Supported Education Evidence-Based Practices (EBP) KIT — http://store.samhsa.gov/product/Supported-Education-Evidence-Based-Practices-EBP-KIT/SMA11-4654CD-ROM

Supported Education Initiatives at the Center for Psychiatric Rehabilitation — https://cpr.bu.edu/resources/newsletter/supported-education

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What is the Focus?

The *Focus* newsletter highlights important issues in mental health, providing timely information on a range of topics, including supported education, organizational development and sustainability, peer-to-peer services, youth transition and system transformation. Have a suggestion for a topic? Let us know!

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Supported Education: Examining the Evidence

On its face, supported education is a relatively simple, common sense idea. It's based in the realization that for any individual, participating in higher education can be challenging. There are higher expectations in terms of autonomy, responsibility, self-reliance and independence. At the same time, obtaining an undergraduate degree is an important milestone that results not only in career opportunities, but also brings with it a sense of accomplishment and validation. So, while it requires significant effort, it bestows significant benefits.

For people with mental health needs, the pressures of higher education can be especially difficult to deal with. Trying to manage the academic and social pressures of postsecondary education while maintaining mental wellness is hard, and can be further complicated by the fact that many mental health conditions typically begin to emerge during late adolescence. Nonetheless, the benefits of getting a degree remain clear, and people with mental health needs deserve access to those benefits. That's where the practice of supported education comes in. If the value of higher education is universally accepted, but nearly two-thirds of individuals with mental health needs drop out (see http://thedailycougar.com/2012/11/27/sixty-four-percent-of-college-students-with-mental-health-issues-drop-out/), why not provide those students with tools, resources and supports to help them succeed?

While the logic behind supported education may seem obvious, it takes more than common sense for an innovative practice to become widely accepted. It takes evidence. With evidence comes credibility. With evidence comes the opportunity to replicate a practice across multiple settings and institutions. With evidence comes ac-

knowledgment that a practice is worthy of the investment of significant resources.

What kind of evidence has been used to justify the implementation of supported education? What has been learned along the way?

Findings from the Center for Psychiatric Rehabilitation at Boston University

One of the first institutions of higher education to engage in supported education, and to begin gathering data about its effectiveness, was Boston University. BU's foray into supported education began in 1990's with the creation of an on-campus program to offer skill-building and practical supports for students with mental health needs. As with any quality supported education effort, this College Mental Health Initiative was designed to provide resources to both students and faculty and staff. For students, the program offered individual assessment of student functioning on campus across health, learning, living, social, emotional, and financial domains, and developed interventions in cooperation with Behavioral Health and Disability Services programs on campus. It offered emotional support and coaching through weekly meetings, e-mails, cell calls, and text messages, and included a strong campus-wide mental health awareness and education component. For faculty and staff, the program assisted in the development of accommodations, and shared understanding of rehabilitation and recovery throughout the campus community.

Through support from The National Institute of Disability Rehabilitation and the Center for Mental Health Services, BU built on their initial efforts to create a *Higher Education Support Toolkit* (https://cpr.bu.edu/resources/curricula/higher-education-toolkit). This toolkit included components designed to help students identify the specific barriers to their academic success, and resources meant to assist students in finding strategies to overcome those barriers. The kit was broken down into three parts, with the first including checklists for self-assessment, the second offering forms to connect students with campus resources, and a final section on accommodations and how to advocate for them.

In conjunction with the development of that toolkit, BU also conducted a somewhat non-traditional review of the evidence surrounding supported education, called a "Plain-Language Summary Systematic Review of Supported Education." As the name implies, it sought to take academic studies regarding supported education and distill them into a format that would be easy for consumers, families and providers to grasp. Here's what it determined, as described in an August, 2009 newsletter:

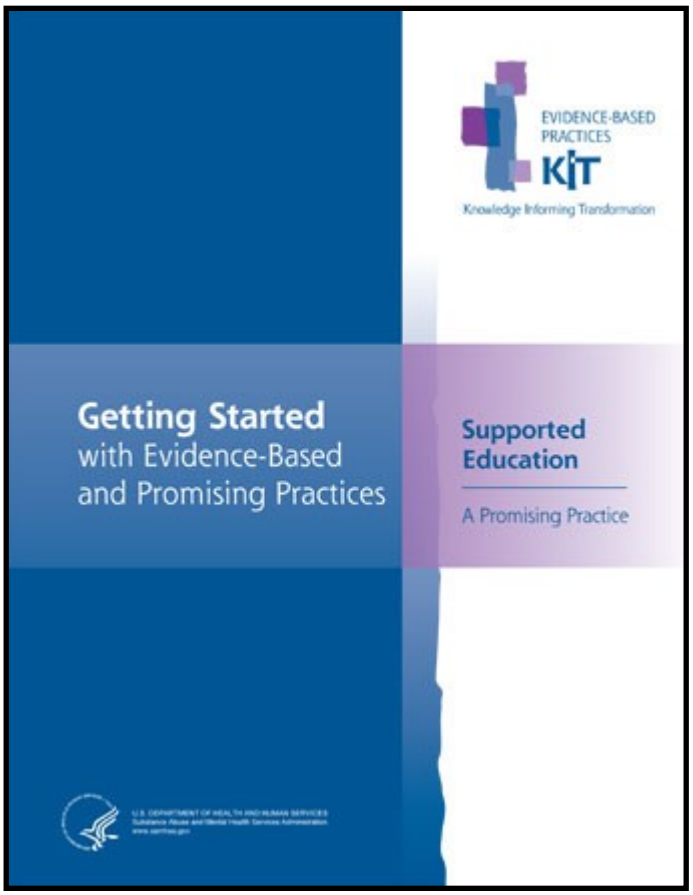
> *. . . Our systematic review concludes that there are limited effectiveness data for supported education programs. . . . . Evidence from existing studies suggests that individuals with significant psychiatric disabilities can enroll in and pursue educational opportunities in integrated settings in the community. There is preliminary evidence that supported education can help individuals identify educational goals, find and link to resources needed to complete their education, and assist them in coping with barriers to completing their education. There is very preliminary but insufficient information that supported education can increase the educational attainment of individuals with psychiatric disabilities. Because many studies are short-term and focus on course completion, there is no rigorous evidence to suggest that supported education will lead to a greater number of individuals with psychiatric disabilities possessing advanced degrees or certificates. Further, there is no rigorous evidence that supported education leads to higher employment rates among participants.*
>
> ***If supported education is to become a viable service alternative and widespread intervention and if mental health policies are to emphasize educational attainment, more effectiveness research on supported education models is critically needed.***

So, while Boston University believed in supported education enough to develop and implement some initial approaches, the people responsible for making it happen recognized the limits of their understanding. While the practice made sense, and seemed to work, it had not yet been entirely proven.

The SAMHSA Supported Education Evidence-Based Practices KIT

In 2012, SAMHSA released its *Supported Education Evidence-Based Practices (EBP) KIT.* This publication was primarily intended to give institutions of higher education the basic information they needed to create and implement their own supported education programs. In essence, it took a cue from programs like that at BU, and offered other institutions a sense of how they might go about designing similar efforts. The fact that SAMHSA was willing to present supported education as a practice worthy of replication was in itself a sign of its validity. To underscore that credibility, the Supported Education EBP KIT also included a section entitled "The Evidence" to outline the case for supported education's value.

"The Evidence" began by noting that supported education is a natural outgrowth of supported employment, which *is* an evidence-based practice. Supported employment has been proven to substantially increase employment outcomes for people with mental health needs. However, as the report noted, its deficiency lies in the fact that while participants do gain employment, a significant percentage were found to terminate employment within six months, and their jobs tended to be entry level or low-skill. This deficiency in a sense set the stage for supported education. By supporting consumers in post-secondary education, supported education would have the potential to create the conditions for longer term employment in high-skill jobs that would be aligned with participants' ambitions. As the report notes, "Supported Education can contribute in a very meaningful way to ensure that developmental steps can be mastered and consumers can go forward to develop careers or qualify for meaningful work, thus decreasing the possibility that they will suffer the economic hardship and deprivation that has often accompanied the diagnosis in the past."



The report identified evidence in multiple areas, including program outcomes, post-secondary education completion, increased need for supported education programs and employment. In terms of program outcomes, it examined the Boston University program, and noted that "participants had significant increases in pre-post class enrollment and competitive employment. . . . Decreased rates of hospitalization and increased self-esteem were also reported." Evidence also showed that "consumers participating in Supported Education sustained stronger student identities, returned to college at higher rates, maintained higher academic aspirations, and reported greater ease in the transition to more normative settings following hospitalization." Dropout rates for supported education students were similar to those among the greater student population, and they

completed 90% of the credits they attempted.

Factors that were found to contribute to staying in school were those that seemed to highlight the importance of social connections and campus-wide community support, which remain key components of a quality supported education program. They included "meaningful and consistent involvement with the mental health system, assistance with admission and readmission, reduced course load, access to a peer support group, having an academic advisor and personal counselor, financial aid, campus orientation, and learning skills workshops." While psychiatric symptoms were reported to create barriers to completion, "environmental supports" like helpful, understanding faculty, access to treatment, and relationships with peers were helpful. Other identified barriers included external and internal stigma, difficulty managing symptoms, limited resources, limited knowledge of campus supports, and a lack of service coordination.

In terms of employment, the report noted a lack of quality information to correlate supported education participation with better employment outcomes. However, preliminary evidence seemed to indicate that, as one would assume, better education outcomes would lead to better employment outcomes. Conversely, lack of education was found to be a barrier to employment. One study mentioned in "The Evidence" found that "where Supported Education programs have been implemented, significant effects on employment have been noted." Another found that "Supported Education is a consistently significant predictor of employment outcomes across populations. It was a more significant predictor than supported employment, skills training, vocational assessment, or participation in a psychosocial clubhouse."

"The Evidence" concluded by asserting that supported education is a "promising practice" based upon current evidence. It then pointed to several questions that might be examined to enhance to evidence base for supported education:

- What measures indicate successful outcomes?
- What services are most effective in promoting positive education outcomes?
- What factors predict successful completion?
- What secondary benefits does supported education promote?
- How does supported education participation affect long-term employment outcomes?
- What are the costs and benefits of supported education?

Evidence-Based Practice: The Next Plateau

As a recent webinar entitled *Supporting the Education of Young Adults with Serious Mental Health Conditions: State of the Science & Practice* (http://www.umassmed.edu/TransitionsRTC/about-us/whats-happening/2015/December/webinar-series/) describes, some of these questions are beginning to be answered. There is a clear correlation between educational attainment and long-term employment outcomes. The high cost of long-term disability is also well known. Therefore, it seems clear that any practice that allows people to

succeed in post-secondary educational settings is worth pursuing. CAFÉ TAC's own examination of supported education efforts have also found indications that the practice is worth replicating, as documented in the "Supported Education at the University of Utah" video (http://cafetacenter.net/2015/02/cafe-tac-video-supported-education-at-the-university-of-utah/).

Of course, one could ask the question, if there is abundant evidence that lends credibility to the concept of supported education, and the idea seems to make sense on an intuitive level, why does it matter whether it becomes an evidence-based practice? What does that designation mean, practically?

When a practice becomes an "evidence-based practice," that means that it has met a scientific standard for effectiveness. It has been defined as "the integration of clinical expertise, patient values, and the best research evidence into the decision making process for patient care" (http://guides.mclibrary.duke.edu/c.php?g=158201&p=1036021). In other words, the evidence base is a three-legged stool, composed of professional expertise, consumer input and research data. The notion of evidence-based practice grew out of the medical field, where clinical research has long been a part of the field's advancement. In terms of mental health, the application of the term "evidence-based" can be understood as indicating a similar level of scientific rigor. If a practice is evidence-based, it has been confirmed that it works in multiple settings. It means an intervention is reliable, and will produce results wherever it is implemented, as long as it is put in place with fidelity to the ideal model.

This is where the notion of evidence becomes important for supported education. Over the past two decades, supported education has grown from a good idea, to a promising practice that has been attempted and delivered positive outcomes for a significant number of students with mental health needs. Even so, not every supported education program looks alike, and there remain questions about the specific details of how and why it works, and what components it should include. The important next step for supported education will be for SAMHSA to add it to the 350 interventions currently included in its National Registry of Evidence-based Programs and Practices (see http://nrepp.samhsa.gov). Once that occurs, it will be clear what benefits supported education affords, and what components every supported education program should include. When supported education reaches that next plateau, it will become the standard for how students with mental health needs should be accommodated, instead of the exception, and thousands of students with mental health needs will gain access to the emotional, psychological and financial benefits of higher education.

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