arise, integrating skills development with environmental resources. Bridging services primarily focused on academic capacity-building with dedicated counseling and coaching, the SRC will allow for greater resource coordination while addressing existing gaps in service. In addition, utilizing public information campaigns and peer speakers, the SRC will promote a campus environment that supports resiliency and wellness, as well as reducing stigma related to mental illness. Ongoing services will be provided to faculty, staff, and administrators in order to more effectively meet the needs of the target populations. Given that these types of services have not been commonly provided at the university level, the Student Resource Center can serve as a "vanguard model" which, if funded, could be infused throughout California.

The onset of mental illness and its psychosocial impact can diminish learning opportunities and severely curtail people’s life chances when, due to a lack of adequate support, they are unable to gain admissions or successfully complete postsecondary education. Students are now experiencing more frequent and complex mental health difficulties and suicide is their second leading cause of death. Those contending with mental health issues exhibit retention rates far below those of the general population, with 86% as compared to 37% withdrawing before completing a degree. Students receiving the types of services that the SRC will provide have been shown to complete their education in a manner commensurate with those not facing mental health related challenges.

The SRC will provide individual academic counseling and coaching to approximately 400 students per year (unduplicated), peer mentoring to 120, groups to 200, and socialization events for 200. It will offer an estimated 10 in-service presentations annually to faculty, staff, and administrators on issues related to mental health and ongoing individual consultation to 30. Outreach will be provided to 250 individuals and orientation to 70. It is anticipated that the public information campaigns will reach 8,000 people per year during campus-wide events. The SRC will operate with a program coordinator, an administrative assistant, a peer counselor/advocate, and as volunteers, three interns and 10 peer mentors. An Advisory Committee will provide leadership to the program. Yearly evaluations will be conducted and the results disseminated within the campus and community.

Link 8

Why Supported Education is needed at our Universities

The college-age onset of mental illness

The onset of mental illness generally occurs between the ages of 17 and 25, the same years in which many young adults leave home to attend college (Kessler, Foster, Saunders & Stang, 1995). College students contending with mental illness need support to remain in school but are often reluctant to seek services due to unfamiliarity with accommodations or the stigma surrounding mental illness (Salzer, Wick & Rogers, 2008). Additionally, in order to receive accommodations and services from Disabled Students Services (DSS), students are responsible for informing DSS of their disability and providing documentation. Students experiencing the onset of mental illness may not be able to assume this responsibility. It has been estimated that that 86% of students experiencing mental illness withdraw from college before completing their degree (Salzer, Wick & Rogers, 2008). The intention of supported education on the college campus is to provide the needed supports, interventions and linkages to DSS and community services to prevent students from dropping out of school and assist with speedy reinstatement when a drop occurs.

Inadequate Disabled Student Service staffing and fluctuations in student needs for support

Every postsecondary institution is required by law to provide accommodations to persons with disabilities to insure equal access. Colleges rely on their Office of Disabled Student Services (DSS) to assess student needs, acquire documentation of disability, arrange for appropriate accommodations, and provide disability related counseling to students on how to navigate the environment. However, state funding for DSS is limited and large funding cuts in these categorical funds are expected in the coming years. Programs serve hundreds of students with minimum staffing. Appointments must be made in advance, are usually limited to one half hour and are focused on determining and arranging for accommodations. Although students with disabilities resulting from mental illness require most of the same accommodations required by students with physical disabilities, experience at the community colleges reveals that their needs for accommodations may fluctuate widely over the course of a semester or year (Stringari, 2003). Service plans may need to be jointly evaluated by students and DSS staff more frequently. Most often, the DSS staff does not have the time to meet with students quickly and respond with needed service modifications. Supported education staff in partnership with DSS, can pick up part of this service gap by being available for personal support, problem solving, making recommendations regarding plan modification and advocacy.

Difficulty experienced by persons with disabilities at career transition points

The experience of many educators suggests that students with all types of disabilities often experience stress and anxiety when confronted with educational and employment transition points. One possible reason for this is that their present system of personal, social and academic supports is threatened by the change. They are rightfully concerned whether they can access the new supports they need to succeed in a new environment. These transition points include transferring to a new institution, entering a new program, beginning graduate school, beginning the thesis process, starting an internship, beginning employment or changing jobs. Also, administrative tasks related to transitions such as school and job applications, registration, applying and reapplying for financial aid or loans, securing letters of recommendation, creating resumes, thesis proposals, etc. can create anxiety and stress. Supported education staff can provide students with support during these transitions. It is important for educators to remember that anxiety and difficulty with career or educational transition points is not an indication that an individual is inappropriate for higher academic study or professional employment.

Effects of the stressful academic environment

The university environment can be very stressful for both students and faculty. Discussions with faculty and students reveal that pressure from competition and high expectations are experienced by everyone in the campus community. All are vulnerable to stress and its related emotional and physical symptoms. There is often hesitancy by students to ask for personal support for fear of being judged as unstable and not appropriate to attend the university. Students who may already be sensitive to stress, such as those recovering from mental illness, can find it difficult to withstand the pressure described above. The personal and social supports, wellness training and atmosphere of safety provided by supported education programs can help mitigate these consequences.

Stigma and prejudice

The university community, like our society as a whole, still harbors a great deal of stigma and prejudice against persons experiencing mental illness. Researchers have reported stigma as a large barrier to their

success (Unger, 1998). Although institutional goals target a diverse student body and its accompanying strengths and advantages for society, many faculty and students still harbor deficit-based beliefs about persons in recovery from mental illness. Some believe that providing personal support and accommodations to students experiencing emotional difficulties should not be part of the role of universities and assume that needing such support is evidence that a student is not capable of working as a professional.
The above beliefs and related stigma reinforce the tendency of students to hide personal problems or mental illness and to not seek help. A high percentage of students recently surveyed reported that they feared discrimination if they were to disclose their experience with mental illness to their professors and peers (Salzer, Wick & Rogers, 2008). Anti-stigma education as part of a comprehensive supported education program can help professors and students to better understand the needs and strengths of students in recovery and their potential for making a positive contribution to their chosen profession.
Lack of service coordination between college student service units Students recovering from mental illness often utilize services from many different college student services units. Each of these support services develops an individual plan with students that guide the provision of supports and services. These plans can reflect differing and sometimes opposing philosophies, approaches and directions for the student and may not always incorporate recovery principles. Supported education staff, at the request of the student, can work with the various student service units to align multiple service plans and coordinate services delivery.
Lack of service coordination between student services units and community mental health and recovery providers
College students who are being supported by community mental health and recovery agencies and peer organizations have service plans, rehabilitation and recovery plans, WRAP plans, Advanced Directives, Twelve Step plans, etc. These are used by students in guiding their recovery and include the identification of key support persons and resources. Supported education staff and services, at the request of the student, can be included in these plans allowing them to participate in a coordinated support network.
The need for improved educational and professional employment outcomes for persons recovering from mental illness
Since the passage of the Mental Health Services Act (MHSA) and the adoption of the Recovery paradigm by all mental health agencies, there is an ongoing need for mental health employees who have personal experience with mental illness as a consumer or family member. The MHSA mandates that mental health consumers and family members be employed to work at all levels of the mental health system. Subsequently, increasing numbers of consumers and family members are being employed in mental health; however, the vast majority of those jobs are entry level peer support service positions. Supported education programs at the university level, with strong ties to social and behavioral science academic programs and stipend opportunities, would support consumers and family members to become licensed Social Workers, Psychologists, Psychiatrists, Psychiatric Nurses, Marriage and Family Therapists, Occupational Therapists and Rehabilitation Counselors and thereby help meet the mental health workforce needs for professionals with this type of life experience.

Link 9

SKILLS STRENGTHENING FOR THE EDUCATIONAL ENVIRONMENT

Research has shown that a majority of students with psychiatric disabilities may require assistance in learning or strengthening skills related to one or more of the following:

- Selecting classes
- Having peer relationships (e.g., meeting people, managing small tasks)
- Concentrating in class
- Completing registration process
- Applying for educational finances
- Tolerating stress
- Executing a plan of action
- Making and carrying out decisions
- Remembering materials for class
- Working in small groups
- Meeting with professor/advisor
- Asking questions
- Responding to feedback
- Managing unfamiliar surroundings
- Taking notes
- Listening
- Utilizing college resources and administrative services
- Managing crowded test-taking situations
- Managing crowded parking
- Dealing with panic caused by difficulty processing instructions
- Dealing with panic caused by hallucinations
- Commuting to campus
- Maneuvering around campus
- Clarifying assignments
- Managing time
- Managing free time on campus
- Retaining learned material

Skills may be taught or strengthened during disability-related counseling, in group settings such as peer support groups and special classes, or may be compensated for through educational accommodations.

Karen Unger, 1998

Link 10

TYPICAL ACCOMMODATIONS AND SERVICES FOR STUDENTS WITH PSYCHIATRIC DISABILITIES

- Assistance with registration and financial aid
- Extended time for exams
- Change of location for exams
- Parking
- Tape recorders
- Note takers
- Seating arrangement modifications
- Beverages allowed in class
- Peer support groups and peer counseling
- Identified place to meet on campus before or after class that is non-threatening
- Time management and study skills training
- Wellness Education and Special emphasis instruction

Link 11

EXAMPLES OF SUPPORTED EDUCATION SUPPORTS AND SERVICES THAT COULD BE PROVIDED IN THE UNIVERSITY SETTING

University supported education programs will reflect the uniqueness of that setting; however, many of the program components and supports will be similar to those used by the California community colleges.

Supports and services that provide access:

- Outreach and recruitment at community colleges
- Special orientations and campus tours for new and transferring students
- Transportation assistance
- Assistance with financial aid applications and appeals
- Linkage to Disabled Student Services (DSS)
- Linkage to and coordination with Extended Opportunities Programs and Services (EOP&S) prior to enrollment
- Linkage to the Department of Rehabilitation and Workability IV
- Assistance with campus housing applications and linkage to housing support staff
- Assistance with transfer, bachelor program and graduate school applications
- Linkage to Bachelor level stipends for students bound for Title IV E and Mental Health subsidized masters programs
- Assistance with Title IV E and mental health stipend applications
- Assistance with scholarship applications

Supports and services that result in retention:

- Linkage to and service coordination with university student services units, DSS, personal counseling and student health services
- Linkage to and advocacy for educational accommodations through DSS
- Linkage to local mental health and social service agencies
- Service coordination between the college student services units and community mental health, rehabilitation, peer and recovery providers
- Identified, accessible crisis intervention support
- Faculty and peer mentoring
- Assistance with the development or modification of a student Wellness Recovery Action Plan (WRAP) to include support options at the university
- Wellness, recovery and empowerment seminars
- Peer support groups
- Faculty trainings on the support needs and accommodation possibilities for students with psychiatric disabilities
- Anti-stigma trainings for faculty, staff and students

Supports and services that facilitate career success:

- Job coaching and peer support (over and above supervision) for students at field placements and internship sites
- Advocacy with instructional departments for extended time to complete academic and stipend programs
- Advocacy with instructional departments for reduced time spent at intern sites and/or work schedule flexibility
- Job placement services and job coaching upon graduation
- Benefits counseling and assistance with Pass plan creation
- Linkage to and active assistance with loan assumption programs
- Advocacy with instructional departments for extended time for the stipend payback period and allowing part-time employment and/or volunteer service
- Mentoring by working professionals and peer mentoring
- Research and evaluation

Link 12

COLLEGE OF SAN MATEO TRANSITION TO COLLEGE PROGRAM

San Mateo County's **Transition to College (TTC)** program has served as a state and national model and research site for Supported Education since 1991. The program, a partnership between San Mateo County Behavioral Health and Recovery Services and the College of San Mateo (CSM), has been an integral part of the college's Disabled Students Programs and Services for 18 years and has successfully supported individuals with psychiatric disabilities to attend college and achieve academic, career, and Recovery goals. The program's unique approach combines Recovery focused instruction, educational case management, accommodations, peer support and vocational certificate programs to assist students to succeed. Traditionally, the attrition rate at colleges for individuals with psychiatric disabilities has been exceptionally high as a result of anxiety, low stress tolerance, lack of academic and social skills, and low self-esteem. Transition to College has reversed this trend and is significantly assisting San Mateo County in meeting its recovery, employment and workforce development goals.

The Students

Students in the Transition to College program are individuals recovering from severe mental illnesses such as schizophrenia, bipolar disorder or manic depression and are self-referred or referred by community agencies, college staff or consumer groups to the program's adult or Transition Age Youth (TAY) case managers. Most of the students entering the program are initially unemployed and most adult students have been ill for more than 10 years. Seventy-five percent of all students enrolling in the program have unsuccessfully previously attempted college and prior to entering the program, had abandoned any hope of achieving educational or career goals. Once enrolled in the program, students find new hope for recovery and employment success. Thus far, TTC has served more than 2,500 individuals over a period of 17 years. Approximately 100 students are presently active in the program each semester.

Special Class Sections Provide a Safe Re-Entry to College

Students in the Transition to College program experience a safe beginning or re-entry to college through attendance in courses on college orientation, study skills, wellness, and peer counseling. These Recovery focused courses are all specially designed with the needs of individuals with psychological or psychiatric disabilities and separate sections are offered for adults and TAY. Students report that these classes are most helpful in providing encouragement and support and in developing their self-confidence in the college environment. These courses also build toward certification in Peer Support Services and employment as a peer service provider in the community.

As a result of attending classes, often within weeks, students show improvement in the following areas:

- Higher self-esteem and increased self-confidence in the campus environment
- Improved study skills and increased knowledge of campus resources
- Improved interpersonal skills
- Improved classroom skills (i.e., higher personal, academic and career goals; increased number of long-term goals)
- Counseling and referral skills that can lead to employment
- Interest in employment and readiness for the workplace

Case Management, Counseling and Peer Support

Students are regularly advised and encouraged by college Disabled Student counselors and San Mateo County Behavioral Health employees or contractors stationed at the campus in the roles of instructors, educational case managers and peer counselors. Educational case managers maintain liaison with community therapists and mental health providers serving the students and coordinate campus services with college faculty and staff. Weekly support groups and study labs led by peers and staff provide additional support.

Educational Outcomes

Prior to the development of the Transition to College program, the attrition rate for students with psychological disabilities at College of San Mateo was approximately 90% to 95%. Since the implementation of the program, the attrition rate for students enrolled in the program has only been 17% to 20%. Students complete 90% of the courses in which they enroll with grade point averages between 2.0 and 3.3. Degree, certificate and transfer rates equal those of the non-disabled population.

Recovery Outcomes
Research conducted on the CSM campus by Boston University and University of Arizona revealed that students enrolled in Transition to College report a greater level of satisfaction with their quality of life than persons recovering from mental illness who are not attending college. Students also had decreased incidence of hospitalization.

Employment Outcomes
As part of the above mentioned research**,** approximately half of the students in the Transition to College program were found to be employed during their enrollment or at the completion of their studies. Those completing AA Degrees and or certificates are expected to show higher employment rates (study in progress). Antidotal evidence gathered though student feedback suggests that many students who were unable to succeed at competitive employment before entering the program find work with the help of program employment services; usually after two semesters of attending classes

Workforce Development Outcomes
An average of twenty-five percent of Transition to College students complete degrees and/or certificates through CSM's Human Services Certificate and Degree Program qualifying them to work as paraprofessionals in local mental health and social service agencies (longitudinal study in progress). The Human Services Certificate and Degree Program offer sub-certificates in Peer Support Services, Family Development, Community Health Work and Psychosocial Rehabilitation (PSR). Because of its success, the Human Services program serves as an example of a college/community partnership that is meeting local social service workforce development needs.

Collaboration Key to Program's Success
Key to the Transition to College program's success is the community collaborative called the Community Recovery Association (CRC). The CRC is made up of representatives from the college, San Mateo County Behavioral Health and Recovery Services, Caminar, Mental Health Association of San Mateo County, National Alliance for the Mentally ILL, Hearts and Souls Consumer Network, County Vocational Rehabilitation Services, the Department of Rehabilitation and numerous other agencies. These community groups were instrumental in the development of the program and continue to steer the program through regular monthly meetings of the CRC. They also contribute staff time to the program and provide funds for books, achievement celebrations, and other supports.

The college and mental health and rehabilitation community are motivated to work together in that they have overlapping missions. Mental health and rehabilitation agencies must assist and support their clients to assume meaningful roles in the community. Colleges must prepare these students with the skills and knowledge to assume those roles. Neither can achieve complete success without the support and cooperation of the other. Continued success over the years through collaboration now fuels the process.

Link 13

Example of a university supported education collaborative

On-campus Partners

- University Disabled Student Services
- University Disabled Students Association
- University Student Services Administration
- University Health Services
- University Personal Counseling Services
- Campus Recreation Department
- Campus Housing Administration
- Various university academic programs that teach or value social justice and diversity
- Various campus clubs and organizations that promote inclusion, social justice and diversity
- Campus Security

Community Partners

- Local community college Disabled Student Services and Supported Education Programs
- Department of Rehabilitation
- Workability IV
- County Mental Health Services
- Mental health peer support contractors
- Mental health consumer advocacy groups
- County Health and Human Services
- Alcohol and other Drug Services
- Mental Health Association
- National Alliance for Mentally Ill
- Independent Living Centers
- Community family counseling services agencies
- Suicide Prevention Services
- Veterans Services

Link 14

Examples of possible resource reallocations and staff redirection for university supported education partners

- **The university** provides office space, phone and computers for the project.
- **Student government** provides a meeting space, project mentor, start up funds, publicity, etc.
- **Disabled Students Club** assigns a club officer to assist the program, provides leadership and support in the development of anti-stigma education materials, lectures and forums, hosts receptions, fund raisers, tours and orientations for new students.
- **College housing** assigns a representative to participate in the project to assist in referral to the program and work with project peer counseling staff on prevention, outreach and crisis intervention referral.
- **Campus recreation** department assigns a representative to the project to assist in creating access to recreation activities for students and to provide referrals to the project.
- **University DSS** assigns part of a counselors time to work closely with the program, be the liaison to the project, assure smooth referral to DSS and access to accommodations for students.
- **University personal counseling services** assigns part of a faculty member's time to act as a liaison to the project to assure a smooth referral process for participating students and assigns interns to work in the program as service providers.
- **University Health Services** assigns a liaison to the project to assure a smooth referral process for participating students to health services, to educate other college health providers of the needs of persons in recovery, participate in new student orientations provided by the program, participate and help deliver wellness seminars, etc.
- **University School of Social Work** assigns a faculty liaison and assigns interns to work with the project as researchers to track outcomes and as service providers in the program.

Examples of possible mental health community resource reallocations and partial staff redirection to supported education

- **State Department of Rehabilitation** (DOR) assigns staff to consult to students at the campus supported education center or at DSS. DOR partners with the supported education collaborative and DSS to allocate funds for a Workability IV program at the college to provide professional employment placement and support for persons with disabilities.
- **County mental health** reassigns staff to spend time at the campus supported education site or redirects one of its contractors to the supported education program as a service provider.
- **Mental health consumer organizations and peer support contractors** assign peer counselors to the campus supported education center as service providers and provide empowerment and wellness training to students at the supported education center.
- **National Alliance for the Mentally Ill, the Mental Health Association** and consumer groups provide anti-stigma training to the campus community and seminars on supporting students and family members with mental illnesses. They hold fund raisers and establish a wrap-around fund and a scholarship for students in financial need.
- **The State Department of Mental Health** provides consultation and training to the supported education staff, university faculty and their partners on serving students in recovery from mental illnesses and connects the program to funding sources.
- **Suicide prevention services** provide trainings and campus assessment surveys as part of program outreach.

Link 15

Example of a Community College/Community Mental Health Memorandum of Understanding

MEMORANDUM OF UNDERSTANDING BETWEEN SOLANO COMMUNITY COLLEGE DISTRICT AND SOLANO COUNTY MENTAL HEALTH DIVISION

JOINT AGREEMENT: PROGRAM TO SERVE STUDENTS WITH PSYCHIATRIC DISABILITIES

INTRODUCTION

Solano Community College (SCC) District, through the Disability Services Program (DSP), offers educational support services to students with disabilities, including psychiatric disabilities. DSP is currently serving about 120 psychiatric disabled students per year. Many of these students also receive services from Solano County Health & Social Services, Mental Health Division (SCMH).

SCC's DSP and SCMH will cooperate in supported education activities for students with psychiatric disabilities. The cooperative effort will include activities on the college campus, which help to ensure the access and retention of students with psychiatric disabilities. All of the SCMH activities on campus will be coordinated through SCC's DSP office.

I. GOALS

A. Establish support services that will address the specific needs of students who have psychiatric disabilities.
B. The SCMH staff, in coordination with DSP staff, will provide workshops and in-service training for SCC staff in a variety of topic areas.
C. SCC's DSP staff will provide periodic in-service training to SCMH staff in a variety of areas such as: SCC course offerings, the process of admission of new students, availability of support service for students with psychiatric disabilities, and policies and procedures of the DSP.
D. Maintain a good working relationship between SCMH and SCC's DSP.
E. Ensure student access to other needed community resources, such as the Department of Rehabilitation, the Solano Employment Connection, One-Stop Career Center, the Independent Living Resources, etc.

II. PARTICIPANTS (Students to be served)

In general, participants are SCMH consumers who have been diagnosed by a licensed psychologist or psychiatrist to have a psychiatric disability (i.e. limitation of a major life activity). In addition, participants must have functional limitations in the educational setting due to their disability, are 18 years of age or older, able to benefit from the instructional programs of the college, and is able to comply with the Student Code of Conduct. Participants must also be eligible to receive educational support services from SCC's DSP program (see board policy regarding equal access for all disability groups).

A. The formal definition of psychiatric disabilities from the Task Force on services to students with psychiatric disabilities is as follows:

A diagnosis from American Psychiatric Association Diagnostic and Statistical Manual, Fourth Addition – Revised DSMIV-TR, or succeeding equivalent revisions, that is coded on Axis I or II, and reflects a psychiatric condition that interferes with a major life activity, with the following exceptions:

Exceptions:

1. V Codes: Conditions not attributable to a mental disorder that are a focus of attention or treatment; or
2. All other conditions identified as exceptions in the American with Disabilities Act (28 CFR 35.104).

III. SUPPORT SERVICES

A. SCMH staff will:

1. Ensure that interventions support student course retention in coordination with SCC's DSP Counselor.
2. SCMH clinicians and staff will work closely with DSP staff to address emergent concerns and link with appropriate clinical care.
3. Provide workshops and in-service training for SCC staff in the area of working with students with psychiatric disabilities.
4. Assist students to access needed community services, which may include Department of Rehabilitation, Workability, Solano Employment Connection, Job Placement, DSP, and other needed mental health services.
5. SCMH clinicians and staff will document activities on the campus in accordance with SCMH documentation and billing requirements.

B. Solano Community College DSP will provide

1. Note taking/tape recording
2. Test taking facilities
3. Liaison with tutoring
4. Liaison with instructors
5. Liaison with community agencies.
6. Priority registration
7. Prescriptive programming
8. Disability-related academic, vocational and personal counseling

IV. PROGRAM ADMINISTRATION

A. Responsibilities of Solano County Mental Health Division are as follows:

1. Identify and hire Mental Health staff and maintain personnel, salary, accounting and payroll records for these positions.
2. Assign a liaison staff to act as an administrative single-point-of-contact. This individual will maintain a close working relationship with the SCC DSP office in order to assure the success of the program.
3. Share responsibility with SCC for identifying training topics and implementing training, as needed.
4. Maintain liaison with SCC officials regarding changes with SCMH programs, services, and/or policies.
5. Participate with SCC in periodic administrative review of program goals.
6. Obtain necessary authorization to exchange confidential client information

B. Responsibilities of Solano Community College are as follows:

1. Share responsibility with SCMH for training, and evaluation activities to determine training and training needs of SCC faculty.
2. Maintain contact with SCMH to provide information and updates on significant changes to SCC programs, services, and/or policies.
3. Participate with SCMH in periodic administrative review of the program.
4. Obtain necessary authorization to exchange confidential client information.

V. BUDGET

BUDGET Each party shall bear its respective staff cost and not look to either party for compensation.

VI. EVALUATION

Program evaluation will be the joint responsibility of SCMH and SCC District.

VII. TERM

This memorandum of understanding (MOU) will remain in effect for five years from date of signature(s) and will be subject to review and renewal at the end of this time period.

Designated persons responsible for administrative oversight and evaluation of the terms of this agreement.

Approved as to content:

_____ **Date** _____
Director of Mental Health Division
Solano County H&SS Department

_____ **Date** _____

Dean of Counseling & DSP Services
Solano Community College

The undersigned hereby agree to all the terms and conditions as set forth in this joint agreement.

_____ **Date** _____

Department of H&SS
Solano County
_____**Date**_____

Superintendent/President
Solano Community College

Note: Other Items not covered in the above example that could be included in a memorandum of understanding are:

- Workers Compensation
- Discrimination, Sexual Harassment, and Workplace Violence policies
- supervision
- employee disciplinary action
- right of refusal related to the assignment of a specific individual based upon work performance issues
- specific work space required, e.g., access to phones, computers, District systems, private office versus shared work space, classrooms, accommodations or special equipment, etc.
- reporting requirements
- student records
- Union issues

Link 16

Examples of funding sources for supported education programs

- **Department of Rehabilitation (DOR):** DOR funds for the reintegration of persons with disabilities into meaningful roles in society have been primarily focused on vocational training and expedient employment services. DOR does fund partnership programs with universities in the form of Workability IV programs as well as individual student plans. Although, they are active participants in supported education programs through staff redirection and funding individual student plans, their guidelines do not allow them to fund general supported education services.
- **Substance Abuse and Mental Health Services Administration (SAMHSA):** The Substance Abuse and Mental Health Services Administration (SAMHSA) is a great source of funding and continually has RFP's out for response by agencies and community coalitions. Evidence of proven collaboration, capacity and skill in responding to mental health issues and substance abuse are valued.
- **Mental Health Services Act (MHSA):** Since the passage of the Mental Health Services Act (MHSA) most groups interested in funding supported education are looking toward MHSA dollars. Supported education could be funded as part of a MHSA Workforce Development, Early Intervention and Innovation Plans or included as part of a MHSA Full-Service Partnership contract for TAY.
- **Community Foundation Grants:** These grants are available in most communities through their local community foundation. Community foundations are partial to coalitions of community stakeholders and will fund projects that show promise of future sustainability.
- **College Program Improvement Grants:** These grants are given by colleges and universities to improve existing instructional programs. These grants could be applied for by demonstrating a link between supported education and degree completion, although funding amounts are usually modest.
- **Corporate Foundations:** Local, regional, national, and global corporations frequently have a not-for-profit arm that support educational and non-profit organizations. They usually have very specific program focus or interest areas.
- **Individual and Family Foundations:** Examples are: The David and Lucile Packard, Robert Woods Johnson Foundations and Zellerbach Family Foundation. These three foundations have specific interest in health related issues

Link 17

Examples of supported education program options that require no new funds or significant staff reassignment:

- Outreach and recruitment by participating organizations to their constituency.
- Jointly sponsored orientations and campus tours for new and transferring students.
- In-service trainings for faculty on psychiatric disabilities presented by mental health, DSS and peer staff.
- Bi-annual stakeholder meetings to coordinate services.
- Relocate existing services offered in the community to the college campus such as a peer support group from the local self-help center, NAMI seminars and classes, etc.

Examples of supported education program options that require some funding from existing college and community partner budgets through staff redirection and reallocation of resources:

- Office and meeting space provided by the university
- Part-time staffing of a program office by mental health, rehabilitation and peer services providers, campus organizations and advocacy groups to provide supported education services.
- On-campus support groups provided by mental peer advocacy groups.
- Career or wellness classes co-taught by existing college staff and/or community peer staff.
- College DSS counselor assigned as a contact person for program participants and students.
- College Psychological Services counselor and/or intern assigned as a contact person for program participants and students.
- Social work intern is assigned to the program by the School of Social Work.

Examples of supported education programs options that require new funds

- Staff is hired to provide program coordination, educational case management, peer counseling, intern supervision and other supported education services on campus.
- Staff is hired to provide outreach.
- College creates a new DSS specialist position to support students with psychiatric disabilities.
- College hires adjunct faculty with appropriate experience to teach career, empowerment and wellness classes for consumer students.

Link 18

Examples of supported education applications infused into instructional program cultures

- Outreach to community college transfer centers and human service programs with large populations of students with disabilities.
- Mentoring seminars for community college transfer students and university undergraduates with psychiatric disabilities; providing information about the profession, encouragement about the need for persons with disabilities to enter the field and assistance with BA, MA and stipend applications.
- Clear and non stigmatizing departmental statements of inclusion and support for students with physical and psychiatric disabilities.
- Active education and supportive discussions with all students about available supports accommodations possibilities, crisis intervention, and emergency leave.
- Presentations to new program students by DSS, health and personal counseling services and supported education staff.
- Education to all program students and faculty about mental health, mental illness, recovery and the value to the profession of social workers with life experience with mental illness.
- Presentations on the experience of mental illness to classes by consumer groups
- Seminars and safe retreats for faculty on supporting student with disabilities.
- Informal meetings with faculty from other academic programs with similar values to discuss how to create a safer and more supportive environment for persons recovering from mental illness.
- Faculty mentoring for students in recovery.
- Peer coaching and study groups.
- Flexible policies and options for field work, internships and stipend payback.

Link 19:

Summaries of research findings and issues for evaluating supported education programs

Outcomes research. The most current summary of the literature was prepared in 2008 by the California Institute for Mental Health. It is available at: http://cimh.org/Portals/0/Documents/SEd-Final.doc

In addition to describing and systematically assessing the existing research, it provides information on how to access statistics about persons with psychological disabilities in each California college and university and the number of public mental health clients who are potentially eligible for post-secondary supported education. The document also includes a "fidelity scale" to assess supported education programs that was developed by Diane McDiarmid of the University of Kansas School of Social Work and a discussion of the differences between supported education and supported employment and services for transitional aged youth.

Two other reviews of the literature are:

Mowbray, C. T., & Collins, M. E. (2002). The effectiveness of supported education: Current research findings, in C. T. Mowbray, K. S. Brown, K. F. Norman & A. S. Soydan (Eds.), *Supported education and psychiatric rehabilitation*. Linthicum, MD: International Association of Psychosocial Rehabilitation Services.

Carlson, L., Eichler, M. S., Huff, S., & Rapp, C. A. (2003). *Tale of Two Cities: Best Practices in Supported Education*. Lawrence: University of Kansas School of Social Welfare, Office of Mental Health, Research and Training. Available: www.srskansas.org/hcp/MHSIP/EvidenceBased/Articles/TALEOFTWOCITIES.pdf

Evaluation issues. Below is a fairly comprehensive list of outcomes that have been of interest to investigators. Most studies looked at only a few.

- Penetration rate: For those in a mental health agency population who previously had some college or have a high school degree, the percent that return to college
- Hospitalization or other indication of relapse that threatens educational success
- Self-perception: i.e., self-esteem, mastery, empowerment, self-concept.
- Satisfaction with the supported education program
- Participation rates: percentage who are in supported education programs who actually enroll and participate in education; hours participate or number of completed classes; full-time student or not; grades (or passing classes).
- Diploma or course completion rates (compared to other college or junior college students)
- Duration of sustained studies thought to contribute to vocational success
- Employment, concurrent or subsequent: any, hours, full-time, average wage, suitability of job based on education achievement
- Does supported education lead to career development consonant with educational achievement

If you are planning research into the effectiveness of supported education, consider addressing these issues:

What are key program elements, that is, the "active ingredients" of a supported education program?[3]

What would be a relevant comparison group?

- All other students
- Other disabled students
- Other students with psychiatric disability but not in a supported education program

How would you design and measure the effectiveness of programs for "first break" or other younger students who are trying to finish their schooling rather than return after years out of school?

What is the extent and the effects of stigma regarding psychiatric disabilities in higher education?

What patterns and consequences of disclosure do students follow in the higher education environment?

What are the different needs of persons from different ethnic groups (and/or international students)?

[3] Mowbray suggests that to isolate key "active ingredients" a researcher would need a core program and then randomize people to various combinations and permutations of other programmatic elements. For example, in the Michigan program, a class room setting seemed to work better for academic preparation and a support group worked better for quality of life and empowerment; both worked better than individual efforts. Other important program variables we don't know much about are site (on campus or not—or both), optimum balance of skills training, knowledge increases, and a focus on career; optimum duration of the program (with long-term and returns allowed as options); staff ratio; staff background (mental health, rehabilitation or education background), and content of a curriculum if classes are provided.