AN OVERVIEW OF SUPPORTED EDUCATION

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Supported education is a unique application of a psychiatric rehabilitation approach for people with psychiatric disabilities who are trying to return to school. Supported education holds the risk and the promise of real world achievement. Its conceptual base parallels that of supported employment; both share the fundamental purpose of helping people with severe psychiatric disabilities gain or regain their rightful roles in the world. For many, after spending five, ten, or more years away dealing with the devastating effects of mental illness, returning to campus represents a courageous transition of shedding the identity of patient for that of student. The chance to study and the chance to work offers a door back into a meaningful life, from a life that has been diminished by isolation, relinquished responsibility, and loss of hope. In the last ten years some decisive factors have lined up to widen that door, making it possible for people to go through it, to recognize their dreams of becoming a student.

The first key factor is new disability legislation. The reauthorization of the Rehabilitation Act of 1973 (Public Law 92-112) resulted in the Rehabilitation Amendments of 1992, legislation that promotes consumer participation and empowerment and the opportunity to create services that meet an individual's educational and vocational needs. The Individuals with Disabilities Education Act of 1990 (IDEA) of 1990 (PL 101-476) contains language designed to improve educational interventions and outcomes for people with disabilities. Finally the landmark Americans with Disabilities Act (PL 101-336) was passed in 1990, mandating equal access and accommodation to all academic settings, public and private. The second important factor is the availability of clozaril, which has helped reduce symptoms to allow people with psychiatric disability who were previously too disabled to participate in vocational activities, including school. The third key factor, which may well be a direct result of the first two factors, and is the reason for this handbook, is the
increased recognition of supported education as a valid rehabilitation intervention for persons with psychiatric disability, and the consequent burgeoning of supported education programming both nationally and internationally. This chapter focuses on this third and final factor, to provide an overview of supported education, and to elucidate that which makes it unique.

The mission, goals, and principles of supported education services are defined by its roots in the foundations of psychiatric rehabilitation. The mission is to help students with psychiatric disabilities to choose, get, and keep an educational setting of choice. Supported education services help students learn the skills, access the supports, and identify and use the academic adjustments necessary to successfully complete a class, course, or degree or training program. The philosophy and principles of supported education emphasize the values of individualization, self-determination, and support. Program operations embody these critical factors, and throughout the process build in dignity and hope.

While the mission, philosophy, and program components of supported education programs are very similar across all the major approaches, it is an intervention that easily translates to a myriad of models and programs. There are many different ways to help someone go to school, and these are defined in part by where a program is based, who administers it, and how it is paid for. The way the program components of supported education compile is a product of several significant variables, including geography, setting, funding sources, density of population, available resources, and the attitude, philosophy, and interplay of key stakeholders from mental health and rehabilitation agencies, area schools, consumers, and families. These unique compilations have produced a variety of different supported education models and initiatives: community-based models, campus-based models, community organization-based models,
clubhouse based programs, consumer and/or family run programs, and even some hospital programs, all of which are described in various chapters throughout this handbook.

Yet underlying all of the supported education models and initiatives are the defining principles which serve on the one hand to differentiate supported education as a uniquely empowering rehabilitation intervention, while at the same time provide a unifying thread linking an array of supported education programs and services. These six vital principles include dignity, self-determination, normalization, reasonable accommodation, skills and supports, and hope. Following is a discussion of each, with an illustration of how each are operationalized in the supported education process.

**Dignity**

The first of these principles is dignity. Supported education services should be provided in a manner and in an environment that protects privacy and enhances personal dignity. Services should be provided with an eye to maximizing independence, and confidentiality protected whenever possible. Returning to school is a very difficult process for students who with psychiatric disability, especially at the beginning, and is fraught with pain and struggle. Charier (1996), describes her experience at school:

"What I feel and experience is the omni powerful pull of the darkness, despair, and anxiety of my mental illness beckoning from within, threatening to take me away at any given moment. Each moment of every day is a struggle between two worlds of existence for me. The world of "normalcy", and the dark world of my "mental illness." A constant battle is being waged within the interior of my mind and soul each day as I struggle to sit in a classroom and try to absorb, understand, and integrate the new and challenging information that the college experience engenders."
The focus on choice and independence, together with the practical assistance of skill teaching, academic adjustments, and supports, all help to uphold the principle of dignity as the student makes the long journey from hospital to classroom to graduation.

**Self-Determination**

One of the ways to best operationalize dignity in a supported education program is to promote choice, which means to build active student involvement into all program activities. In essence, the student should retain the fullest possible control over his or her own life. This means that the student is the one to set goals, evaluate progress toward those goals, and in general be assisted to take responsibility for the many choices that present themselves throughout the supported education process. This is not without risk; it can be terrifying to let go of the "patient role," and take responsibility for choices and decision making. But underneath there remains fear, fear of failing, fear of succeeding, fear of the illness lurking to resurface. The shift from "patient" to student is a powerful one, fraught with the fear of failure, and for many, the equally terrifying fear of success. Yet it is critical that supported education be done with students, and not to students (Anthony, Cohen, & Farkas, 1990). As in all rehabilitation interventions, students must be “active and courageous participants in their own rehabilitation” (Deegan, 1988, p. 12).

**Normalization**

Services should be provided using the most non-stigmatizing, integrated settings and methods possible. Ideally, supported education services should be integrated or generally consistent with the normal routines of life within the college community. Putting services into an integrated setting not only increase dignity, but can also increase attendance and success. A current computer skills training supported education program at Boston University boasts an
attendance of 87%. Kohn, the director, notes that because the program is campus based, the students are joining clubs at the University, using the athletic facilities, the coffee shops and the student union. Each new connection is a step out of patienthood to a more normal relevant life. An important part of normalizing services is making sure that they are available and accessible to those who use them. Supported education service providers should be visible and easy to access, and housed in a setting that is non-stigmatizing. There is now a considerable body of research that shows the very prominent role that stigma plays in the discrimination against people with psychiatric disabilities (Link and Cullen, 1990, Eliott and Frank, 1990; Zernitsky-Shurka, 1988). The label of "mental patient" can have a significant demoralizing effect (Link, Mirotznik & Cullen, 1991). Unger (1994) cites the stigma of mental illness as a primary obstacle to equal access to educational programs for people with psychiatric disabilities. Insufficient services at Offices of Disabled Student Services for students with psychiatric disabilities, psychiatric withdrawal and mandatory withdrawal because of mental illness are all practices that have a discriminatory effect. Fear and lack of knowledge about how to serve students with severe psychiatric disability prevents participation in existing resources and the development of new ones (Unger, 1992, 1994).

**Reasonable Accommodation**

School is not a treatment environment, it is a goal environment, and is the primary means for most individuals, disabled or not, to acquire credentials and advance professionally. Disability, however, creates barriers that make competing in the school setting difficult, and the school setting itself is often fraught with barriers that interfere with functioning for people with all types of disabilities. This necessitates the principle of reasonable accommodation which means providing modification to academic requirements necessary to ensure that such requirements do not discriminate against students with disabilities, or have the effect of
excluding students solely on the basis of disability (Jarrow, 1992). The purpose of providing reasonable accommodations is not to dilute academic requirements, but rather to equalize the playing field for all, regardless of disability. Students with physical disabilities need curb cuts, wheelchair ramps, and interpreters to access campus buildings and participate in regular classrooms. Students with psychiatric disability have emotional barriers that just as real and just as daunting as the lack of wheelchair ramps are to a person using a chair. Emotional barriers need emotional ramps to increase the accessibility of school, and now are mandated by law: In school settings, they are called academic adjustments.

Academic adjustments can be made in the classroom, allowing a student to bring a tape recorder or have an accompanier with them. Examination adjustments might include a specific amount of extended time or a quiet setting in which to take an exam. Administrative adjustments might be declaring part time status as full-time or getting extra assistance in registering and selecting classes or course load. Working with faculty, staff, and administration to provide concrete information and education about mental illness and in particular, academic adjustments, is an integral part of many supported ed programs. Cook and Solomon (1993) write in the conclusion to their article about the Community Scholar Program outcome study: “College and vocational/trade school instructors are the gatekeepers who can play a pivotal role in the success or failure of post-secondary endeavors. Without their support and cooperation, efforts aimed solely at students are doomed to failure” (p.95).

Skills and Supports

The development of student skills and of environmental supports are the cornerstones of rehabilitation. Together they attempt to improve both the person or the person's environment, and have long been used in both physical and psychiatric rehabilitation approaches (Wright,
Research literature has indicated repeatedly that a person's skills, not symptoms, relate most strongly to rehabilitation outcome (Anthony & Margules, 1974), and that persons with psychiatric disabilities can learn a variety of physical, emotional, and intellectual skills regardless of their symptomatology. These skills, when integrated with support for the use of these skills in a school setting, can have significant impact on the student’s educational outcome (Anthony, Cohen, & Farkas, 1990; Dion & Anthony, 1987).

People with psychiatric disabilities often need little on-site training to perform job tasks and typically they do not require intensive on-campus support to succeed at school. More often, however, as students, people need assistance in applying social and emotional and intellectual skills to master the challenges of the school environment and its academic and social demands (Danley et al, 1992). In supported education, skill teaching primarily focuses on school-adjustment skills, with subject-specific skills a close second.

Just as we try to foster "vocational maturity" in supported employment, "academic maturity" is equally critical. In order to develop vocational maturity, supported employment coaches help workers understand the work-adjustment skills. Work adjustment skills cut across all jobs and include punctuality, attendance, taking directions, or maintaining the required pace. Skills necessary for academic maturity might be explicit competencies, like completing applications, taking notes, or asking questions., or more implicit ones such as managing symptoms, coping with stress, overcoming test anxiety, socializing, participating in group work with other students, or improving concentration.

The Choose, Get, and Keep approach to psychiatric rehabilitation was first developed as a way to describe and deliver supported employment services (Danley & Anthony, 1987; Danley,
Sciarappa, & MacDonald-Wilson, 1992). The approach readily lends itself to the process of supported education (Sullivan, Nicolellis, Danley, & MacDonald-Wilson, K., 1993), with its recognition that in order to be successful students, supported education participants may need assistance in any of these three phases of supported education. Choosing involves selecting a school that is a match for values, career interests, finances, and academic potential. Getting means securing enrollment in the school of choice. Keeping means maintaining an acceptable level of academic success and personal satisfaction until graduation.

Supported education is a process that begins with the decision to go to school. Students may need assistance in making the right decision about which school, how it will be paid for, getting ready for an admission interview, writing an application essay, gaining financial aid, etc. All of these activities require skills. Once someone is in school, the keeping skills may include such skills as selecting classes, registering for classes, or using administrative services. Academic skills include clarifying assignments, managing time, following schedules, completing written assignments, preparing for tests, taking tests, asking questions, answering questions, working in small groups both inside and outside class, managing internal distractions, and negotiating with professors.

The use and success of these skills are enhanced by the availability and use of relevant supports in the educational setting. Supports are the people, places, things, and activities that are provided to and for students to enhance student success and satisfaction at school. People supports include, family, therapists, friends, academic advisors, professors, co-students, peer mentors, campus-ministers, supported learning specialists. Things supports include telephones, cars, disabled parking stickers, tape-recorders, computers etc. Places supports include student lounges, churches, halfway houses, disabled student offices, counseling centers, career libraries
etc. Activity supports include; individual meetings, therapy, AA, exercise, hanging out, remedial study workshops, gay support groups.

Supports should be individualized, which means tailored to meet the unique and changing needs of each student. They should be of infinite duration, meaning available for as long as students need and/or want such support. Recent data shows that individual meetings that provide emotional support are the type of support service most used and desired by supported education participants. The Thresholds program found that the most common support was check-in meetings between the student and the mobile education support worker. This type of individual support is both the foundation and the mortar of a successful supported education program; it is critical to have a chance to talk, explore, vent, share fears and successes, etc. Participant's have to have ample opportunity to talk about their experience with people who understand the enormity of what they are trying to do.

**Hope**

Supported education begins and ends with hope. Hope is an essential ingredient in rehabilitation and is critical for anyone who is undertaking a return to school. Hope has long been recognized as critical ingredient in the rehabilitation (Wright, 1980; Anthony et al., 1990); psychotherapy (Frank, 1981) and recovery process (Deegan, 1988). Programs need to be infused with hope in order for participants to survive the day to day difficulties. But how do we go about this huge task of creating a program based on hope? We have help. Education in and of itself creates hope. The structure of having to be somewhere during the day creates hope. Using ones mind and intellect creates hope; attending classes on a college campus with others who are also getting an education creates hope; being stimulated by new ideas by people excited about those
ideas creates hope. Re-connecting with former talents and abilities such as writing, speaking, and connecting with others creates hope.

We create programs of hope by helping supported education participants to acknowledge negative realities and not avoid them. We create programs of hope by helping people explore their feelings, by celebrating their accomplishments, by staying involved and not allowing ourselves to sound disinterested or uncaring. We create programs of hope by stressing the positive, by increasing people’s network of support, and by being willing to acknowledge the struggle of returning to school and shedding the patient role. Anything that we can do to help them understand this experience, is critical. Using metaphor is one way to do this. The analogy of psychiatric disability to physical disability is widely used and very helpful in demystifying the illness and seeing the role that skills and support play in rehabilitation.

The following quote from Pat Deegan illustrates the philosophy and principles of supported education; why it is so important to help people who have had a severe mental illness to get up and get going to school, even if their symptoms are still with them. Pat is a clinical psychologist who is Director of Training at the National Empowerment Center in Massachusetts. Pat is also a mental health consumer and is the author of some of the most inspiring and passionate writings on the struggle to recover from psychiatric disability. This passage is from her keynote address at the Connecticut Conference on Supported Employment, entitled A Letter To My Friend Who Is Giving Up (Deegan, November 15, 1989):

Healing does not happen quickly. We cannot will or command healing to happen. Healing happens at a level prior to what can be willed. For instance, healing comes in the same way that sleep comes. When we want to sleep at night, we assume the posture of one who is already asleep. In other words we fake it for awhile. We begin to curl up, fix the pillow a certain way, perhaps let out a certain weary sigh. And finally begin to imitate the breathing and the bodily posture of the sleeper. And then, by some mysterious process which we do not understand, a
moment arrives when sleep comes. Sleep comes and settles on this imitation of itself which we have been offering to it. Thus we succeed in becoming what we were trying to be, e.g. one who is sleeping. The same is true for healing in the recovery process. We cannot will healing to happen to us. However, just like in the example of sleeping, we can assume the posture of one who is surviving and recovering. We can swing our legs over the side of the bed, stand up, face the promise and the pain of the day, seize the day and live it. This is the posture of recovery. And although it cannot be willed, healing will come in its own time, in its own way. Healing and recovery will slowly come and settle on this imitation of itself which we have been offering to it (p. 1).

As we strive to overcome attitudinal barriers and "open the doors" of educational institutions for people with psychiatric disabilities, supported education can become a means to increase vocational options, build self-esteem, and create hope for a more prosperous future. In this Handbook, we salute the efforts and initiatives in supported education that are being implemented with so much energy and success.
REFERENCES


