MH Supported Education Literature Review

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Introduction

As consumers seek to re-enter society and adjust to normal life outside the mental health system, employment, education and housing have become fundamental components of the consumer’s recovery goals and the standard for psychiatric rehabilitation. While standard community care and old psychosocial rehabilitation models, such as self contained education, prevocational training, sheltered workshops and transitional employment are still very much in use, supported education, along with supported employment and supported housing, are the current models used in recovery oriented mental health systems. Supported education has emerged as best practice in psychosocial rehabilitation for consumers with serious mental illness, but proven evidence-based practices for supported education models are very limited. Supported education programs and research do not have evidence-based practices that contain the rigorous, consistent and repeated methodology of supported employment. However, effective outcomes and significant findings in program attendance, enrollment in post-secondary education, self-esteem, peer support and reduced healthcare costs make supported education a strong effective practice for the treatment and rehabilitation of adults with serious mental illness.

This literature review summarizes the history, methodology, outcomes and evidence-base practices of some of the most effective supported education programs and the evaluations of these programs. Three literature reviews from articles published by Mowbray et al. (2005), Leonard & Bruer (2007) and Morrison (2008) were used to guide the literature review on the evidence-based practices in supported education. In addition, other programs, such as The Michigan Supported Education Program, Mowbray (2000) that have received
extensive follow-up evaluations and critical reviews, were studied and summarized. Best practices and evidence-based practices in supported education were reviewed in the works of Unger (1998), Stout & Hayes (2004) and Bond & Campbell (2008), as well as in the supported employment studies of Cook & Day (2006) and Crowther (2001). There is strong evidence for the greater use, funding and research in supported education, using evidence-based practice theories that do not require randomized controlled trials, such as the Grounded Theory\(^1\) that looks at the way needs of the consumer are assessed, met and have a positive effect on the consumer.

**History of Supported Education Programs**

Supported education has recently become relevant in the psychosocial rehabilitation literature and in its efficacy as a best practice in mental health, but its origins and development started over 35 years ago and continues to evolve today. The “Redirection Through Education” program, one of the first supported education programs, was developed in Toronto, Canada at Lakeshore Hospital in the fall of 1973 with two instructors from George Brown College. The program started as a self contained classroom model, where the consumers were taught life skills and Basic English and math inside the hospital, to prepare consumers for re-entry into post-secondary education. In the beginning there were 20 students. With additional funding from Canada’s Ministry of Health and the college, three additional teachers were added and the program expanded to 65 students in 1979. In 2000-2001, the program served 92 students and moved from a self-contained classroom to an on-site program under a mainstream college division serving under prepared students on the

\(^1\) See Morrison (2008) where grounded theory (GT) is summarized from (Strauss & Corbin 1998) as “theory grounded in data, in which procedures are being applied flexibly and creatively and there is an interplay between qualitative and quantitative analysis at both micro (individual) and macro (programme) level.”
college campus to give students greater access to mainstream college classes. This program is a good example of how a supported education program can develop and move students into conventional education.

In the mid-1970’s, the Western State Hospital started the Patient and Family Education Program at their facility in Tacoma, Washington. Pierce Community College was paid to provide supported education services to all groups within the hospital. Numerous classes were offered, including adult basic education, H.S. Diploma/GED, psycho-educational classes, health and wellness, women’s health issues, medication education, HIV education, substance abuse education, empowerment symptom management, recovery and family/consumer illness education. These self-contained supported education classes enroll about 500 students per semester, which comes to an extraordinary 62% of all hospital patients. Although this program has never been evaluated, the relatively high usage of this supported education program supports its efficacy as a psychosocial rehabilitation method.

In the 1980’s, the Laurel House in Stamford, Connecticut established the clubhouse with one full-time supported education teacher who counseled students on their educational plans, helped with registration and financial aid, assisted with course work, facilitated an educational support group and travelled to campus to help students. Staff and peer support played a key role in the development of the clubhouse in the Laurel House. Outcomes, such as the 70 students returning to post-secondary education in 1998, show the effectiveness of this clubhouse design, despite the fact that program has not been evaluated in the research literature.

In Upstate New York, the Four Winds Hospital in Saratoga established a supported education program, while the Four Winds Hospital in Westchester did not. The Four Winds-
Saratoga hospital used a self-contained model, where consumers have access to educational opportunities at colleges, among an array of treatment options. The Four Winds-Saratoga is near a college campus while The Four Winds-Westchester hospital is not. The experimental (Saratoga) and control (Westchester) groups were matched and compared. Proximity of the hospital to the college campus factored significantly in whether students enrolled in college, enrollment status (full-time or part-time) and degree plans. Despite many design flaws, the significant outcomes of two matched groups are an important comparison to review.

The Kennedy Service Center in Trumbull, Connecticut established a supported employment program in 1989 where gaining access to and completion of post secondary educational opportunities helps students obtain vocational goals. This on-site model is funded by the State Department of Mental Health to provide supported education classes with an emphasis on making use of existing supports available on the college campus. This program, along with the supported education programs in metropolitan areas of Detroit and Houston, demonstrate the effective collaborations between service agencies, mental health authorities and colleges.

The Houston Community College model was created when the Houston Community College system partnered with the Mental Health and Mental Retardation Authority (MHMRA) of Harris County, Texas in 1992. The Office of Supported Education at a college was formed in July 1992 to assess the needs of the consumer, train support staff and to provide on-site support for students. An on-site college re-entry program called the “The Entry/Re-entry Program for Students in Transition” was instituted on campus. This program taught symptom management, study skills, Basic English and math, career counseling, peer
support, assisted with college admission and provided enrollment help. A case management aide training program was designed and implemented by the college with MHMRA funding the consumer trainings, books, tuition and clothing. These programs serve about 200 students per year, but not all consumers have access to the programs. For example, the participants in the case management aide training program are screened applicants and two thirds of the applicants are not accepted into the program. Despite the limitations, this program had a high success rate (Housel & Hickey, 1993). Mental health evidenced based practices recommend that programs such as this, which prepare consumers for enrollment and post-secondary education and train them as case management aides, be provided because they are effective and meet the needs of the consumers (Morrison, 2008).

The Michigan Supported Education Program, started in mid-1990s, serves the Detroit metropolitan area through funding from the Detroit-Wayne County Community Mental Health Agency. This program prepares consumers with serious mental illness for enrollment at one of two local community colleges, Wayne County and Henry Ford. This program combines the on-site and self-contained models by being located on a college campus, but in separated classroom program. It adds experiential learning with staff members from the program, including one mental health consumer, and provides college program staff for hands-on training and access to college resources to teach skills necessary for educational advancement. This program separates itself through its consumer driven programming and coordination between the program staff and case managers. Outcomes were measured at the program’s conclusion, at six months and twelve months. This study was one of the few to make comparisons at pre- and post-test at different time periods. Despite high attrition and a high functioning sample, the assessment tool, consumer driven classes and unprecedented
coordination of services and supports makes this program worth studying as a best practice in supported education.

**Supported Education Models and Philosophies**

Supported education has evolved and expanded, as consumers and mental health practitioners continue to seek and find psychosocial rehabilitation methods that go above and beyond the usual psychiatric care for patients. Rigorous studies of the old rehabilitation methods included meta-analysis and show these older methods intended to prepare consumers for employment. Some studies have shown the old psychosocial rehabilitation methods, such as prevocational training, were only as effective as standard community care and some even promoted dependency, deterred clients from finding competitive employment and were restricted to the United States (Crowther et al. 2001). Current models of psychosocial rehabilitation, especially supported education, have been studied in a variety of methods, including meta-analysis, qualitative analysis, descriptive statistics and interviews. The philosophies of supported education methods have also varied. Some methods for implementing supported education include programs that are available to all students, others are specialized programs for high functioning consumers, some train consumers to become case management aides and others are partitioned programs that include the aforementioned programs and/or any combination of self-esteem and self-confidence building workshops, prevocational training and education to increase skills and abilities to increase employment outcomes, like competitive employment and increased wages. The old and current psychosocial rehabilitation methods can be seen in the models that have been development in support education.
Initially, supported education use three models, but these models have been adapted and changed to meet the needs of consumers, to accommodate new mental health service delivery methods and fit into new budget constraints. Self-contained classroom models, the most frequently used and evaluated, use specifically designed classroom, structured curriculum with a strong vocational focus and academic skill concentration and supportive staff relationships (Unger et al., 1991). Students are not in regular classes, may not receive academic credit and the goal is to get students to move to self-contained classes with support.

The on-site model is sponsored by a college or university, individual focused, gives access to services available to all disabled students, has the benefit of specialized mental health staff or peer support. There are only a few reported studies of this model. Students attend regular classes, receive academic credit, receive support from college’s Disabled Student Services or College Counseling Service and give support only on-site.

Mobile supported education model is provided through mental health agencies, allows student self selection of education setting, gives program support on-site on an individual and flexible basis (Hoffman & Mastrianni, 1993). There are also very few reported studies of this model. Students attend regular classes, receive academic credit, get support from community based mental health services and receive support on-site and off-site.

The clubhouse, a frequently used new model, offers individual counseling with tutoring, mentoring and group support plus workers from mental health agencies on-site and group-based classroom preparation on a college campus. Other new models include the free standing model, a stand alone diverse program funded by host mental health agency or college, consumer alliance model and combination models. Funding for these supported education models comes mostly by state and county mental health agencies, then state
vocational rehabilitation programs, colleges and universities. As the models of supported education have changed, the methodology for implementing and studying these models has varied greatly and the outcomes measured are dependent on the different methodologies.

Methodology

The methodology for implementing and studying supported education varies in the selection of participants, the goal or mission of the program, the management of the programs, services provided, program and peer support, definition and use of evidence-based practices and assessment and measures used to determine outcomes. The most common selection criteria for participants of supported education programs are at least one year time of serious mental illness and prior education, where the participant has either previous college credits, a high school diploma or almost completed high school diploma or GED (Unger et al. 1991, Dougherty et al. 1992, Hoffman & Mastrianni 1993, Housel & Hickey 1993, Mowbray, C. 2000). The age of participants is usually between 18-45 years of age with the mean age on the high end of the range, for example, 36.9 years (Collins, Mowbray & Bybee 2000) and 39.5 (Morrison & Clift 2006). Some programs selected participants through applications and interviews (Unger et al 1991, Housel & Hickey 1993). Sometimes, the funding entity selects participants after an application process (House & Hickey 1993).

The goals and missions of supported education programs differ from program to program. The textbook supported education program defines its goals as the participant’s enrollment in post-secondary education (Hoffman & Mastrianni 1993, Housel & Hickey 1993, Dougherty et al. 1997, Mowbray, C. 2000, Gilbert et al. 2004). Other programs focus on the preparation of participants for enrollment through enhancing basic education skills, familiarity and experience using of college academic resources, developing and practicing
coping skills, career exploration and planning and helping participants reach vocational goals (Unger, et al. 1991, Housel & Hickey 1993, Petella, Tarnoczy, & Geller 1996). The plethora of supported education programs and their different goals naturally leads to a variety of support education classes and interventions.

While classroom instruction is the most logical and prevalent service in supported education, many other types of classes and interventions are effectively practiced. Classroom instruction has been used in different formats and with different content. As discussed previously, the self-contained classroom is most commonly found type of classroom instruction (Unger et al. 1991, House & Hickel 1993, Mowbray 2000). Individual instruction is also used, especially where staff is limited (Dougherty 1997, Gilmur 1997). Group sessions, such as workshops and support groups, are also available to students in some programs (House & Hickel 1993, Petella, Tarnoczy, & Geller 1996, Mowbray 2000). A hands on experience with campus resources is an important teaching method (Mowbray 2000, Gilmur 1997). Workshops that cover a wide range of topics and are used to teach skills, such as obtaining financial aid, using the college’s educational supports, promoting education, organization and study skills are an important supplement to any supported education curriculum (Petella, Tarnoczy, & Geller 1996).

Individual counseling, peer and staff mentoring are offered by some programs (Mowbray 2000). Paid internships are offered by case management aide training programs (House & Hickel 1993). Different teaching methods used with the learning disabled, multi-modality teaching, repetition and stimulus reduction are also used (Gilmur 1997). Pre-assessments of career interest and educational planning are offered (Housel & Hickey 1993, Petella, Tarnoczy, & Geller 1996).
Given the variety of services offered, it is often hard to tell which interventions produce specific effective outcomes. Other factors, such as program support, funding and management of supported education programs could be the reason for some outcomes.

Support from mental health agencies, colleges and other consumers play a vital role in the implementation, effectiveness and outcomes in supported education programs. Programs, such as Redirection Through Education, the Michigan Supported Education and Houston Community College model, were all developed in conjunction with or through a partnership between mental health agencies, colleges and mental health authorities, who also provided the majority of funding (House & Hickel 1993, Gilmur 1997, Mowbray 2000). Colleges played key roles by housing some supported education programs on campus, creating a division within a college for supported education, allowing use of existing services, and encouraging use of existing services for under prepared students. Mental health agencies and mental health authorities provided on-site support in the form of mobilized case managers, individual and group counseling and consulting psychologist for situational problems. Consumers were encouraged to share with case managers, get tutoring and encouraged to use the college’s support services. Collaborations between supported education staff and case mangers were also encouraged to discuss how to best support the student’s educational goals. Support, in some cases, continued after the supported education program, during future hospitalizations (Gilmur 1997), and in offers of employment opportunities to successful graduates (House & Hickel 1993). A thorough and inclusive support system for supported education makes an ideal climate for a selected group to engage in these effective supported education programs and enroll in post secondary education.
The assessment and evaluation of supported education programs use both qualitative and quantitative methods, but these measures often fall short of the criteria for evidence-based practices. Pre-interviews often conducted and used as a baseline for creating questionnaires. Pre-assessments of students are based on group discussions lead by program staff and the ranking of categories of needs based on importance in areas, such as information, skills and support. After interventions, post-assessments were made during follow-up interviews by program staff of either experimental (active in classroom instruction) or control group participants (not active in classroom instruction). Some studies only did post-intervention assessments. Some studies did program/model comparisons, for example, comparing a program with inpatient supported education to an inpatient program that did not have supported education (Hoffman and Mastrianni 1993). Some studies did in-program assessments and follow-up assessments, like the three-year program and three-year follow up of Cook and Solomon (1993). Other studies used measures of psychosocial wellness, such as Antonovosky’s Short-form Sense of Coherence scale (SOC13), Social Adjustment Scale Self Report and the Rosenberg Self-Esteem (Unger et al. 1991, Totty et al. 1993, Mowbray et al. 1999, Morrison 2008). These assessments and evaluations were analyzed to design programs, implement curriculum and support services, produce questionnaires and create questions for post-assessment interviews.

The concrete achievable goals, vast array of services and supports offered by supported education, along with a high functioning sample, helped consumers achieve good measurable outcomes, but these conditions do not meet the criteria necessary for evidence-based practices. “Evidence-based practices are a system of evaluating research using hierarchy and basing practice on that system” says Harrison (1998) (Morrison 2008). Most
methodological designs and studies of supported education start by using qualitative analysis, such as interviews, surveys and/or focus groups to determine the program curriculum that meets the needs and desires of students, to determine which outcome variables will be assessed at pre- and post-intervention and to follow up participants with interviews to verify common themes and significant outcomes of quantitative measures analyzed. Hence, most studies of supported education do not meet the criteria to be classified in the hierarchy of evidence for evidence-based practices. The very few studies that provided enough information to be included in the hierarchy of evidence were mostly non-randomized, non-experimental, descriptive studies. One study, Collins et al. (1998), that did use a randomized control trial, could not single out a specific type of supported education intervention that was most effective or why the supported education interventions were effective. Other studies, Bellamy and Mowbray (1998), Isenwater et al. (2002) and Sasson et al. (2005) yielded to design flaws, such as a self-selected sample, insufficient follow-up of the experimental group and non-standardized measures. These studies were also hindered by very small post-intervention samples. The value of using a hierarchy of evidence over qualitative evidence is under debate because qualitative research is subjective and the experience of supported education varies among its participants. Hence, the evidence base for supported education needs effective outcomes that account for how the outcome measures are funded, consider the treatment preferences of consumers and that make sure the consumer receives the most suitable treatment for their circumstances.

Outcomes

The outcomes reported by the supported education programs in this literature review are relevant and significant enough to make the case for supported education as an evidence-
based practice. The outcomes show consumers can reach educational goals, achieve vocational success, increase self-esteem and self-perception, reduce hospitalizations, learn to reduce or manage their mental illness symptoms and report overall higher levels of satisfaction. Most of the outcomes were recorded at the end of program and a few studies reported follow-up post program results. Educational attainment and involvement was the most frequently reported outcome. Significant enrollment numbers in post-secondary education by consumers participating in supported education programs was reported by most studies measuring this outcome (House & Hickel 1993, Tutty et al 1993, Lieberman 1993, Dougherty 1997, Mowbray et al. 1999). Outstanding findings, such as the House & Hickel (1993) outcome that 82% of the supported education participants enrolled in regular college, show the effectiveness of the supported education model. Enrollment has also been measured by whether a course has been taken, the average number of classes taken, part-time or full-time enrollment and if a degree has been earned (Dougherty et al 1992, Wolf & DiPietro 1992, Cook and Solomon 1993, Hoffman and Mastrianni 1993, Lieberman et al. 1993, Collins et al. 1998, Unger et al. 2000). Another significant finding by Hoffman and Mastrianni (1993) showed the 88% percent of the participants in supported education enrolled full-time compared to 58% percent of a match control group. Increases in enrollment in post-secondary education were also reported (Unger & et al. 1991, Dougherty et al. 1992). Other studies reported outcomes in the percentage of participants returning to college, greater participation in college or vocational training, class completion rate, type of class taken, grades achieved, planned graduate degree completion, graduate degree completion, more specific educational goals over time and educational enrollment as the most important goal (Unger et al 1991, Dougherty et al. 1992, Wolf & DiPietro 1992, Hoffman and Mastrianni 1993, House &

Vocational achievement and employment success were another significant outcome of supported education interventions. Increases in competitive employment were the most relevant employment outcome. Unger et al. (1991) reported increases in competitive employment from 19% pre-test to 42% post-test. Housel & Hickey (1993) found an 87% rate of competitive employment for program designed for students to become case management aides. This program was replicated for two subsequent supported education classes, one which had a 100% rate of competitive employment. Other supported education interventions reported employment outcomes of gaining employment, keeping employment and increased working hours and wages (Dougherty et al. 1992, Cook & Solomon 1993).

Self-esteem and other self-perception outcomes were found. Increases in self-esteem were the most frequent finding (Rosenberg Self-Esteem, p<.05, Unger et al. 1991, Cook & Solomon 1993, Mowbray et al. 1999, Collins et al 1998, Tutty et al. 1993, Isenwater, Lanham & Thornhill 2002). Increases in coping mastery (Cook & Solomon 1993) and increases in positive coping behavior with increased attendance in supported education program (Mowbray et al. 1999) were also found. Increases in quality of life and significantly improved social adjustment were also discovered (Tutty et al 1993, Mowbray et al. 1999). Significant increases in productive activity, defined as engagement in college or vocational education or paid employment, were found, especially when compared to control groups who did not receive supported education interventions. Mowbray, Collins & Bybee (1999) reported that supported education participants were 1.86 times more likely to be involved in

The were only three studies that reported significant findings in the area of hospitalizations, but these findings are so profound that they represent the effectiveness of supported education as a best practice in mental health. After supported education interventions, significant reductions in hospitalizations, in-patient and day treatment programs were found (p<.05, Unger et al. 1991, Tutty, Belanger & Gregory 1993, Isenwater, Lanham, & Thornhill 2002). Isenwater, Lanham, & Thornhill (2002) found a monumental decrease in hospitalizations, reported in number of days. The number of days in the hospital fell from 415 days before supported education intervention to zero days after the supported education intervention. This led to a significant difference in government spending per student (Isenwater, Lanham, & Thornhill 2002). The savings for the government were 8,127.18 pounds per year or 12,545.12 dollars per year.

Most students reported higher levels of satisfactions, especially when compared to control groups (Cook and Solomon 1993, Collins et al. 1998).

Some studies measured outcomes with measures of psychosocial wellness. The Social Adjustment Scale Self Report was used with mixed results. Tutty et al. (1993) and Mowbray et al. (1999) found differences favored graduates of supported education, while Collins et al. (1998) found not favorable results for graduates of supported education. Using Antonovosky’s Short-form Sense of Coherence scale (SOC13), Morrison (2008) found 70% of lower initial scorers made significant positive gains after they exited the supported education program.
Some studies measured outcomes in symptom management. Tutty et al. (1993) reported significant decreases in symptoms. Increased control over symptoms is often displayed in classroom group empowerment and school efficacy (Collins et al. 1998) and sometimes no differences between groups in empowerment, school efficacy and social support are shown although symptoms are controlled (Mowbray 1999). Symptom management also increases interpersonal skills, confidence, motivation and independence (Isenwater, Lanham & Thornhill 2002). These finding present the case for supported education as an effective rehabilitation intervention for the severely mentally ill.

Conclusions

Supported education is a strong effective practice for treatment and rehabilitation of adults with severe mental illness, but more research and study is needed on a wider range of the adult population with severe mental illness, how to expand supported education to consumers not in close proximity to colleges and universities, the most effective methods for using supported education as a necessary treatment and an optional treatment choice for consumers and a standard set of methods and measures for supported education outcomes that do not require randomized controlled trials. Supported education uses a variety of selection methods, but the most programs include only high functioning consumers with high levels of baseline education (Gilbert et al. 2004, Bruer et. al 2006). More interventions and research needs to be done with lower functioning consumers. Different types of educational programs must be offered, especially for excluded consumers, due to large numbers of rejections in some programs to keep within best practices in supported education programs (Unger 1998). Programs should attempt to incorporate both high functioning and low functioning consumers. Requiring academic and career counseling, pre-testing and submission of
academic transcripts can make sure of consumer’s preference for academic education over work or vice versa and keep lower and high functioning supported education students from becoming isolated or disinterested in academic achievement. Pre-assessments, along with basic English and math and subject specific courses geared toward students’ interest could help students without the prerequisite education background go on to enroll in college. Offering short prevocational training with vocational career and job search counseling would help those seeking longer and more meaningful employment. Then, shelter workshops would be reserved only for the lowest functioning consumers with an emphasis on reducing psychological distress, symptoms and the need for learning support. An emphasis on on-site and mobile support specialist for supported education should be the focus until the consumer has completed his or her educational goals.

The location of supported education programs, in reference to college campuses, should not be a prerequisite for offering supported education interventions. Self-contained classrooms, on-site and clubhouse models that offer an accepting environment for a definitional transformation from patient to student can still be offered to consumers in hospitals, community mental health agencies and even residential facilities. These programs must be properly funded and validated with students integrating into the mainstream college classroom whenever possible. This requires a close working relationship between mental health agencies and colleges. Also, colleges must keep an open door or revolving enrollment policy with regard to supported education students. Houston Community College system is a good example of a supported education program that provided the needed support to students with a multifaceted design which created new academic programs and removed barriers to college enrollment. The union between Western State Hospital and Pierce Community
College in Tacoma, Washington shows that when education is seen as a right for the individual with serious mental illness that consumers will engage in educational activities. Funding partnerships between county, state and federal mental health agencies and colleges are necessary to eliminate the barriers to funding supported education. This may be done by locating supported education programs inside of existing mental health programs, like prevocational training or supported employment programs or existing college programs, like the Office of Disabled Students.

Supported education must continue as an effective best practice in psychosocial rehabilitation, develop into a standard care model and become more readily available as a treatment option for consumers seeking to re-enter society. Quality evidence-based practices necessitate good psychosocial rehabilitative practices which are “inclusive, continuous and individualized” while keeping the consumers diagnosis, history, background, desires and dreams in mind. These quality evidence-based practices will be ever changing, encourage good partnerships with good providers, be relevant to the population it serves with an eye toward positive outcomes. Newly emerging supported education programs must find a way to offer a variety of psychosocial rehabilitative services that consumers need and desire, regardless of their setting, diagnosis, socio-economic and/or education level. These programs must be relevant and keep evolving to meet the ever-changing educational and psycho-educational needs of the students. For example, consumers with dual diagnoses need Basic English and math skills to live independently and a group classroom setting to help build social skills taught in a school setting. Supported education also can increase the desire to stay in school and complete school, as well as lead to longer terms of competitive employment. These outcomes will help consumers adjust to normal life outside the mental health system.
The greatest need in supported education is a standard set of methods and measures for evaluating supported education programs. Currently, studies of supported education use small samples and many different outcomes measures to reproduce valid results. Definite themes have emerged from the outcomes of the research on supported education. Educational attainment, self-esteem building, hospital care and cost reductions and symptom management are four definite themes that need developing for standard measurement in supported education. Another emerging theme is support, especially peer support. Peer support helps factors that contribute to learning uptake, which leads to reduced symptoms and a reduced need for learning support. A culture of support for education among staff and peers is seen when education goals are revealed. These themes could be established independently and correlated to determine the relationships between themselves and other factors such as age, gender, race, functioning, diagnosis, aspirations, dependency and employment. Supported education has impacted psychosocial rehabilitation as a treatment practice and has the potential to redefine the literature on evidence-based practice in social science area, where non-randomized quantitative and qualitative research is the norm.
References


