HIGHER EDUCATION AS A PEER SUPPORT INTERVENTION

A Project

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Abstract

of

HIGHER EDUCATION AS A PEER SUPPORT INTERVENTION

by

Christa J. Thompson

In 2009, a rural county behavioral health department and community college implemented a supported education program to promote the success of its consumers. While anecdotal comments indicated the program was successful, it was unclear to what extent students were benefitting from supportive services, and of those services offered, which were most helpful. A secondary data analysis was conducted using 25 course evaluations integrating support service variables. Results showed that assistance with registration, tuition, and transportation were most essential to participant success. All students reported improved relationships with others and increased self understanding as a result of taking the course. Additionally, of students receiving support services, the most positive outcomes included: feeling more useful to others, being interested in new things, feeling hopeful, and having more confidence. The ability to generalize the data was limited due to the small sample size (N=25); however, this is typical of rural service areas. The success of the program, even with the small number of participants, indicates the positive potential for supported education as an intervention in psychiatric rehabilitation.

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Susan Taylor, Ph.D., MSW

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Chapter 1

THE PROBLEM

Introduction

In 2009, Calaveras County Behavioral Health Services (CCBHS) implemented a supported education program to promote the success of behavioral health consumers enrolled in psychosocial rehabilitation courses offered at Columbia College in Sonora, CA (Appendix A). This program was designed for completion in two to three semesters, resulting in a locally approved certificate, and employment or volunteer opportunities. As behavioral health consumers began taking these courses, employment opportunities in the area substantially declined. Staff of CCBHS noticed that program participants did not seem daunted by the lack of jobs. Rather, students seemed to have gained substantial confidence and interpersonal skills from their educational experience. The original goal of post education employment became secondary.

Some consumer participants have informally commented that the psychosocial rehabilitation courses have benefited their emotional wellbeing through a better understanding of their diagnoses and by learning techniques they can use to support themselves and others. Other consumers stated that while the educational experience was life changing, they could not have successfully completed their courses without the supports provided by CCBHS. What remained unclear at the end of the first year of this project was if the courses alone led to these subjective improvements, and if these supports did in fact contribute to their success. Finding statistical evidence regarding the emotional wellbeing benefits of the program and identifying what services contributed to
these benefits will assist CCBHS and other agencies to tailor supported education programs that ensure consumer success and as a secondary benefit, create billable revenue for the county.

The following chapter will discuss the background of this project, including an overview of the funding that led to the implementation of CCBHS’ supported education program. The problem this research project will address and the purpose of the study will also be discussed. The researcher will describe the theoretical framework used in the study and will define key terms as they will be used in the project. The chapter concludes by disclosing the study’s assumptions, justifications, and limitations.

Background

The Mental Health Services Act (MHSA, Proposition 63) was approved by California voters in November of 2004 to fund innovative services within public mental health and the community. By taxing millionaires one percent of their income, significant funding was funneled to the county level, with specific guidelines regarding how these funds should be spent. MHSA included several strategies to support meaningful change, including the creation of Community Services and Supports, Prevention and Early Intervention Programs, and Workforce Education and Training.

A major goal of the MHSA Workforce Education and Training component was to prepare behavioral health consumers and their families to work for the public mental health system. As a result of their extensive personal experience, it has been argued that behavioral health clients and their family members are best positioned to change the system from within. In order to qualify these subject matter experts for employment,
MHSA provides funding to educate consumers for every level of work, from volunteering to upper management. After an extensive needs assessment, what was missing most in Calaveras County was entry-level education as the first step in a meaningful career ladder for consumers.

With this additional funding, CCBHS was able to sponsor two new psychosocial rehabilitation courses at Columbia College, in nearby Tuolumne County. In order to support student success, CCBHS also implemented a supported education program for behavioral health consumers participating in these courses. While employment was a major intent of the MHSA funding and the courses offered at Columbia were intended to support that goal, budget constraints within the county left few career opportunities available for consumers and family members.

Despite the lack of jobs to encourage participation, the program itself did seem successful, as evidenced by an 80% course completion rate among students. The program was one of two recipients of the California State Association Innovation Award and a Challenge Award winner for counties with a population under 50,000 (2010). The program was recognized as an Innovation in Workforce Development in the National Rural Health Association Compendium of Rural Best Practices (2010). In addition, CCBHS presented their rural supported education program at the California Association of Social Rehabilitation Agencies (CASRA) Annual Conference and the National Association for Rural Mental Health (NARMH) Conference in 2010.

CCBHS also observed a significant increase in volunteerism, community involvement, and other indicators of emotional wellbeing among supported education
program participants. Participants seemed more self-assured; they appeared to have a better understanding of their illnesses and were working to advocate for themselves and each other. This body of evidence, while circumstantial, prompted an interest in studying the actual emotional wellbeing effects of the program, the course, educational supports offered to participants, and the participants themselves.

Problem Statement

The most significant challenge faced by the CCBHS supported education program has been the lack of job opportunities for participants upon graduation. Employment was a major goal of the MHSA Workforce Education and Training component. Potential employment opportunities were also the primary justification for Columbia College in creating the Psychosocial Rehabilitation Certificate. The CCBHS supported education program came under the MHSA Workforce Education and Training category of creating “Career Pathways,” which established a plan to support consumer employment, as well as staff career advancement. However, without job opportunities within public mental health, a meaningful career path did not exist when students completed their courses. In addition, most community colleges cannot justify creating a new program without a demand from the job market.

Another challenge faced by this program was a lack of data to support the subjective, non-employment benefits that CCBHS staff and administration has observed. It was unclear if consumers were benefiting without added employment opportunities. If there was a benefit, no data existed to show if emotional wellbeing was improved by
engaging in educational opportunities, and if so, and what specifically was causing or influencing the improvement.

The data CCBHS had access to was limited to demographic information the department gathers from consumers receiving supported education and assistance with college enrollment and class registration. However, the data CCBHS collected was inadequate as well because it did not represent all participants in the program at Columbia. The Psychosocial Rehabilitation Certificate program, and specifically the Peer Support course studied as part of the project, is attended by other Calaveras County and Tuolumne County residents who do not access supportive services offered by CCBHS staff. It will be central to this study to obtain data on all course participants (i.e., those who are receiving services and those who are not) to determine if emotional wellbeing benefits are experienced, regardless of available ancillary supports.

To determine how the different aspects of the program benefit participants, the researcher identified as independent variables the Peer Support course and the supportive services offered by CCBHS and Columbia College. The researcher examined the dependent variable of improved emotional wellbeing for participants. Once these variables are evaluated, it is expected that there will be some determination of which variables, if any, improve emotional wellbeing, and in what specific areas emotional wellbeing may improve. The study acknowledges there may be some additional variables that impact the participant that are not tied to the Peer Support course or supportive services (e.g., family support or prior experience in a community college setting). To the degree that these are identified, they will be reported in the final analysis summary.
Study Purpose

The primary purpose of this study is to examine whether or not increased education in Peer Support improves emotional wellbeing for rural behavioral health consumers, and if so, what aspects of their educational experience are most beneficial. If actual participant benefits are established by this study, correlations can be made with the supportive services utilized most. For instance, if providing school supplies proves to be underutilized, while assistance with transportation turns out to be the determining factor in student success, then CCBHS can budget additional funds toward transportation. This will allow CCBHS and potentially other agencies and community organizations to tailor their programs with appropriate services that will meet the needs of rural behavioral health consumers as they return to school.

A secondary purpose of this study will examine if supported education in psychosocial rehabilitation can be successfully used as a rural peer support intervention. Analyzing the course evaluation data collected from students will identify the actual benefits student perceive that they received as a result of participating the CCBHS education program. Knowing the potential benefits behavioral health consumers can achieve through participation in a supported education program will allow CCBHS and other agencies to tie consumer education to their individual treatment plans. Once the link between therapeutic benefits of supported education and therapeutic treatment goals is established, agencies can bill state and federal funding sources (such as Medi-Cal) and thus derive revenue to support similar programs.
Also important to this study is establishing that a successful supported education program can be implemented in a small, rural county such as Calaveras. While urban areas face their own challenges, small rural communities are often hardest hit by economic downturns and unemployment trends. In addition, isolated towns and poor transportation networks work against rural community members seeking a higher education. A lack of precedent also affects how those in rural communities feel about their ability to return to school and get an education, particularly without support. If research can show that even the smallest of rural counties can create an award-winning program that promotes emotional wellbeing, then it opens the door for other small, rural counties to do the same.

Theoretical Framework

The foundation for the study is grounded in systems theory. In order for the supported education program to be successful, multiple groups must work together at several levels. For instance, to implement the program in 2009, CCBHS partnered with Tuolumne County Behavioral Health Department and received technical assistance from the California Institute for Mental Health in order to propose the original psychosocial rehabilitation certificate program to Columbia College. Ongoing collaboration was required in order to then implement the program. Once the certificate program was accepted by the curriculum committee at the College, CCBHS began to work with consumers to design the supportive services they would need as students in order to succeed. That collaboration is also ongoing in order to make the supported education program as a whole successful. Families, external support systems, and future volunteer
opportunities also play a role in the consumer/student’s system, in order to ensure their success. The level of conflict between administrative organizations has determined the efficacy of the program as a system to support consumers as end users. Similarly, the ability for staff to assist consumers in navigating the system, and their own personal system, is a large part of the supported education CCBHS seeks to provide.

This type of supported education is closely related to the paradigm of mental health recovery, which stresses the importance of consumers recovering a meaningful role in their lives, in the community, and in the therapeutic services they receive. The concept of mental health recovery and client-led services is currently driving the way public mental health services are implemented and provided to the community. As a result, consumers have become more involved in the direction of their services and the services offered by public mental health as a whole. To facilitate this process, supported education promotes not only consumer career advancement, particularly within the public mental health system, but supported education also seeks to promote individualization, dignity, and hope.

As supported education has become more defined and structured, the goals have become increasingly aligned with those of psychosocial rehabilitation including the promotion of normalized community integration, access to resources (including college), and the skills needed for symptom management and college-level participation in class and through assignments. Advocacy is also at the heart of both the recovery movement and supported education. Consumers are supported and encouraged to identify and pursue opportunities they may have lost because of their illness, which allows them to explore
their options and pursue individual goals that define them as students, peers, and leaders—not just “patients.”

The concepts of mental health recovery and supported education are also in line with the core social work values of client advocacy, empowerment, and self-directed care. As the global mental health profession has evolved and continued to move away from the hierarchical medical model, several clinical modalities (such as systems theory) have emerged. These newer theories, particularly those in the second and third wave of behavioral therapy have significantly increased their focus on the importance of person-in-environment, client-driven services, and personal empowerment. Some of these more recent treatment modalities include Acceptance and Commitment Therapy (ACT), Assertive Communication, and Feminism, just to name a few. Compared to these, supported education is absolutely in line with modern clinical theory and current therapeutic approaches to working with clients.

Definition of Terms

- **Calaveras County Behavioral Health Services (CCBHS).** CCBHS is a public agency in a small, rural county in the Sierra Foothills with a population of approximately 47,000. The mission of CCBHS is to empower consumers and their families to create more satisfying, fulfilling, and productive lives by supporting wellness, recovery and hope.

- **California Association of Social Rehabilitation Agencies (CASRA).** CASRA is a statewide organization of member agencies that service clients and family members of the California public mental health system. CASRA has designed a
curriculum in Psychosocial Rehabilitation for use in community colleges, universities, and behavioral health organizations.

- **California Department of Mental Health (DMH).** DMH has oversight of the California mental health system and ensures effective, efficient, culturally competent services. This is accomplished by advocacy, education, innovation, outreach, understanding, oversight, monitoring, quality improvement, and the provision of direct services.

- **Career Pathways.** A category of the MHSA Workforce Education and Training component to increasing the number of consumer and family members enrolled in mental health education programs and the number employed in the public mental health system.

- **Columbia College.** Columbia is located in Tuolumne County, a small rural community is the Sierra Foothills. Columbia offers Associate in Arts Degrees, Associate in Science Degrees, Associate in Science (Occupational Education) Degrees, and Certificates of Achievement that can be completed in two years.

- **Consumers.** Consumers are active or past clients of the public mental health system. Taken from MHSA language.

- **Family Members.** Family members refer to relatives of past or present consumers (clients) of the public mental health system.

- **Mental Health Services Act (MHSA).** MHSA (or Proposition 63) was approved by voters in 2004 to impose a 1% tax on income in excess of $1 million to increase county mental health funding. The Act addresses prevention, early intervention,
and service needs as well as infrastructure, technology and training elements that will support this system.

- **Peer.** A Peer is someone who shares a like experience or background with someone else as part of a group. In the context of Behavioral Health Services, it is someone who shares personal experience with mental illness and or substance abuse. May also provide services or support to other peers.

- **Peer Support.** Peer Support is a concept of mutually interdependent relationships which promote wellness, harmony, and a culturally-congruent sense of self beyond the disabling effects of the condition known as mental illness. S/he encourages the individual to exercise choice and the right of self-determination in pursuit of a life fully lived.

- **Psychosocial Rehabilitation.** Psychosocial Rehabilitation, or Social Rehabilitation, is based on a fundamental belief in the capacity of individuals to grow beyond the disabling effects of their diagnosis. Psychosocial Rehabilitation involves the creation of an intentional community with attention on the interconnections of consumers with their social and physical environments.

- **Recovery.** Recovery in a mental health context refers to regaining a meaningful quality of life by someone with mental illness. Recovery is a deeply personal, non-linear experience, which begins with acceptance of the illness and occurs as the individual develops a new sense of self, which incorporates the reality of having a severe mental illness. Recovery in a substance abuse context refers to the process of reducing the dependence of a substance abuse or alcohol addiction.
• **Supported Education.** Supported education is the process of helping people with a diagnosis of mental illness and/or substance abuse addiction to participate in an education program so they may receive the education and training they need to achieve their learning and recovery goals.

• **Workforce Education and Training.** Workforce Education and Training is a component of the Mental Health Services Act that provides dedicated funding to remedy the shortage of qualified individuals to provide services to address serious mental illness and to promote the empowerment and employability of consumers and family members in the public mental health workforce.

**Assumptions**

This research project aims to deeply examine as many aspects of the CCBHS supported education program as possible in order to determine its actual benefits. However, there are a few assumptions the researcher has made. First, it is assumed that all those registered in the Peer Support course have had some form of personal experience with mental illness and thus are interested in improving emotional wellbeing. Second, it is assumed that most participants from Calaveras County have engaged the program through CCBHS; whereas most participants from Tuolumne County have not received similar supportive services as part of their enrollment. Lastly, it is also assumed that the particularly small sample size would be representative of a larger group. Without any way of determining the above factors as part of this study, the researcher asks that readers assume these premises to be true.
While not a prerequisite, the Psychosocial Rehabilitation certificate program was marketed toward those with some sort of experience with mental illness, either personally or through a family member. Thus, students would likely seek an outcome of improved emotional wellbeing as a result of participating in the course, and would benefit from supportive services. The Peer Support class in particular is designed to help people with “lived experience” with mental illness (and co-occurring disorders in addition to mental illness) to reach out and support others with a similar background. However, it may very well be that some course participants heard about the program through the college catalog or some other means and may not have similar motivations as the target population.

Also, even though most participants are likely engaged in mental health services either from CCBHS or the Tuolumne County Behavioral Health Department (TCBHD), it is highly probable that only Calaveras County participants were offered supportive services through their behavioral health department as TCBHD does not currently have an active supported education program. However, both groups have access to supportive services through Columbia College. The course evaluation inquires about these services and this study will examine those results as well.

Lastly, because Columbia College supports a small, rural population, class size is typically much smaller than that of urban schools. In addition, the Psychosocial Rehabilitation program is a specialized certificate that does not necessarily have mass appeal with students who do not have personal experience with behavioral health challenges. While the retention rate for the Peer Support course has been between 60-80%, the targeted population for this class may struggle with symptoms of some form of
mental illness, which may necessitate dropping out of the program. Consequently, the pool from which the secondary data was obtained is significantly limited. However, course evaluations from two Peer Support classes make up the secondary data for this study, which should be representative of a larger group in the future.

Justifications

After an exhaustive search and review of the literature, this appears to be the first study to determine the emotional wellbeing benefits of a rural supported education program. Once these outcomes are identified, the benefits of a higher education, particularly one in psychosocial rehabilitation, can be translated into a peer support intervention, which can then be utilized by CCBHS and other rural communities to generate billing revenue. The rural workforce education and training programs created through the MHSA Workforce Education and Training component would also be able to show positive outcomes for consumers and family members despite a current lack of employment in the public mental health system, which will ensure a significant measure of program success even during times of economic downturn.

If this study shows positive outcomes, then obtaining a job in the public mental health system will not be the only (or perhaps even primary) reason to participate in supported education. Evidence that higher education in psychosocial rehabilitation can assist consumers to meet their behavioral health recovery goals can translate into billable time and additional revenue to fund the supportive services that promote participant success. As Medi-Cal billing is often what keeps public mental health departments afloat,
identifying new and effective ways of providing treatment can expand local revenue. Most importantly, these new ways of supporting behavioral health benefit the consumer.

In addition, the study will hopefully lead to additional research in the area of rural supported education and alternative forms of therapeutic activity that can benefit those in mental health recovery. MHSA has done much to fund the efforts of small, rural counties to improve mental health services and to find new and innovative ways to support those with behavioral health challenges. The rural programs funded by MHSA have received statewide and national recognition. Some outcomes are according to plan, and others have produced unanticipated yet pleasant surprises. However, it is the research and analysis of these programs that will lead to additional funding opportunities and potential program replication in the future.

Limitations

The researcher also acknowledges some limitations to the scope of the study. Beyond the Peer Support course and the supported services offered by CCBHS and Columbia College, there may be other variables that could contribute to participant success, such as financial security, strong family support, or previous experience attending a community college. There may also be additional variables that limit participant success, such as type of mental illness and severity of symptoms. To protect participants, sensitive information was not be collected or addressed as a variable. To promote the external validity of this study, every attempt was made to report non-sensitive additional variables, if and when encountered. However, the intent of this research project is not the study of these external variables, but rather the specific
benefits of the course itself and the efficacy of any accompanying supportive services offered by CCBHS and/or Columbia College.

In addition, this study did not examine the outcomes and benefits of the other psychosocial rehabilitation courses, including Helping Skills A and B, Introduction to Psychosocial Rehabilitation, and Work Experience. As Peer Support is the recommended first course of the program, and likely the most appealing to behavioral health consumers, course evaluation data from this course was the only data set utilized by this project. In the future, the researcher intends to collect data on all courses to evaluate the benefits of the psychosocial rehabilitation supported education program as a whole.

Lastly, the study did not examine the supports offered by Tuolumne County Behavioral Health Department as they do not have a formal supported education program as part of their sponsorship of the courses at Columbia College. The Department originally intended to offer a program similar to CCBHS, however funding and staffing shortages prevented them from offering any formal support. Although Tuolumne students may not receive services from the Behavioral Health Department, all students are offered supportive services by Columbia, including assistance with enrollment and registration, financial aid, and accommodations for disability. The study focused on these services as an additional source of support.
Chapter 2

LITERATURE REVIEW

Introduction

For the past several decades, consumers of behavioral health have begun a recovery movement that has changed the way therapeutic support is provided. As a result, “treatment” began to extend far beyond talk therapy, drugs, and institutionalization. Advocacy groups emphasized that consumers want and need the same things that many others take for granted: a fulfilling and meaningful life. Mental health services began to include programs to support consumer education, employment, and housing. The impetus behind many of these initiatives was to help consumers become contributing members of society. However, as consumer participation increased in these community-based programs, it appeared that their emotional wellbeing also increased in ways traditional treatment had not been able to achieve.

In particular, several states began to invest in supported education programs to promote consumer success in school. Typical programs include orientation to community college, hands-on help with registration, as well as assistance with tuition and fees (Chandler, 2008). Support and study groups are integral to supportive services; these are often provided by “peers,” or other consumers who have completed a similar education program. Supported education programs can be cost effective as many consumers are considered disabled, which along with very limited income, make them eligible for Board of Governor’s Waivers. Thus costs can be limited to fees, books, and staff time.
In order to identify the actual effects of supported education programs, several studies have been conducted to determine both employment outcomes and changes to emotional wellbeing. Three major studies have been conducted; one in Chicago and one in Michigan, and a comparison study of East and West Coast supported education programs. Published research results have varied. Some studies show significant improvement to participant employment and emotional wellbeing, whereas others show no change at all. The researcher found no studies which assert that supported education has a negative effect on employment or wellbeing. After an exhaustive search and review of the literature, it appears that no studies have been conducted on supported education programs in rural areas, which have been particularly impacted by educational and geographical challenges unique to these communities.

This literature review will discuss the background of traditional mental health versus the recovery movement, the latter of which stresses the need to promote the emotional wellbeing of behavioral health consumers. A current overview of supported education will also be provided, with references to leading experts in both recovery and psychosocial rehabilitation. The literature on three major studies will then be reviewed, along with some of the positive and negative results that researchers have found thus far. Next, supported education program challenges will be highlighted, followed by an overview of rural-specific issues. Lastly, recommendations for successful supported education program will be discussed. Finally, this chapter will conclude with a summary of the literature review findings.
Background

In decades past, a diagnosis of mental illness often meant a lifetime in demeaning institutions or in a drug-induced stupor meant to control the unruly. A hundred years ago, one did not even need a medical diagnosis to be institutionalized; being a part of a minority group or in any way stepping out of social norms could result in a commitment to a mental institution. More recent traditional therapy could include preschool-like arts and crafts or stigmatizing field trips in big white buses. In addition, the media has a long history of portraying those with mental illness as dangerous and unfit for society. All of these factors have contributed to the marginalizing and isolation of those with mental illness (Bellamy & Mowbray, 1998); a virtual annexation that has contributed to decades of stigma and discrimination of those who do not fit into social norms.

In addition to the external discrimination that those with mental illness face, the rejection by society often leads to an internalized stigma and significant loss of self-worth and the confidence needed to succeed in the mainstream. As the recovery movement gained steam, the importance of consumer empowerment came to the fore. The concept of mental health recovery emphasizes the ability of behavioral health consumers to reclaim a quality of life that provides them meaningful goals and pursuits beyond that of their diagnoses (Chandler, 2008, p. 1). Like all of us, behavioral health consumers need to feel a sense of control in their own lives and destinies; they too need to feel like they have an equal opportunity to achieve what many take for granted (Bellamy & Mowbray, 1998; SAMHSA, 2006).
Around this same time, the concept of self-esteem was also receiving more attention among experts in the field of behavioral health. In the 1980s, Virginia Satir emphasized the need for self-esteem among youth and adults alike; as a result of her extensive work Satir virtually canonized the term “self-esteem” into the therapeutic vocabulary. In terms of psychosocial rehabilitation, which also proliferated in the 1980s, self-esteem is “based on the assumption that improved functional status leads to higher self-esteem” (Torrey, Mueser, McHugo & Drake, 2000, p. 229). According to leading experts on this shift, on par with self-worth was the need for hope, “that people can and do overcome the barriers and obstacles that confront them. Hope is the catalyst of the recovery process” (SAMHSA, 2006, p. 1).

Within the recovery movement however, it was still unclear what determined hope and self-worth for behavioral health consumers. There was little research to support that education or employment alone had any direct correlation to improving consumer self-esteem (Torrey, Mueser, McHugo & Drake, 2000). Nonetheless, most researchers agreed that without a solid hope for the future and a sense of self-worth, or self-esteem, consumers would simply not have the confidence they needed to achieve their recovery goals, including a meaningful life and contribution to society (Mowbray, Collins, Bellamy, Megivern, Bybee & Szilvagvi, 2005). It was this disconnect that appears to have led to interest in supported education and a study of the benefits of programs in the more populated urban areas.
Supported Education

The concept of supported education stemmed from Psychosocial Rehabilitation concepts regarding consumer-driven services and programs (Unger, 1993; Egnew, 1993). As consumers became more professionally involved in the direction of their services, education became the pathway to a new career in mental health as well as a new way to make meaning of their lives. Like anyone, consumers wanted respect and acceptance as individuals and not just diagnoses (Bellamy & Mowbray, 1998). Consequently, supported education originally intended to support consumer career advancement, individualization, dignity, and hope (Chandler, 2008; Mowbray, Korevaar, & Bellamy, 2002). Supported education would allow “individuals to trade the identity of mental patient for that of student and may lead to job and career advancement” (Chandler, 2008, p. 1).

As universities began to acknowledge the need for structured programs that would support consumer-driven services, several pilot projects were implemented including the five year Continuing Education Project (CEP) initiated by Boston University’s Center for Psychiatric Rehabilitation in 1983 (Unger, 1993). The CEP led to similar career development programs that later became the foundation for supported education that “promoted collective empowerment by providing a mutual help-group atmosphere and by involving students in the programmatic development” (Bellamy & Mowbray, 1998, p. 409). The legislature also appeared to acknowledge the need for improvement in supporting disabled students as evidenced by increased funding for this purpose. With added federal and state funding came rules and restrictions that still govern how supported education operates.
As supported education became more defined and structured, the goals began to coincide with those of psychosocial rehabilitation (or social rehabilitation) including normalized community integration, access to resources including college, and the skills needed for study and symptom management. Consumers were encouraged to reclaim opportunities they may have lost because of their illness, to explore their options, and to pursue individual goals that could define them as something other than patients (Dalquist, Stafford, Patterson, Baptista, Hosseini, Sherman & Curran, 2007; Collins, Mowbray & Bybee, 2000). Higher education, often starting with community college programs, became the first step for many consumers in reaching their individual goals. With the support of disability services, consumers began to enroll in courses that would help them understand themselves and support others.

With the passing of the Mental Health Services Act (MHSA), several counties in California were able to fund well-defined supported education programs, including the one in Calaveras County. According to the California Department of Mental Health, MHSA education and training funds were intended to improve mental health services, through the inclusion of consumers and family members with experience in the public mental health system (2008). A California Mental Health Planning Council task force noted: “Increasing opportunities for employment for consumers would produce many benefits for them. The Task Force identified consumer employment not just as a means of contending with California’s human resources crisis but also as part of an empowerment vision of recovery” (2003, p. 5).
**Major Studies**

The research on effects of supported education appears to be limited to a few major studies and evaluations of other strictly urban programs. Early studies were fairly simplistic in form and appear to have begun in 1984 as presented in the article "Education for the young adult chronic client" (Chandler, 2008, p. 1). However, there are three major studies that are often referenced in connection with supported education. These include the Chicago-based Community Scholars Program (Cook & Solomon, 1993; Razzano, Pickett, & Cook, 1997), the Michigan Supported Education study (Collins, Bybee, & Mowbray, 1998; Collins, Mowbray, & Bybee, 1999a, 1999b, 2000; Mowbray, 2000; Mowbray, Bybee, & Collins, 2001; Mowbray, Bybee, & Shriner, 1996; Mowbray, Collins, & Bybee, 1999), and a comparison of two programs on the East and West Coast (Unger, 2000; Unger & Pardee, 2002). These studies have formed the basis of this literature review, although it must be noted that none are from a rural area, which this study specifically addresses.

In the Chicago Program, Cook, Solomon, Razzano, and Pickett queried 102 participants prior to beginning vocational and trade school programs during a three year study period. Of those queried, 84% had a high school diploma or General Education Development (GED) certificates. In addition, 50% had attended some college, and 11% received a degree. The average age of participants was 29 years of age. In all, 86% of participants were taking psychiatric medications and most reported a history of multiple psychiatric hospitalizations. Educational supports included remedial education, individual
assessment, life skills training and onsite case management. At the end of the three year study, 42% of participants completed at least one course (Chandler, 2008).

The three-year Michigan study began at Wayne Community College in 1992 with 397 participants. These were provided one of three conditions defined as support group, classroom, and individual. Those classified as “individual” were designated as the control group. Groups met twice a week to provide peer support (Bellamy & Mowbray, 1998). The average age of participants was 36. Around 75% had a high school diploma or GED certificate, with 25% stating they had not yet completed high school. Approximately 50% reported some college. On average, participants had been receiving mental health treatment for 14 years. When participants were interviewed a year later, 43% dropped out after the initial orientation session. However, 21% were fully participating in educational programs compared to the 10% at baseline (Bellamy & Mowbray, 1998; Chandler, 2008). When participants graduated from the program, researchers found that “group members participated most, followed by classroom participants, then those assigned to the individual condition” (Chandler, 2008, p. 1). Among graduates, 46% of the group members were employed or in school. Most importantly, Bellamy and Mowbray noted “major transformations of self in line with recovery goals occurred” (Chandler, 2008, p. 1). It is significant to note that aspects of individual mental health variable such as diagnoses did not seem to affect outcomes.

A third major study compared two programs on the East and West Coast with a total of 124 student participants. Inclusion was based on random selection, with all others excluded. Among employed graduates, 71% stated that education provided them the
skills they needed to do their current jobs (Chandler, 2008). Unger and Pardee also analyzed outcome differences between the two programs; “few statistically significant differences were found, perhaps due to many common program elements” (Chandler, 2008, p.1). In all, Unger and Pardee found no significant changes in quality of life or self-worth in either program.

Positive Results

Aside from the studies highlighted above, researchers have reported additional outcomes of supported education beyond course completion rates and post-education employment. For instance, according to some researchers (Goldman & Lakdawalla, 200; Goldman & Smith, 2002; Fuchs, 1982) supported education in appears to be contributing to consumers’ ability to process information about their diagnoses and make healthy decisions about the services offered to them (Chevalier & Feinstein, 2007). Studies in Great Britain have found “increases in self esteem, social functioning, independence, cognitive abilities, and confidence” (Isenwater, 2002, p.1). These are crucial results as they reinforce that supported education can provide participants with the skills and comfort level to achieve their recovery goals, which often include employment and/or additional education.

Outcomes from additional studies have included increased normalization in the community, increased consumer confidence, decreased stigma and discrimination, and decreased rates of hospitalizations (Barton, 1999; Chevalier & Feinstein, 2007; Isenwater, 2002; Collins, Mowbray & Bybee, 2000). Researchers have found other unintended results in conjunction with supported education. It is evident that most
supported education programs have the goal of consumer employment and/or the development of core competencies to help consumers reach their recovery goals. However, several researchers have reported additional outcomes of empowerment, self-awareness, and peer advocacy among consumer participants (Bellamy & Mowbray). These studies lend credibility to the theory that supported education need not be strictly limited to employment outcomes.

The findings above correlate with the results of Michigan’s supported education program. Researchers studying the Michigan program found that students with “greater participation [in the education program] showed greater quality of life, empowerment, school/vocational enrollment, and encouragement from mental health workers” (Bellamy & Mowbray, 1998, p. 404). This type of empowerment is essential for consumers to reach their recovery goals, become part of a meaningful community, and improve the public mental health system from within. The ability to make and meet subsequent goals (such as additional school/vocational enrollment) may indicate increased confidence and a willingness to take on new things.

The study of the Chicago supported education program also found promising results. Researchers for that program found that “major transformations of self in line with recovery goals occurred” among participants (Chandler, 2008, p. 1). Their findings also highlight an important distinction. The study placed an emphasis on the participant’s recovery goals versus sole emphasis on program goals of employment and/or continued participation in an educational program.
All of the studies that showed positive results emphasize the importance of personal outcomes for the participant, particularly those related to mental health recovery. According to the leading studies referenced above, there appears to be a solid foundation regarding the overall employment and emotional wellbeing benefits of supported education, particularly in psychosocial rehabilitation. That said, researchers have also found some negative results from studies that will be highlighted below.

**Negative Results**

While the positive results of supported education are clearly supported in the literature, it is worthwhile to note the negative results in order to clearly examine what does not work. For example, while the Michigan and Chicago programs appear positive, the comparison study of East and West Coast supported education programs did not find any significant outcomes around quality of life or self-esteem—either positive or negative. In addition, when comparing the two programs, researchers found little differences in programmatic features or outcomes, which further limited the value of the comparative study (Chandler, 2008). The lack of significant findings does not necessarily negate the success of supported education; instead it seems to point to a need for further study, particularly comparison studies of distinctly different programs (i.e. urban supported education programs versus rural programs).

The most notable study with negative findings was written by Salzer, Wick, and Rogers in 2008. A study of the completion rates among supported education programs found that 86% of consumer participants drop out before completing their program compared to 37% among the general student population (Salzer, Wick, & Rogers, 2008).
The study also found that barriers to course completion included prolonged absences from school due to psychiatric hospitalizations as well as the early onset of mental illness among younger students (Salzer, Wick, & Rogers, 2008). Salzer, Wick and Rogers noted that significant discrepancies in dropout rates may be a result of symptoms associated with a consumer’s specific mental illness.

While these findings are clearly negative, it is not surprising to encounter significant dropout rates among consumers with serious mental illness, particularly if their illness is not being effectively treated at the time and the consumer becomes highly symptomatic. Individual drop-out rates may also be linked to a lack of encouragement from mental health workers or other supportive service providers, which the literature shows may greatly contribute to consumer success and higher course completion rates (Bellamy & Mowbray, 1998, p. 404). Either way, depending on diagnosis, consumers may have a difficult time completing any structured program—not just supported education. Nevertheless, many consumers may return to college or universities when symptoms subside, and end up completing their program.

While not directly addressed in the literature, transportation is a major barrier that often impacts the success of supported education participation and course completion rates. This is particularly true for rural areas that may not have local community colleges or universities within their county borders. In addition, behavioral health consumers are often without personal vehicles, due in part to a lack of income or legal infractions that have resulted in the revocation of their driver’s license. Rural consumers are especially affected by geographic barriers, as rural areas typically have less income opportunities in
order to fund a car, gas, or insurance. These consumers often need to travel much farther in order to obtain services, education, and employment. Public transportation is often not a viable option in rural areas.

Overall Challenges

There are a number of challenges that supported education programs must address in order to support student success and course completion rates. Community colleges in general have been struggling with their retention rates among the general population who do not have the unique barriers that behavioral health consumers face (Povich, 2006). While on-campus disability services exist, many consumers do not realize that these offices can offer them accommodations for their disability as well as additional supports (Salzer, Wick, & Rogers, 2008). Also, the individual deficits related to mental illness that supported education seeks to improve may contribute to an 86% dropout rate among consumer participants. These barriers include an inability to manage symptoms, a lack of overall confidence in community settings, and poor study skills that limit full participation in education programs (Salzer, Wick, & Rogers, 2008).

Consumers receiving social security disability insurance benefits often struggle with very low fixed incomes and may find it difficult to pay for tuition and fees, as well as other school expenses. Inability to pay may qualify consumers for Board of Governor tuition waivers; however the cost of books and transportation may prevent them from moving forward. Unfortunately, not all supported education programs provide the assistance needed for these types of expenses.
Community perception of those with mental illness and/or substance abuse disorders is an ongoing challenge. Stigma and discrimination against behavioral health consumers may prevent community colleges from reaching out to this population. The media has done much damage in representing those with serious mental illness as a threat to society. Newscasters that overly-emphasize a “campus shooter” as mentally ill do not necessarily shed light on the need for increased screening and mental health services that consumers need on campus—rather they too-often sensationalize tragedies. As such, consumers may avoid engaging in a school community in fear of the stigma they expect to face (Bellamy & Mowbray, 1998)

Community colleges also lack the marketing to appeal to underserved groups (Mowbray, Megivern & Holter, 2003). Particularly as community colleges face ever increasing budget cuts, these institutions have less and less funding, especially for marketing and specialty programs that may not appeal to a wide population. Conversely, consumer stakeholder groups also lack the marketing to target community colleges in their advocacy and encourage them to reach out and create programs for those with mental illness and/or substance abuse disorders. In order to achieve success, particularly in rural areas, it is essential for colleges, advocacy organizations, and public behavioral health departments to work together to reduce on-campus stigma, increase supportive services targeted at behavioral health consumers, and to market to the consumer population in such a way that they feel welcome on campus.
Rural Issues

Challenges and barriers to providing supported education services are significantly compounded in rural areas. People become geographically disconnected by miles of two-lane highway and dozens of acres between neighbors. As a result, despite their typically tight-knit communities, rural residents are often much more isolated than their urban counterparts. Rural areas also experience higher rates of co-occurring mental illness and suicide, with approximately 40% of those with mental illness reporting substance abuse and higher rates of suicide attempts (U.S. Department of Health and Human Services, 2007). Behavioral health consumers are further isolated by a lack of income, poor transportation, and few natural supports. In addition, a consumer’s individual symptoms and widespread social stigma around mental illness create a social isolation from the community as a whole (Gustafson, Preston & Hudson, 2009; Murphy, Mullen, & Spagnolo, 2005).

Rural communities are often perceived as pastoral, quaint little towns that exemplify a simpler way of life, such as the fictitious prairie towns portrayed on the Little House on the Prairie or The Andy Griffith Show. However, most common representations of ‘Rural America’ do not reflect the real challenges faced by rural communities. These often isolated rural areas “grapple with issues of substantial ethnic and cultural diversity, deteriorating infrastructure, pervasive poverty, limited employment opportunities, and declining population bases.” (Sawyer, Gale, & Lambert, 2006, p.9; Mullen, & Spagnolo, 2005). These same barriers work against anyone trying to obtain a higher education, and
particularly affect behavioral health consumers who have far fewer resources than even a ‘typical’ rural resident.

In spite of significant challenges, Rural America has unique strengths that contribute to the provision of supportive services. “Rural people and places are creative, resilient and build their communities upon the strength of their relationships” (Richgels & Sande, 2009, p. 17). While the lack of anonymity may at times be a barrier, the familiarity creates a sense of community that consumers can tap into for supports. These communities can become families for those without natural supports and can wraparound someone in need the way a public agency might for someone in crisis. Similarly, the lack of rural funding is clearly a challenge; however necessity has led to increased collaboration and creativity in service provision. As a result, rural communities have developed innovative ways to support mental health recovery, including unique supported education programs.

One of these programs is the Supported Education Career Ladder in Calaveras County. In 2010, this program won the prestigious Innovation Award from the California State Association of Counties (CSAC). According to CSAC, Calaveras was able to create two relatively cost-effective supported education programs, “despite occupational shortages due to geographic barriers, inaccessible educational opportunities, and a lack of local colleges and universities” (California State Association of Counties, 2010, p. 2). This program was also recognized by the Compendium of Rural Best Practices/Models as an Innovation to Strengthen Rural Health Care in the area of Workforce Development (National Rural Health Association, 2010). Calaveras’ supported education program has
experienced a course completion rate ranging from 60 to 80 percent—which is significantly high compared to similar urban programs.

*Recommendations*

From a macro perspective, in order for behavioral health consumers to fully succeed in college-level education programs, more is needed than just the provision of therapeutic services such as medication management, support groups, and assistance with tuition or transportation. Normalizing consumer participation in educational institutions and in the workforce is vital to reducing stigma and increasing opportunities for growth (Murphy, Mullen, & Spagnolo, 2005). Communities and educational institutions need to take on a meaningful role in developing natural supports for those who are underserved by the public and disadvantaged by the economy (Murphy, Mullen, & Spagnolo, 2005). By creating supportive communities, those who are socially isolated can become fully contributing members of society, which will no doubt increase the emotional wellbeing of the individual and the community itself.

On a micro level, it is essential for mental health professionals to embrace innovative ways of supporting consumers and collaborating with colleges, community-based services, and advocacy groups (Bellamy & Mowbray, 1998; California Institute for Mental Health, 2010). Finding new ways to bill for the supports consumers need to succeed outside of the behavioral health clinic is the only way to truly support each consumer’s unique recovery goals. Innovation is needed to see beyond the constricted rules and regulations of state and federal funding; however, such creativity is not impossible. In addition, the ability to bill sources such as Medi-Cal for services like
supported education will also bring in much needed additional revenue into the public
behavioral health system, which can then sustain these more innovative programs.

In order to serve all those with disabilities, supportive service agencies on and
off-campus must continue to combat the tendency to silo their efforts and limit their
services to those they perceive as their target population. On-campus disabled student
services may need to get creative when serving persons with disabilities that might not
seem as obvious as a wheelchair or walking stick, as less obvious conditions may be
more difficult to accommodate. Creatively serving behavioral health consumers often
requires service providers to “think outside the box” in order to identify atypical supports
that may be needed to ensure student success. For instance, someone who hears voices
may benefit from a tape-recorder for lectures or they may need an old Blue Tooth headset
to wear on campus in order to avoid strange looks when he or she responds to those
voices. By working closely with both students and their mental health support staff,
disabled student services can tailor their supports to meet the greatest need.

Lastly, agencies need to pool their funds so that supported education programs
can provide for all of the expenses associated with promoting student success among
participants. This is especially true for small, rural counties who often have limited
funding available for innovative programs. For the supported education program in
Calaveras County, Tuolumne County co-sponsored the courses offered at the local
community college within their jurisdiction. The Department of Rehabilitation has also
brought agencies together in order to pull funds and create supported education and
employment programs (California Institute of Mental Health, 2010). When it comes to
supporting others, no agency is as strong alone as they are when combined with the resources, experience, and skills of another organization.

Summary

Over the years, mental health treatment has evolved from psychiatric institutionalization, traditional talk therapy, medication management. While these are still “big business” in the behavioral health industry, in recent years, the rise of the consumer movement has greatly influenced what therapeutic treatment looks like. The Medical Model has been replaced by a Client-Led Model, which has given rise to increased consumer empowerment. Consumer advocacy has led to new and innovative community-based programs in supportive education, employment, and housing. In order to improve the system from within, consumer participation and employment has increased in the public behavioral health system. Perhaps more importantly, research continues to show that consumer wellbeing increases as a result of participation in these innovative programs—in ways that traditional treatment has not been able to achieve in the past.

Funding such as that from the Mental Health Services Act has increased opportunities for public agencies to create programs within the community to educate consumers for the workforce. Partnerships with agencies such as the Department of Rehabilitation have also led to innovative collaborations to support consumer educational and employment. Despite a current lack of employment opportunities, especially for behavioral health consumers, behavioral health agencies have experienced significant success through their supported service programs. These programs, such as those that support college-level education for those with serious mental illness, have empowered
consumers to more fully participate in their communities and to recover a rich and meaningful lifestyle that was lost as a result of their illnesses.

With the shift toward consumer recovery, supported education programs to promote consumer success in school have been implemented nationwide. Several of these programs have been studied to determine both employment and emotional wellbeing outcomes. Results from three major studies in Michigan, Chicago, and the coastal states have varied; however, most studies show positive results. Unfortunately, it appears no studies have been conducted in rural areas, which have been particularly impacted by the unique educational challenges.

This literature review has discussed the background and benefits of supported education. While literature exists on three major studies, as well as additional positive and negative findings of supported education in general, there does not appear to be sufficient research on rural supported education programs. Given the challenges faced by rural communities, it is necessary to research programs in these areas, such as the one in Calaveras County, in order to determine the outcomes and recommendations for rural supported education.
Chapter 3

METHODOLOGY

Introduction

The intent of this study was to determine if higher education in psychosocial rehabilitation improves emotional wellbeing for rural behavioral health service consumers, and if so, what aspects of their educational experience are most beneficial. Thanks to funding from the Mental Health Services Act (MHSA), Calaveras County Behavioral Health Services (CCBHS) implemented a supported education program in conjunction with psychosocial rehabilitation courses offered at Columbia College, in nearby Tuolumne County. A major intent of the MHSA funding is to educate mental health consumers and family members for employment in public mental health. Unfortunately, due to county budget constraints, few positions are available.

However, despite a lack of job opportunities, the supported education program appears to be successful. CCBHS has seen a notable increase in volunteerism, community involvement, and other indicators of emotional wellbeing among supported education program participants. It is unclear, what measurable outcomes of success the program may be experiencing. The increase has prompted an interest in studying the actual emotional wellbeing effects of the program, the course and educational supports offered to participants, and the program participants themselves. The study hopes to identify 1) the unique emotional wellbeing benefits experienced by program participants and 2) what aspects of the program are most successful in promoting student success and course completion.
The study proposed that the independent variables of psychosocial course material and educational supports offered in Calaveras County could lead to the dependent variable of improved emotional wellbeing for consumer participants. The study acknowledges there may be additional variables not tied to the psychosocial rehabilitation courses at Columbia or the supported education services offered by CCBHS. The study sought to identify these variables as they existed to the extent possible within the research methodology.

Once identified, it was hoped that these benefits could be translated into specific therapeutic interventions that could be utilized by CCBHS and other rural communities to improve consumer wellbeing and contribute to behavioral health recovery goals. If such a link were to be established, then the rural workforce education and training programs created through MHSA funding would be able to show positive outcomes for consumers and family members despite a current lack of employment in the public mental health system. This causal link would then establish a significant measure of program success even during times of economic downturn.

This chapter on Methodology outlines the study design utilized to obtain the information needed to establish the effectiveness of the CCBHS supported education program. The study sample is described in detail, followed by a description of the data collection techniques. The chapter discusses the data analysis approach used in order to determine program outcomes. A summary follows, including an overview of the next steps of the project.


**Study Design**

Determining the emotional wellbeing benefits of the psychosocial rehabilitation supported education program sponsored by CCBHS was accomplished through an exploratory study of this new area of learning. This project uses a pre-experimental design with a program evaluation post-test survey. This study was approved by the California State University, Sacramento, Division of Social Work Committee for the Protection of Human Subjects (Appendix A). It utilized a pre-experimental design based on the analysis of secondary quantitative data in the form of a course evaluation obtained by the instructor (Appendix B). The course instructor obtained informed consent from students and authorized the researcher to use his evaluation data, both of which are attached (Appendix C and D).

The course evaluations were designed to query where students are from, how satisfied they were about the course, whether they accessed supportive services from their county behavioral health department or from the college directly, if students felt that these services were essential to completing the course, if their participation increased their emotional wellbeing, and if so, in what ways was their wellbeing improved. It was expected that these program evaluation surveys would show an increase in emotional wellbeing among participants, irrespective of any additional services participants may have engaged. However, it was also expected that student responses regarding supportive services would show a direct correlation to increased wellbeing, if such services were accessed. Lastly, the researcher expected to see a correlation between Calaveras County
students and the engagement of supportive services, as CCBHS actively promoted the program and had extensive supports to provide their students.

In evaluating the actual benefits of psychosocial rehabilitation supported education program sponsored by CCBHS, this study was designed to address the following questions: 1) Are there unique emotional wellbeing benefits experienced by program participants? 2) What is the impact of supported education programs in the improved well being of participants? 3) What type of program participants (i.e. demographics) succeed with the curriculum and supportive services and which ones struggle and/or drop out?

Improved emotional wellbeing was determined through the attached anonymous program evaluation administered by the psychosocial rehabilitation instructor at Columbia College. The instructor utilized this survey to determine his student’s demographics, satisfaction with the course, access to supportive services (if any), and emotional wellbeing outcomes (if any). The evaluation was administered on the last day of class. The instructor distributed the program evaluation along with an informed consent packet and instructions. After providing this information and answering any questions, the instructor left the room so that students could fill out their evaluations in true anonymity. Students placed the evaluations in a sealed envelope (separate from the sealed envelope containing the informed consent forms that the instructor retained in a locked cabinet). Evaluations were given to the researcher by the instructor and the researcher entered the evaluations into an online survey tool. Aggregate results were shared with the instructor and other parties related to the research.
Study Sample

The secondary data used in this study included students participating in the Spring 2011 and Fall 2011 Peer Support classes at Columbia College. Students participating in the Peer Support class were the only ones studied as Peer Support is recommended as the first course in the Psychosocial Rehabilitation Certificate program. It was the first course for many program participants. It was expected that 15-20 students would be surveyed in each course, with an expected minimum of 25 responses for the duration of the study.

The focus of the study was a program evaluation post-test to determine emotional wellbeing at the end of a Peer Support course. The evaluation obtained demographic data and determined which aspects of the supportive services offered to participants were most beneficial in assisting the student in completing the course. The evaluation queried students regarding their perception of the course, if the course increased their emotional wellbeing, and if so, what specific areas of emotional wellbeing were improved.

Participants were students from both Calaveras and Tuolumne Counties. The psychosocial rehabilitation program offered at Columbia College, and particularly the Peer Support course, was targeted toward persons who have lived experience with mental illness and/or substance abuse. These courses are designed to bring out self-awareness in participants and help them to support others with a similar background. As such, it was assumed that many students would have some form of mental illness and/or substance abuse disorder, which may work against their completion of the course and contribute to the low sample size for this study. Reflecting the population, the researcher predicted that a range of ages and backgrounds would be participating in the program. However, as
more people tend to retire in rural communities, it was expected that there would be more older adults than younger ones.

The data set available for this research project is small, in part because of the small sample sizes typical for rural areas, and because of student drop-out rates as described above. The researcher also acknowledges that the limited data set may impact the validity of the data and strength of the correlations. However, this limitation is typical when trying to obtain data to evaluate most rural programs and as such it is often unavoidable. The course instructor is committed to obtaining at least 30 responses over two semesters beginning May 2011 and ending December 2011, if possible.

Data Collection Techniques

Improved emotional wellbeing will be determined through secondary data taken from an anonymous Peer Support course evaluation administered by the psychosocial rehabilitation instructor at Columbia College between May 2011 and December 2011. The instructor was committed to administering this evaluation each semester in order to determine the basic demographics of his class, student satisfaction with the course, student access to supportive services, and emotional wellbeing outcomes (if any). The instructor also obtains informed consent from each participant and will retain the attached consent forms in a locked cabinet. The researcher will then obtain the secondary data directly from the course instructor and will input the information into an online survey data entry and reporting program (SurveyMonkey.com) for data collection, primary statistical analysis, and data graphing.
SurveyMonkey.com is a password protected online program that allows users to create surveys that can be taken anonymously, either online or via a printed version of the same survey. Responses from printed surveys can be entered directly into the system, as if the response was given online. Data can then be manipulated to sort by County, participants, or any other field. The researcher would be able to compare and contrast the results of the group as a whole with separate results for Calaveras and Tuolumne county participants. As Tuolumne County does not currently have a formal program to provide supportive services, this enabled the researcher to create a control group of sorts to compare with students in Calaveras who receive significant supportive services. The program will also generate charts and graphs, some of which will be used to illustrate statistical outcomes within this research project.

There was no conflict of interest in the data collection technique utilized by the researcher as the instructor employed by Columbia College administered the evaluation and collected the primary data. The researcher acknowledged it would not be appropriate to collect this data or obtain any additional data personally as the researcher is employed by CCBHS to administer supportive services and may have a professional relationship with several participants that could influence their evaluation responses. To ensure that the evaluation data provided by program participants is completely anonymous and unbiased, the researcher obtained this data in secondary form only.

To further protect participants and the validity of the evaluation data, the instructor conveyed to students that participation in the program evaluation was completely voluntary. The instructor obtained the attached informed consent from all
course participants so they were clear regarding their role, their ability to opt out, and the use of the data that they were providing. Students also had the opportunity to ask any questions they may have regarding the evaluation, informed consent information, or use of the data they provided. The instructor agreed to seal evaluations and limit access to only the researcher for data entry purposes. Informed consent forms were sealed in a separate envelope and retained in a locked cabinet by the course instructor. Results were reported in the aggregate by the researcher and shared with the instructor and CCBHS as related to the research.

Data Analysis Approach

This project analyzed the data using a pre-experimental design with a program evaluation post-test survey. To establish the cause and effect of the different components to the CCBHS program, the researcher used a factor analysis of multiple independent variables. These variables included the course itself as well as supportive services offered by CCBHS and by Columbia College that was expected to have a cluster effect on the dependent variable of improved emotional wellbeing. Student demographics were analyzed as a contributing factor to the cluster effect of improved wellbeing. While the overall statistical power of the data being analyzed was somewhat weakened by the relatively small sample size.

Data inputted into an online survey program (SurveyMonkey.com), which allowed the researcher to produce primary statistical analyses based on the questions and responses provided. Data was analyzed for correlations between student type, supportive services accessed, course completion, and ultimately, improved emotional wellbeing. The
correlations established the strength and direction of the relationship between education in psychosocial rehabilitation, access of supportive services, and a positive effect on student wellbeing, particularly for consumers of behavioral health services. Data was also downloaded into a format that can be read by Microsoft Excel for additional analyses, charting, and graphing.

It was expected that the data will show that significant correlations will exist between access to supportive services, course completion, and improved emotional wellbeing. This study hopes to find which supportive services have contributed most to student success. The data should also show what particular areas of emotional wellbeing are improved for students. For example, the study will find if emotional wellbeing is improved through a more positive outlook on the future, improved confidence, increased participation in the community, and other areas of emotional wellbeing as applicable. Knowing which supportive services are most beneficial and what areas of emotional wellbeing are improved will enable this program and others like it to customize their supportive services to meet consumer needs. This empirical data will also strengthen the use of supportive education as a therapeutic intervention.

Summary

In summary, the researcher will be conducting an exploratory study using a pre-experimental design with a program evaluation post-test survey in order to determine if higher education in psychosocial rehabilitation improves emotional wellbeing for rural behavioral health service consumers, and if so, what aspects of their educational experience are most beneficial. The data set will include anonymous course evaluations
from a minimum of 25 students participating in the Peer Support class as part of the psychosocial rehabilitation certificate program at Columbia College between May and December of 2011. Confidential data will be collected using SurveyMonkey.com, an online survey and data entry program. This data will then be reported in the aggregate, presented in this project, and shared with parties related to the research.
Chapter 4

RESEARCH FINDINGS

Introduction

As findings regarding the effects of psychosocial rehabilitation on consumers have been antidotal in the past, the opportunity to obtain hard data to support the benefits of this program was significant. A qualitative study would likely have net more of the same results already obtained by CCBHS; a number of students that verbally report interpersonal improvement after attending one or more of the classes associated with the program at Columbia College. Consequently, quantitative survey data was determined to be the best method to measure the actual impact of this program.

Given the size of the counties participating in the program and the size of the college itself, it was likely that the sample size for the data set represented in this research would be small. However, this was an initial study for this program, and as the literature review found, this may be an initial study for any program of its kind. The researcher hopes this study will lead to additional research in this area.

This section will introduce the demographics of the students participating in the Peer Support course of the Psychosocial Rehabilitation Certificate Program at Columbia College in comparison to local overall demographics. Next, there will be a discussion of the overall findings followed by the specific findings of the research. Last, the section will conclude with a summary of the findings from this initial study.
Demographics

Identifying who participated (and more specifically completed) the courses within the Psychosocial Rehabilitation Certificate Program is a significant part of the study. From an outreach and engagement perspective, a goal of the program is to attract a student body that is representative of the surrounding community. In addition, this data will assist CCBHS in engaging specific student populations in the future (i.e. older adults or Latinos). This data will also help the department to identify those who may not be attending or completing the sponsored courses in order to tailor their program to support those persons from dropping out.

For instance, as shown in Figure 1, the program has not attracted any Latino students, despite the growing population in Calaveras County. This is something CCBHS may want to examine as Spanish is a threshold language for the county and having Spanish-speaking Latino Peers with an education in psychosocial rehabilitation would be an asset to the community, aside from the mental health benefits to the participants. When this program was first launched at Columbia College, there were three Latina students (out of 12 students total), and the department offers scholarships for underserved populations including Latinos. Consequently, this discrepancy is noteworthy.

On the other hand, it is significant to note the percentage of Native American students participating in the program. While the actual number of participants may not be high, the percentage is reflective of Calaveras County’s demographics (see Table 1). This factor was of particular interest as CCBHS has had an ongoing challenge outreaching to and engaging Native Americans. Having trained persons is significant.
The figure above clearly shows a predominantly Caucasian majority among the student participants in the program. While diversity is typically preferred in most cases, and the department would prefer to have more Latino participants in the program, the percentage of Caucasian participants is representative of the surrounding counties (see Table 1). It is also possible that other races and ethnicities are actually represented but ambiguously reported as “Multiple” or “Other” race/ethnicity. However, as noted in Table 1, a significant number of people do consider themselves as “some other race” as reported in the 2010 census. As such, the data represented in Figure 1 may still be somewhat reflective of the local demographics as listed in Table 1.
Table 1

Profile of 2010 Calaveras County Demographic Characteristics (U.S. Census Bureau)

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<tbody>
<tr>
<td>White</td>
<td>42,216</td>
<td>92.6</td>
</tr>
<tr>
<td>Black or African American</td>
<td>590</td>
<td>1.3</td>
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<tr>
<td>American Indian and Alaska Native</td>
<td>1,618</td>
<td>3.5</td>
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<tr>
<td>Asian</td>
<td>944</td>
<td>2.1</td>
</tr>
<tr>
<td>Native Hawaiian and Other Pacific Islander</td>
<td>173</td>
<td>0.4</td>
</tr>
<tr>
<td>Some other race</td>
<td>1,955</td>
<td>4.3</td>
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**HISPANIC OR LATINO BY ORIGIN**

<table>
<thead>
<tr>
<th>Total population</th>
<th>45,578</th>
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<tr>
<td>Hispanic or Latino (of any race)</td>
<td>4,703</td>
<td>10.3</td>
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<tr>
<td>Mexican</td>
<td>3,560</td>
<td>7.8</td>
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<td>Puerto Rican</td>
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<td>Cuban</td>
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<tr>
<td>Other Hispanic or Latino</td>
<td>929</td>
<td>2.0</td>
</tr>
<tr>
<td>Not Hispanic or Latino</td>
<td>40,875</td>
<td>89.7</td>
</tr>
</tbody>
</table>

As Table 1 shows, Calaveras County is predominantly Caucasian with very small percentages of African Americans, Asians, and Hawaiian/Pacific Islanders. The largest minority populations represented in the county are Latinos, followed by those who identify as “some other race,” then Native Americans. Ideally, those participating in the Psychosocial Rehabilitation Certificate program would reflect this demographic make-up as closely as possible. In the two classes reporting, there have been no students who have reported as strictly African American, Asian, Hawaiian/Pacific Islander, or most concerning, Latino. One recommendation this study will make to CCBHS will be to increase outreach efforts to the Latino community for this program.
Overall Findings

While the sample size for this research is relatively small, the findings have been significant. Noteworthy results have been found in both the area of supportive services and emotional wellbeing outcomes. This subheading will lead with the supportive services that students engaged as these services appear to have a direct correlation to the magnitude of positive impact on each student. Next, the subheading will discuss areas of improved student emotional wellbeing (as an end result). The next section will address any associated contributing factors as found in the data.

To begin, in analyzing some initial data, the researcher discovered an interesting phenomenon. *All* students from Calaveras County engaged supportive services from CCBHS. Conversely, *no* students from Tuolumne County engaged similar services from their behavioral health department (in part because of a lack of capacity within the department, students were more likely to engage Columbia College support services). As such, Tuolumne students became somewhat of an unintentional control group to determine the correlation between supportive services and increased wellbeing.

The different supportive services engaged through CCBHS and Columbia College is illustrated in Figure 2 and 3 on the following page. Most utilized by Calaveras County students was clearly enrollment/registration assistance followed by financial aid and transportation assistance. Having the instructor available at the Peer Run Center in Calaveras also appeared to be a major support. At Columbia, most accessed academic counseling followed by financial aid. Also significant is the number of people who did not engage Columbia College services at all.
Figure 2

Supportive Services Engaged through Calaveras County

Figure 3

Supportive Services Engaged through Columbia College
While the data regarding who accessed supportive services from who was of interest, the statistics on the emotional wellbeing outcomes for Peer Support students was most remarkable. Of those surveyed, 100% of respondents would recommend this course to others. What is more, 100% reported that simply attending the Peer Support course improved their emotional wellbeing. Figure 4 shows the specific areas of emotional wellbeing that students were asked to self-assess upon completing their Peer Support class. The most substantial finding from this query is that at least some students showed improvement in all areas of emotional wellbeing—no category is left blank in Figure 4 other than “I see NO change in my emotional wellbeing.”

Figure 4

*Impact of Peer Support Class on Emotional Wellbeing*
Overall, it is significant to note that regardless of supportive services engaged, the aggregate results for all students queried shows the most substantial improvement to emotional wellbeing in the area of “Better Understanding of Myself.” The second most selected improved area of emotional wellbeing for this combined data set is “Better Relationships with Others,” followed by “Feel More Useful to Others.” Notably, most of the remaining areas of emotional wellbeing vie closely for fourth place.

For consumers who often struggle with depression and anxiety, among other disorders and symptoms, these outcomes are tremendous accomplishments after just four months of a once-a-week class. The areas of emotional wellbeing that students were asked to self-assess could just as easily be treatment plan goals. However, treatment for such goals often takes many months, sometimes years, of small groups or individual therapy. These results were accomplished in a fraction of the time with twice the capacity of a typical therapeutic group.

While going to college irrespective of the area of study may in itself provide certain benefits such as “More Confidence in Myself,” “Interested in New Things,” or “Closer to my Personal Goals” (see Figure 4), a course of study in psychosocial education appears to have the added benefit of teaching the students about themselves and those around them—a significant education for those with mental illness. Thus, the course in Peer Support seems to have an overall effect that one would expect to see for anyone returning to school, while at the same time has the added benefit of improving emotional wellbeing in the area of interpersonal understanding.
It is interesting to compare this study with data from Columbia College (Table 2). Given the small population of the Psychosocial Rehabilitation (PSR) Certificate Program in comparison to Columbia’s student body is likely that the majority of those queried by Columbia have not participated in the PSR program. Notably, the majority of students report that Columbia College (CC) had somewhat of a positive effect to no effect on their self-development, self-confidence, personal identity, or ability to cope.

Table 2

*Table 2*

*Columbia College (CC) 2010 Accreditation Student Survey (Columbia College)*
Specific Findings

Per the previous subheading, one of the more interesting and unexpected findings was the discovery of an unintentional control group. Clearly, Calaveras County students were the only ones accessing true supportive services sponsored by the behavioral health department, while Tuolumne County students relied on the class alone or limited services from Columbia College. Once the aggregate data was studied, an additional analysis was necessary to identify any correlations between access of supported services and improved emotional wellbeing—beyond simply taking the Peer Support course since that correlation had already been established. This led to a secondary analysis of the data, which created statistically significant differences between the two counties.

As expected, the data for Calaveras showed a stronger correlation between access of supportive services and overall improved wellbeing. Figure 5 illustrates an interesting phenomenon; compared to the respondents from Tuolumne County in Figure 6, Calaveras County students were much more likely to check off a greater number of improved areas of emotional wellbeing. While Calaveras students reported the same top three areas as the aggregate data, they appeared to experience greater overall improvement.

Tuolumne County students, however, seem much more conservative in their responses (Figure 6). Tuolumne respondents reflected more closely the aggregate data in that the top three responses stand out most clearly. Nonetheless, a significant number of students selected multiple responses in addition to the top three as Figure 6 suggests. It is noteworthy though, to see the figures side by side and to see the overall picture for each county as it relates to their access to supportive services.
Figure 5

Impact on Emotional Wellbeing for Calaveras County Students

Figure 6

Impact on Emotional Wellbeing for Tuolumne County Students
Summary

In conclusion, while small, the data for this initial research study has proven to be mighty. The demographics in themselves are interesting to note, primarily for CCBHS. It is hoped that the department will examine this information and look at ways to continue the successful outreach and engagement of Native American students and greatly improve its marketing to the Latino community.

Students seem to need specific services to succeed. According to the data, participants accessed assistance with registration, financial aid, and transportation most frequently. Students that accessed support services offered at Columbia College also took advantage of their academic and career counseling often. It also appears that having the course instructor easily accessible is another valuable support.

Having access to these types of supportive services appears to have a strong correlation to improved emotional wellbeing for participants in the Psychosocial Rehabilitation Certificate Program. While the students respond that Peer Support course completion alone improved their emotional wellbeing, those that accessed significant supportive services (such as those in Calaveras County) showed a greater number of improved areas of emotional wellbeing.

The areas of emotional wellbeing that students were asked to self-assess are significant, particularly because many participants are mental health consumers. The greatest areas of improved emotional wellbeing were greater understanding of self, improved relationships with others, and feeling more useful—all of which are incredibly therapeutic milestones for anyone, but particularly so for consumers.
Chapter 5

RECOMMENDATIONS

Introduction

According to data analyzed for this study, the Psychosocial Rehabilitation Certificate Program has had a positive impact on the emotional wellbeing of students; 100% of students responded that participation in the Peer Support course alone improved their wellbeing. When queried regarding specific areas of improved emotional wellbeing, those who accessed supportive services offered by CCBHS noted the most areas of improvement. While the program seems to have exceeded its objective (considering the original goal was increased employability), there is room for improvement.

For instance, the program should reflect the demographics of the surrounding community. However, 10% of the Calaveras County population is Latino and none of the students in the last two Peer Support classes queried identified as Latino. It may be that some Latino students identified as “Multiple Race/Ethnicity” or “Other,” but the survey did not allow for further detail beyond those descriptions. Additional areas for improvement involve the expansion of this study to capture additional detail regarding the needs and areas of improved emotional wellbeing for those with substance abuse disorders, older adults, and other populations that face mental health concerns.

This chapter focuses on the major findings of this study and will evaluate the hypothesis established at the outset of this project. Next the chapter will outline potential applications for the findings of this study. Lastly, areas of expansion for this study will be discussed followed by a concluding summary.
**Major Findings**

As was noted in the previous subheading, access to supportive services appears to increase emotional wellbeing among participants in the Psychosocial Rehabilitation Certificate Program at Columbia College. While all students in the Peer Support class report improvement, it seems that additional support contributes to increased engagement and success in class and a greater number of areas of improved wellbeing as a result. According to survey data, the supportive services students accessed most through CCBHS were assistance with registration, financial aid, and transportation.

Supportive services in general appears to have had a critical influence on increased wellbeing as the majority of students who had access to those services selected several (if not all) supports provided by CCBHS. Perhaps it was reassuring to simply know that staff were available to assist with barriers that often seem overwhelming when trying to navigate a school system. The course instructor was also readily available to students, on their turf so-to-speak. He kept his office hours at the consumer clubhouse. This was another support that ranked high on the access list and may have contributed to student success and ultimately, their increased wellbeing.

Columbia’s most accessed support was by far academic and career counseling, which has been a challenge for CCBHS to offer due to scope and capacity limitations. Many students are clearly interested in direction regarding their educational and employment goals—particularly how their efforts in school will translate to self-supporting jobs in the future. While CCBHS has been interested in developing a corresponding supported employment program, this goal has not yet been realized.
This study identified the independent variables of psychosocial rehabilitation course material in Peer Support and various supportive services offered by CCBHS and Columbia College, as well as the dependent variable of improved emotional wellbeing for participants. As stated, 100% of participants reported that completing the course alone improved their emotional wellbeing. The curriculum focused on understanding self and helping others with similar struggles (particularly mental illness). The relevance of this variable emphasizes the need for students, particularly those with mental illness, to gain a personal understanding about their own inner challenges and to find new ways to be useful to others (Personal Understanding, Better Relationships with Others, and Feeling More Useful were also the highest ranking areas of improved emotional wellbeing).

The other independent variables in this study were supportive services. Most relevant were the need for financial aid, transportation, and direction with future goals. College itself can be particularly intimidating, and some consumers have not thought about the future in some time; support with those barriers is essential to this program. Small counties are typically hard hit by the economy and consumer’s fair even worse. While tuition waivers are tremendously helpful, textbooks or even school supplies can be cost prohibitive. Assistance with these costs has cut out costly student loans.

Particularly for rural programs, the need for transportation cannot be overlooked. Calaveras County does not have a community college within its borders. Some students with cars travel close to two hours just to get to Columbia; those who rely on public transportation have just four buses to choose from—none of which run at night. So assistance with gas cards and carpools have been the deciding factor for some students.
Evaluation of Hypothesis

The hypothesis for this study proposed that the course in Peer Support and supportive services offered by CCBHS would lead to improved emotional wellbeing for consumers in the Psychosocial Rehabilitation Certificate Program at Columbia College. The study acknowledged there could be additional factors not tied to the program that may affect the outcomes of this study, which have been reported to the fullest extent possible. Those factors aside, the evidence appears to support the hypothesis.

Statistically, 100% of participants agree that the Peer Support course improved their emotional wellbeing. Most Calaveras County students engaged a significant amount of supportive services, most of which were assistance with registration, cost of books and supplies, and transportation. Most Calaveras County students also reported a higher number of improved areas of emotional wellbeing, which appears to show a strong correlation and also supports the study hypothesis.

It is also hypothesized that the benefits of improved emotional wellbeing as a result of participation in a psychosocial rehabilitation certificate program can be translated into specific therapeutic interventions and MediCal billable services. If such a link can be established, then the rural workforce education and training programs created through MHSA funding would be able to show positive outcomes for consumers and family members despite a current lack of employment in the public mental health system. This causal link could then establish a significant measure of program success even during times of economic downturn. While this hypothesis has yet to be established, the results of this study are an important first step toward that goal.
The Literature Review for this study examined the history of mental health treatment and recovery as well as the advent of psychosocial rehabilitation. This movement has led to innovative community-based programs in supportive education, employment, and housing. As discussed in the Literature Review, supported education programs have been implemented nationwide. Most programs have had the goal of employment for program participants. However, as this study has shown, supported education programs have the capacity to provide significant benefits in addition to employment. Additional study is needed in this regard, and hopefully this study will lead to similar studies in other areas. Nonetheless, as mental health treatment and psychosocial rehabilitation continues to evolve, supported education could perhaps become a new avenue of intervention.

Several supported education programs have been studied for employment and emotional wellbeing outcomes. Results from three major studies in Michigan, Chicago, and the East and West Coast vary; however, most studies have shown positive results. Unfortunately, it appears no studies were conducted in rural areas. The emphasis of the Literature Review was the need for a rural study. With the challenges faced by rural communities, it seemed necessary to research programs in these areas, such as the one in Calaveras County, in order to determine the outcomes and recommendations for rural supported education. While limited in its sample size, this study may be the initial research on supported education in rural counties. It is hoped that this study will lay the groundwork for future research in this area.
Practical Applications

The statistical and empirical success of CCBHS’ supported education program in conjunction with the Psychosocial Rehabilitation Certificate Program at Columbia College suggests that such a model could have practical applications in other settings. The most obvious application for replication is in other rural mental health clinics in partnership with local community colleges. Public mental health clinics, particularly those in California, would be able to use MHSA funds similarly to CCBHS. However, there are several other applications that may be able to experience similar success. For instance, rural colleges may explore on campus options, substance abuse treatment centers could implement a similar model, as could primary care clinics and domestic violence centers. This subheading will explore these potential applications.

Funding is always a deciding factor when implementing a new program. A major opinion of this study is that the emotional wellbeing benefits of this program are so significant that the supportive services offered should be eligible for MediCal/MediCaid billing. With the billable reimbursement for time and some extra leg-work to identify existing programs that will assist with the cost of transportation, fees, books, and supplies (such as grants, donations, vouchers, etc.), most any mental health clinic could provide a similar program. This would allow application for non-public mental health clinics, such as federally qualified health clinics or community based organizations, in partnership with a rural community college willing to provide the certificate program.

Another option is to provide the behavioral health-sponsored supportive services directly on campus. A few community colleges in California (such as in San Mateo) have
implemented a similar model with significant success. The benefits of this approach include “one-stop” access to services provided by behavioral health and by the college, increased collaboration between the two partners, and fewer transportation challenges. As far as the literature shows however, this model has not been implemented at a rural community college. According to the CCBHS model, it would only require one staff person from behavioral health; and per the previous paragraph this person may be able to offset the cost of the program through MediCal/MediCaid billing and grants.

Most closely related to applications in mental health are potential applications in substance abuse clinics. As Calaveras has an behavioral health model that includes clients with mental illness and substance abuse disorders, students from Calaveras reflect that make up. Most (if not all) substance abuse treatment clients have a history of trauma and the rates of co-occurring disorders (substance abuse disorder and mental illness) are high among this population. As such, the potential for this group to experience similar positive outcomes of improved emotional wellbeing, particularly in the areas of Personal Understanding and Improved Relationships with Others (top two responses in this study).

Among substance abuse treatment clients, those most affected by trauma appear to be perinatal clients. Although not captured in this study, it appears that participants in CCBHS’ perinatal substance abuse treatment program were the most active participants in the program, next to those who were strictly mental health program clients. From antidotal perspective only at this point, it appears that those who have participated in the supported education program at CCBHS have remained in recovery for a significant duration of time. These clients are typically considered as having co-occurring disorders,
due to their high rates of trauma and trauma-related mental illnesses and it seems they have benefited from the psychosocial rehabilitation-based curriculum as well as the supports that have assisted them financially. A similar supported education program, or aspects of educational supportive services, could potentially be embedded into a perinatal treatment program to gain similar results. Or, existing programs could be targeted at this population based on the outcomes of this study.

Similarly, in-patient treatment programs could weave education-based supportive services into their program, particularly toward discharge. Many treatment programs do not emphasize mental health education. As clients prepare to enter back into their lives, surrounded by the people, places, and things that once triggered their use, perhaps a program that taught them about mental illness, trauma, and helping others with a similar experience might make a significant difference in their recovery.

Another group greatly affected by trauma is victims of domestic violence. As such, domestic violence centers may also be able to implement a supported education program similar to CCBHS or in a scaled-down version as described in the paragraphs above. Like those with mental illness, victims of domestic violence may lack confidence, personal understanding, and hope for the future. It seems most do want to help others though. Consequently, the Peer Support curriculum and the psychosocial rehabilitation program may be ideal for this population as well—particularly if it leads to similar outcomes as this study shows. Given the sensitive nature of what this group has experienced, likely the program would have to be offered to just this population.
Lastly, this type of program has a potential application in primary care as well. According to this study, teaching those with mental illness about themselves and how to help others with similar struggles has a positive effect. Perhaps teaching primary care clients about the effects of physical illness and how to help others using a Peer Support model may have similar positive effects as found in this study. While new curriculum, certificate programs, and supportive services would have to be designed, piloted, and studied, it seems that the possibility might exist for promising results.

**Proposed Expansion**

This study, while successful, was limited in its scope. The focus was restricted to just two semesters of the Peer Support class and queried a relatively small sample size of 25 students. The Psychosocial Rehabilitation Certificate Program consists of the Peer Support class as well as an Intro to Psychosocial Rehabilitation, Helping Skills, and Work Experience course. To truly research the utilization and emotional wellbeing outcomes of the program as a whole, it would be beneficial to survey students in each course. A comparison could also be done to see which course is most beneficial.

Additional criteria that may be useful to query students about include course completion date, birth date, and zip code. If this study is expanded and surveys are offered on a regular basis, having a course completion date may help to determine which cohorts benefited more than others. Birth dates would allow the researcher to track certain students over a period of time and may allow tracking of individuals within specific groups for CCBHS such as mental health participants versus substance abuse treatment participants. With transportation being a particular challenge, having zip codes
would provide information about how far students were travelling to school. Depending on what additional information students provided on their surveys, it may also be appropriate to add emotional wellbeing criteria to the existing evaluation survey.

Another potential area for expansion of this study is to follow up with program participants, perhaps with another survey. If it were possible to obtain mailing addresses, the researcher could then mail follow up surveys to see how the participant’s emotional wellbeing has improved, sustained, or declined since completing the program. Some additional follow up questions regarding the program pertinent to the research could be asked as well, such as, “How are you using what you learned in your daily life?” If the supported education program were to add on an “Aftercare” component, then a follow up survey might be able to be done in conjunction with that process.

The previous subheading outlined several potential applications for supported education programs similar to the one sponsored by CCBHS. Nonetheless, to strengthen the likelihood of success for several of these applications, more research is needed and can be done using the CCBHS program. For instance, CCBHS has reported that student participants from CCBHS’ perinatal substance abuse treatment program appear to have done particularly well in the Columbia program and seem to be maintaining their sobriety as a result. However, because that level of detail (type of client) was not captured in the data collected for this study, there is no way to determine that hypothesis statistically. A study focusing on perinatal clients, or one that would be able to filter out that population would be ideal for a future research design and to assist CCBHS in tailoring their program to meet all of their clients’ needs.
Similarly, a study that could gather data on older adult participants would be useful for Calaveras and other rural counties that typically have higher rates of seniors compared to their urban counterparts. CCBHS has observed that a significant number of older adults have participated in their supported education program, as this study reflects. This is significant as many older adults in the program are returning to school after 20, 30, or even 40 years—which brings its own unique challenges. Future research targeted at this specific population should draw out those challenges and query these participants regarding any specific needs they have as well as what aspects of the program were particularly useful in assisting them to complete each course. It would also be helpful to identify ways to target this population in the future. Older adults are at risk for a number of mental health concerns but can be a challenge to engage in traditional therapeutic approaches. Perhaps a supported education program in psychosocial rehabilitation would be more successful, particularly if there were statistics to support positive outcomes.

Although not captured in this study, CCBHS has reported that the last two semesters of the Peer Support class has seen an influx of the clients from the women’s groups offered by the department. This new “cohort” could be relevant because, like the perinatal group, they are already bonded and receiving support from a group and each other. Apparently, this group has been traveling together, studying together, and sharing their struggles as they return to school. According to research, this is the best model to utilize in a supported education program. It would be useful to track this group to see if this secondary level of support provides additional benefits and contributes to their success in completing the course.
A relevant criterion of the Columbia program is that a high school diploma is not required for enrollment and registration. In fact, it seems that even students without a GED were able to attend. The lack of prerequisites presents some significant advantages and disadvantages. So many mental health and substance abuse consumers have faced lifetimes of uncompleted goals and rejection. Consequently, countless clients have not finished high school and their illnesses and disorders have kept them from attempting future challenges. Having a supportive program that removes the barrier of requiring a diploma or GED has been a significant draw for consumers. While that seems clear, the result has been an influx of students that are not nearly as prepared for college-level work as a typical student coming straight out of high school with a diploma. It is hypothesized that some of these students may not be completing the courses sponsored by CCBHS. Data may show that an additional preparation course is needed for this group as part of this program. Tracking this group would also be a useful future study and could be done via birth date or through some other mechanism.

Conversely, several student participants have diplomas and some college experience. In fact, it appears that some have completed other certificate programs, associate degrees, and even bachelor degrees. It would be helpful to determine if the added education contributes to course completion, especially in comparison to the data gathered regarding those without high school diplomas or GEDs. Data regarding the motivation for these students to return to school, particularly for a lesser certificate, would also be interesting and could benefit future marketing campaigns.
Conclusion

A checkered history, some heroic advocacy, and new public policies have led to major progress in the mental health recovery. These advancements have resulted in a variety of supportive service programs for housing, employment, and education. While the benefits of supported education have been studied to some extent, the scope appears limited to employment as an outcome. It appears that few studies have examined the effect of emotional wellbeing as an end result, and apparently no studies have been conducted in rural areas—until now.

Calaveras County observed significant changes when their clients participated in the Psychosocial Rehabilitation Certificate Program they sponsored with Mental Health Services Act funding. Clients were becoming more confident, more positive about the future, and more involved in the community. However, these funds were meant to train consumers for employment not personal development; but due to the economy, jobs were not available at the rates students were completing the program. Nonetheless, it appeared that there were secondary benefits of CCBHS’ supported education program that were clearly worth studying—which lead to this study.

While the data set available was admittedly small, the results have been relatively significant. As this project has reported, a surprising 100% of 25 reported that completing the Peer Support course alone improved their emotional wellbeing. Those that accessed supportive services reported the most areas of improved emotional wellbeing, thus supporting the hypothesis that supportive services contributes to the dependent variable of improved wellbeing. Students reported improvement in all areas of wellbeing; the
highest ranking areas being Personal Understanding, Improved Relationships with Others, More Useful to Others. All areas of improvement reported could easily translate into treatment plan goals, which would allow the time spent on supportive services to be billed to MediCal or MediCaid. The strong results of this study, the ability to bill, and some access to grants, would allow the CCBHS program to be replicated in other applications—which is the ultimate goal of the project.

The researcher also hopes that this project will lead to future studies in similar areas. As reviewed in the literature, there does not appear to be any other studies of rural supported education programs. As the previous subheading discussed, this study is just the tip of the iceberg. There is still so much research to be done regarding the CCBHS program alone. The researcher plans to continue this study locally; however more work is needed throughout California and nationally so that wider research is available for meaningful literature reviews, significant grants can be won, and real progress can be made in the area of rural supported education.
Appendix A. Psychosocial Rehabilitation Program

Psychosocial Rehabilitation Skills Attainment Certificate

Would you like to know more about supporting others in their recovery from mental illness?

In as little as two semesters, you can earn 12 units and a locally-recognized skills attainment certificate that will provide an introduction to mental health recovery, and will prepare you for entry-level and volunteer positions in behavioral health. This is also a great first step toward a career in Peer Support, Personal Service Coordination, or Case Management. You will learn:

- Helping & listening skills
- Basic wellness & recovery values
- Self-management & boundaries
- Ethics & confidentiality
- Cultural competency

The following classes are required to complete the Psychosocial Rehabilitation program:

| Fall     | PSYCH 52: Introduction to Peer Support |
| Spring   | PSYCH 56: Intro to Psychosocial Rehabilitation |
| Fall     | GUIDE 10A & 10B: Helping Skills, Part 1 & 2 |
| Fall/Spring | WKEKP 97: Work Experience in Human Services |

For registration information, call Admissions & Records 209.588.5231 or see www.gocolumbia.edu
For program information, call Calaveras County 209.754.6525 or Tuolumne County 209.533.6245
Co-sponsored by Calaveras and Tuolumne Counties, thanks to the Mental Health Services Act

11600 Columbia College Dr, Sonora, CA 95370 | 209.558.5100 | www.gocolumbia.edu
Appendix B. Human Subjects Approval

TO: Christa Thompson  
FROM: Committee for the Protection of Human Subjects  
Date: May 10, 2011

RE: YOUR RECENT HUMAN SUBJECTS APPLICATION

We are writing on behalf of the Committee for the Protection of Human Subjects from the Division of Social Work. Your proposed study, "Higher Education as a peer support intervention in rural areas."

___X___ approved as ___X___EXEMPT ___NO RISK ___MINIMAL RISK.

Your human subjects approval number is: 10-11-11. Please use this number in all official correspondence and written materials relative to your study. Your approval expires one year from this date. Approval carries with it that you will inform the Committee promptly should an adverse reaction occur, and that you will make no modification in the protocol without prior approval of the Committee.

The committee wishes you the best in your research.

Professors: Jude Antonyappan, Maria Dinis, David Demetral, Susan Eggman, Serge Lee, Kisun Nam, Maura O’Keefe, Sue Taylor, Santos Torres

Cc: Dr. Sue Taylor
Appendix C. Peer Support Course Evaluation

### Peer Support Course Evaluation

#### 1. Demographic Data

1. **Sex**
   - [ ] Male
   - [ ] Female
   - [ ] Other

2. **Age**
   - [ ] 18-25
   - [ ] 26-35
   - [ ] 36-45
   - [ ] 46-55
   - [ ] 56-65
   - [ ] 65+

3. **Race/Ethnicity**
   - [ ] African American
   - [ ] Asian/Pacific Islander
   - [ ] Caucasian
   - [ ] Latino
   - [ ] Native American
   - [ ] Multiple
   - [ ] Other

4. **County of Residence**
   - [ ] Calaveras County
   - [ ] Tuolumne County
   - [ ] Other (please specify)

5. **Highest level of education completed prior to this course.**
   - [ ] High School Diploma/GED
   - [ ] Associates Degree
   - [ ] Bachelor's Degree
   - [ ] Master's Degree
   - [ ] Doctoral Degree
   - [ ] I have NOT yet completed a diploma/degree program

6. **Types of educational experiences you have participated in where you did NOT receive a degree (mark all that apply).**
   - [ ] Some High School
   - [ ] Adult Education Program
   - [ ] Trade School Program
   - [ ] Some Community College
   - [ ] Community College Certificate
   - [ ] Some Additional College
   - [ ] Online Training
   - [ ] Other (please specify)

### 2. Course Evaluation

1. On a scale of 1 to 5, how would you rate the SUBJECT MATTER taught in this class?
   - 1=Very Satisfied, 2=Satisfied, 3=Somewhat Satisfied, 4=Dissatisfied, 5=Very Dissatisfied
   - [ ] 1
   - [ ] 2
   - [ ] 3
   - [ ] 4
   - [ ] 5

2. On a scale of 1 to 5, how would you rate the HANDOUTS used in this class?
   - 1=Very Satisfied, 2=Satisfied, 3=Somewhat Satisfied, 4=Dissatisfied, 5=Very Dissatisfied
   - [ ] 1
   - [ ] 2
   - [ ] 3
   - [ ] 4
   - [ ] 5
Peer Support Course Evaluation

3. On a scale of 1 to 5, how would you rate the INSTRUCTOR for this class?
1=Very Satisfied, 2=Satisfied, 3=Somewhat Satisfied, 4=Dissatisfied, 5=Very Dissatisfied
☐ 1  ☐ 2  ☐ 3  ☐ 4  ☐ 5

4. On a scale of 1 to 5, how would you rate this course OVERALL?
1=Very Satisfied, 2=Satisfied, 3=Somewhat Satisfied, 4=Dissatisfied, 5=Very Dissatisfied
☐ 1  ☐ 2  ☐ 3  ☐ 4  ☐ 5

5. Would you recommend this course to others?
☐ Yes  ☐ No

3. Supportive Services Evaluation

1. If you received supportive services from Columbia College, which of these were MOST beneficial? Please check the top THREE.
☐ Academic, Career, or Personal Counseling  ☐ Financial Aid Assistance
☐ Academic Achievement Center Tutoring  ☐ Library Assistance
☐ Academic Achievement Center Computers  ☐ On-Campus Health Services
☐ Support from Student Disability Services  ☐ I did NOT receive services from Columbia
☐ Other (please specify)

2. If you received supportive services from County Behavioral Health, which of these were MOST beneficial? Please choose the top FIVE. (Note: The Living Room is a Consumer-Run Clubhouse in Calaveras.)
☐ Individual College Planning  ☐ Transportation Assistance (Carpools)
☐ Enrollment/Registration Assistance  ☐ Instructor Available at the Living Room
☐ Financial Aid (Tuition, Fees or Books)  ☐ Computers at the Living Room
☐ School Supplies (Notebooks, Pens, etc.)  ☐ Peer-Run Study Group
☐ Special Equipment (i.e. Tape Recorders)  ☐ Individual Tutoring Sessions
☐ Transportation Assistance (Gas Cards)  ☐ I did NOT receive service from Behavioral Health
☐ Other (please specify)
Peer Support Course Evaluation

3. If you received supportive services, do you feel these helped you complete this course?
   - Yes
   - No
   - I did NOT receive any supportive services

4. Do you feel that completing this course has improved your emotional wellbeing?
   - Yes
   - No

5. If you answered yes to the previous question, in what ways do you think your emotional wellbeing has improved? Please check all that apply.
   - [ ] Increased Hope for the Future
   - [ ] Feel More Useful to Others
   - [ ] Better Relationships with Others
   - [ ] Interested in New Things
   - [ ] More Involved in the Community
   - [ ] Closer to my Personal Goals
   - [ ] Better Understanding of Myself
   - [ ] Increased Ability to Solve Problems
   - [ ] More Confidence in Myself
   - [ ] I see NO change in my emotional wellbeing
   - [ ] Other (please specify)
Appendix D. Informed Consent Form

Informed Consent Form
Title of Project: Supported Education Course Evaluation
Principal Investigator: David Sackman, MFT

We invite you to take part in a research project sponsored by your instructor and Calaveras County Behavioral Health Services which seeks to identify a more effective means of providing supported education. Taking part in this study is entirely voluntary. We urge you discuss questions about this study with your instructor. If you decide to participate you must sign this form to show that you want to take part.

Purpose of the Research
The intent of this study is to determine if supported education in psychosocial rehabilitation improves the emotional wellbeing of participants, and if so, what aspects of the program are most beneficial. You are being offered the opportunity to take part in this research because you have completed a course in Peer Support (as part of the Psychosocial Rehabilitation certificate program) and you may have participated in the supportive services offered by Behavioral Health Services and/or Columbia College. Approximately 40 people will take part in this research, which is limited to students who have completed a course in psychosocial rehabilitation. About 20 people are expected to take part in your class, and another 20 people are expected to take part in the Peer Support class offered in Fall 2011.

Procedures
Should you choose to take part in the study, you will be given an anonymous course evaluation to fill out during class. Once complete, all evaluation forms will be sealed in an envelope until the results can be entered into an online survey program by a staff person at Calaveras County Behavioral Health Services. Once all evaluations are entered, they will be stored in a secure location. The data in the online survey program will be analyzed by Behavioral Health Services and the results will be shared with your instructor and other persons connected to this research. Your instructor will not have access to any individual responses. Your informed consent form will be sealed in a separate envelope and will be stored in a secure location by your instructor.

Time Duration of the Study
If you agree to take part in this study, your involvement will be limited to this course evaluation. Additional time will not be required of you.

Potential Risks
There are no expected risks to participants of this research study.

Potential Benefits
While you may not benefit directly from taking part in this research study, the results of this research may guide future supportive services offered to other participants of this course and additional psychosocial rehabilitation courses offered as part of this program, including those you may take in the future.
Statement of Confidentiality
Your evaluation will be reviewed, stored, and analyzed by Calaveras County Behavioral Health Services and will be kept in a secured area. In the event of any publication or presentation resulting from the research, no personally identifiable information will be shared. Your Instructor, as well as staff of Calaveras County Behavioral Health Services, may use your evaluation data and share it with other specific groups in connection with this research study.

Compensation for Participation
You will not receive any compensation for being in this research study.

Voluntary Participation
Taking part in this research study is voluntary. You do not have to participate in this research. If you choose to take part, you have the right to stop at any time. If you decide not to participate or if you decide to stop taking part in the research at a later date, there will be no penalty or loss of benefits to which you are otherwise entitled.

Contact Information for Questions or Concerns
You have the right to ask any questions you may have about this research. If you have questions, complaints or concerns, contact your instructor at 209-754-6555.

Signature and Consent/Permission to be in the Research
Before making the decision regarding participation in this research you should have:

- Discussed this study with your instructor.
- Reviewed the information in this form, and
- Had the opportunity to ask any questions you may have.

Your signature below means that you have received this information, have asked any questions you have about the research and those questions have been answered.

Participant: By signing this consent form, you indicate that you are voluntarily choosing to take part in this research.

Signature of Participant ___________________________ Printed Name ___________________________ Date _______________
Appendix E. Authorization Letter for Data

April 25, 2011

Calaveras County Behavioral Health Services
Attn: Christa Thompson
891 Mountain Ranch Road
San Andreas, CA 95249

Dear Ms. Thompson,

I hereby authorize you to utilize the program evaluation data I obtain from my Peer Support class at Columbia College during Spring and Fall of 2011. I understand that you will enter this evaluation data into SurveyMonkey.com for analysis and that your results will be reported in the aggregate. As part of this release, I expect that you will share your results and any subsequent reports with me and other parties related to this research.

Please contact me should you have any further questions regarding this data. I can be reached at 209-754-6555. Thank you for your inquiry in this regard.

Sincerely,

[Signature]

David Sackman, MFT
Adjunct Professor
REFERENCES


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