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HELPING THEM HELP THEMSELVES: SUPPORTED ADULT EDUCATION FOR PERSONS LIVING WITH MENTAL ILLNESS

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Abstract

This case study of the Ontario Shores Supported Education Program (OSSEP) illustrates the importance of a hospital-based education program for adult learners living with mental illness and its impact on participants' quality of life and hopes for the future. The findings demonstrate that supported education programs catering to the needs of adults living with mental illness have the potential not simply to provide skills for future employment, but more broadly to improve participants' ability to manage daily life, increase self-confidence, and improve rehabilitation efforts. With ongoing cuts to community-based adult education programs, this research indicates the importance of ensuring specialized supported education programs are introduced and maintained for persons living with mental illness. For hospitals like Ontario Shores Centre for Mental Health Sciences, such programs can be an important part of patients' recovery and rehabilitation process.

Résumé

Cette étude de cas du Programme d'éducation assistée (Supported Education Program) d'Ontario Shores (OSSEP) illustre l'importance d'un programme d'éducation en milieu hospitalier pour les apprenants adultes atteints de maladies mentales ainsi que son impact sur la qualité de vie et l'espoir sur l'avenir des participants. Les résultats montrent que les programmes d'éducation assistée répondant aux besoins des adultes atteints de maladies mentales ont le potentiel non seulement d'offrir des compétences pour un emploi éventuel, mais également de développer la capacité des participants à gérer leur vie quotidienne, d'augmenter leur confiance en soi et d'encourager leurs efforts de réadaptation. Avec la réduction en cours du budget des programmes communautaires d'éducation pour les adultes, ce travail indique l'importance

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d'assurer l'introduction et le maintien de programmes d'éducation assistée spécialisée au profit des personnes atteintes de maladies mentales. Pour les hôpitaux comme Ontario Shores Centre for Mental Health Sciences, tels programmes peuvent être un constituant important du processus de rétablissement et de réadaptation des patients.

Introduction

Using Sen's (1999) concept of capability deprivation as a guiding principle within the transformative learning framework (Mezirow, 1997), our case study investigates the social, economic, and quality-of-life implications of a hospital-based education program for adult learners living with mental illness. We examine the learning experiences of those seeking literacy and essential skills in the supported education program at Ontario Shores Centre for Mental Health Sciences, a public hospital in Whitby, Ontario, providing a range of specialized assessment and treatment services for in-patients and out-patients living with complex and serious mental illness. As part of its vocational rehabilitation service, the hospital offers the Ontario Shores Supported Education Program (OSSEP) for out- and in-patients, 21 years of age and older, in literacy skills, academic upgrading, computer skills, and high school and post-secondary school credits. Grace (2013) argued that lifelong learning for everyone “should be about acknowledging learners’ abilities and capacities, nurturing potential and possibilities, building respect and rapport, enhancing access and accommodation, and enabling learning to occur in a range of sites in the home, the workplace and the community” (p. 32). This perspective of lifelong learning fits well with the goals of supported education in general and with OSSEP in particular.

With the onset of psychiatric disorders tending to occur between the ages of 18 and 25 (de Girolamo, Dagani, Purcell, Cocchi, & McGorry, 2012; Kessler, Amminger, et al., 2007), the most common years for finishing high school and pursuing post-secondary education, it is important to consider the best ways in which educational support for adults with mental illness can be designed and provided. In Canada, approximately 10% of the population aged 15 or older report experiencing some form of mental health illness (Centre for Addiction and Mental Health, 2013; Statistics Canada, 2013). Like other disabilities or impairments, mental health disorders are a significant barrier to the successful completion of secondary and post-secondary education (Breslau, Lane, Sampson, & Kessler, 2008; Corrigan, Barr, Driscoll, & Boyle, 2008; Grace, 2013; Kessler, Foster, Saunders, & Stang, 1995; Megivern, Pellerito, & Mowbray, 2003), as well as to attaining and maintaining employment. Since even the most basic service-oriented job often requires at least a high school diploma, without access to education, persons living with mental illness face increased risk of depression, unemployment, homelessness, and suicide (Arbesman & Logsdon, 2011; Soydan, 2004). Grace, among others, argued that holistic adult education is needed not just for economic purposes. We agree, and argue that real access to education for those living with mental illness is important for improved quality of life. While focusing on improved quality of life does not preclude efforts to improve vocational skills, these efforts must be preceded by more general education to support such things as the development of life skills, self-confidence, and hope for the future. It is the transformative nature of adult education, the roots of supported education, and the need created through current gaps in literacy and basic skills training in Ontario that provide context for OSSEP.

Context and Background

According to Mezirow (1997), transformative learning occurs when the “frames of reference” or “structures of assumption” (p. 7) are changed. As a result of their learning experiences within OSSEP, participants may undergo shifts in what Mezirow calls points of view and habits of mind. While habits of mind take much longer to change, changes in points of view are easier to measure and occur more readily. The staff in the supported education program provide opportunities for participants to be exposed to new ideas, points of view, and routines. While the education experienced by adults in most education programs is primarily instrumental in nature, communicative learning also occurs as individuals learn to understand the meaning of what is being taught, including values, purposes, feelings, and beliefs (Mezirow). When students are encouraged to talk about what they are learning, what is being taught and learned is validated. The availability of face-to-face learning opportunities is, therefore, particularly important for those who are vulnerable and need to develop the so-called soft skills of being able to work well with others, communicate effectively, and so on. The identification of goals—why individuals feel they need education—is also important to successful participation and completion of education. These goals may be short-term at first (e.g., learn to read), but long-term thinking (e.g., to qualify as an electrician) is also key to persistence and success.

In terms of the social, economic, and quality-of-life implications of programs such as OSSEP, Sen’s (1999) capability deprivation argument provides interesting insights. For many OSSEP participants, their ability to develop their capabilities has been hampered by a lack of education and access to literacy and basic skills training in the past. While poverty is one aspect of capability deprivation, Sen also discussed disability as part of a “coupling” of disadvantage: the difficulty in earning an income is coupled with difficulty in functioning. Mental illness can prevent a learner’s growth and development and, ultimately, can create capability poverty as well as income poverty. Indeed, Sen (1999) argued that those who have an illness or disability may require more income than others because of that illness or disability. Sen’s (1999) perspective is important for this study, because it not only takes into consideration the functional ability to earn an income, but also encourages attention to the “ends that people have reason to pursue, and, correspondingly, to the freedoms to be able to satisfy these ends” (p. 90). We believe that supported education programs provide one important step toward building those freedoms.

Rooted in American efforts to provide for students with disabilities as required by the 1973 Rehabilitation Act, current supported education programs build on early models of supported education and supported employment (Anthony & Unger, 1991; Soydan, 2004). Beginning in 1984, for example, Boston University’s Center for Psychiatric Rehabilitation’s classroom-based career education program provided services for those who already had some level of education and were preparing to pursue post-secondary programs (Soydan). Other research has examined supported education programs that help patients to begin or continue post-secondary education (Arbesman & Logsdon, 2011; Gutman, 2008). Many of these programs are designed solely for those who have at least some high school education and who aim to pursue further education (Mowbray, Collins, Bellamy, et al., 2005). With roots in supported employment as part of occupational therapy, most supported education programs have been designed with the ultimate goal of getting a job. Other supported education programs have been tailored to assist students enrolled in vocational certificate

courses (e.g., horticulture and hospitality) (Best, Still, & Cameron, 2008). While preparation for integration into the job market is important, we argue that the benefits of supported education to general quality of life, including the ability to manage one's own finances, read for enjoyment, fill out forms, and the like, should also be considered. In other words, supported education programs must include those patients who may not have the goal of attending a post-secondary institution or attaining a job that requires that level of education. Access to education benefits persons living with mental illness at the very fundamental level of being able to participate in and enjoy life independently. As previous research has found, participants in supported education programs often experience an identity transformation from patient to student, an increase in aspirations, and a sense of personal empowerment (Bellamy & Mowbray, 1998; Corrigan et al., 2008; Hoffmann & Mastrianni, 1993; Isenwater, Lanham, & Thornhill, 2002; Leonard & Bruer, 2007; Mansbach-Kleinfeld, Sasson, Shvarts, & Grinshpoon, 2007; Unger, 1993). The self-confidence felt by participants when they achieve their goals, no matter how big or small, encourages participants to make new goals and to aim higher.

Although much of the published academic research we have so far identified is American, some similar Canadian programs have been noted. For instance, George Brown College in Toronto has several programs under the umbrella name Redirection through Education that cater specifically to adults with mental illness who want to return to school, work, training, or other "productive" activities in the community (George Brown College, 2014; Gilbert, Heximer, Jaxon, & Bellamy, 2004). Such programs are important given that Mowbray, Collins, and Bybee (1999) found that participants in group or class settings of supported education programs were more likely to succeed than those who attempted to pursue education on their own. In addition to success in education, the participants in group or class settings experienced positive changes in self-perception, self-esteem, social adjustment, and functioning (Mowbray, Collins, & Bybee). A scan of specialized programs at other universities and colleges across Canada showed few programs that specifically provide supported programs for adult students with mental health disorders.

OSSEP is a hospital-based program in Durham Region that caters to some of the most vulnerable people in Canadian society who would otherwise have no access to literacy and basic skills programs. Durham Region has been significantly affected by the lack of accommodation of disability in mainstream community-based adult education and literacy programs. The executive director of the Literacy Network of Durham puts it in perspective:

Most mainstream literacy and basic skills programs lack the resources or expertise to address the needs of diverse student groups. This is most certainly true in the case of learners who struggle with mental health disorders who require specialized classroom accommodations such as frequent breaks, uncrowded working space, and instructor flexibility. Sadly, in the case of funded, quality-assured programming, instructors must narrow their focus to those who are most likely to succeed quickly without requiring any additional supports or services. Mental health institutions that can offer their own literacy and basic skills program are far more adept at delivering the required wrap-around supports and can often deliver instruction without the significant constraints of some learning outcome expectations. (J. Agnew-Kata, personal communication, June 15, 2014)

Programs like OSSEP are uniquely positioned to meet the needs of those with mental health problems who would be unlikely to be given access to other programs or to succeed in them. Even program participants are aware of their limited opportunities, with some making comments about accessibility such as “I think that this is the only place to access schooling opportunities.”

OSSEP Design

OSSEP design follows a psychosocial rehabilitation model, which values normalization, self-determination, support and relationships, hope and recovery, and systems change (Mowbray, 2004) and draws on the choose-get-keep model to empower participants to choose their own goals, work within the program to accomplish them, and keep their student status until their goals are achieved (Mowbray, Collins, Bellamy, et al., 2005; Soydan, 2004). The supported education model provides a strategy to prepare participants to move from being a patient to being a student and empowers them to succeed in a school setting, both of which aid in the recovery and rehabilitation process (Bellamy & Mowbray, 1998; Leonard & Bruer, 2007; Mowbray, Collins, Bellamy, et al., 2005; Soydan, 2004). The rationale of the program is to create a sense of hope for its participants and an understanding of the value of education: “schooling gives meaning and purpose to one’s life, resulting in improved self-esteem, increased confidence and a sense of hope” (Huntington, 2013, p. 1). As Wanda Huntington, the OSSEP coordinator, states in the OSSEP summary:

Many of our patients became mentally ill during their natural schooling years and did not complete either their secondary or post-secondary goals. Once they have experienced improved health, within the community or while in the hospital, they look towards a future goal of gainful employment which is augmented by an improved or upgraded educational level. (Huntington, 2013, p. 1)

OSSEP started in 2007 as an aid to rehabilitation and was both small and ad hoc. Since its inception it has become a year-round program with regular hours and a dedicated space within the hospital. ESL training and computer training have been added to the original math, reading, and writing support programs. The staff of five is supported by volunteers and peer tutors who offer individual tutoring-style support for students. Two sessions with about 20 to 25 participants take place daily from 10 a.m. until noon and from 1 p.m. until 3 p.m. Enrolment in the program has grown from seven participants in 2007 to the current total of 65 to 70 regular participants, including both in- and out-patients. This growth has been due, in part, to the transfer of many patients from programs outside of Ontario Shores that have closed, such as the literacy program at Oshawa’s John Howard Society.

Our informal and preliminary survey of supported education programs in hospital settings across Canada has shown that OSSEP appears to be fairly unique, with its combination of both upgrading and essential and basic skills training in a hospital setting. This program design is an interesting and important one to study to determine if and how this model could be used in other settings. Of the few supported education programs in hospital settings in Canada, most such programs are located in Ontario. For example, the North Bay Regional Health Centre offers education programming through HOPE (Healing Opportunities Promoting Empowerment) and vocational services. In addition,

the Royal Ottawa Mental Health Centre and the Waypoint Centre for Mental Health Care in Penetanguishene offer tutorial-style educational services. These programs, however, are not as extensive as OSSEP.

Saskatchewan and Manitoba are the two other provinces that have mental health institutions with educational supports similar to OSSEP. In Saskatchewan, the North Battleford Hospital Centre offers programming from basic literacy to GED achievement. Since many clients become ill in their late teens, achieving a GED is a common goal for students in this program; however, the North Battleford program also helps students who wish to pursue post-secondary education. Students can enroll in online post-secondary programs or go to the local community college and return to the Education Centre at North Battleford for support as needed. The program is staffed by one teacher and a teaching assistant. The program runs each day from 9 a.m. to 11 a.m. and 1 p.m. to 4 p.m., with scheduling being as flexible as is needed by students to accommodate the rest of their schedule. As in OSSEP, the students determine their own educational goals.

In Manitoba, the Selkirk Mental Health Centre program also runs on the choose-get-keep model. Through its vocational training program, patients can learn and develop work skills, computer skills, and data entry skills. In addition, students can work toward achieving their GED and explore post-secondary education options. Programming is designed around the needs and abilities of each student and is adapted to student goals, much like OSSEP. When students complete the program, or when they are ready to be reintegrated in the community, there are five community partners with whom students can be placed. The Manitoba program is quite small and ad hoc, as there is only one staff member and no volunteer system. Both the Selkirk and North Battleford programs operate much like OSSEP did in its early days with one staff member. The remaining provinces seem to rely on community groups to provide educational support for adults living with mental illness.

Methodology

Begun in June 2013, this research is part of a two-year SSHRC-funded Insight Development project whose research team includes those with backgrounds in policy, history of education, adult education, and mental health nursing, as well as a literacy assessment specialist who acts as a consultant on the project. We also have the participation of the OSSEP coordinator and the manager of the program, who have both helped inform the project and have welcomed recommendations for improvement of their program framework.

To understand the experiences of the students at OSSEP, we used a mixed-methods approach that simultaneously collected quantitative and qualitative data. In other words, during the interviews we asked some questions that were close-ended to allow us to gather responses that could be quantified (i.e., demographics such as age and sex and self-reported diagnoses and literacy improvements on a scale). During the same interview, we also asked open-ended questions that allowed participants to explain their experiences in their own words; these responses were later transcribed verbatim from the audio recordings. Given the small sample (n=42 students), we used descriptive rather than inferential statistics as well as qualitative theme analysis. We follow a similar mixed-methods study to that of Wittink, Barg, and Gallo (2006), whose study of patients' self-reports of depression, medical condition, and demographics had a quantitative analysis that produced descriptive statistics deepened by semi-structured interviews that yielded a qualitative theme analysis, as did

ours. Their study also had a relatively small sample size of 48, which precluded inferential statistics, but like ours was still able to gain insight into patient perception of their treatment and those, in their case doctors and in OSSEP's case vocational rehabilitation workers and teachers, that are put in place to help them. The relatively short length of the SSHRC Insight Development Grant and our small sample size also precluded using exploratory or explanatory mixed methods that would require two-stage data collection.

We interviewed participants, staff, and volunteers using an interview guide designed to collect demographic information, experiences in the program, approaches to learning, and quality-of-life indicators. These interviews were held in private rooms; participants were given \$20 honorariums and were allowed to remain anonymous. Given the heightened concern for anonymity and security due to the vulnerability of the population being studied, all data were kept on password-protected, encrypted USB keys and an encrypted external hard drive. Our analysis captured the incidence of opinions, underlying motivations, and trends and themes. Chi-square and gamma analysis revealed the basic relationships between original and improved skills. Basic frequencies and descriptive statistics were run to determine student-scaled self-reported improvements in a number of areas, including math, writing, and reading skills as well as levels of confidence, independence, and social skills. A qualitative theme analysis was conducted by searching the transcripts for themes manually and then using NVivo to look for further themes and frequencies.

Findings

It gives people the opportunity to pursue an education...I think it is healthy, definitely, to be part of the program, for sure. (OSSEP participant)

Preliminary findings from our first round of interviews revealed several key themes: the value of education, changes in self-awareness and recovery, increased confidence and independence, and continuing stigma. Results also suggest that adult learners acquiring literacy and essential skills have hope, are persistent, and believe in their success: 23.8% reported having reached their general goals of education, while 73.8% believe that they will. Our preliminary results support the finding that education for the mentally ill can increase literacy and numeracy and can be a catalyst for an increase in their quality of life. Education and participation in OSSEP can act as an aid to recovery for most students.

Interview Participant Profile

The participants or "clients" of the program represent those both living within and outside of the hospital; usually there are 60% in-patients and 40% out-patients. The participants we interviewed (n=42 out of the possible 65 to 70 registered participants) included, of those who disclosed, 42.9% in-patients and 54.8% out-patients, were mostly male (65.2%) and single (89.1%), and ranged in age from 21 to 53 (mean age of 33). These statistics are reflective of the usual student population as reported by OSSEP staff. Of the 30 people who disclosed an ethnic background during their interview, just over a quarter identified as Caucasian (28.3%). Other ethnicities included West Indian (10.9%), African Canadian (6.5%), and South Asian (2.2%). Twelve participants (26.1%) did not disclose, while the remainder included single students who identified as Middle Eastern, East Asian, Aboriginal, or other. In terms of educational background at entrance into OSSEP, 81% had completed at

least some high school, with Grade 10 being the most frequently completed grade. Seven individuals (15.2%) had completed some college courses and one (2.2%) had taken some university courses. Our results reflect the findings of Corrigan et al. (2008), who found that over a third of their sample of 120 patients had not finished secondary education, while a third had not pursued post-secondary schooling after graduating and only 12% had gone on to complete post-secondary education.

Previous Experiences with Education

I have always been a good student...I got sick and I neglected my school work, I was in high school when I got sick, but I was an A student and A+ student before I got sick, and for instance in biology I got an 85 on the first two tests and I got sick and I started getting 60s. (OSSEP participant)

Friends; friends skipping off all the time. You never thought. Now that I look back, I should have went to school. But then...played around at school. Yeah, I really wish I would have [stayed in school]. It would have been nice. (OSSEP participant)

Participants were asked to talk about their prior educational experiences. For most participants, high school was their highest level of education. While some respondents indicated that they had positive experiences and support in high school prior to attending OSSEP, most had negative previous educational experiences, especially when that education coincided with the onset of their illness. Some indicated that their grades dropped considerably when they began exhibiting symptoms of their illness, while others had to quit school completely. Some participants finished high school and enrolled in college or university before becoming ill and dropping out. Some participants noted that support was available, but they did not take advantage of it or felt school was unnecessary at the time. Many also expressed regret at not making the most of that time because they found it much more difficult to return to school as an adult. Most previous experiences of education have been within what Field (2006) called a “conscripting culture” (as cited in Grace, 2013, p. 131); in Ontario, youth are required to attend school until the age of 18, no matter whether they are engaged in their learning, are bored, or are otherwise challenged. For those living with mental illness, especially if their illness is combined with a learning disability, social pressures and a lack of opportunities and supports often result in a disengagement with education. Such youth are often blamed for their lack of success and, indeed, often internalize this blame, which then carries into their adult years when they encounter precarious employment combined with ongoing mental health challenges.

Motivations

I didn't really have [a goal]. Just to keep my mind occupied, and just to see how much I can do. I've taken so much medication over the years, you know, I just want to see where I am. (OSSEP participant)

Most of the participants had either or both educational (67.4%) and/or vocational (50.0%) goals when they began in OSSEP, but some simply desired some form of mental stimulation and increased self-awareness. Although many had a job as a long- or short-term goal and

may have already been working as a volunteer, others stated that they were not worried about finding work. A few were already working for charitable organizations such as the Salvation Army or at jobs within the hospital as part of their vocational rehabilitation. Many felt confident that they would be able to return to employment such as construction work, with one participant commenting, “there are lots of jobs if you are not picky.” A few worried that having a job might reduce their disability pension and they would not be able to afford their medications on top of regular living expenses. This fear is one that is common among adults living with any form of disability (Grace 2013), as is the fear, as one participant commented, that minimum wage employment would lead to temptations to steal or deal drugs.

As Collins, Bybee, and Mowbray (1998) and Corrigan et al. (2008) found, participants in supported education generally desire further education. Corrigan et al. also found that achieving a sense of accomplishment (51.9%), finding employment (47.1%), gaining a sense of pride (46.2%), and interacting with people (41.3%) were all important factors in the decision to take part in a supported education program. These findings reflect ours. For some in OSSEP, there was a general desire to gain more skills and knowledge, improve themselves, be stimulated mentally, develop writing and numeracy skills, become more independent, and develop interpersonal skills. One participant commented on what they hoped to gain as something more indefinable: “I don’t know how to describe it, but the feeling of acceptance. The acceptance of being a normal person, you know, like doing things that an everyday person would do, an average person would do in their everyday life. That is a big goal for me.” For others, their goals were more specifically vocation-oriented: to begin a landscape business, become a welder or electrician, work as a janitor, become a social worker or law clerk, and so on. Similarly, Megivern et al. (2003) found that although 29% of their respondents cited career goals as a reason for pursuing higher education, 71% claimed that a desire to learn was their motivation.

Barriers

At first I was a bit afraid of a school environment, so I had to be a little bit encouraged to come here, and so with her encouragement I did come and I haven’t regretted it at all. (OSSEP participant)

An underlying barrier to education for most participants was fear generated by a number of different personal issues, including mental health problems, learning disabilities, social isolation, and medication. Many of the participants identified more than one barrier to education. Not surprisingly, the most commonly identified barrier to education was mental illness (52.2%). This was followed by a learning disability (34.8%), social isolation (30.4%), medication (23.9%), lack of access to a program (19.6%), problems with an instructor or instruction (19.6%), language (10.9%), culture (4.3%), and other (19.6%). In addition, participants focused on lack of motivation, not understanding their mental illness at onset, anxiety about learning, and lack of support from family and friends as contributing factors preventing the completion of high school and further education. These findings affirm the importance of providing accessible and supported education programs for those living with mental illness. A main focus of OSSEP is to create a supportive and safe environment for learning and to combat any fears that participants may have.

Impacts of the Program

I have a hard time public speaking. And last year, [a staff member] invited me to, not a conference, but a meeting, and I had to speak in front of a crowd of people. And she asked me to write something about how schooling helped me, and I had to share a bit of my story in front of everyone, so it took a bit of courage. (OSSEP participant)

I feel more positive. I feel more positive about myself. (OSSEP participant)

For many participants, finding success in OSSEP has improved confidence both in their ability to learn and in life generally. Sometimes it was simply gaining awareness that they were not alone in dealing with mental illness and struggling to learn—the knowledge that others face similar challenges made a difference to them. Being on a schedule and having a plan for the day (e.g., to attend OSSEP sessions) gave meaning and shape to daily life and a reason to get out of bed in the morning. The feeling of increased self-confidence and purpose often led to more ambitious goals of further education or training for a specific vocation (e.g., electrician, social worker, personal support worker). That confidence, for one participant, resulted in being able to speak publicly in front of a large group: “I have even spoken at the lecture hall on graduation day, or Education Celebration. That would not have been possible five years ago, it wouldn’t have happened.” Another commented that s/he no longer “feels like a dummy” or left out in conversations. Yet another participant believed that her/his improved confidence has affected other areas of her/his life: “It makes you a better person at work, because you have full confidence in the things you say and sound smarter if you use proper English.”

After participating in OSSEP, the changes in learning (as identified by respondents) ranged from improved literacy and numeracy to new interests in reading and a desire to learn. The group structure was noted by some as providing a sense of positive-ness that helped in building problem-solving skills and in avoiding feelings of frustration. When participants discussed the impact of OSSEP, the sense of pride in their accomplishments was clear, especially in learning basic skills such as math, reading, and writing. Some participant comments, such as “Changes in my learning? I was actually learning in math!” and “I was learning in one day what would have taken me three weeks to learn,” show their enhanced learning and their awareness of their progression. There were self-reported improvements in various skills, including 38.1% of students reporting improved reading skills, 38.1% reporting improved writing skills, and 31.7% reporting improved math skills. Given these self-reported statistics, we are preparing new learning checklists in these three areas to improve the ability of students to track their progress. We believe that by working with the program administrators to make improvements in OSSEP assessment tools, tutor training methods, and other resources, these rates of improvement will continue to increase.

Overall, most participants felt that the program was a positive experience that has provided an encouraging and affirmative learning space for students. This positive attitude among participants, as well as the staff and volunteers, is important. It not only encourages participants to return each day, but also allows the opportunity for rapport between staff, volunteers, and participants to grow. A strong rapport with staff and volunteers is an important part of keeping participants engaged in the program. A few participants indicated that they attended OSSEP because of one instructor who previously worked in

another program outside of the hospital. Another participant commented that s/he missed working with an employee who was no longer at OSSEP. Although not every participant interviewed had a positive experience with all staff members, the majority believed that the staff and volunteers were friendly, patient, and understanding. Indeed, the most common complaints included that the program was not offered for enough hours each day, the space could get too crowded, more staff or volunteers were needed, and better resources (such as computers and Wi-Fi) were required. For out-patients, the distant location of the hospital made it difficult to attend the program regularly.

Discussion and Conclusion

I think that there should be more centres like this that are open for people that don't just have mental health problems or other abilities that they are lacking, that they need help with, or maybe there should be more of these places than there are [that are] easier to get to, because this place is pretty far. (OSSEP participant)

Our early findings about OSSEP's impact suggest that it can provide a model for other programs, not just in Durham Region but across Canada. It is a program designed to support adult students living with mental illness in their goal paths, which may include employment goals, the primary focus of most programs in mental health hospitals, as well as broader educational goals. Gutman (2008) and Gutman, Kerner, Zombek, Dulek, and Ramsey (2009) found that participants in supported education were more likely to enrol in post-secondary programs than those who did not take part in supported education. Gutman et al. (2009) noted that some factors unrelated to the program also affected the success of participants. Having a stable residence and regular attendance positively influenced success, while inconsistent medication and moderate child care responsibilities negatively influenced success. The influence of child care responsibilities may suggest that child care assistance may be beneficial to pursuing education. Similarly, Hoffmann and Mastrianni (1993) found that supported education encouraged young adults to return to school and to maintain a student identity.

Our findings are limited by the fact that any changes in education levels, confidence, skills, and so on, are self-reported. Given the nature of many mental illnesses, such perceptions may not be very accurate. However, we believe that even the perception of self-improvement may help in building confidence, providing hope, and improving participants' quality of life. Here, the guidance of staff is essential in ensuring that participants pursue activities appropriate to their actual abilities without undermining that hope and confidence. This broader view of the transformative nature of education for persons living with mental illness shifts the usual focus of supported education from being solely vocationally oriented to being more holistic and aimed at improving overall quality of life.

Supported education programs that were not specifically directed toward enrolment in post-secondary institutions include clubhouse models that offer adult and basic education programs, as well as GED and high school courses (Holter & Paul, 2004; Mowbray, Megivern, & Holter, 2003). One program, the New Beginnings School, was described as being relaxed and informal (Holter & Paul), which allowed participants to progress at their own pace. Some courses, such as those in computer skills, provided benefits beyond

job preparation; Koblik, Kidd, Goldberg, and Losier (2009) found that one such program resulted in improved social inclusion as well as vocational training. Such programs are more similar to the current offerings of OSSEP, which focuses on remedial education and upgrading.

Our preliminary findings reflect those of, for example, Gibbons et al. (1980), who found that adult self-learners are better able to gain control over their lives because they develop perseverance, self-discipline, and self-confidence. Our research extends and reinforces this finding in its focus on the impact of education on adults living with mental illness. Given the similarities between supported education and adult education, and that one in five adults experiences mental illness, our research can add depth to adult education programs. It can also serve to advocate for more flexibility in literacy and basic skills programs. In terms of the social, economic, and quality-of-life implications of programs such as OSSEP, we can return to Sen's (1999) capability deprivation argument. Given Sen's characterization of human capability development as necessary for freedom, mental illness not only limits growth and development, but also prevents learners from achieving the self-determination and independence that are integral parts of freedom. Further, Sen (2008) argued that having capability is not only an advantage but a form of power. He also described capability as central to the human obligation to create justice and equity that accompanies that power (p. 336). It is these aspects of freedom, justice, and equity that OSSEP and adult education ultimately hope to give to students.

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