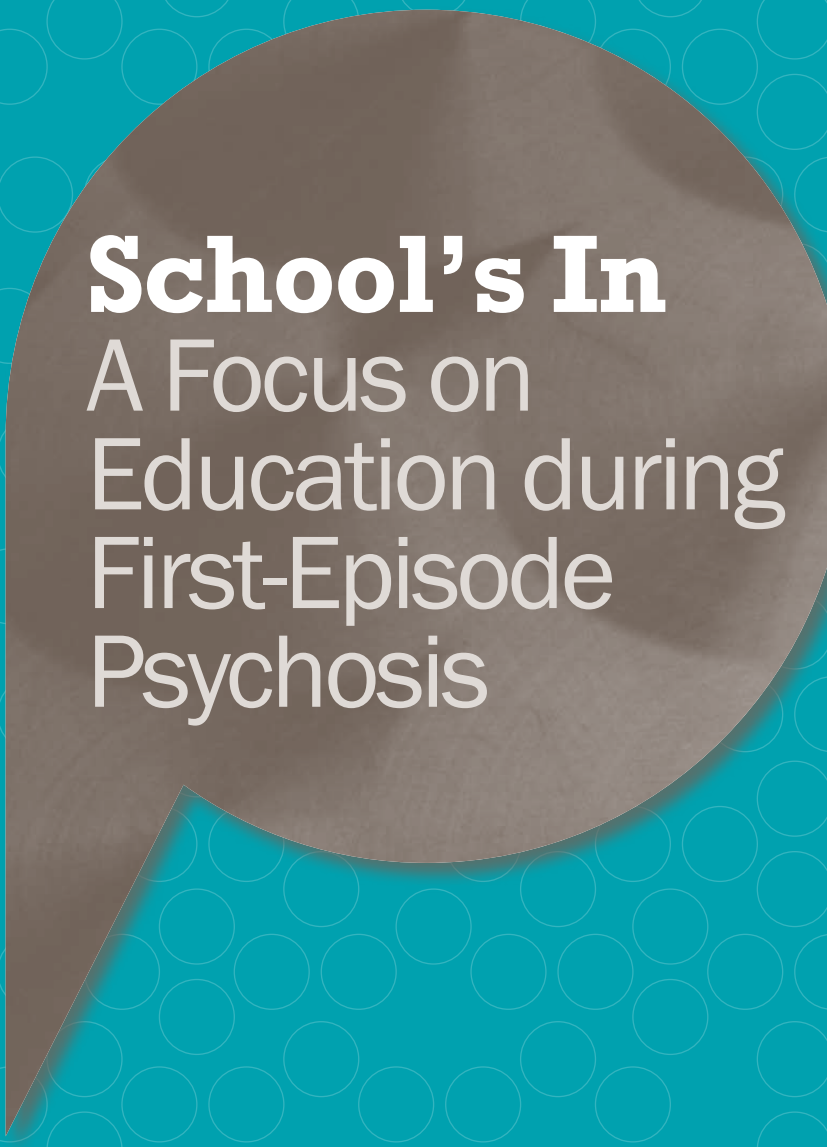


School's In

A Focus on Education during First-Episode Psychosis

Orygen YOUTH Health Research Centre

EPPIC
Early Psychosis Prevention and Intervention Centre

The EPPIC National Support Program of Orygen Youth Health Research Centre has produced this document as part of its work to support the scaling up of the EPPIC model within headspace, the National Youth Mental Health Foundation, in Australia.

ISBN 978-0-9871102-9-9

Suggested citation

Ring, J (2013). School's In: A Focus on Education during First-Episode Psychosis. Orygen Youth Health Research Centre.

Acknowledgments

This manual was written by Judy Ring, Assistant Principal at the Travancore School. Medical writing assistance was provided by Raelene Simpson and Sarah Fraser.

Disclaimer

This information is provided for general education and information purposes only. It is current as at the date of publication and is intended to be relevant for Victoria, Australia and may not be applicable in other jurisdictions. Any diagnosis and/or treatment decisions in respect of an individual patient should be made based on your professional investigations and opinions in the context of the clinical circumstances of the patient. To the extent permitted by law, Orygen Youth Health Research Centre will not be liable for any loss or damage arising from your use of or reliance on this information. You rely on your own professional skill and judgement in conducting your own health care practice. Orygen Youth Research Centre does not endorse or recommend any products, treatments or services referred to in this information.

Orygen Youth Health Research Centre

Locked Bag 10
Parkville Vic 3052
Australia

www.oyh.org.au

School's In

A Focus on Education during First-Episode Psychosis

Contents

Introduction

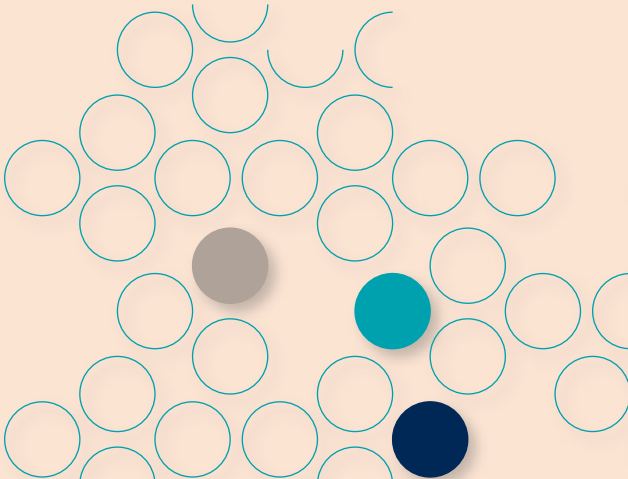
Context of this manual

The content of this manual has been derived from evidence combined with many years of experience of planning, implementing and delivering early psychosis interventions to young people and their families. This manual presents the principles behind establishing an educational service within an early psychosis service, and emphasises the benefits of early, targeted intervention to prevent educational disconnection and disadvantage. This manual is aimed at individuals responsible for early psychosis service planning and development, and, more specifically, those managing educational services within the service. It also serves as a model of educational intervention for educational professionals working within an early psychosis service, but does not present a definitive approach for this work.

Many of the examples presented in this manual come from experiences of the Travancore School that has operated within Orygen Youth Health Clinical Program for young people with significant mental health issues, including first-episode psychosis. Although this manual has been developed based on the Early Psychosis Prevention and Intervention Centre (EPPIC) Model, it is likely that the information regarding service establishment and interventions can be extrapolated to the broader youth mental health field.

Overview

This manual has five sections: **Education in an early psychosis service, Setting up an education service within an early psychosis service, Education services in practice, Professional support for educators** and **Evaluation.** The **Education in an early psychosis service** section discusses the rationale behind educators working with young people with first-episode psychosis, while the section **Setting up an education service within an early psychosis service** describes supported education and the partnerships between mental health services and the education sector. **Education services in practice** provides a practical 'how to' guide to the provision of education services in an early psychosis service. The section on **Professional support for educators** highlights the importance of team work and professional development of educators as part of an early psychosis service. The **Evaluation** section emphasises the need for ongoing research and evaluation in this area.



PART 1

Education in an early psychosis service

Education in an early psychosis service

Educational issues in early psychosis

A report by the National Centre for Vocational Education Research (NCVER) examined early school-leaving and low school attainment in the Australian general population. It found that failure to complete school negatively affected prospects for employment and led to other difficulties, such as poverty, homelessness and poor development of an independent adult identity[1]. The report also found that attainment of a year-12 qualification was seen to improve young people's opportunities and prosects in these areas. With regard to those experiencing psychotic illness, the educational stagnation seen in adulthood was linked to educational failure during mid-to-late adolescence[2].

Participation in senior schooling, or the equivalent in vocational training, is often interrupted or ended by the onset of a mental illness[3, 4]. It is estimated that a third of school-aged young people with early psychosis are not participating in learning or employment[5]. There is an indication that the functional disability, defined as any long-term limitation in activity resulting from a condition or health problem, associated with the early onset of mental illness can be more severe than adult onset. This can result in not achieving pre-morbid educational or vocational goals and financial dependence into adulthood[6]. The importance of school completion was highlighted in a study that compared the employment rates of adults with schizophrenia who completed year 12 with those who did not complete year 12[7]. Employment rates were higher among the year 12 completers compared with non-completers, despite the course of illness[7].

The ability to remain in education, and subsequently, enter the workforce, is related to positive outcomes both for individuals in the development of self-efficacy and financial independence, and for communities in allowing meaningful participation and the development of human capital[8].

Adolescent development and psychosis

First-episode psychosis often occurs during mid-to-late adolescence to early adulthood, which is also the critical developmental period where the skills and experiences are obtained that lead to the independent functioning adult. One of the key developmental tasks for young people on their journey to adulthood is the move into higher levels of education, training and employment[6] that sets the trajectory for career, financial independence and self-actualisation. A greater delay in reaching the markers of transition to adulthood is evident in young people with first-episode psychosis. This was particularly the case for the early marker of educational attainment when it was observed that progression from basic compulsory education levels to further vocational training or higher education co-occurred with the onset of first-episode psychosis[9].

Failure to progress to adulthood alongside healthy peers can affect self-confidence and competence[10]. It is developmentally appropriate to target this early phase of transition to adulthood with specific interventions. A tailored educational intervention for first-episode psychosis forms the scaffolding of these steps for a group of young people who, given their mental health issues, need additional support to hurdle the transition[11].

Recovery from mental illness

Providing appropriate services to aid all aspects of recovery from mental ill health in young people is accepted as a bench mark across the world. The International Declaration on Youth Mental Health aims to ensure that every young person with mental health issues is able to receive 'the help they need when and where they need it'[12]. Key actions of the declaration include:

- focus on resilience, hope and recovery
- ensure access to youth-friendly services and support.

It describes one of the 10-year targets as '90% of young people will report being engaged in meaningful educational, vocational or social activity 2 years after first accessing specialist mental health intervention and support'.

When working with young people with first-episode psychosis, it is important to maintain a belief in recovery. Chronic illness is not the only outcome for these young people – a range of outcomes can be anticipated[5]. It is therefore important to give all young people every opportunity to access a complete recovery, including functional recovery.

The provision of educational services and programs is in line with an increasing focus on functional recovery outcomes in psychiatry[8]. There is an understanding that mental health interventions need to take into account the disruption to education[8]. A 12-year follow-up study by Lay et al. investigated the educational and occupational functioning of adolescent-onset psychosis. From their findings, the authors recommended the implementation of programs to promote school reintegration following a first episode of psychosis, '... to facilitate the continuation of education to the highest possible grade'[6].

We also are beginning to understand the impact of these interventions on recovery itself, as those interventions made early in the experience of psychosis can have a direct effect on alleviating the level of disability[13]. This has been supported by work that links adult vocational outcomes to successful completion of schooling for people with schizophrenia[14].

The mental health benefits provided to a young person by employment, such as social contact, identity and productive use and structure of time[15], would also be provided by participation in education. It has been shown that young people want to have the same experiences as their healthy peers with regard to daily activities and roles[16]. In addition, the focus on supporting continued education may contribute to mental health recovery and reduced hospitalisations[17]. An audit of young people's goals and group choices from the EPPIC program found that 76% of young people with early psychosis asked to participate in an educational or vocational skills group, indicating the priority of this area during the early stages of recovery[18].

A specialised education service is able to address some of the key psychosocial recovery principles[19], such as the provision of normalising activities based around the development of strong supportive relationships and providing hope for recovery. This makes this type of educational service compatible with other functional recovery programs offered by a mental health service. Specialised education staff members are able to build the competencies and key personal learning skills required by young people to enable a smoother transition to external education settings.

The experience of first-episode psychosis is seen to be a highly traumatic one, not only due to the intensity of the acute phase of illness, but also during the recovery phase. This is understood to be as a result of the disruption to development, loss of control over one's own life[20], the fracturing of sense of self[21], the threat to a hopeful future and for some, ongoing symptoms. A timely re-engagement with education provides the opportunity to minimise the trauma associated with first-episode psychosis, through a return to routine and a normalising structure. It also can provide an opportunity to learn new skills, develop new goals and provide hope, all of which can aid recovery[20].

Teaching and learning

Education providers understand that the risks and barriers to educational attainment for young people with early psychosis will be an important part of a youth mental health centre. Access to a specialised educational service with experienced teaching staff within an early psychosis youth service will bring the following benefits for service users:

- links to national and state curriculum, ensuring smoother transitions back to mainstream education
- teaching and learning programs that reflect current educational practices
- the existence of strong pedagogical practice that builds opportunities for student learning. Many in this cohort of students will be experiencing challenges to learning and will benefit from a high standard of practice
- a tailored educational service, as highlighted by Goulding, that can better meet the specific needs of this population to address the high level of dropout(s)[22]

- specific knowledge of educational systems and options with links to educational networks and services that can enhance opportunities for individual pathway planning
- teachers with an understanding of the impact of negative symptoms and changes to cognitive functioning who are well placed to support young people with first-episode psychosis, particularly during the early stages of recovery.

Across Australia, all young people are required to attend school or other approved learning programs until they are 17 years old[23]. As there are a number of young people in this age group with first-episode psychosis who are not engaged in regular education and are lacking the confidence, emotional and psychological resilience to return to mainstream education, the provision of a temporary special education placement enables the release of the community's obligations. This means educational provision for these young people is in line with the right of all children to access education and the right of those with disabilities to access education that meets their needs, as outlined in the Commonwealth Disability Discrimination Act 1992[24].

Integrated model of mental health and education service provision

The collaboration between mental health and other services, specifically with education, is recognised as quality practice that can best address young people's needs[14]. Furthermore, educational services are seen to be part of a recommended multidisciplinary care team structure[25]. The Commonwealth Government's Fourth National Mental Health Plan outlines the following action:

> *'Coordinate the health, education and employment sectors to expand supported education, employment and vocational programs which are linked to mental health programs.'*[26]

A strong working partnership with the education sector is indicated for mental health services.

The literature reports that young people with first-episode psychosis have significant challenges in maintaining and building their educational credentials. It is well understood that educational attainment is associated with future vocational opportunities, resulting in benefits to both the individual (in supporting their recovery and quality of life) and to the community. Educators and health care providers have a responsibility to maximise the learning options and reduce any time away from learning. Specialised educational interventions delivered by educators in close collaboration with mental health services are well placed to offer high-quality support.

PART 2

Setting up an education service within an early psychosis service

Setting up an education service within an early psychosis service

A developmental approach to supported education

Supported education is an intervention commonly mentioned in psychiatric literature. The structure of the intervention can vary greatly, and little is recorded on work with young people. However, there is a call for this to be the intervention of choice for young people in order to address potential long-term disability and suicide risk[9].

The model described in this manual adopts features of other supported education programs, such as promoting hope for recovery, working through supportive relationships, individual choice and establishing a normal student identity with similarly aged peers[19]. However, this more traditional model of supported education has not addressed the needs of secondary-aged students. The education service described here provides a unique set of interventions that use a developmental approach, offering a range of educational supports and strategies to specifically meet the needs of young people. Responding particularly to the needs of school-aged young people with first-episode psychosis, the service offers a classroom model as an interim step from the acute phase of illness through to participation in mainstream school. This has similarities to a program for young adults within higher education[17] that found that provision of a small, safe classroom offered an environment for individual development and improved self-esteem where participants could focus on learning relevant skills.

This model also has elements in common with the supported employment/vocational intervention the Individual Placement and Support model. Please refer to the *Working it out: Vocational Recovery in First-Episode Psychosis* manual for more information. Specifically, the program is integrated into an early psychosis service, there is a focus on the eventual participation in a mainstream setting and it is available for any young person showing interest in their continued education.

Establishing the partnership between mental health and education

Inter-sectorial partnerships are seen as essential to addressing the wider needs of those with mental ill health[4]. An integrated service model that provides care for young people across a range of needs through co-location and a multidisciplinary team approach is seen as an effective model[27]. Partnerships between the education and mental health sectors, both nationally and internationally, have resulted in improved wellbeing for students and their school communities[28]. A supported education program involving mental health services and the technical and further education (TAFE) sector in New South Wales reported the need for high levels of collaboration between education and health[29].

Within a specialised early psychosis service, partnership with special educators can provide a 'bridge' between a clinical service and mainstream learning environments. The specialist teachers can make sense of a clinical perspective and treatment plan within a school environment. They can also assist case managers to understand the stressors, supports and resources within a mainstream school environment.

The inclusion of an education service within an early psychosis service is consistent with the developmental needs of young people. Waghorn et al. state that the inclusion of specialised staff that are trained to support student learning is a contributing factor to successful outcomes, and that, 'this responsibility should not simply extend the case management duties of existing community mental health staff'[14].

One current example of an existing partnership model is between the youth mental health service at Orygen Youth Health Clinical Program and the Travancore School in Melbourne. The Travancore School is a Victorian special education setting that supports the educational needs of students with mental health issues. It provides teachers to young people who are inpatients or receiving ongoing community case management and for outreach support to those attending other school settings. The school has worked in a collaborative and integrated way with local child and youth mental health services for many years.

Hospital schools are present in the metropolitan areas of most states across Australia. Most of these schools are currently offering services to mental health patients within a Child and Adolescent Mental Health Service (CAMHS) (0–18 years) or a Child and Youth Mental Health Service (CYMHS) (0–25 years) in addition to medical patients. These educational settings are potential partners for mental health services that are establishing an early psychosis service. This type of service requires external funding for educational service staff. Hence, consultation with state government education departments will be required to discuss options for access to state-funded teachers or other funding models and partnerships. One possibility is for the service to negotiate a Memorandum of Understanding with the relevant education body for the delivery of services. Once access to staff is arranged, a resource agreement will be required to determine individual service responsibilities.

Specialist teachers recruited to work in an early psychosis service would be expected to meet the requirements of teacher registration within their state. They would also need to have knowledge and experience in teaching an older adolescent population with a strong commitment to student wellbeing. The work requires strong collaborative skills and the ability to advocate for individual students with a range of professionals. Specific knowledge in the delivery of senior secondary curriculum, career planning, knowledge of the wider education and training environment and supporting students with additional needs is an advantage in the role. Specialist teachers working within an early psychosis service would also require extensive knowledge of issues that impact on the education of young people with mental health disorders.

Teachers in the multidisciplinary team

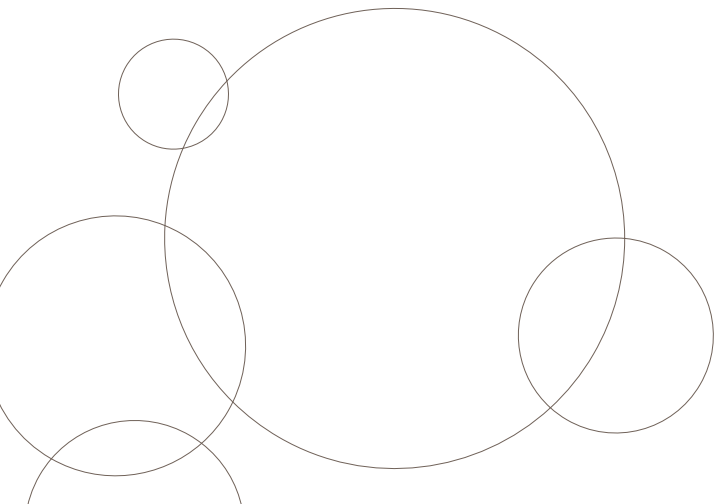
An early psychosis service will benefit from teachers being integrated into the multidisciplinary team in a way that allows them to fulfil their professional responsibilities. This will allow a consistency of approach, reduce confusion for the young person and their family, and avoid duplication of roles.

The key to successful professional collaboration within a multidisciplinary team is clarity around each professional's role. For the specialist teachers, this will include discussions around issues such as contact with family members, feedback to schools around mental health, presenting alternative pathways to the young person, managing crisis, following up absences, conducting assessments, establishing risk and record keeping.

Promoting the program

Teachers will need to promote the program, their services and their skill set to the clinical staff. This is particularly important if clinicians have no previous experience working with an education provider. Effective educational interventions start with targeted referrals from case managers. Their knowledge of this option as an important aspect of functional recovery is essential.

Attendance at meetings and case presentations, opportunities to meet with new staff during their induction, participation in all-staff events and displays/open days all assist in promoting the education program and allow informal opportunities to discuss possible referrals and interventions.



Setting up the environment

Establishing a learning environment will depend on the program options and modes of delivery; however, all program options will need to consider the resources required to provide a safe/low stimulus environment. Consideration should be given to the following:

- If the service has plans to deliver education within an inpatient setting, there will need to be a program space and staff space within that setting.
- A recovery program option will require a group teaching space, staff office space and access to individual appointment spaces.
- If offering an applied learning or Vocational Education and Training (VET) program, specific spaces and/or equipment will be required.

Any learning spaces will need to offer a safe and secure environment for staff and students and provide timely access to additional crisis support. Responsibility for the management and maintenance of learning spaces will need to be negotiated between the services.

Provision of a group environment

The provision of an educational service that includes learning groups, as opposed to only one-on-one support, expands the possibilities and benefits to young people. The use of groups to enhance the treatment of young people with first-episode psychosis has been shown to build hope, improve interpersonal skills and help young people to focus on realistic goals[30]. Providing a small group setting that furthers education also allows young people to gain the support of peers in a non-judgemental environment in line with the known desires of this cohort[16].

The classroom model contributes many of the positive features of group work as a recovery intervention for this cohort: the establishment of a peer group, the ability to set and achieve goals, the rebuilding of social skills and providing normative daily structure. These are all developmentally appropriate for this age group. A peer group culture normalises experience, reduces isolation and assists with coping. It also allows fun and entertainment to be part of the experience[31].

Program elements

Strategies and interventions that are known to assist school engagement for at-risk students include: targeted, individual pathways and career planning; small groups that respond to individual needs; project-based or applied learning options; and targeted assistance to support skill development, including social skills[32]. These elements should form the basis of educational program delivery. An outreach program should also be a key component, in response to existing research around the primary aim of getting young people back into mainstream options as soon as possible.

The ability to provide a range of interventions maximises the possibility of meeting individual needs.

The Orygen Youth Health Clinical Program –Travancore School model

Overview

The current program at Orygen Youth Health Clinical Program (OYHCP) demonstrates one model for the integration of educational services into the clinical program. The following description of the OYHCP–Travancore School model demonstrates how a joint service arrangement can work in practice.

A small teaching team (currently three full-time positions) offers a range of educational services across the youth mental health service, which includes the early psychosis service (EPPIC) and programs specialising in other disorders. Here, the teaching staff, while managed as part of a separate service, the Travancore School, have an established role within the multidisciplinary team. This occurs at several levels:

- Specialist teachers sit within the psychosocial recovery team, alongside specialist group workers and the vocational worker(s). Within this team, teachers have a responsibility for the coordination of educational groups and other interventions within the larger group program. For more information about the group program at OYHCP, please see the manual *All Together Now: Therapeutic Group Work for First-Episode Psychosis.*
- A teacher will also form part of a small working team (a Mini Team) with the primary case manager, key group worker and any other relevant staff for an individual young person's educational recovery plan. In this forum, the young person's goals and support planning are discussed with each worker to clarify their particular role and establish a system for ongoing feedback and review.

In supporting day-to-day operations, agreements have been developed around a range of key issues, which are presented in the following sections.

Privacy and consent

Teachers are asked to sign a confidentiality agreement when they begin the program that outlines their responsibilities regarding use and disclosure of information from young people. The same form is used by the mental health service for student placements and visiting professionals. The teachers are also accountable to the privacy policy from their own organisation. They seek formal consent from parents/carers to engage in work with schools as a part of outreach support for students.

Record-keeping and files

The specialised education service maintains its own files, which contain basic student information and a record of all work related to the student's education. Teachers are given access to the clinical file but do not write in the notes. They are also able to submit reports that can be included in file correspondence. All other relevant information is sent to the case manager or group worker, who makes a record in the continuation notes that this information has been provided and notes where it is filed. Summary information around educational progress is also included as part of the group program review process.

Duty of care

Specialist teachers maintain their commitment to their professional responsibilities in line with relevant professional standards. Teachers have specific responsibilities around duty of care for students, including a legal mandate to report suspected abuse. Clarification of the impact of this on day-to-day operations is made on a case-specific basis.

Program funding

The Travancore School provides funding for all of the educational program requirements, including technological hardware and software, educational materials, stationery and professional learning needs. Materials for jointly delivered programs are negotiated on a program-by-program basis.

Professional learning

OYHCP provides a range of professional learning opportunities and gives the education staff access to any relevant staff training in regards to mental health training. All other professional learning is funded by the Travancore School.

Line management

Direct line management for teachers is through the Travancore School, which also manages their performance and development process. The school principal has regular contact with senior clinical staff to discuss any issues around a teacher's work.

Establishing an education space

Co-location is a key element of the partnership between OYHCP and Travancore School. In this model, OYHCP has provided a space for the teaching team to run education programs and use as office space. This is located in close proximity to the group program space and is connected to the site's duress system. OYHCP maintains the external space and is responsible for utilities. The Travancore School provides all of the internal requirements, including furniture.

Communication and transport

The teachers are allocated an email address within the mental health service to assist communication with clinical staff, and the school provides teachers with mobile phones to support outreach work. OYHCP allows teachers access to clinical vehicles for outreach visits. They also have access to Travancore School vehicles (housed on another site).

PART 3

Educational services in practice

Educational services in practice

Overview

Each young person presents a set of individual needs, and their readiness to embark on specific interventions will vary. A specialised education service will therefore need to involve a range of options. Young people may choose to access several or only one of these options, which can include:

- educational planning and consultation
- support to engage with career plans, including enrolment with courses (e.g. VET)
- support in returning to school or selecting and enrolling in a new school
- support to maintain a current school placement
- group work in a small classroom environment to:
  - support learning within an external enrolment
  - facilitate and deliver an individual learning program
  - develop and practise school routines
  - build personal learning competencies
- group work with a vocational or skills-based component
- work experience placement
- formal educational assessment
- secondary consultation (for case managers).

Aims of the education service in an early psychosis youth service

The overall aim of the program is to help young people commence or maintain meaningful participation in ongoing learning through the development of individual learning goals that are compatible with clinical treatment. Specific interventions will have additional aims.

For individual pathways planning, aims include:

- to provide hope for the future and promote self efficacy
- to provide information on educational options
- to support the development of career plans.

For on-site learning programs:

- to provide a safe learning environment for young people unable to attend mainstream schooling
- to assist the learning and development of specific skills and knowledge

- to maintain routine and a sense of the self as a learner with developmentally appropriate activity
- to create opportunities for social learning.

For transition and outreach:

- to prevent or minimise disconnection with mainstream education
- to support mainstream educational providers to meet the needs of young people with first-episode psychosis.

Referral to the education program

Referrals for educational services will generally originate with the case manager. If educational services are situated within a psychosocial or functional recovery service component, referrals would follow existing procedures and be presented to that team. Case managers can refer their young people to the psychosocial recovery team for a range of functional recovery interventions. Some referrals may be for general psychosocial services. Generally, a group program worker would meet the young person to determine specific goals and interests and match these to available interventions. If educational interventions are indicated, this would be passed on to a key teacher. If a referral clearly requests a specific educational intervention, for example, outreach support, this will be followed up directly by a teacher. The referral will then require additional follow-up with the case manager by the allocated teacher. The teacher should complete an educational referral form with the case manager that clarifies the specific aims of the educational intervention and gathers relevant background information. This background information includes:

- family or accommodation issues, including guardianship or independent minor status
- current mental health issues, intrusive symptoms, medication side-effects, engagement in treatment
- other relevant health issues (e.g. asthma, allergies)
- relevant past assessments (e.g. neurocognitive, autism spectrum disorder)
- any history of concerning behaviour
- current stressors
- ability to self-manage and seek help
- treatment goals that relate to possible educational goals.

The referral conversation with the case manager is an opportunity to collect information that will improve the effectiveness of the work with the young person and to avoid activity duplication or working at cross purposes. The case manager may not have detailed information about current or past schooling, but this is best obtained from the young person during the initial interview. It will be important to get details of any contact or conversations with the current education provider to ensure seamless and consistent school liaison.

(Please see Appendix 1 for an example of an Educational Referral Form)

Administrative requirements

Student management database

A simple database or spreadsheet can be developed to log and track referrals. Recommended fields include:

- Student name
- Case manager
- Student contact number
- Age
- Dates of commencement and closure
- Specific programs accessed (e.g. groups, outreach, pathways planning)
- Current educational enrolment (if applicable).

The inclusion of educational or vocational status on completion of service will assist in the collection of outcome data. Long-term follow-up information can also be added to the database if this is being collected.

Entries can be colour-coded for easy reference, for example:

- Open-active
- Open-on hold
- Closed.

Files and record-keeping

An individual educational file should be created for each student. Files should contain the following relevant items:

- completed referral form (see Appendix 3)
- initial assessment form
- individual learning plan
- career plan
- signed consent forms
- external program enrolment (e.g. Victorian Certificate of Applied Learning [VCAL])
- assessment reports
- Victorian Assessment Software System (VASS) record or local equivalent – VASS is a web-based application that allows enrolments for the Victorian Certificate of Education (VCE), VET and VCAL. It also allows results to be entered and stored on the central Victorian Curriculum and Assessment Authority (VCAA) database.

An electronic format for ongoing file notes will support the tracking of meetings, emails, school visits and other significant information. This is particularly relevant for recording elements of outreach work, and ensures that work with a student can be continued by another teacher if needed. The education service can keep an electronic student file with access to a purpose-built database; this can allow file notes (as above) as well as attachment of reports, assessments and any other relevant items in the student file. The education service will also need to determine its processes and requirements for a file archiving system that allows retrieval of files when individuals have an additional period of work with the education service.

Engaging young people with the education service

Relationship management

The initial meeting with the key teacher is an opportunity to develop the relationship with the young person as well as commence the assessment process. It is important to clarify the young person's expectations and clearly outline what the educational service is able to offer. It also provides an opportunity to start the development of specific educational goals.

The engagement of young people with early psychosis is often challenging. Low motivation, decreased organisational skills and lack of confidence can all interfere with participation. A high number of young people drop out of care during the early stages. When the young person is well engaged with their case manager, and with the service in general, engagement with the education service is more likely to be successful. However, it is equally important that the teacher develops their own working relationship with the young person. For some young people, involvement with educational goals and activities can feel very normal and this can contribute to engagement with the education service even when engagement with the clinical program is tentative.

As with other health care professionals, teachers need to set aside the time to build quality relationships as part of an engagement process[25]. This can involve good listening skills, regular catch-up meetings with the young person, meeting with them in a familiar/comfortable space and supporting them with the problems they have. Productive relationships between students and teachers in a supported education program have been considered a key element to the program's success[17].

Recent work around engagement[31] tells us that the quality and nature of relationships with young people with first-episode psychosis significantly influences engagement, and that relationships perceived as negative can affect attendance[33]. Young people value empathy, care, real listening and real conversations that are not just limited to the work at hand. Workers need to be flexible, non-judgemental and able to identify and support a young person's strengths. Judgemental attitudes and perceived lack of understanding have been identified as barriers to engagement[34]. Providing a peer-group culture encourages young people to stay engaged.

An engaged approach by teachers includes consideration of their physical proximity and conversational style. Young people, particularly during the acute stage of illness and early stages of recovery, will be wary and uncertain about the teacher's approach. It is important that young people are respectfully listened to and their input is accepted and given due consideration. Body language needs to present support but not be overbearing. The following strategies can assist teachers:

- Introduce yourself and your role. Do not assume they have been told or will remember either. Always introduce anyone else that is present, and explain their role.
- Use side-by-side seating with a non-threatening posture and limit direct eye contact.
- Avoid conversations in noisy, highly-stimulating environments.
- Maintain a slow, quiet approach with a calm and quiet tone of voice, and avoid conversations with a high emotional content.

- Spend time listening and seeking to understand before offering suggestions on what could or should happen next. When there is a need to transfer information, try not to overwhelm young people with questions, and seek to obtain information through the use of conversational style.
- Offer support and suggestions but avoid taking over with your own plan. '[I]t is about giving them as much independence and responsibility for themselves as possible, while at the same time acknowledging their personal reality and symptomatic experiences'[35].
- Carefully use and respect interpersonal space: allow more space than normally considered adequate for moving around. Walking and talking can relieve restlessness.
- Keep conversations to the point. Respect a conversational pace that is comfortable for the young person, and avoid being insistent – be alert for signs of increasing stress and restlessness.
- Be honest about what you can and cannot do for them.
- Do not expect to gather a large amount of personal information in one session – stagger these conversations by:
  - explaining the purpose of each contact/conversation and seeking the young person's input
  - allowing an extended response time to direct questions to allow for slower processing, and repeating things if necessary.
- If the young person is experiencing psychotic symptoms, do not minimise or argue with their hallucinations or delusions, but seek to acknowledge obvious distress or fear. It is also important not to collude with delusions or encourage paranoia.
- Keep in mind that emotional and verbal responses may be limited, but this should not be interpreted as a lack of feeling or understanding.

An initial meeting between a young person and a teacher can benefit from the presence of the case manager. This builds on the existing relationship with the case manager and demonstrates how the team of professionals can work together towards the same goals and share information.

Engagement in learning

Once a student is engaged with the teacher and has agreed to take part in a new learning program, consideration should be given to specific strategies to engage them in the learning process. Students who have disengaged from learning require a thoughtful and structured approach to re-engagement. A number of students with first-episode psychosis have disengaged from school under stressful circumstances, for example, embarrassing or erratic behaviour or interactions, that have left them feeling inadequate or out of place in a learning environment. Strategies need to include: understanding the student's experiences and perceptions around disengagement; offering a changed approach to learning that addresses the aforementioned concerns; and establishing new negotiated learning possibilities that involve students in decision-making and are flexible and modifiable[36]. All of these strategies are made possible by strong, respectful relationships.

Initial assessment

Assessment of young people referred to the education service has several stages and foci. Initially, it will involve building a picture of the student, their educational history, the impact of their illness, their skills and strengths and goals for the future. Information from initial discussions with the student combined with information from the case manager and family can help to build an education history. Information that forms part of this initial assessment will include the details outlined below.

- **Personal information** – includes contact information, parent/carer contacts, accommodation type, access to transport, Centrelink involvement and any existing benefits. The initial information form is a guide for a conversation that will provide the teacher with rich information about the young person and their educational history, interests, strengths and hope for the future. Some of this information may have been provided by the case manager at referral, but it is useful to get the young person's description of things. This is ideally done during an initial meeting, but can be staged according to the individual needs and presentation. Engagement with the teacher is a primary aim.
- **Self-assessment of skills and interests** – includes the young person's own brief description of literacy and numeracy skills, hobbies, current leisure time activities, sports they participate in and particular skills (e.g. second language, IT skills). Young people with first-episode psychosis can often feel that they lack skills. Conversations to help them recognise the skills and knowledge they have can assist with developing the student–teacher relationship and provide knowledge for future planning.
- **School history** – this helps to gain a sense of the young person's stability/mobility, completion, attendance, viability of returning to last placement, previous schools attended, year levels completed, attendance and subjects most enjoyed. It is important to remember that a long conversation about schooling history can be uncomfortable for some young people. A number of young people with first-episode psychosis have been out of formal education for some time, or may have left school while significantly unwell. They can be unclear about what levels/subjects have been completed and may never have collected final school reports. If this is the case, it can be important to get their (and a parent if under 18 years) permission to contact their past school for this information. If the student has attempted units of their senior certificate it is possible to obtain their official record. In Victoria, see www.vcaa.vic.edu.au/. Those outside Victoria should use appropriate local or country-specific resources.

If there is a current school placement, it is important to the discuss details of what is being attempted, what is the level of completion, current challenges and what is working well.

- **Work or work experience history** – a record of any paid employment and particular tasks performed. Include periods of school work experience or work placements as part of VET. Relevant unpaid work should also be included (e.g. babysitting for family members).
- **Current educational or career goals** – discuss any long-term goals the young person has. Many young people in this age group do not have clear ideas for their future careers; it is important to acknowledge that this is common, but also something

that they can start to explore with a teacher. At times a young person may have a definite career idea. It is important then to discuss with them how they arrived at this goal. Find out if they have had any previous career counselling, determine their level of knowledge of the job requirements, any steps they have taken towards this and whether it is an appropriate fit for them as an individual.

- **Goal-setting** – develop initial goals for things they would like to work on with you. Goal-setting is a useful way to give focus to your work with the young person and to ensure that it is in line with their wishes. Maintaining motivation can be very difficult for young people with first-episode psychosis; it can be assisted by having clear goals that enable them to see progress. However, this goal-setting process is often difficult for a young person. They may have had no prior experience with articulating goals, or they may have previously felt pressured into developing goals that were meaningless to them and never followed-up.

It is important to ensure that educational goals are compatible and relate to clinical goals. Relevant information obtained through the educational assessment should be communicated to the case manager to complete the picture of the young person and their needs. Ongoing consultation with the case manager and group worker will be required as the program interventions are developed. Once agreed goals are established, the specific type of intervention can be discussed and an Individual Education Plan (IEP) developed.

Developing an Individual Education Plan

Creating an IEP enables the structured consolidation of assessment information and goals into a 'best fit' learning program for the young person. The IEP is a document that is developed collaboratively with relevant parties, parents/carers, educators, specialist support staff, the case manager and the student, and reviewed on a predetermined basis to meet the young person's individual needs and priority goals. It will consider the student's current level of performance, and include implementation strategies and relevant assessment information. See the box on the next page for features of an IEP.

Key focus questions to assist with the development of an IEP[37] are:

- What are the student's strengths?
- Where is the student functioning within the context of the general curriculum?
- How is the student faring with relevant assessments?
- What kind of goals and benchmarks do we have for this student?
- What kind of support or help might be important for the student?
- What can we each do to help improve this student's performance?
- What learning and instructional strategies and environments work best for this student?
- Is the student receiving the appropriate and necessary accommodations and modifications?
- What can be done at home to support the student's learning?
- What educational programs will help the student reach their long-term goals?
- Do we need assistance from other persons (within or outside the school)?
- How can we address any behaviour issues the student may have?

FEATURES OF AN IEP

An IEP should:

- outline a meaningful educational program
- be age-appropriate, holistic in its approach, flexible and future-orientated
- be a strengths-based model with a focus on the student's potential to achieve good educational outcomes
- consider key long-term goals that reflect learning outcomes in social, academic and life skills development
- establish short-term goals that will lead sequentially to the achievement of long-term goals
- ensure that the goals are measurable, achievable, supported, time-framed and aim to retain the student at school
- clearly articulate individual and shared responsibilities
- provide guidance for the Student Support Group (for more information, please see Appendix 2)
- contain a record of important decisions, actions, student behaviour and progress
- be a useful transition tool
- be reviewed every six months.

From the Individual Education Plan Guidelines, available at:
www.education.vic.gov.au/school/teachers/health/pages/edplans.aspx

When developing an IEP:

- It is important to collect existing information around the young person's mental health status and other issues that may have an impact on learning, such as current cognitive difficulties; include strengths, interests and preferred learning styles, if known.
- Including both short- and long-term goals helps to ensure that short-term goals are logically linked to long-term ones and educational goals do not conflict with clinical treatment goals. Use the SMART goal format to help with setting goals. Self-articulated goals give a platform for regulating behaviour, develop focus and encourage the development of personal plans[38].
- Outline the actions required to meet the goals.
- Clearly note who will do what, and when.
- Develop an agreement with the young person as to what success will look like for evaluation. Explain that plans can be modified if they are not working as expected, and that this does not mean they have failed, only that the plan was not appropriate for them at that time.

CASE STUDY 1

Gretel, aged 15 years, finished a long inpatient stay with her future schooling unresolved. Her recovery was slow and she was still experiencing positive symptoms, such as responding to auditory hallucinations and disordered thinking. Her social interactions with staff and peers were at times odd or inappropriate. Educational assessment showed she possessed foundation literacy and numeracy skills but had difficulty with abstract thinking and higher order skills. Her school expressed a desire to continue to support her, but did not feel equipped to manage her presentation.

An IEP was developed by the specialist teacher in collaboration with her existing school, case manager and family, and Gretel started attending the onsite classroom program several days a week. A 'shared care' arrangement for her educational program was negotiated. Gretel was to attend the education service classroom three days a week and work towards units of the Foundation VCAL certificate. She was able to receive a high degree of one-on-one support and an individually devised program built around her interests. Any areas of concern or signs of relapse were quickly noted by the teaching staff on site and referred to the case manager. On the other two days, she was to attend her school with the support of the school counsellor and an aide. A management plan was developed by the school counsellor and the specialist teacher in consultation with the case manager, which included the involvement of a teacher aide as a support person, participation in whole class and one-to-one activities and a safe space for recess and lunch breaks. The plan also focused on Gretel's participating in some applied learning programs that she felt were her strengths. Her family supported her to develop independent transport skills.

This arrangement continued for 18 months. Gretel continued to slowly recover, with noticeable improvements in her self-confidence and social interactions. She was able to increase her days at school to three. She was eventually successful in completing her Foundation VCAL certificate with units delivered jointly between the two education services. Gretel went on to an entry level TAFE program.

Interventions

The types of educational interventions offered can fall into four categories, covered in this section. The categories are:

a. On-site classroom-based or small group learning programs
b. Transition and Outreach Support
c. Individual Pathways Programming and Support
d. Secondary Consultation.

This range of interventions, delivered within a collaborative treatment model, is consistent with the model of interventions described in the *Strategic Review of Re-engagement Models for Disengaged Learners*, which categorises interventions into wellbeing, pedagogy, outreach and pathways[39].

On-site classroom-based or small group learning programs

Overview

The focus of these programs will be determined by the numbers and skills of the staff available. Some programs can successfully be delivered through a partnership with group workers (please see Part 3 Implementing Groups in *All Together Now: Therapeutic Group Work for First-Episode Psychois*) or a partnership with a local VET provider. Classroom programs will also vary in focus and content if delivered within an inpatient program as opposed to an outpatient or recovery program. Programs that have been successfully delivered to this cohort include:

- academic programs where students have been able to bring in curriculum from external mainstream programs, such as VCE or equivalent
- academic programs where the program is developed and taught by the on-site teacher; in Victoria it has been possible to offer units from the VCAL certificate
- applied learning programs with a focus on VET skills. This can be accredited training delivered in partnership with a registered training organisation (RTO) or 'taster' programs, such as a gardening program
- creative programs with an arts focus.

Within each specific program, the development of an IEP will articulate the specific learning goals relevant to the activity; these goals can include social, behavioural, communication and skill development. An estimate of the expected length of time the young person will attend the program will contribute to the relevance of the plan.

Pedagogy

To provide effective teaching and learning and a basis for looking at best teaching practice, the following framework is suggested:

Applied learning principles

Applied learning can respond to some of the challenges faced by young people with first-episode psychosis. It can positively affect motivation, engagement, confidence and transition from school[39]. The concepts that underpin applied learning as recommended by the Victorian Curriculum Assessment Authority[40] are listed below.

- Start where the learners are at.
- Negotiate the curriculum and engage in a dialogue with learners about their curriculum.

- Share knowledge and recognise the knowledge learners bring to the learning environment.
- Connect with communities and real life experiences.
- Build resilience, confidence and self-worth – consider the whole person.
- Integrate learning; learning should reflect the integration that occurs in real life tasks.
- Promote diversity of learning styles and methods; different learning styles require different teaching methods.
- Assess appropriately; the assessment method that best fits the learning content and context should be used.

Other useful pedagogical frameworks include:

- Principles of Teaching and Learning P-12 (PoLT) (see Appendix 5)
- e5 Instructional Model – www.education.vic.gov.au/school/teachers/support/Pages/e5model.aspx
- Principles of Adult Learning (to consider when working with some of the older students).

Curriculum

To develop or access appropriate curricula for learning programs, refer to the local/regional curriculum documents used within mainstream settings. Linking learning programs to mainstream curricula where possible will support student transitions and facilitate shared learning arrangements.

In Victoria, VCAL provides a focus for applied learning programs at a senior secondary level and covers literacy, numeracy, work-related skills and personal development. VCAL has the flexibility to manage individual units being completed at any time of the year if the service becomes a recognised provider. Within this certificate, individual learning projects can also be developed around student strengths and interests.

Provision of the other senior secondary certificate in Victoria, the VCE, is challenging for a small education service with rolling enrolments. Students wishing to complete this certificate as a pathway to higher education can enrol with another provider and bring the curriculum with them to the on-site classroom. This has been very successful when working in partnership with a state or regional distance education service. In Victoria, this is possible by enrolling with Distance Education (see www.distance.vic.edu.au).

The Australian Curriculum covers a range of learning areas that are currently being rolled out nationally. The Australian Curriculum documents can be accessed at www.australiancurriculum.edu.au/. AusVELS is the Australian curriculum in Victoria, and it currently provides curriculum up to year 10 level across the areas of English, Mathematics, History and Science. See http://ausvels.vcaa.vic.edu.au/

The Australian Curriculum also includes seven general capabilities, one of which includes Personal and Social Capabilities. This involves the skills of managing wellbeing, relating well to others, and making informed decisions about one's life. It is very relevant to the learning of this group of young people and can provide a focus for some learning goals and support work in other key learning areas.

Assessment

After the initial assessment, the next phase is assessment for the development of student learning. This is required when students plan to attend classroom sessions and complete an individually tailored learning program. A number of different assessment practices, as described here, can be used for different purposes.

Assessment FOR learning

This type of assessment occurs when teachers gather initial information or use inferences about student progress to inform their teaching. This may involve formal tools, such as:

- **diagnostic testing** – e.g. Compass Literacy and Numeracy Assessment, Progressive Achievement Tests (PAT) in Mathematics, PAT – Reading
- **screening tests** – e.g. Stanford Reading Screening Test
- **tests of general ability** – e.g. Australian Council for Educational Research General Ability Test, Core Skills Profile for Adults
- **inventories** – e.g. VIA Adolescent Strengths Inventory, Abiator's Online learning Styles Inventory Test, the VARK Questionnaire
- **site-specific tools** – e.g. interviews, guided conversations.

These assessment tools can give information about student knowledge, skills, learning styles or strengths and are an essential part of developing the initial learning plan. Teachers may also refer a student for psychological testing to assess cognitive capacity and changes in cognitive functioning, or other assessments conducted by clinical or allied health professionals (e.g. social skills assessments).

Informal, short, formative assessment strategies can also be used during a period of instruction. Some examples include:

- visual (e.g. thumbs up/down, graphic organisers)
- observations (e.g. checklists for group work)
- questioning (open and focused)
- written (e.g. priority activity)
- verbal (e.g. think, pair, share)

For additional examples see http://quipsd.org/domain/292.

Assessment AS learning

This type of assessment occurs when students reflect on and monitor their progress to inform their future learning goals. Student self-monitoring needs to occur regularly. Strategies for this type of assessment may include:

- using 'traffic lights' – i.e., the use of a green/yellow/red card or symbol for students to indicate their level of understanding
- student-led conferencing
- ticket out the door – i.e., students provide feedback on an element of their learning for the day
- three-minute pause
- reflective journals.

Assessment OF learning

This type of assessment occurs when teachers use evidence of student learning to make judgments on student achievement compared against goals and standards. This is required specifically when delivering a prescribed curriculum, for example, VCAL units or measuring against national standards.

Assessment may include both formal and informal tools, such as:

- feedback tools
- review and reflection tools
- rubrics.

Transition and outreach support

Assisting young people in their transition back to mainstream education, and offering support to maintain this, is a key role for specialist teachers in an early psychosis service. Providing young people with the option of mainstream educational placement is always the end goal. Current evidence shows that the most successful outcomes are obtained from mainstream placements[41].

The first role in transition is to assist the young person to find a suitable school or provider. Some young people will choose to return to their previous school; however, a new placement may be required for the following reasons:

- the student has been away for some time, is now disconnected and peers have moved on
- the student left the school in the context of their psychotic presentation, causing them to feel embarrassment or concern about stigma
- a more flexible and supportive learning environment is required
- the student's educational goals have changed.

When considering a new placement, a range of features should be investigated, including supports for student wellbeing, program/subject options, location and transport options/flexibility. Organising visits to prospective settings with students and their families will assist in decision-making.

Once the mainstream placement has been decided, whether this is the existing or new school environment, the specialist teacher role includes supporting the student to understand and prepare for the school or program's expectations. They will also have to support the school in their understanding and planning for the student with first-episode psychosis. It is helpful to suggest the school establish a student support group (SSG) to oversee and develop the initial transition plan and provide ongoing support or crisis management plans. Discussions should cover the availability of additional supports from within the school's current resources, or the feasibility of obtaining additional funding (such as Program for Students with Disabilities [PSD] funding, in Victoria, or other relevant government initiatives). Any additional applications for funding can be organised through the SSG. (See Appendix 2 Student Support Groups)

Please note: The following box is based on the assistant principal from Travancore School's explanation of the initial process of working with a local school to help a young person with their education goals.

SPECIALISED EDUCATION SERVICE INVOLVEMENT IN RETURNING TO MAINSTREAM SCHOOLING

A teacher from the Travancore School will seek written permission from the young person and their family before approaching a school for the first time. The teacher will ask the young person to identify their preferred school contact (e.g. their year level coordinator, wellbeing coordinator or assistant principal). In some cases, the young person's case manager may have already made these contacts and may have already sought the required permissions. The teacher will then make contact, and carefully explain their position and how they are helping the young person. They should clearly outline the type of support they can provide and give an indication of the approximate time frame of their involvement. They may also need to clarify for the school the role of the case manager and the mental health service. It is during this time that the teacher can informally enquire about the young person's current school profile (academic, social and behavioural) and try to develop a working relationship with the school. Schools are generally willing to embrace the support offered by a specialised education service that works specifically with mental health; however, it is vital to clarify as early in the process as possible whether the expectations of the student, family and school regarding a return to school are aligned. If so, the teacher then begins discussion of the young person's return-to-school plan. Firstly, the teacher clarifies any current concerns the school may have regarding the student's support needs and begins the process of working with the school to plan for the student's return. The specialised education service will come to an agreement with the school on how to progress the work, clarify the key roles and communication strategies.

If a school believes that they are no longer an appropriate placement, or the young person is unhappy returning to that particular school, the teacher will start the discussion about alternative learning environments. Alternatives can be a different school, a TAFE program or another community education placement; this is all discussed with the young person and their family and is ultimately the young person's decision.

CASE STUDY 2: RETURN TO SCHOOL PLAN

Michelle is a year 11 VCE student seeking to return to school following several weeks' absence as a result of her mental health. Michelle is very motivated to go back to school. Her support group is concerned about her ability to manage the stresses at school and have developed a plan to monitor her return.

Michelle's support group personnel are:

Case manager	**Lisa**
Specialist teacher	**Paul**
School wellbeing	**Julie**
Year-level coordinator	**Francesca**

Michelle's goal this term is to attend every day at school. The support group recognises that Michelle may occasionally need some downtime at home to regroup. Any absences will be passed on each Friday by Francesca to Paul. Francesca will also collect information on all upcoming assessment tasks from Michelle's teachers to forward to Paul.

A previous plan between Michelle and the support team to help Michelle manage stress and anxiety when at school has been developed, which includes the roles of each member. The strategies in the plan include Michelle trying to stay in all classes using her list of coping strategies, rather than exiting to Julie.

If anxious she will try to 'ride it out' until the end of the period, then report to Julie if needed. If necessary, she will exit class (with use of a 'class pass') and go to Julie. Exit data to be passed on to Paul from Francesca.

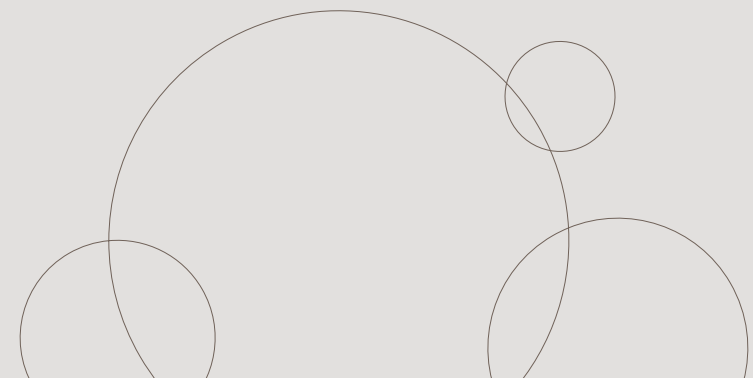
Michelle is to attend appointments with Lisa each Monday at 4 pm after school. In part, this appointment reviews how school is going and how the coping strategies are working for Michelle.

Paul is to catch up weekly with Michelle (to monitor progress at school around absences, exits, work requirements) after the case management appointment.

Michelle to catch up with Julie weekly/fortnightly (they will work out a time).

Paul will call Julie each week to share relevant information.

This plan will be reviewed by the team at a later date.



Support provided by the specialist teacher to the student can include:

- developing skills to manage the school environment (e.g. navigating the location, interpreting the timetable, locating key personnel)
- building confidence and knowledge in the use of school resources (e.g. library, student wellbeing/support, information and communication technology facilities, career guidance/resources, homework groups)
- negotiating financial assistance if required for text books, uniform, camps and activities
- organising access to tutoring.

A major role of the specialist teacher in their collaboration between the school, student, and family is that of advocacy. This includes:

- developing an understanding of the negative symptoms of illness and addressing existing or potential stigma. Negative symptoms and related absences from school may be interpreted as disinterest in learning or lack of motivation. The school staff can benefit from understanding the role of continued educational engagement in recovery and that waiting until students are well before returning to school is not always in their best interests
- consideration of the cognitive difficulties that may result from the psychosis, and the subsequent learning accommodations that may be required. It may be important to remind schools that educational equity is not about giving all students the same but giving each student what they need
- giving the student access to a suitable subject selection in line with their strengths and interests – this is particularly important when students are struggling with low motivation and confidence
- trying to develop timetable commitments that will maximise opportunity for success. The level of commitment appropriate for each student will vary according to past experiences, symptom severity and confidence; flexibility and the availability of part time attendance may be critical to a successful transition
- arranging assessment options that can allow for additional hospital admissions or changes to medication; alternative assessments or a reduced number of assessment pieces may be necessary if students have been absent or suffered a relapse
- Understanding the management of relapse in the context of educational pathway – an understanding of the 'vulnerability–stress relationship'[42] can explain the need to modify potentially stressful circumstances for an individual demonstrating vulnerability to relapse by altering environmental factors[43]. Stress within the educational setting may centre on assessment deadlines, exams, volume of commitments and peer or social stressors
- collaborating with the case manager and the student to communicate a plan to recognise and manage early warning signs of relapse and ensure the school support personnel understand their role and are comfortable with the plan.

Once the mainstream placement is underway, the specialist teacher may continue to meet with the SSG, specific school staff and the student as required. A key role at this stage is to support and encourage the student to use support options within the school and develop the essential support relationships there. Once this is established, the educational outreach support can be handed over to the school. If the young person is still receiving care from the early psychosis service, ongoing communication will be between the key school support person and the case manager.

CASE STUDY 3: DAISY

Daisy was referred to the education service following an extensive inpatient admission while in year 10 at a local secondary school, where she was assessed as experiencing first-episode psychosis. She had an EAL (English as Another Language) background and a history of long-standing bullying at school. Daisy consistently affirmed her goal of returning to school despite concerns from her support people that this would be too stressful for her and would not be supported by the school.

Daisy was encouraged to attend the on-site classroom as the first step in her pathway back to school and started attending several times a week. She was well supported by her family, who regularly transported her to the program. At this time Daisy was displaying ongoing positive (psychotic) symptoms, and had minimal social interaction with adults or peers, answering only ‘yes’ or ‘no’ to direct questions. Over time the key teacher slowly built a relationship with her and discovered her keen sense of humour. She was gradually encouraged to participate in short peer group activities designed around academic work.

She continued in this program for 6 months, working on some year 10 Maths units and developing literacy skills as well as social competencies.

In line with her desire to return to mainstream school, a new school that met her parent’s requirements was approached. The school agreed to a part-time enrolment at the beginning of the year with a plan to increase to full time. A SSG was set up, comprised of the assistant principal, school psychologist, year-level coordinator, home group teacher, careers teacher, Daisy and her mum and the specialist teacher from the early psychosis service. Some of the school personnel expressed concerns about the suitability of the placement. They worried about how to manage her ongoing positive symptoms and the amount of school work that she would be able to complete. The specialist teacher was able to strongly advocate for Daisy, emphasising that she had a clear goal, wanted to be at school and had done everything asked of her. This was eventually accepted by the SSG, and full-time enrolment commenced. The specialist teacher gradually reduced his time with Daisy as the school wellbeing team picked up the day-to-day support. The group continued to meet to review and support her. A career pathway was developed that took into account her additional needs and included a VET component that matched her career goals.

For students who are transitioning to higher education, a set of guidelines have been developed to support the student, staff and the institution[44]. Student services departments in universities and TAFE colleges are the key source of resources and support, including access to a Disability Liaison Officer (DLO) and counselling services. Students transitioning into higher education are advised to make contact with student services upon enrolment to establish relationships, set up liaison with mental health service case managers and discuss possible support plans. The specialist teacher should inform the student of the support options and services and actively establish the relationship together.

Individual pathways programming and support

Many young people are confused and pessimistic regarding their future career options following the experience of psychosis. Their experience may have resulted in a downgrade of academic achievement or a complete halt to their education. Any previous hopes and plans can feel impossible to achieve. At this time it is useful for young people to be able to work with a teacher with careers skills to present the possibilities and pathways to rekindle career plans. Young people and their families are often not familiar with pathways through the education and training systems, other than the standard 6 years of continuous secondary schooling followed by higher education. Knowledge that there are other ways to achieve a career goal, or even other careers not previously considered, may provide a more relevant pathway and can help with rebuilding hope. We know that the experience of psychosis often results in a great sense of loss, both of self-concept and hopes and dreams[3].

Ongoing engagement with a mental health service is reinforced by a service that provides opportunities that have a future focus, is committed to working with the young person to find solutions and helps to establish goals that are not solely defined by illness[31]. Career counselling and pathways planning can provide this by instilling hope and building self-efficacy.

The creation and implementation of an individual's pathway plan helps the young person to develop knowledge and understanding of education, training and employment options, and develop skills to effectively manage their careers and pathways throughout their lives. The recommended steps in the process of building a career plan include:

- Understanding the self – exploring interests, hobbies, values (e.g. What aspects are important for you in a career?) and strengths (See Appendix 4 for example of a strengths profile).
- Exploring career options – matching knowledge of self with a range of career possibilities. Several resources exist that can offer a structured approach to this work. For example, My Future (www.myfuture.edu.au) is a free national online career information and exploration site designed for young people. It is important to encourage young people to develop options within their career plan that can be adjusted as they gain experience and to include knowledge of employment prospects, salary and promotion pathways.

- Exploring educational and training pathways – the My Future site provides information on available higher education and vocational training options nationally. Familiarisation with other local providers such as Adult Community Education providers, Community or Neighbourhood Houses or Learn Local organisations (in Victoria) is also important. VET options can change regularly – the most accurate information about course offerings and commencement dates will be obtained by direct contact with the provider.
- Building a career portfolio – assist the young person to organise their information, resume, achievements and career research.
- Identifying supports and networks – consideration of friends, family or community contacts who may be able to provide knowledge of a career or some voluntary work or work experience in the field.
- Identifying personal learning skills needed to pursue career related goals – these may involve personal organisation skills, such as time-management, planning and social competency skills (e.g. working with others in teams, help seeking, problem solving, ability to build and maintain appropriate relationships).
- Practise those skills – if the young person has become disconnected from community-based activities, attending group programs within the early psychosis service is one way to develop these skills.

In developing a pathways intervention, close working relationships with the clinical group program and the vocational program are important. A career plan may entail practising essential skills through engagement in groups, or a referral to the vocational consultant to find some part-time work. Considerations for career planning (in addition to the current mental health presentation) also include family and community expectations, social support networks (including needs of students in out of home care), cultural issues and specific supports (e.g. workers within specific culturally and linguistically diverse communities), intellectual disability/developmental disorder, and the importance of maintaining appropriately high expectations for all young people.

Opportunities for work experience (refer to relevant state guidelines) should be considered. Young people who have had a disrupted school experience may have missed the opportunity to participate in formal work experience. If they have had no prior experience of the workforce, a work experience placement can be helpful. Consideration should be given to suitable and supportive placements. Initial placements may be considered within the wider organisation, for example, with the grounds staff or in the cafeteria. The organisation of external placements needs to consider issues around disclosure (please see *Working it Out: Vocational Recovery in First-Episode Psychosis*).

Resources to support teachers in the development of career plans can be found at: www.education.vic.gov.au/school/teachers/support/Pages/mips.aspx.

Examples for some Career Plan templates can be found at: www.education.vic.gov.au/school/teachers/teachingresources/careers/carframe/Pages/yr10plan.aspx.

CASE STUDY 4: MIRHAN

Mirhan (16 years old) was born overseas and came to Australia aged 10 years as a refugee with his mother. He was diagnosed with bipolar disorder and attended the early psychosis service. Mirhan had been asked to leave his current school midway through year 11 (VCE) due to his concerning behaviour. He was referred for pathways planning by his case manager during term 4 of that year.

The teacher met with Mirhan several times and occasionally included his mother and an interpreter. During these sessions Mirhan was able to clarify a career area of interest in sport and recreation. He was also very clear that he didn't want to repeat year 11 but wanted to finish school at the same time as his friends.

The teacher was able to explain the requirements for a VCE certificate to both Mirhan and his mother, as well as the entry requirements for some courses of interest in higher education. Mirhan mapped out a series of pathway options that would lead on to future training in his area of interest. They considered other schools in the area and organised visits to some. One school offered him a place in their Intermediate VCAL program, where he would be seen as a year-12 student. This program also included VET units within the certificate of Sport and Recreation. Mirhan commenced the following year and is now completing his final year of school with plans to move into further training in the field at TAFE.

Secondary consultation

Secondary consultation can support case managers with cases that have not been specifically referred to one of the above interventions. Secondary consultation offers a way to manage a small resource across a larger service by targeting intensive resources to those at higher risk and lower intensity interventions to those with less need or more protective factors[45]. Teachers can offer information and options to assist the case manager with educational issues (e.g. liaison with schools, understanding of pathways and prerequisites), discussions with families and assessing the viability of the young person's own educational plans or a school's response to behaviour. A secondary consultation may lead to a formal referral.

Responding to specific learning needs

Difficulties with concentration, memory and general disorganisation are common traits for this group of students. Cognitive deficits often associated with schizophrenia include attention, memory and recall, processing, critical thinking, planning and organisation[46]. It has been found that cognitive functioning decline occurs during the early stages of illness[47]. A study of school-aged adolescents found that some reduction in intellectual functioning can be present during the early stages of illness[48]. Cognitive deficits are evident several (2–4) years prior to onset of psychosis; this possibly contributes to a lower level of attainment even prior to onset[49].

Specific classroom strategies to assist students with cognitive challenges can include splitting tasks into smaller components, prioritising components and writing down key information to develop lists. The use of personal devices can be an engaging way to approach this. Students aiming to stay connected and up-to-date with learning requirements can benefit from specific study skills in the areas of reading, note-taking, compiling mind maps, drafting sequential thinking and essay planning. Teachers can develop these skills in students through demonstration, modelling and support. Knowledge of a student's preferred learning styles can guide the choice of strategy, particularly when planning adaptations to the learning environment[46].

Teaching strategies

There is a range of inclusive teaching strategies that can be used with students experiencing first-episode psychosis. These may be employed in the on-site classroom within the youth mental health service but also can be suggested to mainstream teachers who are supporting the transition of these students. Many of these strategies can be of benefit to all students. This is important to emphasise with mainstream teachers – they do not always have to have one set of strategies for their student with first-episode psychosis and other strategies for other students. Key teaching strategies include:

- Communication – each teacher should aim to discuss the needs and concerns around each class with the young person and how they can work together to meet those needs.
- Initially, if a student will only be attending part time, it is important that the both student and teacher are clear about work, reading and homework expectations. If important information is missed, ways to communicate this information also need to be discussed.
- If a student is not well enough to attend class they may still appreciate knowing what the class is doing. Communication via email or a class blog can help to keep them connected. Flexible delivery of teaching material via electronic media is particularly helpful for students who are unavoidably absent from class or who cannot participate in classes for extended periods of time. It is important to ensure that this is done in a way that does not put undue stress on the student. Regular communication with the student's case manager will be important for this.
- Information delivered orally can easily be missed. Having a clear written outline of the subject, including assessments and due dates, will help the student.
- Returning to the classroom can be very anxiety-provoking for these students, and this can interfere with the learning process. Working with students to split larger tasks into small, achievable blocks can help reduce anxiety; if there is to be a change of routine, talking through this in advance will also help.
- Ensuring the student has all the necessary resources for the subject will help them feel more at ease. They may not feel comfortable admitting that they do not have necessary materials; this can be a particular issue when a student joins a class midway through the semester.
- When running small group activities, care should be given on how these groups are formed to prevent the student feeling isolated. Ensure that everyone in the group has a specific role.

- Consider ways to develop a culture within the class that is welcoming and respectful of all students. Establishing agreed norms and expectations will assist everyone and provide a framework for managing any inappropriate behaviour.
- Consider a range of assessment strategies that reflect individual strengths and learning styles.
- Where possible, give students access to written notes to support their difficulties with attention, memory and concentration. If the student has a supportive friendship with another student, they may be able to help them to access information they may have missed.
- Regular feedback helps all students. Discuss the forms of feedback that work best for the students. They may prefer written feedback or one-on-one feedback as opposed to public. It will be important for them to receive feedback on their specific goals. For example, if the focus is on attendance rather than completion of prescribed work, the teacher's feedback should focus on this.

Building capacity in mainstream educators

Specialist teachers located within a first-episode psychosis service are ideally placed to build the capacity of staff in mainstream settings. Building an understanding of psychosis, including possible effects on long-term functioning, addressing stigma and improving mental health literacy by presenting accurate information may all improve the experience of students[50]. Clear and accurate information can also assist with the early identification of young people; delay in accessing treatment is recognised as a key factor in recovery[51]. School personnel are well placed to support early recognition and referral of young people with early psychosis. Improvements in identification of young people early in their experience of illness by schools could also bring support and treatment before students drop out, helping them to stay in school[22]. Increasing schools' understanding of early psychosis and its impact on young people means educational experiences can better meet young people's needs and potentially decrease school dropout rates.

The education of other teaching staff can occur in several formal and informal formats. Involving the specialist teacher as a member of the SSG, or having them collaborate in the development of support plans, provides ways of working with and supporting individual students. Examples of learning accommodations and behaviour management plans that have been beneficial for one student may be used successfully with other students. The specialist teacher may be alert to stressors and concerns within the school or of individual teachers regarding safely managing the young person back at school. The school personnel should be given time to discuss their concerns and have plans to address potential difficulties; this will in turn assist the building of a supportive relationship with the student.

Capacity building can also occur in the context of formal professional development programs. One model combines specialist teachers and clinicians to create and deliver targeted learning programs to school staff, building their knowledge and increasing their confidence in meeting the learning needs of these young people. A successful example of this is the development of the *Time to Reflect* training package[52].

This program offers a series of sessions to school staff with the aim of increasing their confidence and competence in supporting young people with mental health issues. It also teaches a reflective practice model to leave participants with a new skill to support the development of their professional practice. Another program relevant for school staff is *Youth Mental Health First Aid*[53], which includes a specific topic about recognising and responding to psychosis in young people. The development of any formal training should address adult learning principles[54] and the *The Seven Principles of Highly Effective Professional Learning* for schools[55].

Education services in an inpatient setting

The provision of educational services for young people with first-episode psychosis in an inpatient setting can be developed along several models, depending on the facility resources and population profile. The inpatient unit may have an existing school facility that is able to cater for the needs of the first-episode psychosis population.

An example of this is the Travancore School model, which runs a classroom within an adolescent inpatient unit. The cohort is secondary school-age students with a range of mental health disorders, including first-episode psychosis. Young people attend classroom sessions for self-contained lessons or to complete schoolwork sent in from their mainstream school. Although admissions can be brief, teachers are able to observe functional classroom behaviour and cognitive functioning, which can contribute to the clinical assessment. Young people can continue to see themselves as learners, which is important in maintaining connectedness and self-efficacy. Teachers have initial contact with the mainstream school to collect and provide appropriate information. Insights gained from the inpatient classroom can assist the development of classroom and learning accommodations to support the student upon return to school. Upon discharge, teachers discuss return-to-school strategies and assist in the development of a support plan. Young people who are not deemed well enough to immediately return to school can be referred on to the classroom program at the early psychosis service, or can consider other educational settings.

CASE STUDY 5: JACKSON

Jackson is a 15-year-old student in year 10 at a local secondary college. He was admitted to the local adolescent inpatient unit following reports of him hearing voices and having significant memory issues. He spent 3 weeks in the unit and attended an inpatient school classroom, where he was initially very distracted and withdrawn, but gradually was able to respond to instruction and complete some independent work.

A specialist teacher from the unit liaised with his school and discovered that he had a supportive relationship with the school welfare coordinator, as well as a long standing group of friends attending the school. The specialist teacher was able to discuss a plan for Jackson's return to school and 'debunk' some myths around psychosis. Accommodations were agreed to that included:

- a gradual return to school
- reducing subjects
- removing expectation for sitting exams and completing homework
- establishing regular catch ups with the welfare coordinator
- giving Jackson a colour-coded timetable to assist organisation
- provision of materials to enable psychoeducation for the teaching staff.

If an inpatient unit does not have a school facility, teachers based in the first-episode psychosis service could offer individual support on a visiting teacher basis. This allows educational liaison with the mainstream school to begin as early as possible, minimising the chance of disconnection and disengagement. As some of these students will access the education service as outpatients, it provides an opportunity to start the relationship.

Education within an inpatient setting can contribute to the assessment of current functioning; therefore, planning for returning to school should begin as early as possible to help maintain a developmentally appropriate focus. Interventions need to be prioritised in relation to length of admission and symptom severity.

PART 4

Professional support for educators

Professional support for educators

Team work

When locating teaching staff within an early psychosis service, consideration should be given to the benefits of team membership for day-to-day on-the-job support. The benefits of working as a part of a team include:

- access to creativity in thinking and a sounding board for testing out ideas and thoughts, which in turn builds confidence between members
- more opportunities to learn new skills and ways of viewing situations
- increasing the speed and quality of work, as each individual's specialist skills can be used for the benefit of everyone; this ensures there is accountability for actions
- access to a support network at the work place that can enhance employee work satisfaction.

As the number of teaching staff will be small, possibly only one, consideration should be given to placing them with an appropriate clinical team. A useful model is to base education services alongside the vocational and group program, due to the common nature of their work and possible shared delivery of services.

If educational services have been negotiated with an existing specialist education provider (e.g. a hospital school) this will enable the teachers to also belong to an educational team. Ongoing contact with other educators is important, as it gives the teachers opportunities to share specific professional challenges and achievements. It also provides opportunities to connect with issues and developments within their profession. There are also positive practical implications of belonging to a larger staffing group, such as providing staff coverage during significant absences.

Professional feedback and development

All professional staff members require ongoing feedback and development to maintain a high standard of practice. Opportunities need to be available for teachers to receive feedback against their specific program objectives. Methods found to be most effective in assessing and developing teaching and learning include student performance, peer observation and collaboration, direct observation of classroom teaching and learning, student surveys, 360-degree assessment and self-assessment[56]. Teachers may request access to a coach, mentor or reflective practice partner as part of their feedback and development process.

A national teacher performance and development process is currently being rolled out across Australia and sets a framework for teacher performance and development. The framework describes a cycle of reflection and goal-setting followed by the collection of evidence to assess performance, engagement in quality professional learning, access to feedback and a formal review process.

Access to professional learning

The development of the specialist skill set required to conduct educational interventions within an early psychosis service will require access to relevant ongoing professional learning. In addition to the learning opportunities described above as part of the current role and performance, teachers will need exposure to current educational initiatives, programs and curriculum reform. Even though some of these initiatives may not appear related to this specialist role, up-to-date educational knowledge is required for them to assist young people in their return to a mainstream environment. It also builds an understanding of the current issues in schools, which in turn strengthens collaborative planning with mainstream teachers.

Specialist teachers will also need to build a working knowledge of the key issues and language used within youth mental health. The ability to understand and discuss clinical presentations and plans and interpret them to other educators is an important skill set for this role. A number of the professional learning opportunities available to clinical staff in the service may also be of benefit to teaching staff; however, the majority of the learning is achieved by attending clinical discussions and case presentations at the service level.

PART 5

Evaluation

Evaluation

Evaluating educational interventions

There is currently relatively little research on educational interventions in young people with first-episode psychosis. Specifically, research with a school-age cohort is not found in the current literature. The implementation of an education service within an early psychosis service presents a unique opportunity to collect data on specific educational interventions with a first-episode psychosis population. Information could be gathered on comparisons of types of interventions and resourcing levels in relation to productive educational outcomes for this cohort.

To ensure ongoing quality assurance and improvement within each program, a range of evaluation tools will be required to collect data to measure effectiveness. Evaluation tools and questions should seek to gather data in line with the stated program aims. This may focus on individual outcomes or the program delivery as a whole.

With consideration of the range of aims, the focus of data collection can include:

- numbers of students engaged in education at or after discharge
- successful completion of individual goals
- student attitudes to learning
- student experiences of learning programs
- feedback on educational interventions from case managers, family, mainstream educators
- student learning milestones, including formal academic assessments and specific skill development (academic and interpersonal skills).

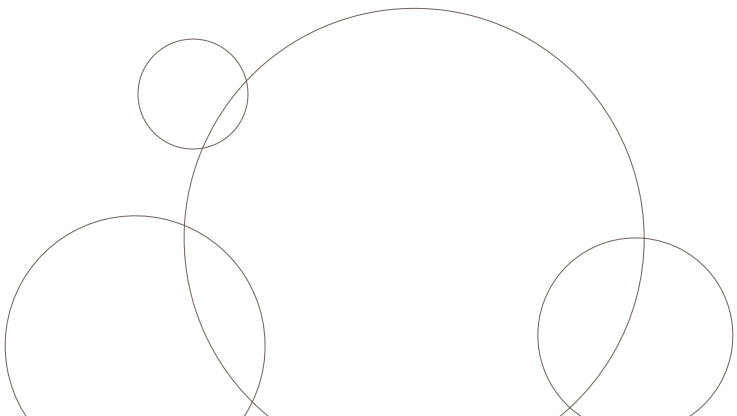
Tools and strategies may involve:

- questionnaires for students, schools, case managers and family members addressing program effectiveness and student outcomes
- measures of goal attainment – student self-assessment and/or staff-assessed
- attendance data
- ongoing data collection and analysis of the numbers and profiles of young people referred
- student focus groups, interviews, case studies
- pre- and post-measures of educational engagement
- case record information retrieval to map out and validate the delivery of the intervention and the resulting student pathways

- existing tools, e.g. Social and Occupational Functioning Assessment Scale (SOFAS), Principles of Learning and Teaching (PoLT), Student Perceptions Survey Middle and Later Years.

Some of the barriers and issues for collection of accurate and reliable data to inform program evaluation include:

- The educational interventions are often open-ended. Young people may have some intermittent involvement and receive only some aspects of the intervention; some young people may discontinue attendance after a short involvement and return at a later stage or not at all. It is important to survey students who failed to complete or dropped out of the program: if evaluation does not include the intermittent or poorly engaged participants, the data is skewed. The format and delivery of programs may meet the needs of some cohorts of young people but not others; this information is important to the future planning and redesign of specific interventions. It is important to remember that involving young people who have not been well engaged in the intervention in the evaluation of the program is difficult.
- Using control group comparisons to evaluate the efficacy of the program is impractical in this setting, as it raises ethical issues in terms of withholding interventions to any young person referred to the program.
- Changes in mental health have an impact on young people's participation in education. The mental health trajectories of individual young people differ and this can have a bearing on their functional outcomes despite receiving similar educational interventions.
- There is little relevant research in this field of intervention. Quality research and evaluation needs to be conducted by experienced researchers with appropriate budgets if quality data is required for analysis of need and impact.



Summary

Participation in school or vocational training is often disrupted by the onset of a mental illness, and it has been reported that approximately one third of school-age young people with early psychosis are not participating in education or employment. The National Centre for Vocational Education Research found that early school-leaving and low school attainment had negative impacts on future employment and were associated with poverty, homelessness and the poor development of an independent adult identity. The ability to remain in education and enter the workforce is associated with positive outcomes in terms of developing self-efficacy and financial dependence.

It has been observed that there is a delay in reaching the early marker of educational attainment in young people with a first episode of psychosis. Failure to progress to adulthood alongside their healthy peers can have a significant impact on their self-confidence and competence; therefore, it is developmentally appropriate to target this period of transition with specific interventions, with a tailored educational intervention for first-episode psychosis as part of these interventions. The provision of educational services is in line with an increasing focus on functional recovery outcomes in mental health; a 12-year follow-up study recommended the implementation of programs to promote school reintegration following a first episode of psychosis 'to facilitate the continuation of education to the highest possible grade'.

Benefits such as social contact, identity and productive use of time provided by employment can also be provided by participation in education, particularly for young people with first-episode psychosis. A specialised education service can address some of the key psychosocial recovery principles for young people with first-episode psychosis by providing normalising activities based around the development of strong supportive relationships and providing hope for recovery. Access to a specialised education service with teaching staff within an early psychosis service provides young people with links to the national curriculum, ensuring smoother transitions back to mainstream education and learning programs that reflect current educational practices.

Collaboration between mental health and education services can best address the needs of young people with first-episode psychosis, as the literature reports that this population have significant challenges in maintaining their education credentials. The integrated model of Orygen Youth Health and the Travancore School consists of a small teaching team offering a range of educational programs across the youth mental service. The Travancore School is a Victorian special education setting that provides teachers to young people who are inpatients, young people attending day programs and for outreach support to young people with mental health issues attending other school settings. Teachers have an established role within the multidisciplinary team, where they are either part of the psychosocial recovery team along with a specialist group worker and the vocational recovery consultant, or form part of a small working team with the case manager, key group worker and other relevant staff for young people.

Online resources

The following web-based resources can provide further information and strategies around delivering educational interventions to young people with significant mental health issues.

Inclusive Schools are Effective Schools
www.education.vic.gov.au/Documents/about/research/inclusiveschool.pdf

Career Resource Guidelines for Young People not in Employment, Education or Training
www.education.vic.gov.au/school/teachers/teachingresources/careers/resourcekit/Pages/unemployed.aspx

The Impact of Mental Health Disorders on learning – A Teacher's Guide was developed as part of a School-Link project in three high schools in the Wyong Shire, Central Coast. It was co-authored by Jean McGuiness and Wendy Fowler, School-Link Project Workers, Children & Young People's Mental Health (CYOUNG PEOPLEMH), Northern Sydney Central Coast Health.

www.ycentral.com.au/filelibrary/impact_of_mental_illness_3_no_cover_.pdf

Strengthening student engagement – Richard Jones
www.leadered.com/pdf/strengthen student engagement white paper.pdf

Information on a range of assessment tools
www.education.vic.gov.au/school/teachers/support/Pages/tools.aspx

Teaching and support strategies for students with additional needs
www.adcet.edu.au/Cats/

Orygen Youth Health: Psychosis Factsheet
http://oyh.org.au/sites/oyh.org.au/files/factsheets/oyh_fs_psyc.pdf

Orygen Youth Health: Getting Help Early
http://oyh.org.au/sites/oyh.org.au/files/factsheets/fact2_gettinghelp.pdf

Orygen Youth Health: Recovering from Psychosis
http://oyh.org.au/sites/oyh.org.au/files/factsheets/fact3_recovering.pdf

Orygen Youth Health: How Can I Help Someone with Psychosis?
http://oyh.org.au/sites/oyh.org.au/files/factsheets/fact4_howcan.pdf

Appendices

Appendix 1: Education Referral Form

Developed by Travancore School

STUDENT INFORMATION

Student Name

Age **Gender**

Student contact Phone/e-mail

Home language **Interpreter required?**

Address

REFERRER INFORMATION

Case manager **Phone number**

Group program key worker **Key teacher**

MH program **Discharge date** (if known)

Service referral date (current episode of care)

Previous episodes of care

Is the family involved with treatment? ☐ **Yes** ☐ **No**

Is the family aware of this education referral? ☐ **Yes** ☐ **No**

Reason for educational referral

Specific goal(s) of education referral (what do we hope to achieve?)

Student strengths/interests:

Primary diagnosis

Other diagnoses / difficulties

Priority educational concern ☐ Psychotic symptoms ☐ Anxiety ☐ Mood ☐ Conduct ☐ Social/Peer ☐ Learning ☐ Confidence ☐ Other

Medical issues/medication details Asthmatic ☐ Yes ☐ No Anaphylaxis ☐ Yes ☐ No

Other agency/program involvement

ASSESSMENTS

Assessment type	Date	Completed by	Comments
☐ WISC			
☐ WAT / ☐ WRAT			
☐ OT			
☐ S & L			
☐ ADOS / ☐ CARS			
☐ Other			

FAMILY INFORMATION

Lives with Independent ☐ Yes ☐ No Independent minor (if u/18) ☐ Yes ☐ No

Guardian Phone

Emergency contact Phone

Relevant family information

SCHOOL INFORMATION

Current school address

School type ☐ TAFE/Uni ☐ Secondary ☐ Targeted setting

Year level **Program**

Key school contact(s)

Phone number

Is the school aware of this referral? ☐ Yes ☐ No

Attendance this year ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Not attending

Disability funding?

Details of any prior school contact

Appendix 2: Student Support Groups

THE STUDENT SUPPORT GROUP SHOULD:

- provide ongoing support by having those with most knowledge of and responsibility for the young person work together to establish shared goals
- involve key people relevant to the student's success:
  - young person
  - parent, guardian or caregiver
  - case manager and/or specialist teacher from the mental health service
  - nominated teacher or year level coordinator
  - principal or other senior teacher to act as chairperson
  - student wellbeing coordinator and/or student support service staff assign action or strategies to various student support group members for implementation
- meet regularly according to the needs of the young person
- convene meetings at any time at the request of the school, case manager, parent, guardian, caregiver or child/young person.

It is good practice for the student support group to continue to meet for a period of time to monitor their progress.

Adapted from Department of Education and Early Childhood Development Individual Education Plan Guidelines

Appendix 3: Initial Assessment Form

Developed by Travancore School

PERSONAL INFORMATION

Student name **Age** **D.O.B.**

Address

Current living situation

Preferred contact number **Email**

Emergency contact person

Contact number

Government allowance ☐ **Sickness Allowance** ☐ **Youth Allowance**
☐ **Newstart** ☐ **DSP**

Current employment agency: (JSA/DES)

Contact person

Current transport	**Drivers licence**	☐ **Yes**	☐ **No**
	Use of car	☐ **Yes**	☐ **No**
	Good access to public transport	☐ **Yes**	☐ **No**
	Currently using public transport	☐ **Yes**	☐ **No**
	Family	☐ **Yes**	☐ **No**

Leisure interests (current/previous)

CAREER PLANS

Do you have a 'dream' job?

Describe

What led you to choose this?

Have you participated in career counselling or made a career plan?

Describe

Would you like a new career plan?

Are you interested in doing work experience?

Do you have an up to date resume?

Do you have a portfolio of your achievements?
(including most current educational report/record)

Have you had experience of interviews? Give details

SELF ASSESSMENT

DO YOU HAVE ANY OF THE FOLLOWING SKILLS?

☐ **Speak another language** (List languages)

☐ **Read/write another language** (List languages)

☐ **First aid training**

☐ **Food handling training**

☐ **Confident using computer packages (Word, Powerpoint, Excel, Myob, etc.)**

☐ **Regular user of social media – details...**

☐ **Search the internet for information**

☐ **Design a web page**

☐ **Coaching others e.g. sport, schoolwork**

☐ **Play a musical instrument** (List instruments)

☐ **Write an essay**

☐ **Prepare a meal for others**

☐ **Grow flowers/vegetables**

☐ **Public speaking**

☐ **Care for babies and young children**

☐ **Confidently use the telephone to seek information and take messages**

HOW WOULD YOU RATE YOUR READING AND WRITING SKILLS?

☐ **I avoid reading and writing**

☐ **I get by when I have to read or write**

☐ **Average**

☐ **I'm confident**

☐ **Reading and writing are my strengths**

HOW WOULD YOU RATE YOUR MATHS SKILLS?

- ☐ Not confident, I often need help
- ☐ I'm confident
- ☐ I can do the basics i.e. money
- ☐ I did really well with maths at school
- ☐ Average

I LEARN BEST BY:

- ☐ Repetition
- ☐ Talking things over
- ☐ Doing things with my hands
- ☐ Working with others
- ☐ Watching others
- ☐ Working independently
- ☐ Listening
- ☐ Being in a quiet place
- ☐ Reading information
- ☐ Being in a noisy place

WHAT HELPS YOU SURVIVE NEW CHALLENGES?

- ☐ Having a reward at the end
- ☐ Asking for and receiving help
- ☐ Being really interested in the topic
- ☐ Having enough relaxation time
- ☐ Support from friends/family
- ☐ Managing stress

SCHOOL HISTORY

PREVIOUS/CURRENT STUDY (INCLUDING THE LAST YEAR COMPLETED/PASSED)

YEAR **20** **20** **20** **20**

Education provider

Program details
(e.g. year level or certificate)

Subjects (if relevant)

Attendance (excellent, adequate, low)

Outcome

Permission to contact

Preferred contact

Aspects that I enjoy/enjoyed the most about previous study
(e.g. subjects, learning, social/peer contact, activities, time use)

Why?

Aspects that I enjoy/enjoyed the least about previous study

Why?

School activitis and achievements
(e.g. subjects, learning, social/peer contact, activities, time use)

WORK EXPERIENCES

WORK PLACEMENT / EXPERIENCE / VOLUNTARY WORK

Dates	Employer/Company	Role	Duties

PAID WORK

Dates	Employer/Company	Role	**Duties** (include approx hrs per week)

Other relevant information

Appendix 4: Strengths Profile

Adapted from 'The Happiness Institute Signature Strengths List' www.thehappinessinstitute.com

Date

Strengths Profile for

We would like to know what you are good at so we can support you to build on your strengths!
This is how you can help us:

Read through the 24 strengths below and tick your personal strengths as you go – even if they apply to you just a little bit.

PERSONAL INFORMATION	Tick
KNOWLEDGE	
I am creative... I think of new ways to do things. I don't like to do things the regular way if I can think of a better way.	☐
I am a critical thinker... I am open minded and take my time to think things through. I can change my mind if I need to.	☐
I am wise... I may not think so, but my friends say I am wise. My friends turn to me for advice. I have my own way of understanding the world.	☐
I am a learner... I love learning new things, in a class or on my own. I love school, reading, and museums. I like to learn in all sorts of places.	☐
I am curious... I want to know about everything. I am always asking questions. I like to explore and discover.	☐
COURAGE	
I am energetic... I often feel excited and energetic. I give my best to everything. I feel like life is an adventure.	☐
I am brave... I am brave when things get difficult. I speak up for what I believe in, even if other people don't agree.	☐

I am hard working... ☐

I work hard to finish what I start.

I like to get things done on time.

I don't get distracted when I work, I like finishing tasks.

I am honest... ☐

I always speak the truth and always do what I say.

I am real and down to earth.

HUMANITY

I am loving... ☐

Sharing and caring relationships are really important to me.

I feel close to others and they feel close to me.

I am social... ☐

I know what other people want and how they feel.

I know how to fit in different groups.

I make other people feel comfortable.

I am kind... ☐

I am kind and generous to others.

I am never too busy to do a favour.

I enjoy doing good deeds for others, even people I don't know well.

JUSTICE

I am fair... ☐

I treat all people fairly.

I give everyone a chance.

I don't let my feelings change the way I feel about people.

I am a leader... ☐

I encourage others to get things done.

I make other people feel included in a group.

I am good at organising activities.

I am a team player... ☐

I do really well as a member of a group.

I am a reliable and loyal group member.

I always do my share and work hard for the success of my group.

CONNECTED

I am hopeful... ☐

I expect the best from the future and I work hard to achieve it.

I believe that I have control over my future.

I have a sense of humour... ☐

I like to laugh and tease.

Making others smile is important to me.

I try to see the light side of situations.

I am grateful...

I am thankful for the good things that happen to me.

I always take the time to express my thanks to friends and family.

I appreciate amazing things... ☐

I appreciate beauty, excellence and skill.

I notice these things in many areas, including nature, art, mathematics, science and in everyday life.

I am spiritual... ☐

I have strong beliefs about the meaning of the universe.

I know my place in the universe.

My beliefs shape my actions and make me feel good.

CONTROL

I have self-control... ☐

I am in control of what I do.

I am a disciplined person.

I am in control of my emotions, I don't let my emotions control me.

I am forgiving... ☐

I forgive those who have done me wrong.

I always give people a second chance.

I forgive people rather than seeking revenge.

I am careful... ☐

I make careful choices.

I don't say or do things that I might later regret.

I am modest... ☐

I don't like to be centre of attention**.**

I prefer to let people notice my strengths.

Other people notice and value my modesty.

When you have finished, look over the strengths you have ticked and write your top 3 strengths in the box below:

1	
2	
3	

Appendix 5: PoLT Components

The principles of learning and teaching p-12 and their components

Students learn best when:

1. **The learning environment is supportive and productive.**
   In learning environments that reflect this principle the teacher:

   1.1 builds positive relationships through knowing and valuing each student

   1.2 promotes a culture of value and respect for individuals and their communities

   1.3 uses strategies that promote students' self-confidence and willingness to take risks with their learning

   1.4 ensures each student experiences success through structured support, the valuing of effort, and recognition of their work.

2. **The learning environment promotes independence, interdependence and self motivation.**
   In learning environments that reflect this principle the teacher:

   2.1 encourages and supports students to take responsibility for their learning

   2.2 uses strategies that build skills of productive collaboration.

3. **Students' needs, backgrounds, perspectives and interests are reflected in the learning program.**
   In learning environments that reflect this principle the teacher:

   3.1 uses strategies that are flexible and responsive to the values, needs and interests of individual students

   3.2 uses a range of strategies that support the different ways of thinking and learning

   3.3 builds on students' prior experiences, knowledge and skills

   3.4 capitalises on students' experience of a technology-rich world.

4. **Students are challenged and supported to develop deep levels of thinking and application.**
   In learning environments that reflect this principle the teacher:

   4.1 plans sequences to promote sustained learning that builds over time and emphasises connections between ideas

   4.2 promotes substantive discussion of ideas

   4.3 emphasises the quality of learning with high expectations of achievement

   4.4 uses strategies that challenge and support students to question and reflect

   4.5 uses strategies to develop investigating and problem-solving skills

   4.6 uses strategies to foster imagination and creativity.

5. **Assessment practices are an integral part of teaching and learning.**
   In learning environments that reflect this principle the teacher:

   5.1 designs assessment practices that reflect the full range of learning program objectives

   5.2 ensures that students receive frequent constructive feedback that supports further learning

   5.3 makes assessment criteria explicit

   5.4 uses assessment practices that encourage reflection and self-assessment

   5.5 uses evidence from assessment to inform planning and teaching.

6. **Learning connects strongly with communities and practice beyond the classroom.**
   In learning environments that reflect this principle the teacher:

   6.1 supports students to engage with contemporary knowledge and practice

   6.2 plans for students to interact with local and broader communities and community practices

   6.3 uses technologies in ways that reflect professional and community practices.

Source: www.eduweb.vic.gov.au/edulibrary/public/teachlearn/student/poltleadchangepedagogy.pdf

References

1. National Centre for Vocational Education Research. Early school leavers and VET. NCVER, 1999.

2. Isohanni I, Jones PB, Jarvelin M-R et al. Educational consequences of mental disorders treated in hospital. A 31-year follow-up of the Northern Finland 1966 Birth Cohort. *Psychological Medicine* 2001; 31: 339-349.

3. Bassett J, Lloyd C and Bassett H. Work Issues for Young People with Psychosis: Barriers to Employment. *The British Journal of Occupational Therapy* 2001; 64: 66-72.

4. Waghorn G and Lloyd C. The employment of people with mental illness. *Australian e-Journal for the Advancement of Mental Health* 2005; 4: 1-43.

5. Edwards J and McGorry P. *Implementing early intervention in psychosis: A guide to establishing early psychosis services.* London: Martin Dunitz, 2002.

6. Lay B, Blanz B, Hartmann M et al. The Psychosocial Outcome of Adolescent-Onset Schizophrenia: A 12-Year Followup. *Schizophrenia Bulletin* 2000; 26: 801-816.

7. Waghorn G, Chant D and Whiteford H. The strength of self-reported course of illness in predicting vocational recovery for persons with schizophrenia. *Journal of Vocational Rehabilitation* 2003; 18: 33-41.

8. Waghorn G, Chant D, Lloyd C et al. Earning and learning among Australian community residents with psychiatric disorders. *Psychiatry Research* 2011; 186: 109-116.

9. Roy L, Rousseau J, Fortier P et al. Transitions to adulthood in first-episode psychosis: a comparative study. *Early Intervention in Psychiatry* 2013; 7: 162-169.

10. Masten AS. Developmental psychopathology: Pathways to the future. *International Journal of Behavioral Development* 2006; 30: 47-54.

11. Masten A. 'Competence, resilience and development in adolescence'. In Romer D and Walker E (ed). *Adolescent psychopathology and the developing brain.* New York, 2007.

12. Inspire Ireland Foundation. International declaration on youth mental health. 2011; viewed 20 June, 2013. http://www.inspireireland.ie/international-declaration-on-youth-mental-health/.

13. McGorry P. Every me and every you: responding to the hidden challenge of mental illness in Australia. *Australasian Psychiatry* 2005; 13: 3-15.

14. Waghorn G, Still M, Chant D et al. Specialised Supported Education for Australians with Psychotic Disorders. *Australian Journal of Social Issues* 2004; vol. 39: pp. 443-458.

15. Jahoda M. *Employment and unemployment: A social-psychological analysis.* Cambridge; New York: Cambridge University Press, 1982.

16. MacDonald E, Sauer K, Howie L et al. What happens to social relationships in early psychosis? A phenomenological study of young people's experiences. *Journal of Mental Health* 2005; 14: 129-143.

17. Unger KA, W; Sciarappa, K; Rogers, E. A Supported Education Program for Young Adults With Long-Term Mental Illness. *Hospital and Community Psychiatry* 1991; 42: 838-842.

18. Woodhead G. Theraputic group work for young people with first episode psychosis. In Gleeson JFMK, Eoin & Krstev, Helen (ed). *Psychotherapies for the Psychosis: Theoretical, Cultural and Clinical Integration.* 2008.

19. Mowbray CT. Supported Education: Diversity, Essential Ingredients, and Future Directions. *American Journal of Psychiatric Rehabilitation* 2004; 7: 347-362.

20. Dunkley J. Understanding adaptation to first-episode psychosis: trauma and growth responses. Swinburne University of Technology., 2010.

21. Jackson H, Edwards J, Hulbert C et al. Recovery from psychosis: Psychological interventions. In McGorry P and Jackson H (ed). *The recognition and management of early psychosis* Cambridge, 1999.

22. Goulding SM, Chien VH and Compton MT. Prevalence and correlates of school drop-out prior to initial treatment of nonaffective psychosis: Further evidence suggesting a need for supported education. *Schizophrenia Research* 2010; 116: 228-233.

23. Australian Curriculum Assessment and Reporting Authority. National Report on Schooling in Australia 2009. 2011.

24. Disability Discrimination Act, Australia, 1992. Section 22.

25. McGorry P. Mental ill-health in young people. *Medicine Today* 2012; 13: 46-52.

26. Commonwealth of Australia. Fourth National Mental Health Plan. An agenda for Collaborative Government Action in Mental Health 2009–2014. Dept. Health and Ageing, 2009.

27. Catania LS, Hetrick SE, Newman LK et al. Prevention and early intervention for mental health problems in 0-25 year olds: Are there evidence-based models of care? *Advances in Mental Health* 2011; 10: 6.

28. Pettitt B. Effective Joint Working between Child and Adolescent Mental Health Services (CAMHS) and Schools. Skills BGDfEa, 2003.

29. Best LJ, Still M and Cameron G. Supported education: Enabling course completion for people experiencing mental illness. *Australian Occupational Therapy Journal* 2008; 55: 65-68.

30. Miller R and Mason SE. Using Group Therapy to Enhance Treatment Compliance in First Episode Schizophrenia. *Social Work With Groups* 2002; 24: 37-51.

31. Stewart KD. Factors Contributing to Engagement During the Initial Stages of Treatment for Psychosis. *Qualitative Health Research* 2013; 23: 336-347.

32. Lamb S and Rice S. Effective Strategies to Increase School Completion Report. Department of Education and Early Childhood Development State Government Victoria, 2008.

33. Buston K. Adolescents with mental health problems: what do they say about health services? *Journal of Adolescence* 2002; 25: 231-242.

34. Leavey G, Rothi D and Paul R. Trust, autonomy and relationships: The help-seeking preferences of young people in secondary level schools in London (UK). *Journal of Adolescence* 2011; 34: 685-693.

35. Bowers L, Brennan, G., Winship, G. & Theodoridou, C. Talking with acutely psychotic people: Communication skills for nurses and others spending time with people who are mentally ill. 2009.

36. Centre for Mental Health in Schools. Engaging and re-engaging students in learning at school. 2008.

37. Preparing for an IEP. 2013; viewed http://www.teachervision.com.au/special-education/ada/37380.html#ixzz2W47qATel.

38. Salmela-Aro KM, Pertti; Koivisto, Petri and Vuori, Jukka. Adolescents' future education-related personal goals, concerns, and internal motivation during the ''Towards Working Life'' group intervention. *European Journal of Developmental Psychology* 2010; 7: 445-462.

39. Davies M, Lamb S and Doecke E. Strategic Review of Effective Re-Engagement Models for Disengaged Learners. University of Melbourne, 2011.

40. Victorian Curriculum Assessment Authority. Applied Learning. 2011.

41. Waghorn G. Submission to Parliament of Victoria into Workforce Participation by People with a Mental Illness. 2012.

42. Ingram RL, David. Vulnerability-Stress Models. In Hankin BA, John (ed). *Development of Psychopathology: A Vulnerability-Stress Perspective.* California, 2005.

43. Gleeson J, Linszen D and Wiersma D. Relapse prevention in early psychosis. In Jackson H and McGorry P (ed). *The recognition and management of early psychosis: A preventative approach*. 2009.

44. Reavley N, Ross A, Jorm A et al. Introduction to guidelines for tertiary education institutions to assist them in supporting students with mental health problems. *Journal of the Australian and New Zealand Student Services Association* 2011; 23-32.

45. Hopkins L, Nisselle A, Zazryn T et al. Hospitalised adolescents. *Youth Studies Australia* 2013; 32: 37.

46. Medalia AR, Nadine. *Dealing with Cognitive Dysfunction Associated with Psychiatric disabilities.* New York: New york State Office of Mental Health, 2002.

47. Addington J, Brooks BL and Addington D. Cognitive functioning in first episode psychosis: initial presentation. *Schizophrenia Research* 2003; 62: 59-64.

48. Bilginer LD, V; Pogge, D; Stokes, J; Harvey, P. Intellectual Functioning in Adolescents With Indicators of Psychosis: Evidence for Decline in Functioning Related to Number of Psychotic Features? *Journal of Neuropsychiatry and Clinical Neuroscience* 2005; 17: 106-113.

49. Ang Y-G and Tan H-Y. Academic deterioration prior to first episode schizophrenia in young Singaporean males. *Psychiatry Research* 2004; 121: 303-307.

50. Sasson R, Grinshpoon A, Lachman M et al. A program of supported education for adult israeli students with schizophrenia. *Psychiatric Rehabilitation Journal* 2005; 29: 139-141.

51. Ross RMG, & Ashok, K. M. Pathways to care and reducing treatment delay in early psychosis. In Jackson HM, P (ed). *The recognition and management of early psychosis: A preventative approach.* 2009.

52. *Time to Reflect: Enhancing the self-efficacy of secondary school wellbeing personnel in regonising and responding to mental health needs of students.* Training Manual. Parkville, Australia: Travancore School and Orygen Youth Health Research Centre, 2013.

53. Kelly C. Youth mental health first aid. *New paradigm,* 2010.

54. Knowles M. *The modern practice of adult education: From pedagogy to andragogy.* New Jersey: Cambridge Adult Education, 1998.

55. Victoria Department of Education & Training. Professional Learning in Effective Schools: The Seven Principles of Highly Effective Professional Learning. Leadership and Teacher Development Branch, Office of School Education, 2005.

56. Jensen B and Reichl J. Better Teacher Appraisal and Feedback: Improving Teacher Performance. Grattan Institute, 2011.

Printed on 100% recycled paper, made carbon neutral.

This manual has been funded by Orygen Youth Health and the Australian Government.