Sluttrapport: SkoleResept – forebygging av skolefrafall gjennom metoden Individual Placement and Support (IPS) for unge med alvorlige psykiske lidelser

Sammendrag

Bakgrunn: Sammenhengen mellom psykiske lidelser og skolefrafall er veldokumentert. Organisasjonen for økonomisk samarbeid og utvikling (OECD) publiserte i 2014 en rapport hvorav det fremgikk at 28 prosent av elever i norsk videregående opplæring ikke fullfører på normert tid, eller ikke fullfører i det hele tatt. I Rogaland fylke oppgir 29% av elever som slutter før fullføring av videregående skole personlige årsaker eller sykdom som grunn for å avbryte. Dette gir dårlige forutsetninger for senere sosial inklusjon, arbeid, og livskvalitet. Psykoselidelser er de alvorligste psykiske lidelsene, og rammer særlig mennesker mellom 16-25 år. Internasjonale studier viser at om lag 70% av pasienter ikke har noen form for arbeid; opptil 90% i Norge. Atten prosent av unge uføre har psykoselidelser, noe som er en høy andel sett i forhold til relativt lav insidens (ca. 2.7 nye tilfeller pr 10 000 pr år). Manglende startkvalifikasjoner fra utdanning kan være medvirkende årsak til dette.

Målsetting: Å bruke IPS som metode for å forebygge skolefrafall hos unge med (risiko for) psykose og som har falt ut av eller står i fare for å falle ut av skole eller utdanning. Som ”suksess” ble definert 50% alminnelig ordinær skole eller utdanning. Problemstillinger:
Er det praktisk gjennomførbart å tilpasse IPS for skole og utdanning?
Hvordan tas prosjektet imot av deltakere, pårørende, og samarbeidspartnere?
Kan SkoleResept forebygge skolefrafall hos unge med alvorlige psykiske lidelser?

Metode: Individuell JobbStøtte (IPS) tilpasset for skole og utdanning. Følgende aktiviteter er gjennomført i prosjektperioder:

Gjennomføring: Det er etablert samarbeid med interne (psykisk helsevern) og eksterne (PPT, skoler, kommunehelsetjeneste) gjennom besøk, møter og deling av informasjon; det er etablert samarbeid med avdelinger i psykisk helsevern; det er utarbeidet en informasjonsbrosjyre; Inklusjon og oppfølging av deltakere fant sted mellom 2014-2016; arbeidsverktøyet ”samarbeidsavtale” - en individuell plan for samarbeid om mellom SkoleResept, deltaker, skole, behandler, samt eventuelle foresatte ble utarbeidet; en tilpasset IPS fidelityskala for utdanning ble utprøvd.

Resultater: Under prosjektets varighet, opprinnelig fra 2014 til og med 2016, var det tenkt 40 deltakere. Takket være finansiering fra Helsedirektoratet til en ekstra stilling, samt integrering av SkoleResept i det eksisterende IPS-prosjektet JobbResept, og en utvidet prosjektperiode, ble til sammen 97 deltakere henvist. De ble alle fulgt i minst ett år etter inklusjon. 61% av deltakerne oppfylte suksesskriteriet, og ytterligere 21% ble innrullert i et spesialundervisningstilbud, Møllehagen Skolesenter, som også gir gjeldende ordinære

vitnemål. Kun 18% klarte ikke SkoleResept å hjelpe til ordinær skole eller utdanning- i denne omgang. De kan selvfølgelig henvises på nytt igjen når de ønsker. SkoleResept er også med i et internasjonalt effektforskningssamarbeid slik at en kan evaluere effektivitet over tid på en forskningsmessig robust måte. SkoleResept har blitt svært godt mottatt av deltakere og samarbeidspartnere.

Oppsummering, konklusjon og videre planer: SkoleResept gir svært gode muligheter for videreutviklingen av et moderne, lett tilgjengelig psykisk helsevern- spesielt for unge, på tvers av gamle skott mellom forvaltningsnivå. Vi arbeider nå for å få SkoleResept forankret i Klinikk for psykisk helsevern barn, unge voksne og rusavhengighet ved Stavanger Universitetssjukehus (PH-BURA). Foreløpig er det ingen klarhet i dette. Avdeling for unge voksne og flyktninger i PH-BURA ønsker imidlertid å fortsette å drifte SkoleResept som del av integrerte Skole- JobbResept, men det vil bli redusert drift i forhold til antall elever en kan følge opp.

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Forord

SkoleResept 2013/1/0072 ble finansiert med bevilgning av Extrastiftelsen Helse og Rehabilitering gjennom Rådet for Psykisk Helse, RPH. Prosjektperioden var fra 01.02.2014 - 01.02.2017. Prosjektleder for JobbResept i Avdeling unge voksne, Psykiatrisk Divisjon ved Stavanger Universitetssjukehus (SUS) Lena Heitmann har vært ansvarlig for levering av intervensjonen i SkoleResept. Prosjektmedarbeider Rune Salvesen ble ansatt i februar 2014, frem til juli 2016, og fikk ansvaret for å lede og igangsette prosjektet. Denne sluttrapporten er skrevet av Lena Heitmann og Wenche ten Velden Hegelstad.

SkoleResept har i løpet av sin 3 års periode hatt to ansatte, en stilling finansiert av ExstraStiftelsen Helse og Rehabilitering ved Rådet for Psykisk Helse og en stilling finansiert av Helsedirektoratet og Fylkesmannen i Rogaland.

I løpet av prosjektperioden har SkoleResept opparbeidet seg et godt nettverk av skoleledere, god kontakt med skolehelsetjenesten, psykologisk pedagogisk tjeneste, PPT og andre samarbeidspartnere i fylkeskommunen slik som oppfølgingstjenestene, OT. Nettverket består også av interne samarbeidspartnere ved Barne- og Ungdomspsykiatrisk avdeling, prosjekt for tidlig oppdagelse av alvorlig psykisk lidelse TIPS og poliklinikker ved Stavanger Universitetssjukehus, samt internasjonale samarbeidspartnere for tjenesteutvikling og forskning.

Stikkord for visjonen bak SkoleResept har vært å fokusere på psykisk helsevern tidlig, i ordinære settinger for å forebygge skolefrafall på grunn av psykiske problemer og at funksjon må bli et primært utfallsmål i psykisk helsevern.

SkoleResept har hatt god støtte i egen ledelse i Avdeling unge voksne ved psykiatrisk divisjon, SUS; Randi Mobæk (direktør) og Frode Jåtten (seksjonsleder) og det rettes en stor takk til dem. Fidelity rater har vært Randi Kydland, NAV.

Vi takker ExtraStiftelsen Helse og Rehabilitering og Rådet for psykisk helse for finansiering i tre år, dette har bidratt til oppstart av SkoleResept og økt fokus på betydningen av å ha blikket rettet på ordinær gjennomføring av skoleforløp på tross av psykisk sykdom.

Kapittel 1: Bakgrunn, målsetting og problemstillinger

1.1 Bakgrunn

Psykoselidelser er de alvorligste psykiske lidelsene, og rammer særlig mennesker mellom 16-25 år. Følgene varer ofte livet ut, med lav arbeidsdeltakelse, lav sosial deltakelse og dårlig livskvalitet. Internasjonale studier viser at om lag 70% av pasienter ikke har noen form for arbeid, hverken full- eller deltid. En nyere norsk studie viste at 63% av pasienter levde kun av trygdeytelser og ikke hadde noen arbeidsinntekt to år etter diagnose. [1]I en annen norsk studie var andelen 90%. Atten prosent av unge uføre har psykoselidelser, noe som er en høy andel sett i forhold til relativt lav insidens (ca. 2.7 nye tilfeller pr 10 000 pr år).

Forløperen til SkoleResept er JobbResept, som svarer på disse utfordringene ved å levere individuell jobbstøtte IPS for unge voksne med alvorlig psykisk lidelse. JobbResept ble etablert som et samarbeid mellom NAV og Stavanger Universitessjukehus (Avdeling unge Voksne og psykoseforskningsprosjektet TIPS) i 2007. Den første målgruppen var psykosepasienter, men senere ble også deltakere med andre alvorlige psykiske lidelser inkludert. Økt fokus i forskning og klinikk på tidlig oppdagelse av og intervensjon ved tilstander som kan være forløpere til psykoselidelser senket alderen på de som ble henvist. Dermed økte etterspørselen for hjelp til å gjennomføre skole og utdanningsforløp.

Psykisk helse og utdanning

Sammenhengen mellom psykiske lidelser og skolefrafall er veldokumentert [2]. Organisasjonen for økonomisk samarbeid og utvikling (OECD) publiserte i 2014 en rapport hvorav det fremgikk at 28 prosent av elever i norsk videregående opplæring ikke fullfører på normert tid, eller ikke fullfører i det hele tatt. Dette er en høyere andel enn gjennomsnittet i Europa, som for det samme året var 13 prosent [3]. I Rogaland fylke oppgir 29% av elever som slutter før fullføring av videregående skole personlige årsaker eller sykdom som grunn for å avbryte [4]. Nasjonale undersøkelser tyder på at om lag 20% av norske ungdommer sliter psykisk i en grad at det hemmer dem i sin daglige fungering[5] . Det betyr at opptil fem elever i hver klasse på videregående skole sliter psykisk.

Mange skoler har satt psykisk helse på dagsorden og arbeider systematisk med å forebygge frafall, men samhandlingsmodeller og integrerte helsetjenester har manglet. Selv om viktigheten av tett oppfølging og tidlig innsats fra ulike sektorer har blitt foreslått som viktige ingredienser for å unngå frafall i skole på grunn av psykisk sykdom ønsket vi å styrke dette med å være bindeleddet mellom pedagogisk kompetanse i skolen og kompetansen på psykisk helsevern.

1.2 Målsetting

Målsettingen for SkoleResept var å bruke IPS som metode for å forebygge skoleutfall hos unge som har høy risiko for å utvikle eller har psykose og som har falt ut av eller står i fare for å falle ut av skole eller utdanning. Som ”suksess” ble definert 50% alminnelig ordinær skole eller utdanning.

1.3 Problemstillinger

1. Er det praktisk gjennomførbart å tilpasse IPS for skole og utdanning?
2. Hvordan tas prosjektet imot av deltakere og pårørende?
3. Hvordan tas prosjektet imot av samarbeidspartnere utenfor psykisk helsevern?
4. Hvordan tas prosjektet imot av henvisere innen psykisk helsevern?
5. Kan SkoleResept forebygge skolefrafall hos unge med alvorlige psykiske lidelser?

1.4 Målgruppe

Unge i alderen 13-25 år med høy risiko for eller etablert psykose, som står i fare for å falle ut av eller har falt ut av skolen og som er i behandling ved psykiatrisk divisjon SUS. Deltakere ble rekruttert fra tidlig oppdagelsessystemet TIPS (Tidlig Intervensjon ved Psykose) og POP (Prevention Of Psychosis), fra Avdeling Unge Voksne, og fra BUPA ved Stavanger Universitetssykehus. Forventet antall deltakere var 2x20; det vil si 20 nye deltakere i de to første årene av prosjektperioden, alle fulgt opp i minst ett år.

Utvidet målgruppe

Grunnet stor pågang av henvisninger også fra unge i andre diagnosegrupper, ble målgruppen i løpet av prosjektperioden utvidet til å inkludere også deltakere med andre alvorlige psykiske lidelser, primært bipolare lidelser.

1.5 Aktiviteter

Følgende aktiviteter er gjennomført i prosjektperioder:

1. Etablering av samarbeid med interne (psykisk helsevern) og eksterne (PPT, skoler, kommunehelsetjeneste) gjennom besøk, møter og deling av informasjon
2. Etablering av og informasjon om henvisningsrutiner til TIPS/POP, BUPA, og AUV
3. Utarbeiding av informasjonsbrosjyre
4. Inklusjon og oppfølging av deltakere (se ”prosjektgjennomføring)
5. Utarbeiding av arbeidsverktøyet ”samarbeidsavtale” (se vedlegg) som er en individuell plan for samarbeid om muliggjøring av skolegang mellom SkoleResept, deltaker, skole, behandler i psykisk helsevern, samt eventuelle pårørende (foresatte)
6. Utarbeiding, i internasjonalt samarbeid, av en tilpasset og integrert IPS fidelityskala for utdanning og arbeid
7. Utprøving og skåring av den tilpassede fidelityskalaen (se vedlegg)
8. Presentasjon av prosjekt og resultater nasjonalt og internasjonalt

1.6 Omfang og begrensninger

Takket være finansiering av en ekstra stilling som har vart utover den opprinnelige prosjektperioden 2014-2016, har prosjektet kunnet tjene flere deltakere enn opprinnelig planlagt. I tillegg har JobbReseptteamet i samarbeid med internasjonale samarbeidspartnere i stadig større grad integrert IPS for arbeid (JobbResept) og IPS for utdanning (SkoleResept)- til sammen kalt Skole- JobbResept. Det har også i stor grad vært med på å øke kapasiteten. Til sammen har fra 2014 til og med 30. Oktober 2017 97 deltakere fått et tilbud ved Skole-JobbResept. Innen prosjektperioden var 72 deltakere inkludert, mot 40 prosjekterte. Kapasitetsøkningen har stått i stil med stor pågang av henvisninger, noe som etter vårt skjønn illustrerer et stort behov.

Begrensninger, eller avgrensninger, til prosjektet har vært knyttet til hvilke avdelinger ved sykehuset prosjektet hører til. Det har kommet en del henvisninger fra andre avdelinger, som en har måttet avslå av praktiske og organisatoriske grunner. Det har vært beklagelig fordi behovet hos den henviste har vært reelt. Videre har det kommet henvisninger som gjelder pasienter med andre typer psykiske plager enn alvorlige psykiske lidelser, så som Asperger’s syndrom (en utviklingsforstyrrelse), psykiske utviklingshemminger, angstlidelser eller andre. En annen begrensning gjelder tidsbruk: Oppfølging av deltakere måtte på grunn av tidsplan begrenses til ett år etter at en hadde kommet inn i ordinær skole/utdanning i minst 50%.

Kapittel 2. Prosjektgjennomføring og metode

2.1 Finansiering

SkoleResept har i løpet av prosjektperioden hatt to ansatte, en stilling finansiert av ExstraStiftelsen Helse og Rehabilitering ved Rådet for Psykisk Helse og en stilling finansiert av Helsedirektoratet og Fylkesmannen i Rogaland.

Budsjett for stilling og prosjekt, ExtraStiftelsen

Søknadsbeløp: 730 000 for 2014, 2015 og 2016.
Derav lønn: 680 000 inklusive sosiale utgifter pr år
Innkjøpte tjenester/honorar: 35 000 pr år
Materiell/utstyr 15 000 pr år

Tidsplan

Etablering av prosjektet (se aktiviteter) og inkludering av deltakere: 2014-2016 (i.h.t. opprinnelig tidsplan)

Oppfølging av deltakere: 2015-2016 (i.h.t. opprinnelig tidsplan)

Utvidelse av oppfølging av deltakere: 2016-2017 (endring i forhold til opprinnelig tidsplan). Det vil si at deltakere følges i ett år etter at de har kommet inn i skole/utdanning minst 50% i 2014, 2015 eller 2016.

Evaluering: 2017

2.2 Metode

Den anvendte metoden for forebygging av skolefrafall vil var Individuell jobbstøtte (IPS) tilpasset til skole og utdanning. IPS er en individuell psykososial intervensjon som bistår pasienter i å gjenoppta arbeid eller skole utfra egne ønsker og mål, med hensyntagende til den enkeltes ressurser men også sårbarheter. Metoden er basert på sju prinsipper [6]:

1. Ansettelse i det ordinære arbeidslivet er det primære målet – «ekte arbeid» heller enn skjermet arbeid og arbeidstrening.
2. Det er ingen eksklusjonskriterier – alle som ønsker det, er kvalifisert for IPS.
3. Jobbsøking kommer raskt i gang – minimal arbeidsforberedende trening.
4. Arbeidskonsulenter/tilretteleggere og klinisk team er samlokalisert og arbeider sammen, med sysselsetting som en integrert del av den samlede tiltaksplanen.
5. Jobbsøking styres av individuelle preferanser og av valg heller enn faglige vurderinger.
6. Bistanden er tidsubegrenset og individualisert, og gis til både arbeidsgiver og arbeidstaker.
7. Det gis rådgivning om finansielle støtteordninger, rettigheter og krav, også med tanke på overgangen fra å være stønadsmottaker til lå bli lønnsmottaker.

I IPS for skole og utdanning følges de samme prinsippene, med forskjell at ”arbeid” er byttet ut med ”skole eller utdanning”. I SkoleResept oppfattes behandlingsrelasjonen og samarbeidet mellom behandlingsapparatet og skole som særs viktige og i tråd med politiske føringer for økt samhandling mellom ulike hjelpeinstanser og forvaltningsnivå. SkoleResept har integrert pedagogisk kompetanse på skolen eller annen utdanningsinstitusjon på den ene, og psykisk helsehjelp på spesialistnivå på den andre siden.

2.3 Medarbeidere

SkoleResept sine to medarbeidere, en finansiert av Extrastiftelsen og en av Helsedirektoratet, utgjorde del av et integrert og tverrfaglig Skole- Jobbreseptteam på åtte medarbeidere med sosialfaglig (med spesialistkompetanse i psykiatri), sykepleiefaglig (med spesialistkompetanse i psykiatri), og pedagogisk bakgrunn. Alle fikk opplæring i metoden av Lena Heitmann og kolleger fra JobbResept, som igjen har fått sin opplæring i metoden fra Recovery College i London, UK. Til sammen har Jobb- og SkoleResept bestått av åtte medarbeidere. Det har vært ukentlige, faste møter med case-gjennomgang og veiledning ved prosjektansvarlig Lena Heitmann. Det har også vært holdt jevnlige veiledninger med psykologspesialist og med-gründer Wenche ten Velden Hegelstad.

2.4 Arbeidsmåte

Behandlere henviser pasienten så tidlig som mulig i behandlingsforløpet til SkoleResept, for å motvirke tap av rollefunksjon som skoleelev. SkoleResept vil være det tiltaket i behandlingen som retter blikket og fokus på funksjonsnivå og fungering *der ute*.

Kartlegging og kontaktetablering i SkoleResept er fasert. Fasene overlapper hverandre og gjentas mange ganger i løpet av oppfølgingsperioden.

Første fase består av diagnostikk av den enkelte deltakers tidligere skole- eller utdanningsforløp, ressurser og utfordringer. Både symptomer og varselsignaler, kognitiv funksjon, medisinbruk, rus(mis)bruk, ressurser i det sosiale nettverket og boligsituasjon inngår i denne utredningen. Kartleggingen gir kunnskap om pasientens mot og evne til fremtidsorientering og danner grunnlaget for videre samtale, støtte, og tilrettelegging. Kartleggingen er ikke statisk, men revideres etter hvert som deltakeren endrer syn eller preferanser, eller gjør seg erfaringer. I **andre fase** hjelpes deltakeren til å få et perspektiv på sin egen fremtid, både i forhold til skole, fritid, vennskap, familie og interesser. Å hjelpe deltakeren til dette er en oppgave både for SkoleResept og hovedbehandler. Det krever en støttende tilnærming der en i samtalene er empatisk og i detalj diskuterer disse emnene. Mange kan føle seg motløse etter eller under sykdom og trenger hjelp til å se egne muligheter og ikke bare begrensninger. I denne fasen brukes elementer og teknikker fra kognitiv terapi, kognitiv atferdsterapi, motiverende intervjuer og problemløsningsmetode. I **tredje fase** skisseres helt konkrete delmål og arbeidsmåter for å nå målene. Delmål skal være spesifikke og konkrete i forhold til tid, sted og involverte samarbeidsparter. Delmål er beskrivelser av ferdigheter og ressurser som er nødvendige for at deltaker skal kunne arbeide mot sitt hovedmål. Arbeidsmåter er tilrettelegginger og tiltak som skal muliggjøre måloppnåelse for deltaker. Tilsammen utgjør kartleggingen et grunnlag for oppfølgingen fra SkoleResept, og det lages en samarbeidsplan over dette. I **fjerde fase** settes samarbeidsplanen ut i livet. SkoleReseptmedarbeideren tar kontakt med elevens skole og samarbeidsplanen blir det felles dokumentet som konkret beskriver for oppfølgingsbehovet av eleven, og veiledningsbehovet for skolen. Målet med samarbeidsplanen er å dele felles syn på både elevens ressurser og behov, men også å etablere et riktig kontaktnett. Ukentlige treff og møter er ikke uvanlig i oppstartsfasen, og målet for disse møtene er å evaluere og tilpasse skolesituasjonen fortløpende med hensyn til elevens tilstand. Samarbeid mellom eleven, SkoleResept og skole er i utgangspunktet ikke tidsbegrenset, men det har vist seg i praksis at behovet for oppfølging og veiledning som oftest gradvis avtar ned til null. Det skjer en fortløpende vurdering av symptomer i samarbeid med hovedbehandler (psykolog eller lege/psykiater), slik at en kan gripe tidlig inn med støtte, intensivert behandling, og veiledning av elev og skole ved behov. Derfor har en valgt fagpersoner innen helsefag som prosjektmedarbeidere i SkoleResept, og

sykehuset som lokasjon. Dette er et viktig poeng i vår tilnærming. I **femte fase** står veiledning sentralt. Relasjonen til kontaktlærer og medelever er viktig medisin for elevene og noe vi hele tiden arbeider for å få så positiv som mulig. Vi er av den oppfatning at åpenhet er en viktig ingrediens i en god relasjon. Den gjør også praktisk, konkret tilrettelegging enklere. I motsetning til de fleste andre IPS-prosjekter internasjonalt [7] unntar som hovedregel eleven SkoleResept fra taushetsplikt om aktuell psykisk tilstand slik at konkrete tiltak kan drøftes i forhold til konkrete symptomer og vansker. Nøkkelpersoner slik som lærer, sosialrådgiver, eller helsesøster tilknyttet skolen, får relevant helseinformasjon nødvendig for tilrettelegginger som eleven trenger. Dette gir deltaker sitt informerte samtykke til og det har ikke blitt opplevd som problematisk så langt.

Kontakt med familie og pårørende.

De aller fleste deltakere i SkoleResept er under 18 år, slik at samtykke og samarbeid med familie eller foresatte og pårørende er viktig. Medarbeider i SkoleResept har, med deltakers samtykke, jevnlig kontakt med foreldre eller foresatte. I mange tilfeller inviteres disse inn på samarbeidsmøter. I tillegg er mange familier med i TIPS/POP sitt familiearbeid, hvor flere familier treffes en gang annenhver uke på kveldstid for veiledning, psykoedukasjon, konkret og praktisk problemløsning og veiledning. SkoleResept har tett kontakt med TIPS og POP som driver disse gruppene.

2.5 Internasjonalt samarbeid: Utvikling av felles intervensjon og fidelityskala

Som ledd i prosjektet er det i et internasjonalt fellesskap utviklet en tilpasning av den opprinnelige fidelityskalaen for IPS [8].

Dette arbeidet har ført til et internasjonalt lærings- og forskningssamarbeid med TIPS nettverk for Psykoseforskning ved Stavanger Universitetssjukhus: University of California Los Angeles, USA; University of Tilburg, the Netherlands; King's College London, UK; Landspitali University Hospital of Reykjavik, Iceland; Vivantes health care providers og University of Berlin, Tyskland; University of Melbourne and the EPPIC centre for early intervention in Psychosis, Australia; og Yale Medical School, Dept, of Psychiatry and the STEP treatment for early psychosis program, USA.

Skole- JobbResept v/ Wenche ten Velden Hegelstad leder denne gruppen. Det har vært månedlige telefonkonferanser mellom alle disse for å utvikle den tilpassede IPS fidelityskalaen og utprøvningen av den. Utgangspunktene har vært at det i det opprinnelige JobbResept oppstod et behov for fleksible overganger mellom utprøving i arbeid, over til utdanning, og tilbake igjen. Det var behov for å følge disse deltakerne gjennom hele prosessen, fra arbeid, til utdanning og tilbake, eller omvendt. Vi har kalt dette for "karriereutvikling", eller "career development", som det kom til å hete i den internasjonale gruppen. Videre var det også en del deltakere som var i lærlingløp, hvor støtte og hjelp med utdanning og samhandling med utdanningsinstitusjonen kom i fokus, og en så at dette krevde egen kompetanse. Og til slutt var det, som beskrevet i "bakgrunn", stadig yngre deltakere som ble henvist til JobbResept og hvor arbeid ikke var aktuelt på grunn av alder. Det ble diskutert i den internasjonale gruppen hvorvidt en skulle ha en egen intervensjon for skole og utdanning, helt separat fra arbeid, eller om intervensjonene skulle integreres. Dels med bakgrunn i tanken om karriereutvikling ble det bestemt å velge en integrert tilnærming. Da trengte en også en integrert fidelityskala. Det støtte på noen utfordringer: Noen av punktene i den opprinnelige fidelityskalaen kunne ikke oversettes direkte fra arbeid og over til skole/utdanning. For eksempel er det et item hvor det blir spesifisert i hvor stor grad deltakere

blir hjulpet til lønnet arbeid, og hvor stor stillingsprosent. Det sier seg selv at dette itemet ikke passer for IPS skole/utdanning. Også ”jobbsøk” er annerledes enn det å finne en egnet skole- eller studieplass. For det første er noen av deltakerne så unge at de fremdeles er i skolepliktig alder, da er skolevalg gitt. For det andre erstattes jobbsøk og oppstart i jobb med ”immatrikulering” i skole/utdanning. Også samarbeidsinstanser er vesensforskjellige. Ved jobb er en naturlig samarbeidspartner, ved siden av arbeidsgiver, NAV, mens ved skole/utdanning er det et helt nettverk av spesialiserte instanser så som PPT, Studentsamskipnaden, Oppfølgingstjeneste, Helsesøster, skoleledelse, lærere, rådgivere, og ofte også foresatte. Sluttresultatet, som fremdeles er under utprøving, ble en skala med to kolonner, en skåre for skole/utdanning og en for arbeid. Det er viktig å huske på at det er teamet, og ikke den enkelte deltaker eller deltakergruppa, som skåres. Dermed kan ett team godt få to forskjellige skårer, en for hvordan det arbeider med IPS arbeid, og en for IPS skole/utdanning.

Det er i samarbeid med Universitetet i Stavanger søkt midler ved Samarbeidsorganet Helse Vest nå i 2017 for en internasjonal, multi-site utprøving av fidelityskalaen og sammenlikning av SkoleReseptintervensjonen. Dessverre fikk en ingen tildeling. Ny søknad om midler er planlagt til våren.

Det har funnet sted to fidelity-ratinger med den tilpassede fidelityskalaen hvor en skårer både IPS arbeid og IPS utdanning. Fidelitygjennomgangen har vært svært nyttig for selv-evaluering av prosjektet og den enkelte medarbeiders ansvar. Uavhengig rater har gitt skåren *god*, dvs. 102 poeng av 125 mulige; og ved siste skåring 22 oktober 2017 ”tilfredsstillende”. Lavere skår ble gitt på grunn av for stor case load per medarbeider; ønskelig er færre enn 20. De to skolereseptmedarbeiderne hadde 30 hver, og de øvrige 37 var fordelt over de fem andre medarbeiderne i det integrerte Skole- JobbReseptteamet.

2.6 Avvik eller endring i prosjektet:

Da prosjektansatt Rune Salvesen gikk ut av sin stilling i SkoleResept, juli 2016, har driften

blitt ivaretatt av prosjektleder Skole-& JobbResept, ved Lena Heitmann. Tilskuddsmidler som var satt til høstsemesteret 2016 ble overført 2017 til å fortsette deltakere i SkoleResept som er avsluttet oktober 2017.

Kapittel 3. Resultater og vurdering av disse

3.1 Måloppnåelse i henhold til problemstilliner

Problemstilling 1: Er det praktisk gjennomførbart å tilpasse IPS for skole og utdanning?

Å tilpasse IPS for skole og utdanning har vært en prosess gjennomgått sammen med internasjonale samarbeidspartnere på feltet. Det måtte tas stilling til hvorvidt en skulle forsøke en separat, eller en integrert tilnærming. Med bakgrunn i behovet for fleksibilitet i overganger mellom arbeidsutprøving og skole/utdanning, falt valget på det siste, tross enkelte utfordringer. En tilpasning av den opprinnelige intervensjonen som var utarbeidet for arbeid, og tilhørende fidelityskala, var nødvendig. Dermed utviklet SkoleResept seg fra å være tenkt som en helt egen intervensjon til å være integrert i Skole-Jobbreseptteamet, men med to medarbeidere som utviklet spisskompetanse på skole- og utdanningssystemet og hjelp til de yngste deltakerne. Disse to hadde kun utdanningskandidater i sine case-loads, men bistod øvrige medarbeidere i sitt arbeid med deltakere som ønsket utdanning i tillegg til eller i stedet for arbeid.

I systemet hvor SkoleResept har operert har det ligget godt til rette for samarbeid med behandlende klinikere. I løpet av prosjektets levetid opplever vi at det har vokst økt fokus på funksjonelt utfall ved behandling av psykiske lidelser hos unge, det vil si hvordan behandling virker på pasientens/deltakerens ”virkelige liv” ute på de arenaer som livet leves. Fordi SkoleResept har blitt integrert i et allerede eksisterende team, JobbResept, har det vært enkelt å gjøre seg kjent, og å få på plass enkle henvisningsrutiner og lave terskler. Særlig det siste kan en også takke samarbeidet med veletablerte TIPS, Tidlig Intervensjon ved Psykose, for. Videre har også den mangeårige erfaringen med IPS-arbeid i JobbResept bidratt til at opplæring av medarbeidere har gått greit for seg.

Problemstillingene 2 og 3: Hvordan tas prosjektet imot av deltakere, pårørende, og samarbeidspartnere utenfor psykisk helsevern?

Prosjektet ble svært godt tatt imot av samarbeidspartnere utenfor psykisk helsevern og av deltakerne selv. En opplevde at det var et stort behov for denne typen intensiv hjelp for elever med alvorlige psykiske lidelser og utfordringer. En rektor på en skole til en av deltakerne sier:

”*Vi på xxx VGS er veldig godt fornøyd med hjelpen våre elever har fått fra SkoleResept. SkoleResept har gjort det mulig med tett og god oppfølging av enkelt elever. I tillegg har det gitt oss faglig trygghet i forhold til oppfølging av disse elevene. En av våres største utfordringer, er å få elever til å komme på skolen / til møter. Her har SkoleResept vært med på å sørge for at elevene stiller til de møtene som avtales.*”

Andre skoleledere sier: ”*Jeg synes det blir litt vanskelig å uttale meg på vegne av hele skolen. Min erfaring med SkoleResept er så langt f.o.f. knyttet til en enkelt elev på min avdeling. Samarbeidet har her fungert bra og klart styrket dialogen og samarbeidet med eleven. I den grad SkoleResept har kunne bidra inn på skolen direkte, har det fungert bra. Det har vært noe uklart (for lærerne i alle fall) hva som har vært SkoleResepts mandat, særlig når det oppstår akutte situasjoner på skolen. Til høsten får vi en ny avdelingsleder i en nystartet avdeling for elevoppfølging. Dette vil nok være rette person å drøfte dette videre med fra høsten.*”

og

"Vi har ved xxx vgs hatt elev med oppfølging fra Skoleresept hos oss i to år. Eleven er nå i ferd med å avslutte med fullført skoleløp, og med svært godt resultat. Dette skyldes i stor grad den oppfølgingen eleven har hatt fra Skoleresept i samarbeid med Sandnes vgs.
Vi har også en del andre elever som kunne ha hatt behov for tilsvarende oppfølging, men de faller lett ut dersom de ikke får det.
Vi er gjort kjent med at vi til høsten får inn elever med stor angstproblematikk (PTSD) og sosial fobi, men har ingen midler til personer som følger dem opp på samme måte som det i år ble gjort fra Skoleresept.

Det er derfor avgjørende for gjennomføring for elever med store psykiske utfordringer at det finnes en person som kan støtte dem når vanskene synes uoverkommelige."

Noen sitater fra deltakerne selv er:

"*Du trenger å bli sett for dine evner alene, slik at du for deg selv kan muliggjøre de livsoppgaver som oppleves som viktige for å ha en framtid. Spørsmålet om framtiden var det som tynget meg mest mens jeg var i psykose. Du trenger så sårt å få en pause fra det sykelige, og mer fokus på det som gjør deg like og normal. Og SkoleResept hjelper deg med det."*
Student, UiS" ;

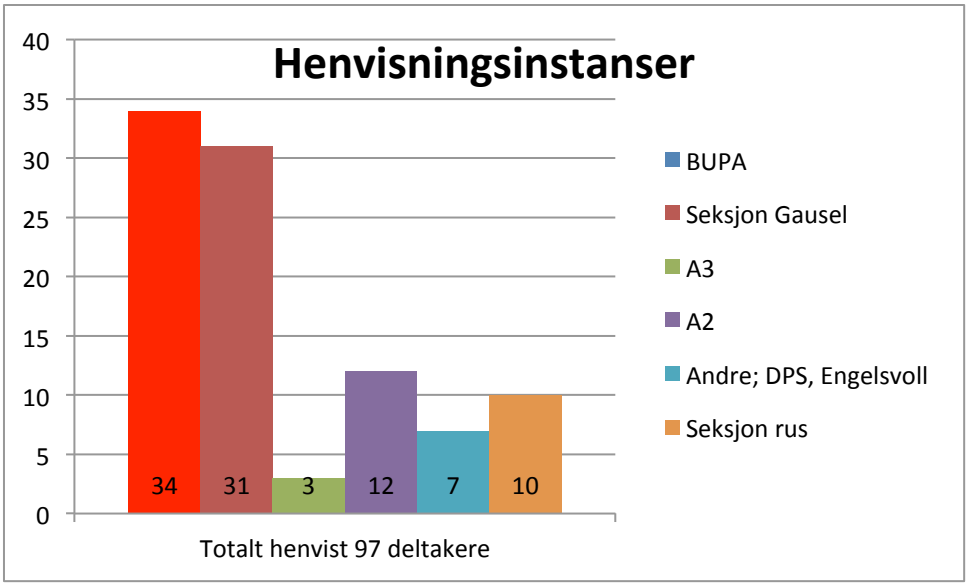
" *SkoleResept hjelper meg til å hjelpe meg selv og da føler jeg meg mer samlet i hode og kropp. Alt dette er verktøy jeg trenger for å ha det bra og det gir meg økt skolelyst."*

" *Jeg synes det er bra å være med på Skole Resept fordi det har hjulpet meg. Jeg synes de er flinke i jobben sin og greier å få ting til*."
Elev, ungdomsskole.

Da SkoleResept her ikke ble forskningsmessig evaluert, nøyer vi oss med å konkludere på bakgrunn av erfaringer og tilbakemeldinger. De har vært udelt positive.

Problemstilling 4: Hvordan tar prosjektet imot av henvisere innen psykisk helsevern?

Figuren (Figur 1) nedenfor illustrerer antall henvisninger fra de forskjellige enhetene i psykisk helsevern ved Stavanger Universitetssjukehus. Det opprinnelige målet for prosjektet var å hjelpe om lag 40 deltakere; som figuren viser er antallet mer enn doblet. Det har kunnet la seg realisere gjennom å integrere SkoleResept med JobbResept og dermed øke kapasiteten. Det figuren imidlertid også illustrerer er en stor pågang på et svært ettertraktet tilbud. Uten at dette er forskningsmessig evaluert kan det tyde på at prosjektet har vært godt mottatt også her.



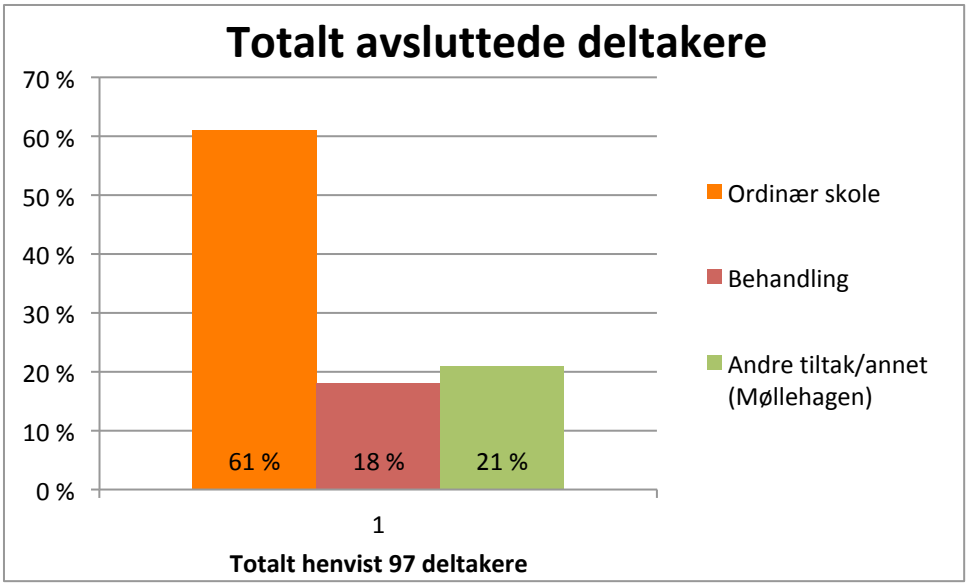
Figur 1. Henvisninger i antall, fordelt over henvisende avdelinger. BUPA: Barne- og Ungdomspsykiatriske sengeposter og poliklinikker; Seksjon Gausel: Avdeling Unge Voksne, poliklinikk og rehabiliteringspost alvorlig psykisk lidelse; A3 og A2: sengeposter seksjon Affektive lidelser og Psykose; DPS: Sandnes Distriktspsykiatriske Senter; Engelsvoll: Langtids institusjonsbehandling alvorlige psykiske lidelser; Seksjon Rus: Avdelinger og poliklinikker for rusbehandling og psykisk helsevern.

Problemstilling 5: Kan SkoleResept forebygge skolefrafall hos unge med alvorlige psykiske lidelser?

Ved siden av en driftsmessig telling av antall deltakere i SkoleResept som etter inkludering i prosjektet har vært aktive i skole eller utdanning, har en integrert intervensjon, hvor også JobbResept er med, blitt forskningsmessig evaluert og publisert[9]. SkoleResept alene er ikke underlagt vitenskapelig evaluering. I den nedenstående gis driftstall:

Av de 97 deltakerne som ble henvist i prosjektperioden er 61% i fullt ordinært skoleløp eller annen utdanning (Figur 2). Tar en i betraktning at det når det gjelder arbeid, kun ca. 40% i diagnosegruppen psykoselidelser er i *noen* form for *noen* grad av arbeid to år etter diagnose [1], og at kriteriet her var å være i ordinær skole eller utdanning i *minst* 50% av vanlig progresjon, mener vi å ha høyde for å tolke resultatet som positivt. Norske tall fra studier om skole/utdanning og alvorlige psykiske lidelser har vi ikke kunnet få tak i.

21% av deltakerne ble avsluttet til spesielt utdanningstiltak, Møllehagen Skolesenter, med tilrettelagt undervisning. Vitnemål herfra er tellende som ordinært vitnemål, men undervisningen er sterkt tilrettelagt og foregår en-til-en eller i svært små grupper.



Figur 2: Avsluttede deltakere, fordelt over resultat. Andre tiltak: Ikke suksess; ikke lykkes med å få til minst 50% skole eller utdanning.

3.2 Overføringsverdi

Lærdommen etter dette prosjektet er først og fremst at oppfølging av spesialisthelsetjeneste i skole og utdanning av unge med alvorlige psykiske lidelser kan være effektivt mot skolefrafall i denne gruppen, men at oppfølgingen bør vare lengre enn ett år. Videre lærdom er at en utadvendt spesialisthelsetjeneste tas godt imot av skoler og utdanningsinstitusjoner, og er et nyttig supplement til eksisterende hjelpeinstanser som PPT og Oppfølgingstjenesten. Prosjektet har vist at sømløs samhandling mellom kommunehelsetjenester, skoler, fylkeskommunale tjenester (PPT og videregående skoler) er mulig å få til.
Innen spesialisthelsetjenesten har inntrykket vært at fungering, i tillegg til symptombehandling, har fått økt fokus i løpet av den tiden SkoleResept har vært et tilbud. Dette legger grunnlaget for økt sosial inklusjon, mestring og livskvalitet etter, eller med, alvorlige psykiske lidelser. Et økt fokus på denne typen behandlingsresultater er klart overførbart til andre helseforetak, og i Helse Midt har denne typen arbeid allerede vært implementert[10]. Vi ser dessverre at initiativer som dette ofte ikke videreføres av helseforetak eller andre etter endt prosjektperiode, tross gode erfaringer og suksess.

Kapittel 4. Formidling

Skole-JobbResept har fått omtale og det er drevet formidling i nedenforstående:

- Work in Progress, konferanse september 2014, Stavanger.
- Deltakelse og presentasjon av SkoleResept ved internasjonal konferanse om første gangs psykoser, IEPA okt.2016, Milano.
- Presentasjon til Nordisk Råds konferansen,« Psykiatri Topmøde» i København nov. 2015, med Helseminister Bent Høie.
- Deltakelse med posterpresentasjon ved Schizofrenidagene nov.2015 og 2016.
- Reportasje i Stavanger Aftenblad, feb.2017. (samt SA i juli 2016)
- Egen todagers konferanse 26. og 27. april 2017, «Work in progress»:

  «Frafall fra videregående skole og psykiske lidelser- problemforståelse, praktiske perspektiver og mulige tiltak».

  Workshop med Prof. Dr. Psychol. Arnstein Mykletun, seniorforsker, Folkehelseinstituttet, avdeling Psykisk helse og selvmord.

  «Hvordan kan man best organisere videregående skole (evt. også ungdomsskole) for å redusere risikoen for drop-out»?

- ENMESH Internasjonal konferanse om helsetjenesteutvikling og psykososial rehabilitering. Groningen, Nederland, oktober 2017. Innlegg i symposium om IPS arbeid og utdanning.
- World Psychiatric Association International Conference, Berlin, Tyskland, oktober 2017. Innlegg i symposium om IPS arbeid og utdanning.
- **Paper: Hegelstad** W ten Velden, Joa I, Heitmann L, Johannsessen JO, Langeveld, J. (2017). JobPrescription- Supported Employment in an Early Detection of Psychosis area; a matched control study (*submitted*). Om den integrerte intervensjonen IPS arbeid/utdanning.

Kapittel 5. Eksempel.

Nedenfor gis en punktvis oppsummering av samarbeidet mellom SkoleResept, deltaker, BUP, og skole:

Jente 16 år, henvises fra behandler på BUP. Henvist rett etter tiende klasse og før oppstart på videregående skole.

Diagnoser: F32.3 Alvorlig depresjon med psykotiske symptomer.
F41.9 Uspesifisert angstlidelse

Henvisning: Pasient søkt videregående skole, trenger oppfølging og tilrettelegging. Hadde i siste halvår av 10. klasse slitt med oppmøte på skolen.

Oppstart:
Oppstartsamtale fant sted sammen med behandler og pasient, samt mor. Vi ga informasjon om SkoleResepts mandat og ble enige om en avklaring av roller.

Kartlegging:
Vi legger vekt på å møte deltaker «der de er», hjemme, på skolen, ute på tur, eller kontor. For denne jenta ble det mest aktuelt å møtes på skolen og på SkoleResept sine kontorer. Det ble avklart hva behovet for hjelp var og hvilke type tilrettelegginger hun hadde behov for i skolen: Vekking om morgenen med pep-talk; rolig leseplass for lekselesing: fikk låne ledig kontor på SkoleResept; øving til muntlige presentasjoner som var angstprovoserende; samtaler rundt sosial angst som av og til gikk over i paranoid mistenksomhet (sterk angst for avvisning), med kognitive teknikker. Vi innhentet samtykke til kontakt med skole. Relasjonsbygging var en avgjørende del i kartleggingsfasen.

I samtaler med jenta brukte vi i tillegg til kognitive teknikker motiverende intervju, psykoedukasjon, og problemløsningsmetode slik den også brukes i familiearbeidet til TIPS/POP.

I kontakten med skole var første skritt et møte mellom deltaker, SkoleResept og avdelingsleder samt sosialrådgiver. Her ble, i tråd med handlingsplanen, informasjon gitt om deltakeren og om SkoleResept. Vi avtalte å møtes før skolestart.

I dette møtet ble behov og mulighet for tilrettelegging fra skolens side og videre oppfølging avklart:

Plan for oppfølging:
- Ukentlige støttesamtaler med deltaker. Viktig med fleksibilitet, og å møte deltaker «der han/hun er», ofte er dette på skolen. I samtale brukes motiverende intervju, psykoedukasjon, kognitiv terapi, og problemløsningsmetode.
- Telefonkontakt med skole, være lett tilgjengelig for drøfting og veiledning
- I oppstart viktig med månedlige treffpunkt med deltaker og kontaktlærer eller annen representant fra skolen.
- Veiledning til skole etter behov
- Gjennomgang av samarbeidsplan med deltaker

- Samarbeidsplan fylles ut, deltaker og kontaktlærer fyller denne ut sammen. (vedlegg)
- Samarbeid med andre instanser: PPT, BUP, fastlege, oppfølgingstjenesten, barneverntjenesten, nav planlegges
- Samarbeid med mor
- Oppfølging tilpasses etter behov, til deltaker er i skole og følger ordinær progresjon, i tråd med deltakers eget ønske.

Kapittel 6. Oppsummering og videre planer

Stortinget ba i 2016 regjeringen om å legge frem en helhetlig tverrsektoriell strategi for barn og unges psykiske helse som omfatter individ og samfunn, og som inneholder både **helsefremmende, sykdomsforebyggende og kurative initiativ**. Dermed utformet regjeringen en strategi for god psykisk helse 2017-2022, **«Mestre hele livet»** (Helse-og omsorgsdepartementet 08/2017) i innledningen påpekes det at god psykisk helse ikke skal være helsesektorens ansvar alene, men se på virkemidler i ulike sektorer. Det har blant annet blitt økt bevissthet om betydningen av psykisk helse i barnehage, skole, frivillig sektor og arbeidsliv. Det påpekes at samarbeidet mellom helsesektoren og andre sektorer skal styrkes. Fra kapittel 7 «*Fremme god psykisk helse hos barn og unge»*, i strategidokumentet står det at beregninger utført av Folkehelseinstituttet viser at mellom 15 – 20 % av barn og unge har så betydelige psykiske plager at det går utover deres daglige fungering. Mange av disse kan sannsynligvis klare seg godt dersom de får tilbud om lavterskelhjelp og tidlig intervensjon.

I regjeringens strategi; **«Mestre hele livet»** står det blant annet at det er sentralt å utvikle felles tiltak og strategier med bedre koordinering av statlige innsatser og virkemidler, som derigjennom vil bidra til bedre samarbeid og koordinering mellom de lokale tjenestene. Det er behov for å bedre evnen til å *oppdage risiko og problemutvikling tidlig*, og evnen til å handle adekvat i de ulike berørte tjenestene.

Veien videre for et sektorløst samarbeid

Hovedformålet med å igangsette prosjektet SkoleResept var å minske skolefravær på grunn av psykiske problemer. Det har vist seg nødvendig å jobbe med psykisk helse allerede i grunnskolen – der tidlig intervensjon og forebygging ved psykiske problemer er viktig. Hvis vi kan bidra med rask kontaktetablering ved mistanke om psykiske problemer hos en elev kan vi bidra til å snu en negativ utvikling i eksempelvis fravær på grunn av dette og det vil gjøre noe med den enkelte elevs framtidsutsikter.

Behovet for denne spesialiserte kompetansen på skolen har blant annet sitt utspring i at behandlere i AUVF / PBU jobber mindre utadrettet enn tidligere og er blitt mer utilgjengelige. Skolene på sin side er dyktige på å tilrettelegge for elevene, men de skal primært drive undervisning av elevene.

Leder i Stavanger kommunes Helsestasjon for ungdom og helsetjenesten for elever, påpeker betydningen av at all tilnærming til ungdommene må ha som fokus å være helsefremmende og forebyggende. Det påpekes også at de har mange elever som går i behandling i PBU, - og det å komme til og fra en poliklinisk behandling er en utfordring. De foreslår at SkoleResept (AUVF/PBU) kunne hatt samtaler ute i skolene. Da slipper ungdommene så mye fravær og stress med forflytning og de klarer lettere å følge opp behandlingen der de er. Det samme gjelder samarbeidsmøter og tilrettelegging, prinsippet må være at hjelpen kommer til elevene og at de ikke dras vekk fra den arenaen de oppholder seg på.

Vi tenker at hvis vi knytter vår spesialiserte kompetanse ut og direkte på de videregående skolene, sammen med helsesøstre, kan vi bidra til at flere unge kan få rask psykisk helsehjelp og muligens unngå langvarige behandlingsforløp ved psykiatrisk klinikk.

Sektorløst samarbeid

Samarbeidsprosjektet bør bestå av likeverdige partnere fra Avdeling for unge voksne og flyktninger i Klinikk for barn og unge, Helse Stavanger HF, Rogaland fylkeskommune og

Stavanger kommune og ved finansiering av et slikt prosjekt bør alle parter stille med en stilling hver.

Ved et eventuelt partnerskap bør det dannes en styringsgruppe bestående av ledere fra de ulike instansene, pluss brukerrepresentanter fra eksempelvis Mental helse, Ung Hjelp også representanter fra elevrådet på de videregående skolene som er med på dette samhandlingsprosjektet. Styringsgruppen bør ha 4 møter per år.

Rapporteringer og dokumentasjon fra SkoleResept foregår på lik linje som ved annen behandling ved Helse Stavanger, HF, og ved behov.

I de stillingene som i dag som jobber med SkoleReseptdeltakere, er driftskostnadene delt mellom Helsedirektoratet og Stavanger Universitetssjukehus, SUS. Det jobbes på ledernivå i Helse Stavanger med å få til en varig forankring i drift av SkoleResept ved Klinikk for psykisk helsevern barn, unge voksne og rusavhenginghet (PH-BURA). Foreløpig er det ingen klarhet i dette. Prosjektdelen som har vært finansiert av Extrastiftelsen og RPH i er avsluttet i oktober 2017. ønsker å fortsette å drifte SkoleResept, men det vil bli redusert drift i forhold til antall elever en kan følge opp.

Nye initiativ

Skole-Jobbresept er representert i en arbeidsgruppe forankret i Stavanger Kommune og Stavanger Universitetssjukehus for etableringen av et Headspacesenter; et lavterskel tverretatlig tilbud for unge som har psykiske eller sosiale utfordringer. Headspacesenter kommer opprinnelig fra Australia: https://headspace.org.au I dag finnes Headspacesentere og aveleggere i Danmark, Irland, USA, Nederland med flere. Tanken er å samlokalisere tilbud i en one-stop-shop. I Stavanger tenker en å koble det sammen med en digital, moderne kommunikasjonsplattform med enkel tilgang på enten ”likemenn”, eller profesjonelle helse- og skolearbeidere.

Til slutt nevnes igjen det internasjonale samarbeidet Skole-JobbResept er del av og som er i planleggingen av en stor, internasjonal multi-site studie på den integrerte IPS for arbeid og utdanning-intervensjonen. Skole-JobbResept har begynt inkluderingen av deltakere tross manglende finansiering og utfører dette arbeidet med tilgjengelige ressurser. I Nederland har ni sites allerede avsluttet inkludering, og i Berlin er inkludering startet i juni 2017. På Yale starter en nå på nyåret 2018. Øvrige sites er i planlegging og tilretteleggingsfasen.

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Vedlegg

- Adapted IPS Fidelity Scale AIPS (Engelsk versjon, ikke oversatt)
- Collaboration Plan (engelsk versjon samarbeidsplan SkoleResept)
- NEET to treat- prosjektbeskrivelse internasjonalt forskningsprosjekt

ADAPTED IPS SUPPORTED EMPLOYMENT AND EDUCATION FIDELITY SCALE 10.27.2015

Rater: **Site:** **Date:** **Total Score:**

STAFFING

Criterion	Data sources	Anchor for scoring	Number of cases	
1. Caseload Size: IPS Workers have individual caseloads aimed at employment and education. The maximum caseload for a full-time IPS Worker is 20 or fewer.	MIS, DOC, INT	1. 41 or more clients per IPS Worker. 2. 31 – 40 clients per IPS Worker. 3. 26 – 30 clients per IPS Worker. 4. 21– 25 clients per IPS Worker. 5. 20 clients or less per IPS Worker. **SCORE:**	SE SEd Total	
Criterion		Anchor for scoring	**SCORE**	
2. Employment/Educational Staff: IPS Workers provide only employment and educational services	MIS, DOC, INT	1. IPS Workers provide employment and education services less than 60% of the time. 2. IPS Workers provide employment and education services 60-74% of the time. 3. IPS Workers provide employment and education services 75-89% of the time. 4. IPS Workers provide employment and education services 90-95% of the time. 5. IPS Workers provide employment and education services 96% or more of the time.	SE	SEd

3. Vocational/Educational Generalists: Each IPS Worker carries out all phases of employment or education services, including intake, engagement, assessment, job or education coaching, placement, and follow-along supports before step down to less intensive form of support from another MH practitioner. (Note: The IPS Worker is not expected to provide benefits counseling to their clients. Referrals to a trained benefits counselor are in keeping with high fidelity. See item # 1 in "Services.")	MIS, DOC, INT, OBS	1. IPS Workers only provide vocational or educational referral services to other programs. 2. IPS Workers maintain their caseload, but refer clients to other vocational and/or education programs. 3. IPS Workers perform one to four phases (such as intake, engagement, assessment, job/education search or placement, coaching and follow-along support). 4. IPS Workers carry out five phases, but not the entire services. 5. IPS Workers carry out all six phases of employment or education services (intake, engagement, assessment, job/education development/placement, coaching and follow-along support).	SE	SEd

ORGANIZATION

1. Integration of Rehabilitation with mental health treatment through team assignment: IPS Workers are part of no more than 2 mental health treatment teams. At least 90% of the IPS Worker's caseload comes from these mental health treatment teams.	MIS, DOC, INT, OBS	1. IPS Workers are part of vocational or educational programs that function separately from the mental health treatment team. 2. IPS Workers are attached to three or more mental health treatment teams. OR Clients are served by individual mental health practitioners, who are not organized into teams. OR IPS Workers are attached to one or two teams, but less than 50% of their caseload comes from these mental health teams. 3. IPS Workers are attached to one or two mental health treatment teams. At least 50 – 74% of the caseload comes from these mental health teams. 4. IPS Workers are attached to one or two mental health treatment teams. At least 75 – 89% of the caseload comes from these mental health teams. 5. IPS Workers are attached to one or two mental health treatment teams. 90 – 100% of the caseload comes from these mental health teams.	SE	SEd

2. Integration of Rehabilitation with Mental Health Treatment Through Frequent Contact Between Team Members: IPS Workers actively participate in weekly mental health treatment team meetings (not replaced by administrative meetings), where individual clients and their employment and educational goals are discussed with shared decision-making. IPS Worker's offices are in close proximity to (or shared with) the mental health team members. Documentation of mental health treatment and employment and education services are integrated into a single chart. IPS Workers help the mental health team think about work for clients who do not yet receive supported employment and education services.	MIS, DOC, INT, OBS	1. None or one element is present. 2. Two elements are present. 3. Three elements are present. 4. Four elements are present. 5. Five elements are present. The five key elements are: • IPS Worker attends weekly mental health treatment team meetings. • IPS Worker actively participates in treatment team meetings with shared decision-making. • Employment and education services documentation (e.g., assessment/profile, support plan, progress notes) is integrated into client's mental health treatment record. • IPS Worker's office/work area is in close proximity to (or shared with) the mental health treatment team members. • IPS Worker helps the team think about employment or education for people who have not yet been referred to the program.	SE	SEd

3. Collaboration Between IPS Workers and Vocational/Educational Rehabilitation Counselors: The IPS Worker and VR counselors (or school counselors, Office of Student Disabilities-OSD,, employment services, teachers, school leadership, parents/carers) have frequent contact for the purpose of discussing shared clients and identifying potential referrals.	DOC, INT, OBS, ISP	1. IPS Workers and VR counsellors have client-related contacts (telephone, email, face-to-face) less than quarterly to discuss shared clients and possible referrals OR IPS Workers and VR counselors do not communicate with each other. 2. IPS Workers and VR counselors have client-related contacts (telephone, email, face-to-face) at least once every quarter to discuss shared clients and possible referrals. 3. IPS Workers and VR counselors have client-related contacts (telephone, email, face-to-face) monthly to discuss shared clients and possible referrals. 4. IPS Workers and VR counselors have scheduled face-to-face meetings at least quarterly. OR have weekly client-related contact (telephone, email, face-to-face) to discuss shared clients and possible referrals. 5. IPS Workers and VR counselors have scheduled face-to-face meetings at least monthly. In addition, there is weekly client-related contact to discuss shared clients and possible referrals.	SE	SEd

4. An SE/SEd Unit: At least 2 full-time IPS Workers and a supervisor are part of the team. The team has weekly supervision meetings devoted to client-related matters. The supervision meetings are carried out according to the IPS model, in which strategies are identified and job and school leads for clients are shared. The IPS Workers provide coverage for each other's caseload when needed.	MIS, INT, OBS	1. IPS Workers are not part of an SE/SEd unit. 2. IPS Workers have the same supervisor, but do not meet as a group. They do not provide coverage for each other's clients. 3. IPS Workers have the same supervisor and discuss clients with each other on a weekly basis. They provide coverage for each other's clients when needed. OR If an SE/SEd program is in a rural area where the IPS Workers are geographically separate with one IPS Worker at each site: the IPS Workers and the supervisor meet by teleconference 2 to 3 times per month. 4. At least 2 IPS Workers and a supervisor form an SE/SEd unit with 2-3 scheduled supervision meetings per month. During these meetings, client-related matters are discussed, strategies are identified and job or education leads for clients are shared. Coverage for each other's clients is provided when needed. OR If an SE/SEd program is in a rural area where the IPS Workers are geographically separate with one IPS Worker at each site: the IPS Worker and the supervisor consult face-to-face or by telephone 2 to 3 times per month. Mental health team members are available to support IPS Workers with activities such as helping someone get to work or school, and job and education needs. 5. At least 2 IPS Workers and a supervisor form an SE/SEd unit with weekly supervision meetings. During these meetings, client-related matters are discussed, strategies are identified and job and education leads for clients are shared. Coverage for each other's clients is provided when needed.	SE	SEd

5. <u>Role of the SE/SEd Supervisor:</u> The team is led by a SE/SEd supervisor. The skills of IPS Workers are developed and improved through outcome-based supervision. All five of the supervisor's key roles are present.	DOC, MIS, INT, OBS	1. None or one role is present. 2. Two roles are present. 3. Three roles are present. 4. Four roles are present. 5. Five roles are present. The five key roles are: • One full-time equivalent (FTE) supervisor is responsible for no more than 10 SE/SEd specialists. The supervisor has no other supervisory responsibilities (supervisors of a team with fewer than 10 people may spend a pre-determined percentage of their work time on other supervisory activities. For instance: a supervisor who is responsible for a team of 4 people may be attached to the SE/SEd team for half the number of contract hours). • The supervisor conducts weekly supervision in order to review the situation of clients and identify new strategies and ideas to help clients with their work and/or education. • The supervisor communicates with the team leaders of mental health teams to ensure that services are integrated and problems within the SE/SEd program are resolved (such as the referral process or transfer of follow-along to MH workers) and to be a champion for the value of work and education. Attends a meeting for each mental health treatment team on a quarterly basis. • Each month the supervisor accompanies IPS Workers who are new or having difficulty building a portfolio of jobs and/or education places in the field. The aim is to improve the skills of the specialists through observation, modeling and giving feedback on their interaction with employers and educational institutions (to help them build a portfolio of jobs and education places). • At least once every quarter, the supervisor discusses current client outcomes with IPS Workers and sets objectives for improving the program results.	SE	SEd

6. <u>Zero Exclusion Criteria:</u> All clients interested in employment and/or education have access to SE/SEd services, irrespective of readiness factors: substance abuse, symptoms, history of violent behavior, cognition impairments, treatment non-attendance and personal presentation. This also applies once SE/SEd services have been set in motion. IPS Workers offer help finding new work when a job has been terminated or a new education opportunity, regardless of the reason for the termination or the number of attempts the client has made. If employment or education screening criteria applies, these are not used by the mental health organization to exclude people. Clients are not screened out, either formally or informally.	DOC, INT, OBS	1. There is a formal policy where clients are excluded by IPS Workers, the case manager, or other practitioners, due to lack of job or education readiness (e.g. substance abuse, history of violent behaviour, low level of functioning, etc.). 2. Most clients are unable to make use of SE/SEd services because they are assessed as lacking readiness (e.g. substance abuse, history of violent behaviour, low level of functioning, etc.). 3. Some clients are unable to make use of SE/SEd services because they are assessed as lacking readiness (e.g. substance abuse, history of violent behaviour, low level of functioning, etc.). 4. No indications for exclusions; neither formal nor informal. Leads do not come from a broad spectrum of sources. IPS Workers offer help finding new work when a job has been terminated or a new education opportunity, regardless of the reason for the termination or the number of attempts the client has made. 5. All clients who are interested in employment or education have access to SE/SEd services. Mental health workers encourage clients to consider employment or education and leads come from many different sources. IPS Workers offer to help find new work when a job has been terminated or a new education opportunity, regardless of the reason for the termination or the number of attempts the client has made.	SE	SEd

7. <u>Focus on Competitive Employment and/or regular education:</u> The agency pursues multiple strategies to promote competitive employment and/or participation in education programs. The intake contains questions about interests in work and/or education. Within the agency various written promotional items (e.g. brochures, bulletin boards, posters) can be found about SE/SEd The focus should be on programs that provide services to (young) adults with serious psychiatric complaints. The agency supports activities enabling clients to exchange experiences with other clients and staff. The agency measures employment and education outcomes and rate of goal achievement, as well as progress working towards these goals and shares this information with the agency leadership and SE/SEd staff.	DOC, INT, OBS	1. None or one strategy is utilized. 2. Two strategies are utilized. 3. Three strategies are utilized. 4. Four strategies are utilized. 5. Five strategies are utilized. The agency promotes regular, paid employment and/or participation in education programs via several strategies: • The intake contains questions about interest(s) in employment and education. • Questions about employment and education are included in all annual (or semi-annual) assessments or treatment plan reviews. • Promotional items about SE/SEd are displayed within the agency (e.g. in waiting rooms and lobbies). • Support for ways for clients to share experiences with other clients and staff (e.g. peer support groups, agency newsletter articles, invited speakers at treatment sessions, etc.,) is provided at least twice a year. • The employment and education outcomes and rate of goal achievement, as well as progress working towards these goals are measured at least once every quarter. The agency shares this information with the agency leadership and SE/SEd staff.	SE	**SEd**

8. <u>SE/SEd Support from Agency Leadership:</u> Members of the agency leadership (e.g. executive board, quality assurance director, department, clinical director, medical director, chief operating officer, chief financial officer, etc…) assist with the implementation and consolidation of SE/SEd programs. All five key components from the agency leadership are present.	DOC, INT, OBS	1. One element is present. 2. Two elements are present. 3. Three elements are present. 4. Four elements are present. 5. Five elements are present. The five core elements are: • The executive board and the clinical director demonstrate knowledge of the SE/SEd principles. • An explicit assessment of the SE/SEd program forms part of the quality process. This review is performed at least once every 6 months on the basis of fidelity measurements. As soon as a high degree of model fidelity is achieved (total score "good" or "exemplary"), assessment can take place at least once per year. • At least one of the members of the agency leadership actively participates in SE/SEd Steering Committee meetings. These Steering Committee meetings are held at least once every six months for high fidelity programs and at least once quarterly for programs that have not yet achieved high fidelity. Steering committee is defined as a diverse group of stakeholders charged with reviewing fidelity, SE/SEd program implementation and execution (delivery of services). The Steering Committee writes action plans aimed at achieving and consolidating high fidelity services. • The executive board communicates how SE/SEd services support the agency's mission and articulates clear and specific SE/SEd goals. This is communicated during the first 6 months of the SE/SEd program to all managers within the agency (e.g. via a project kick-off, newsletters, etc.). After the first six months, communication takes places at least once a year. • The SE/SEd program leader shares information about barriers and facilitators of Evidence Based Practices (EBP) with the management team (including the executive board) at least twice each year. The management team helps the program leader to find and implement solutions to overcome barriers.	SE	SEd

SUPPORT SERVICES

1a.SE: <u>Work/education Incentives Planning:</u> SE: Before starting a new job, all clients are offered help in making an understandable, personalized work incentives plan. This assistance is also offered when the client must make a decision about changes in work hours and pay. The work incentives plan comprises: social insurance, medical insurance and medicine reimbursements, rent and housing benefits, survivor's benefits, pension schemes and every other form of benefit. Clients get information about and assistance with reporting benefits to official institutions.	DOC, INT, OBS, ISP	1. Support for making a work incentives plan is not readily available or easily accessible for most agency clients. 2. IPS Workers give clients contact details for places where they can get information about work incentives planning. 3. The IPS Worker discusses changes in benefits with each client based on work status. 4. Before a client starts a new job, an IPS Worker or a mental health team member offers the client assistance (via a specially trained person) in making an understandable personalized work incentives plan. 5. Before a client starts a new job, an IPS Worker or a mental health team member offers the client assistance (via a specially trained person) in making an understandable personalized work incentives plan. They also help clients obtain access to work incentives planning when clients need to make decisions about changes in work hours and pay. Information and support is offered in reporting income and benefits to official institutions, depending on the benefits the client receives.	SE
<u>1b.SEd:</u> All clients receive extensive financial assistance and advice before and during their training. The support is at least aimed at: gathering relevant financial information and information about previous education programs (bank statements, tax returns, education CV), resolving any existing study debts/loans, assessment of study funding options (grants, scholarships, stipends, etc), exploring alternative funding options and the possible development of these alternatives.	DOC, INT, OBS, ISP	1. One element is present. 2. Two elements are present. 3. Three elements are present. 4. Four elements are present. 5. Five elements are present. The five key elements are: • The collection of relevant financial information and information about previous education programs (bank statements, tax returns, education CV) • Resolving (or working on) any existing study debts/loans • Assessing study funding options • Exploring alternative study funding options • Exploring possible development of funding options over time	SEd

2. <u>Disclosure:</u> IPS Workers provide clients with accurate information and assist with evaluating their choices to make an informed decision regarding what information is revealed (about the psychiatric disability and treatment) to an employer or educational institution.	DOC, INT, OBS	1. No element is present. 2. One element is present. 3. Two elements are present. 4. Three elements are present. 5. Four elements are present. The four key elements are: • Assistance from an IPS Worker does not oblige clients to disclose their psychiatric disability to an employer or educational institution. • IPS Workers offer to discuss with clients the pros and cons of disclosure to an employer or educational institution. This takes place before a client has contact with an employer or educational institution. IPS Workers indicate how disclosure of psychiatric disabilities helps to arrange accommodations and describe their role in the communication with an employer or educational institution. • IPS Workers discuss specific information to be disclosed (e.g. that a client is receiving treatment, the presence of psychiatric complaints, problems with anxiety or phobias, periods of unemployment or dropping out of school etc.) and gives examples of how such matters can be discussed with an employer or educational institution. • IPS Workers discuss disclosure more than once (e.g. if a client has still not found work or started an education program after two months, or if a client reports problems at work or school).	SE	SEd

3a. On-going Work-Based Vocational Assessment: Initial work-based vocational assessment takes place in 2-3 sessions and is updated with information about experiences in competitive employment. A Vocational Profile is made, containing information about preferences, experiences, skills, current adjustments, client's strengths, network contacts (personal contacts) etc. This profile is updated with every new job experience. The approach is solution-oriented, making use of observations from the work environment and surroundings and taking account of any adjustments to the workplace. Sources of information are: the client, the treatment team, clinical records, family members/loved ones and former employers (the latter two only with the client's permission). The vocational assessment is a continuous process based on job experience in competitive employment.	DOC, INT, OBS, ISP	1. Vocational evaluation is conducted prior to job placement with emphasis on assessments within the institution, standardized tests, intelligence tests, and work trial placements. 2. Vocational assessments may occur through a step-by-step approach that includes: previous work experiences (e.g., work units in a day program), volunteer jobs, or set aside jobs (e.g., sheltered workshop jobs). 3. IPS Workers immediately assist clients in finding a suitable job without a systematic assessment of interests, experiences, strengths, etc. and without analyzing job loss (or job problems) for lessons learned. 4. Initial vocational assessment occurs over 2-3 sessions in which client's strengths are ascertained. IPS Workers help clients learn from each job experience and also work with the MH treatment team to analyze job loss, job problems and job successes. The lessons learned are not documented in the vocational profile, OR the vocational profile is not updated on a regular basis. 5. Initial vocational assessment occurs over 2-3 sessions and information is documented on a vocational profile form that includes preferences, experiences, skills, current adjustments, strengths, network contacts, etc. The vocational profile form is used to identify job types and work environments. It is updated with each new job experience. The approach is solution-oriented, using observations from the work environment and surroundings and taking account of any workplace adaptations. Sources of information include the client, treatment team, clinical records, family members and previous employers (the latter two only with the client's permission). IPS Workers help clients learn from each job experience and also work with the MH treatment team to analyze job loss, job problems and job successes.	SE

3b. <u>On-going Educational Assessment:</u> An initial assessment of the educational opportunities takes place in 2-3 sessions based on the Vocational/Educational Profile instrument. The findings are updated quarterly on the basis of experiences and changes in the client's life. Educational opportunities are made on the basis of (1) interests, (2) skills, degrees obtained, internship/externship experiences, personal contacts and available resources (3) preferences (4) education CV, (5) career goals (6) barriers to education, and (7) support needs.	DOC, INT, OBS, ISP	1. Fewer than four domains undergo regular assessment and documentation is not regularly updated. 2. Four domains are regularly assessed. 3. Five domains are regularly assessed. 4. Six domains are regularly assessed. 5. Seven domains are regularly assessed. The assessed domains are: • Interests • Skills, degrees obtained, internship/externship experience, personal contacts and available resources • Preferences • Education CV • Career goals • Educational barriers • Support needs	SEd

4a. Rapid Search for Competitive Employment: Initial assessment and initial face-to-face contact that a client or IPS Worker has with an employer (in connection with competitive employment) occurs within 30 days (one month) after the client joins the SE/SEd program.	DOC, INT, OBS, ISP	1. The first face-to-face contact with an employer occurs, on average, 271 days (9 months) after joining the program. 2. The first contact with an employer occurs, on average, between 151 and 270 days (5-9 months) after joining the program. 3. The first contact with an employer occurs, on average, between 61 and 150 days (2-5 months) after joining the program. 4. The first contact with an employer occurs, on average, between 31 and 60 days (1-2 months) after joining the program. 5. The program maintains contact with the employer, with the first contact with an employer taking place, on average, within 30 days (1 month) after joining the program.	

4b. Rapid Linkage to Educational Activities Initial assessment and initial face-to-face contact that a client or IPS Worker has with an educational institution (in connection with a mainstream educational program, which includes: diploma or GED programs or non-USA equivalents, junior/community college, trade school, or university) occurs within 14 days (two weeks) after the client joins the IPS program.	DOC, INT, OBS, ISP	1. The first face-to-face contact with an educational institution occurs on average after 90 days (3 months) after joining the program. 2. The first contact with an educational institution occurs, on average, between 61-90 days (2-3 months) after joining the program. 3. The first contact with an educational institution occurs, on average, between 31 and 60 days (1-2 months) after joining the program. 4. The first contact with an educational institution occurs, on average, between 14 and 30 days (within 1 month) after joining the program. 5. The program maintains contact with the educational institution, with the first contact with an educational institution taking place, on average, within 14 days after joining the program.	

5. <u>Individualized Job or Education Search:</u> Contacts with employers and educational institutions are based on the client's preferences regarding the type of work or education (relating to what the client enjoys and personal goals) and the client's needs (including experience, skills, symptomatology, health, etc.) rather than the job market or educational settings (i.e. readily available jobs or educational places). A personal plan is developed and periodically adjusted on the basis of the vocational/educational profile form and new work and education experiences.	DOC, INT, OBS, ISP	1. Fewer than 25% of the contacts with employers or educational institutions are based on choices that reflect the client's preferences, strengths, symptoms, etc. instead of availability within the job market or educational settings. 2. 25-49% of the contacts with employers or educational institutions are based on choices that are consistent with the client's preferences, strengths, symptoms, etc. instead of availability within the job market or educational settings. 3. 50-74% of the contacts with employers or educational institutions are based on choices that are consistent with the client's preferences, strengths, symptoms, etc. instead of availability within the job market or educational settings. 4. 75-89% of the contacts with employers or educational institutions are based on choices that are consistent with the client's preferences, strengths, symptoms, etc. instead of availability within the job market or educational settings. 5. 90-100% of the contacts with employers or educational institutions are based on choices that are consistent with the client's preferences, strengths, symptoms, etc. instead of availability within the job market or educational settings. The contacts are in line with the current plan. If clients have limited job or education experience, IPS Workers provide information on a range of job or education options in the community.	SE	SEd

6. <u>Development of Jobs and Educational Opportunities – Frequent Contact with Employers and Educational Institutions</u> Every IPS Worker makes at least 6 personal contacts per week with employers or educational institutions for the clients seeking work or education (Determine the number for every IPS Worker and calculate the average in order to determine the closest anchor). A contact also counts if an IPS Worker visits the same employer or educational institution several times a week. The client need not be present. Client-specific and general contacts also count. IPS Workers use a checklist, keeping a weekly record of the contacts.	DOC, INT, OBS	1. IPS Workers have less than 2 client-specific contacts per week. 2. IPS Workers have 2 client-specific contacts per week OR No record is kept of contacts. 3. IPS workers have 4 client-specific contacts per week. A checklist is also used to keep a record of the number of contacts. This checklist is assessed every month by the program supervisor. 4. IPS Workers have 5 client-specific contacts per week. A checklist is also used to keep a record of the number of contacts. This checklist is assessed every week by the program supervisor. 5. IPS Workers have 6 or more client-specific contacts per week, or 2 contacts times the number of clients looking for work or school when there are less than 3 clients on the caseload (e.g., new program). A checklist is also used to keep a record of the number of contacts. This checklist is assessed every week by the program supervisor.	SE	SEd

7a. Development of Jobs – Quality of the Contact with Employers: IPS Workers build up a relationship with employers via multiple visits in person that are designed to learn the employer's needs, convey what the SE/SEd program offers the employer, describe client's strengths that make a good fit for the job. (Determine the number for every SE/SEd specialist and calculate the average in order to determine the closest anchor).	DOC, INT, OBS	1. The IPS Worker has contact with an employer if a client is receiving job application assistance. OR The IPS Worker rarely makes contact with employers. 2. The IPS Worker contacts employers to inquire about job openings and then shares these "leads" with clients. 3. The IPS Worker follows up on advertised job openings by introducing self, describing the SE/SEd program and asking the employer to interview client. 4. The IPS Worker meets with employers in person whether or not there is a job opening, advocates for clients by describing strengths and asks employer to interview client. 5. The IPS Worker builds up a relationship with an employer via multiple visits in person, which are planned to learn the employer's needs, convey what the SE/SEd program offers the employer, and describe the client's strengths that make a good match for the job and employer.	

7b. Development of Educational Opportunities– Quality of the Contact with Educational Staff and Institutions: IPS Workers build a relationship with educational institutions and staff via multiple visits in person that are planned to find out the educational opportunities within the educational institution and convey what the SE/SEd program has to offer the educational institution. (Determine the number for every IPS Worker and calculate the average in order to determine the closest anchor).	DOC, INT, OBS	1. The IPS Worker has contact with an educational institution/staff if a client is receiving enrollment assistance. OR The IPS Worker rarely has contacts with educational institutions/staff. 2. The IPS Worker contacts educational institutions to enquire about educational programs/opportunities and requirements and shares the information with clients. 3. The IPS Worker introduces self, describes the SE/SEd program and asks the educational institution/staff to meet with the client about the program. 4. The IPS Worker has personal contact with educational institutions/staff to enquire about the availability of educational programs/opportunities, recommend clients by describing their strengths and requests educational institutions/staff meet with client about the program. 5. The IPS Worker builds relationships with an educational institutions/staff via several visits in person that are planned to learn the educational institution's needs and convey what the SE/SEd program has to offer the educational institution, and describe clients strengths that make the program a good fit.	

8a. Diversity of Job Types: The IPS Workers assist clients to obtain different types of jobs.	DOC, INT, OBS, ISP	1. IPS Workers assists clients obtain different types of jobs less than 50% of the time. 2. IPS Workers assist clients obtain different types of jobs 50- 59% of the time. 3. IPS Workers assist clients obtain different types of jobs 60- 69% of the time. 4. IPS Workers assist clients obtain different types of jobs in 70- 84% of the time. 5. IPS Workers assist clients obtain different types of jobs in 85-100% of the time.	Score in SE column

8b. Diversity with Educational Opportunities: The IPS Workers assist clients in obtaining different types of education opportunities/programs, such as full-time education programs (intermediate vocational / higher vocational / university), preparatory and part-time education programs, training courses, apprenticeships, and internships/externships.	DOC, INT, OBS, ISP	1. IPS Workers assist clients in obtaining one or two types of education opportunities/programs, excluding mainstream full-time education. 2. IPS Workers assist clients in obtaining one or two types of education opportunities/programs, including mainstream full-time education. 3. IPS Workers assist clients in obtaining a broader range of education opportunities/programs, including mainstream full-time education. 4. IPS Workers assist clients in obtaining a broader range of education opportunities/programs, including mainstream full-time education. 5. IPS Workers assist clients in obtaining all forms of education. There are no indications of education programs being excluded.	

9a. Diversity of Employers: IPS Workers assist clients obtain jobs with different employers.	DOC, INT, OBS, ISP	1. IPS Workers assist clients obtain jobs with different employers less than 50% of the time. 2. IPS Workers assist clients obtain jobs with different employers 50-59% of the time. 3. IPS Workers assist clients obtain jobs with different employers 60-69% of the time. 4. IPS Workers assist clients obtain jobs with different employers 70-84% of the time. 5. IPS Workers assist clients obtain jobs with different employers 85-100% of the time.	
9b. Diversity of educational facilities: IPS workers assist clients obtain education options with different educational facilites		1. IPS Workers assist clients obtain options with different educational facilities than 50% of the time. 2. IPS Workers assist clients obtain options with different educational facilities 50-59% of the time. 3. IPS Workers assist clients obtain options with different educational facilities 60-69% of the time. 4. IPS Workers assist clients obtain options with different educational facilities 70-84% of the time. 5. IPS Workers assist clients obtain options with different educational facilities 85-100% of the time.	

10a. Competitive Jobs IPS Workers provide competitive employment options that have permanent status rather than temporary or time-limited status. Competitive jobs pay at least minimum wage, are jobs that anyone can apply for and are not set aside jobs for people with disabilities. (Seasonal jobs and jobs from temporary agencies that other community members use is counted as competitive jobs.)	DOC, INT, OBS, ISP	1. IPS Workers provide options for permanent, competitive jobs less than 64% of the time, OR There are fewer than 10 current jobs. 2. IPS Workers provide options for permanent, competitive jobs about 65-74% of the time. 3. IPS Workers provide options for permanent, competitive jobs about 75-84% of the time. 4. IPS Workers provide options for permanent, competitive jobs about 85-94% of the time. 5. 95% or more competitive jobs held by clients are permanent.	
10b. Regular education IPS workers provide support for education within regular educational institutions rather than segregated educational facilities for designated student groups (disadvantaged, having mental health challenges, having physical challenges, learning disabilities, etc.)		1. IPS Workers provide options in regular educational institutions less than 64% of the time. 2. IPS Workers provide options for attending regular educational institutions about 65-74% of the time. 3. IPS Workers provide options for attending regular educational institutions about 75-84% of the time. 4. IPS Workers provide options for attending regular educational institutions about 85-94% of the time. 5. 95% or more educational programs followed by clients are in regular educational institutions	

11a. SE: Individualized Follow-along Supports: Clients receive various types of support when working in a job. This support is based on the job or educational program, the client's preferences, earlier experiences, needs, etc. Support is provided by a variety of people, including members of the mental health treatment team (e.g. changes in medication, social skills training, encouragement), family/loved ones, friends, colleagues and the IPS Worker. The IPS Worker also provides support to the employer or (e.g. information about trainings) at the client's request.	DOC, INT, OBS, ISP	1. Most clients receive no support after starting a job or education program. 2. About half of the working clients receive a narrow range of supports, provided primarily by the IPS Worker. 3. Most working clients receive a narrow range of supports, provided primarily by the IPS Worker. 4. Clients receive different types of support when working in a job or attending an education program. Support is based on the job, school program, client preferences, work and education history, needs, etc. IPS Workers provide employer/educational supports at the client's request. 5. Clients receive different types of support when working in a jo. Support is based on the job, school program, client preferences, work and education history, needs, etc. The IPS Worker also offers support to the employer at the client's request. The IPS Worker helps the client to find a job that is more consistent with the client's preferences and helps the client with various types of education programs and training courses. The site provides examples of different types of support including enhanced supports by treatment team members.	
11b SEd: Individualized follow-along support for education The IPS Worker offers career or study guidance, i.e. helping to find training, a job or education program that is more consistent with the client's preferences. At the start of, and during the education program, the client receives support in arranging: 1. Enrollment, 2. Disability office/accommodation support (if needed, but should be discussed and offered) 3. Financial aid or other income needs, 4. Books and other study materials, 5. Transportation 6. Class schedule management, and 7. Assess study skills, abilities, and needs.		1. Most clients receive no support after starting the search for an education program. 2. About half of the working clients receive 1-2 types of supports listed, provided primarily by the IPS Worker. 3. Most clients receive 3-4 types of supports, provided primarily by the IPS Worker. 4. Clients receive five or more types of support when attending an education program. Support is based on the school program, client preferences, education history, needs, etc. IPS Workers provide educational supports at the client's request. 5. Clients receive all types of support when attending an education program. Support is based on the school program, client preferences, work and education history, needs, etc. The IPS Worker also offers support to the educational facility at the client's request. The IPS Worker helps the client to find education that is more consistent with the client's preferences and helps the client with various types of education programs and training courses. The site provides examples of different types of support including enhanced supports by treatment team members.	

12. Community–based Services: All IPS Workers provide employment and education services such as engagement, job/school finding, and follow-along supports in natural community settings. (Rate each IPS Worker based upon their total weekly scheduled work hours, then calculate the average and use the closest anchor)	DOC, INT, OBS	1. The IPS Worker spends 30% time or less of their scheduled work hours in the community (e.g., 70% or more is spent in the office). 2. The IPS Worker spends 30-39% time of their total scheduled work hours in the community. 3. The IPS Worker spends 40-49% time of their total scheduled work hours in the community. 4. The IPS Worker spends 50-64% time of their total scheduled work hours in the community. 5. The IPS Worker spends 65% or more of their total scheduled work hours in the community.	SE	SEd

13. <u>Time-unlimited Follow-along Support:</u> IPS Workers have face-to-face contact with clients within one week before a new job or education program starts, within 3 days after the job or education program has started, weekly in the first month and at least once a month on average (during one year or longer) once the client has settled into his/her job or school program if desired by the client. Once in steady employment or education, the client is transitioned to step down supports from a member of the MH treatment team. IPS Workers contact the client within 3 days if the client loses the job or is at risk of dropping out of classes or educational program.	DOC, INT, OBS, ISP	1. The IPS Worker has no personal contact with the client in the first month after starting the job or education. 2. The IPS Worker has face-to-face contact with less than half of the working clients for at least 4 months after starting a job or school. 3. The IPS Worker has face-to-face contact with at least half of the clients who are working or attending school for at least 4 months after starting work or school. 4. The IPS Worker has weekly face-to-face contact with the clients during the first month after starting a job or education program. During at least the first year that the client is in steady employment or education, there is personal contact at least once a month on average if the client desires. If the education program lasts shorter than 1 year, this applies to the total duration of this program. 5. IPS Workers have face-to-face contact with the client within one week before a new job or education program starts, within 3 days after the job or education has started, every week in the first month and, on average, at least once per month (during one year or longer) once the client has settled into his/her job or school and if the client desires. If the education program lasts shorter than 1 year, this applies to the total duration of this program. Once in steady employment or education, the client is transitioned to support from a member of the MH treatment team. IPS Workers contact the client within 3 days if the client loses the job or is at risk of dropping out of classes/school.	SE	SEd

14. Assertive Engagement and Outreach by Integrated Treatment Team: Service termination is not based on missed appointments or fixed time limits. Outreach attempts are systematically documented. Integrated team members make engagement and outreach attempts. Multiple home visits are carried out. Coordinated visits by IPS Worker with integrated team member. Contact is made with the family, when applicable. Once it is clear that the client no longer wants to work or study or make use of the SE/SEd services, the outreach is stopped.	MIS, DOC, INT, OBS	1. Indications that 2 or less engagement and outreach strategies are utilized. 2. Indications that 3 engagement and outreach strategies are utilized. 3. Indications that 4 engagement and outreach strategies are utilized. 4. Indications that 5 engagement and outreach strategies are utilized. 5. Indications that all 6 engagement and outreach strategies are utilized: I. The termination of the services to clients is not based on missed appointments or fixed time limits. II. Outreach attempts are systematically documented. III. Integrated team members make engagement and outreach attempts. IV. Multiple home visits are made. V. Coordinated visits by IPS Worker with integrated team member. VI. Contact is made with the family when applicable.	SE	SEd

*Data Sources:

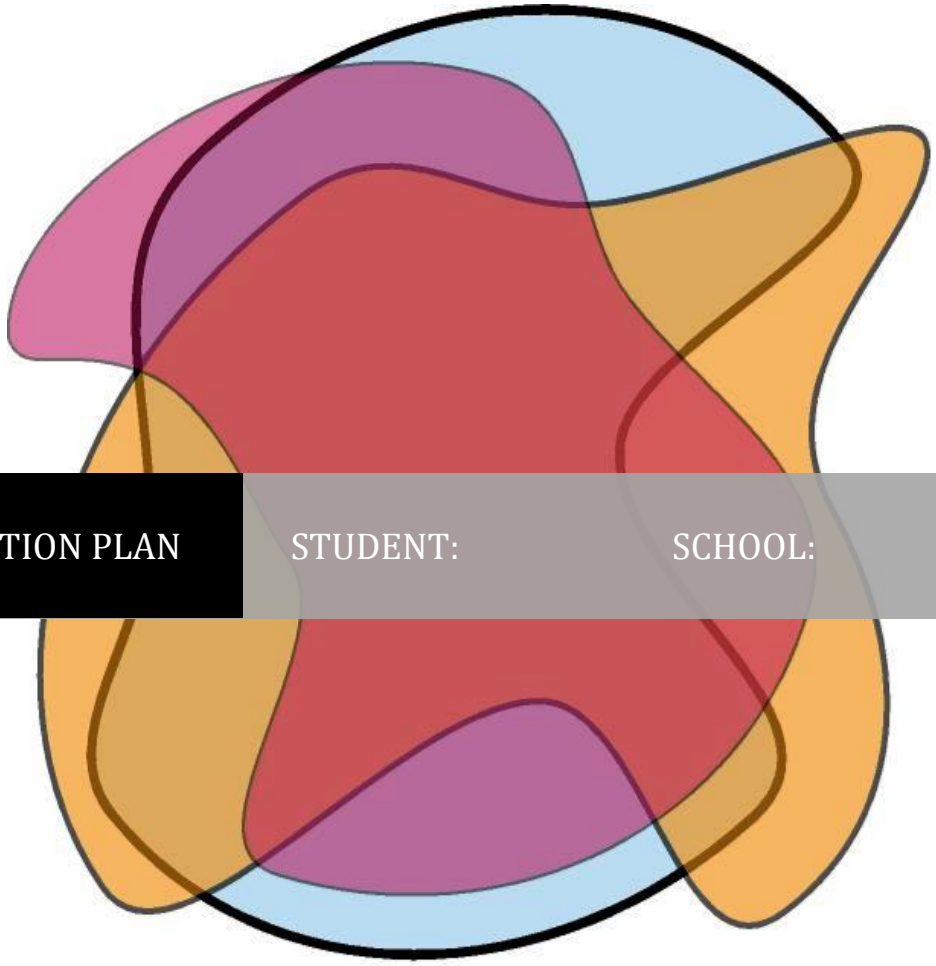
MIS	Management Information System
DOC	Document review: clinical records, agency policy and procedures
INT	Interviews with clients, IPS Workers, mental health staff, VR counselors, family/loved ones, employers, educational programs/staff
OBS	Observation (e.g., team meeting, shadowing IPS Workers)
ISP	Individualized Service Plan

STAFFING		SE	SEd
1	Caseload Size	Number:	Number:
		SCORE	
		SE SCORE	SEd SCORE
2.	Employment/Educational Staff		
3.	Vocational/Educational Generalists		
ORGANIZATION			
1.	Integration of Rehabilitation with mental health treatment through team assignment		
2.	Integration with MH Treatment Through Regular Contact Between Team Members		
3.	Collaboration between IPS Workers and VR/educational Counselors		
4.	An SE/SEd unit		
5.	Role of the SE/SEd supervisor		
6.	Zero Exclusion Criteria		
7.	Focus on Competitive Employment and/or Education		
8	SE/SEd Support from Agency Leadership		
SUPPORT			
1a/b	Work or education Incentives Planning		
2.	Disclosure		
3a/b	SE: On-going Work-based, Vocational assessment/ SEd: On-going educational assessment		
4a/b	SE: Rapid Search for Competitive Employment/ SEd: Rapid Linkage to Educational Activities		
5.	Individualized Job or Education Search		
6	Development of Jobs and Educational Opportunities – Frequent Contact with Employers and Educational Institutions/Staff		
7a/b	SE: Development of Jobs – Quality of the Contact with Employers SEd: Development of Educational Opportunities – Quality of the Contact with Educational Institution/Staff		
8a/b	SE: Diversity with SE SEd: Diversity with SEd		

9a/b	SE: Diversity of employers SEd: Diversity of educational facilities		
10a/b	SE: Competitive Jobs SEd: Regular education		
11a/b.	Individualized Follow-along Support		
12.	Community-based Services		
13.	Time-unlimited Follow-along Support		
14.	Assertive Engagement and Outreach by Integrated Treatment Team		

Maximum SE score = 125
Maximum SEd score = 125

115-125	= Exemplary Fidelity
100-114	= Good Fidelity
74-99	= Fair Fidelity
73 and below	= Not Individual Placement and Support Model



COLLABORATION PLAN

STUDENT:

SCHOOL:

SkoleResept

ExtraStiftelsen
Helse og Rehabilitering

HELSE STAVANGER
Stavanger universitetssjukehus

COLLABORATION PLAN FOR BETTER UNDERSTANDING BETWEEN PUPIL/STUDENT AND TEACHER

NAME: DATE OF BIRTH:

To pupils and students: make this your tool to ensure that the understanding of your challenges in the educational environment are met and safeguarded in the best way possible.
To teachers and tutors: make this your tool to ensure that your institution understands the concrete challenges faced in different situations. This plan is only to be changed under the supervision of a representative of The School Prescription Project.

What am I like on a normal day?

Symptoms that tell me that I am having a difficult time	Signs that can tell the school that I am having a difficult time

Things that trigger me and sometimes wreck my day	

What can I do when things get difficult?

What can the school do for me when things get difficult?

Which supporters of mine can the school contact?		
Name	Affiliation	Phone/e-mail

These are people I do not want you to contact

PLACE/DATE

_____	_____	_____
STUDENT/PUPIL	EDUCATIONAL REPRESENTATIVE	TSPP

SkoleResept

So, what is the goal of The School Prescription Project?

10% of secondary school pupils are in danger of developing school reluctance!
30% of pupils drop out of high school!*
18% of young people with disability benefits suffer from psychosis!**

As an integral part of the psychiatric treatment in the mental health services The School Prescription Project supports pupils and students with severe mental illness, such as psychosis or affective disorders (mania / depression).

Our project will work towards reducing the stigma of pupils and students with a severe mental illness!

Our project will work towards preventing participants from falling out of education due to illness!

Our project should work towards ensuring that educational and social functioning is seen as equally important to traditional treatment of symptoms!

Our project will work towards improving the pupil's or student's motivation based on his or her own wishes for the future!

We will supplement the clinician and support the establishment of a meaningful life!

* Kearney, CA Bensaheb A, School absenteeism and school refusal behaviourJournal of School Health. 2006; 76: 3-7
** Ten Velden Hegelstad W et al. Early detection, early symptom progression and symptomatic remission after ten years in a first episode of psychosis study. Schizophr Res. 2013; 143: 337-43

RÅDET FOR PSYKISK HELSE
ExtraStiftelsen Helse og Rehabilitering
JobbResept
HELSE STAVANGER Stavanger universitetssjukehus

1. Project title: The NEET to treat: *Mental health care interventions for employment and education outcomes in ultra high risk for and first episode psychosis.*

2. Introduction: Schizophrenia and related psychotic disorders have a life-time prevalence of about 2% and typically start in adolescence or early adulthood. A quarter of patients become psychotic via a trajectory of a so-called ultra high risk (UHR) state [1]. Most patients have a remitting-relapsing illness course, however in about 20-30% of cases the course is chronic. However, in spite of about 50% of patients achieving long-term remission [2], unemployment rates of 80-90% for patients with schizophrenia and 60-90% of patients with first-episode psychosis (FEP) [3] are common across Western countries. A recent Norwegian study found an employment rate for schizophrenia of 10%, with an associated annual cost of 1262 million NOK/148 million USD [4]. Spin-off negative effects of this include a poorer quality of life, poorer social inclusion, lower chances of recovery [2] and increased needs for long-term specialist mental health care, including hospitalisations. [5] Addressing this and thus improving patients' quality of life and diminishing their dependence on long-term specialist mental health care should be a central part of treatment, as it falls outside the realm of expertise in the first-line employment- and educational support facilities.

Individual placement and support (IPS)

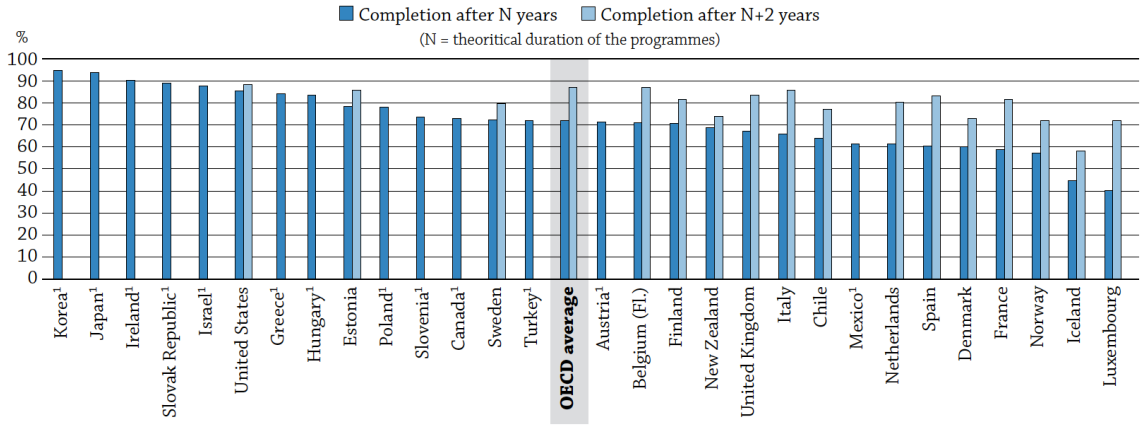
Individual Placement and Support (IPS) is an evidence based supported employment intervention for people with severe mental illness (SMI) including psychosis [6]. At this moment, 23 place-then-train IPS trials have been conducted internationally and evaluated, showing its efficacy [7] in addition to our own which of which the results have been reported nationally [8] and also submitted as a paper which is currently under review. Using this method, in North America, 62% of participants with psychosis gained competitive employment, while in comparing countries the percentage overall was 47% [9]. Why US endeavours have been more successful is unknown. Some of the international differences may be connected to characteristics of local welfare-, educational- and employment services. In Norway, these offer supported employment in competitive work environments, sponsored with public means for up to 24 months. However, these services are either offered late, when the candidate is deemed "ready" and free of symptoms. Alternatively they are not offered at all, because of the prevailing idea that persons with psychosis should be protected from all stress [10]. This is not the case. Instead, resilience can be fostered in spite of symptoms of paranoia, voice hearing, difficulties concentrating, or apathy often associated with psychosis. Indeed, employment has beneficial effects on mental health.

The problem of NEET: Not in Education, Employment or Training

Most careers require formal qualifications. Therefore, completion of secondary, tertiary or vocational education is crucial. The age of onset of most psychotic illnesses coincides with secondary, tertiary or advanced education. Psychosis thus is highly disruptive to educational trajectories and careers. It is known from research that early functional recovery is a strong predictor of later functional and symptomatic recovery [11, 12]. This indicates the need for intervening early preventing drop-out and poor outcome. About 60% of FEP patients receive a disability pension or a similar benefit within two years, and this number increases up to as much as 90% during longer-term follow-up [13]. This is poor functional outcome per definition and is associated with male gender and young age/early age of onset [14-16], poor premorbid functioning [17, 18], substance abuse[19], and psychological trauma [20, 21]. In most OECD countries, between 20 and 30% of students do not complete their secondary education. Of those, about 30% do not do so due to personal or mental health problems[22] (*figure 1)*. In the UK, a large survey among twins born in 1994-1995, showed that young people Not in Education, Employment or Training (NEET) had twice the rate of previous or concurrent mental health problems (60%) of their non-NEET counterparts (30%). Motivation to go into work or education did not differ between the groups, however work related skills and self-perception did [23]. This occurs in spite of existing help available to students; educational advisors, student counsellors, and accommodated education. The services are abundant, at

least in Norway, but they lack coordination across organizational levels (specialist care , first line, and the educational system). Further, as with employment, help is offered late or not at all for the patients with more severe symptoms such as psychosis. There is a need for intervening early, preventing drop-out for these young people; intervening early in itself confers functional advantages as demonstrated by, among others, the TIPS study [24]. Indeed, a recent review suggested that combining IPS with early intervention improves outcomes more compared to either one alone [25]. This however concerns vocational outcomes only, not education, which has hitherto not systematically been tried out.

Chart A2.4. Successful completion of upper secondary programmes



Note: Please refer to Annex 3 for details concerning this indicator, including methods used, programmes included/excluded, year of entry, etc.
1. N+2 information missing.
Countries are ranked in descending order of the successful completion of upper secondary programmes.
Source: OECD. Table A2.4. See Annex 3 for notes (*www.oecd.org/edu/eag.htm*).
StatLink http://dx.doi.org/10.1787/888933115312

Integrated, early IPS intervention

The OECD states that, concerning labour market inclusion, "…the disintegration of mental health care and employment services, as well as the fragmentation within the mental health system itself with municipal primary care and regional specialist care, is a main barrier for labour market inclusion" [26]. Stavanger University Hospital has collaborated with the employment services NAV since 2007 creating work opportunities for patients combined with specialist mental health treatment, using the workplace as a real life therapeutic setting as well as a source of income and a social arena. One specific focus has been on young people with ultra high risk for, or first episode of, psychosis, and hence, intervening early. For this group, a pilot study financed by the Norwegian Employment and Welfare Directorate demonstrated that the intervention brought 50% of participants into competitive employment, compared to 17% in a matched control group [8]. This seems hopeful, however education was not systematically included, which constitutes a barrier to career development for young people. In the study applied for here, our teams will offer an intervention integrating already existing support from the educational system, including student counselling and career advise offices, with specialized mental health care. Thus, integrated intervention means that **a)** the intervention is an integration of first-line support from NAV and educational facilities with specialist mental health care and **b)** the intervention is a combination of IPS for employment with IPS for education.

Fidelity to the IPS approach

IPS trials have been conducted using an intervention fidelity scale[27], which has also been translated into Norwegian [28] . The efficacy of IPS has been shown to be mediated by fidelity. It is defined as the degree to which an intervention adheres to the evidence practise for that intervention[29]. The scale was developed in the US, however the authors recommend further study on international adaptations[30] in order to shed light on the question of different degrees

of efficacy across countries. Further, supported education is not included in the original IPS fidelity scale. Supported education interventions are scarce, have not been tried using the IPS method, and where existing, they are separated from interventions for supported employment[31]. However, helping develop careers often involves transitions between education and work or apprenticeships, trying out different educational courses, trainings, or work places. Several education specific factors are not addressed in the original IPS scale for employment fidelity ". For instance, support from and involvement of primary carers such as parents, financial support, housing, class schedule management, interaction with peers, accommodation of curriculum and classroom situation, are all factors that are unique to education for young people as opposed to employment.

Adapting the IPS fidelity scale to include education
Preceding the study applied for here, an international collaborative (led by TIPS and Job-SchoolPrescription) of clinicians and scientists from six Western countries have developed an adapted version of this fidelity scale which has been piloted and tested for feasibility in Stavanger and at nine sites in the Netherlands. The pilot fidelity score in Stavanger, rated by an external rater, was "good" with a score of 102 out of 125 (115-125 being "exemplary") [32]. Scores in the Netherlands are being calculated.

2.1 Usefulness for patient treatment: The Norwegian government has set a goal to create "The Patient's Health Care". This implies making minimal use of invasive or involuntary treatments, focussing on respect and openness, and on co-decisions regarding treatment options and choices. Emancipation is a key concept. Expanding the IPS approach to including education would provide our younger patients with opportunities and expert support to work at career development in a flexible way, allowing for education to be completed or for transitions between education and work. Patients with severe mental health problems such as FEP or UHR normally wouldn't have that opportunity as still today, staying home and "rest" is a preferred, however ineffective, strategy. It alienates the youth from the social roles that one is to fulfil, becoming an adult. Testing an approach to regaining or gaining education and/or employment will benefit the patient, may prevent need for expensive psychiatric treatment, and may prevent long-term benefit dependence and, not in the least, prevent a poor quality of life. It will augment the real-life relevance of mental health treatment for these patients.

3. Aims and objectives: First, the main aim is to work towards an evidence base for an integrated intervention for supported employment and education for UHR and FEP using the adapted fidelity scale. Outcome measures will be educational or employment attainment and recovery, including the degree of need for specialist mental health care. Second, to investigate local policy, educational and employment differences across six western sites and their influence on the effectiveness of the integrated intervention. Third, to find predictors of benefit from the intervention within individuals. Fourth, to explore the working ingredients of the intervention through qualitative interviews.

Short term goals: The short-term goals concern preparations for the study and will take place while the PhD applicant is on maternity leave (until July 1, 2018), and conducted by the School- and JobPrescription Teams and the main supervisor.

Before start of PhD student: **1)** To translate the adapted fidelity scale into Norwegian. Translations into German and Dutch are in place. **2)** To start inclusion and baseline assessments of participants (N=30 in Stavanger), and conduct baseline fidelity ratings and assessments. **3)** To discuss and decide on specific useful outcome measures in a minimal common data set across all the sites. Input from service users will be valuable here. The main supervisor will conduct this.

After start of PhD student: **4)** To develop a qualitative interview guide together with service-user co-researchers. This task will be completed by the PhD Student. **5)** To continue inclusion of participants and baseline assessments. **6)** To decide on a group of 20 participants for qualitative interviews. **7)** To conduct follow-up assessments. 8) To create a secure, anonymized common data base for all sites.

Long term goals: The long-term goals are to **1)** Evaluate effectiveness of the intervention across sites, using the fidelity scale and **2)** decide for whom, and how, the intervention is of use. Ultimately, the goal is to gather knowledge about how to improve employment and educational outcomes for young people struggling with high-risk symptoms or psychosis through a large, international multi-site study.
Hypotheses: **1)** The integrated IPS employment/education is effective for young people with ultra high risk for or established first episode psychosis. To be investigated by the international collaborative. **2)** Fidelity ratings reflect the content and method of the intervention, and higher scores are associated with superior outcomes. To be investigated by the PhD-student applied for here. **3)** Contextual, or site-specific, predictors of benefit from the intervention include availability of low-threshold jobs; a favourable job market; low disability rates in the population; free or cheap public education; good collaboration with standard employment/educational services already in place. To be investigated by the international collaborative and the PhD student. **4)** Individual predictors of benefit of the intervention are: Older age of onset, female gender, good premorbid functioning, no substance use (never or stopped) [12], and no experience of psychological trauma. To be investigated by the PhD-student applied for here. **5)** Qualitative interviews will reveal underlying mechanisms promoting benefit from the intervention. To be investigated by the PhD-student applied for here.

PhD study:

1. What are the educational attainments 6 and 12 months after inclusion of participants with first episode psychosis?
2. What is the proportion of participants with first episode psychosis in competitive employment 6 and 12 months after inclusion?
3. What are the educational attainments 6 and 12 months after inclusion of participants with an ultra high risk for psychosis state?
4. What is the proportion of participants with employment 6 and 12 months after inclusion of participants with an ultra high risk for psychosis state?
5. Is the intervention associated with improved recovery rates in first episode psychosis?
6. Is the intervention associated with decreased symptom levels in UHR, and decreased rates of need for specialist mental health care including hospitalizations, in the youngest participants aged 13-18?
7. What is the extent to which a higher fidelity score is translated into improved educational and employment outcomes?
8. What are the predictors of benefit from the intervention?
9. Which elements, from the perspective of the participant, of the intervention have been perceived as helpful in attaining and sustaining employment and/or education?

4.

4.1 Design and methods: For the PhD study, the design will be a longitudinal prospective mixed method study investigating the association between predictors, fidelity scores (i.e. the deliverance of the integrated intervention) (quantitative), the elements of the intervention (qualitative), and primary outcomes over one year. This design is weaker than a randomised controlled trial, however it was chosen to ensure good comparability and combination of data from multiple sites conducting studies within different frameworks and with slightly different designs; three of the sites have no-IPS control groups while three don't. Using a naturalistic follow-along study investigating the association between fidelity scores and primary outcomes over time, all sites can contribute with comparable data. The sample will be large

and offer good ecological validity. Mixed model longitudinal analyses with fixed (group) and random (individual) factors. All sites asked have at least baseline and 12 months assessments planned, and at least half will have 24 months.

Sample: Patients with a first episode of psychosis, age 15 to 65 years; meeting the DSM-IV criteria for schizophrenia, schizophreniform disorder, schizoaffective disorder brief psychotic episode, delusional disorder, affective psychosis with mood-incongruent delusions, or psychotic disorder not otherwise specified; being actively psychotic, as measured by a Positive and Negative Syndrome Scale (PANSS) score of 4 or more on at least 1 of positive subscale items 1 (delusions), 3 (hallucinatory behavior), 5 (grandiosity), or 6 (suspiciousness/persecution) or general subscale item 9 (unusual thought content); not receiving previous adequate treatment for psychosis (defined as antipsychotic medication of >3.5 haloperidol equivalents for >12 weeks or until remission of the psychotic symptoms); having no neurological or endocrine disorders with relationship to the psychosis; having no contraindications to antipsychotic medication; understanding and/or speaking the dominant local language; having an IQ score of above 70; and being willing and able to give informed consent.

or

Patients with an ultra high risk state, defined as having attenuated psychotic symptoms and functional decline in the course of the past year, or brief intermittent psychotic symptoms not fulfilling criteria for full-blown psychosis, or schizotypal personality traits and a genetic risk (first degree family history of psychosis); age 13-65 years; having no neurological or endocrine disorders with relationship to the psychosis; understanding and/or speakingthe dominant local language; having an IQ score of above 70; and being willing and able to give informed consent.

All participants are treated according to standard clinical guidelines; i.e. offered anti-psychotic medication in FEP, psychotherapy (UHR and FEP), and family work (UHR and FEP).

In London, UK, all study participants (N=30+30) will be active clients in Early Intervention in Psychosis services within South London and Maudsley NHS Foundation Trust.
In Berlin, Germany, all study participants (N= 50+50) will be active clients in Vivantes Netzwerk für Gesundheit, Klinikum Am Urban, and their Early Intervention Services.
In Reykjavik, Iceland, all study participants (N=20) will be active at Landspitali's Mental Health Services.
In New Haven, Connecticut, USA all study participants (N=50) will be active at the STEP program for first episode psychosis.
In Melbourne, Australia, all study participants (N to be decided) will be active at the EPPIC early intervention in psychosis centre.
In the Netherlands, participants are recruited form nine different mental health care providers (N>200).
In Stavanger, Norway, all study participants (N=30; based on yearly incidence and recruitment) will be recruited via the TIPS-2 first episode or the POP ultra high risk projects, and be receiving specialist mental health care at the Clinic for Child and Adolescent mental health care and Addiction or the Clinic for Adolescent Mental Health Care. TIPS-2 is a naturalistic follow-along FEP study in Rogaland, Norway, including a population-based cohort (350.000 individuals) of FEP individuals from January 2002.The TIPS-2 sample is one of few epidemiological samples of first-episode psychosis worldwide, and service users with varied educational, occupational and social background can thus be included.

In total, approximately 400 participants will be included, which will yield excellent statistical power. This size is also the largest prospective longitudinal study on this type of intervention to date, with a dataset yielding high ecological validity and clinical usefulness and which gives room for advanced multivariate analyses.

For the qualitative part of the study, a stratified sample of 20 persons with ultra high risk states or first episode psychosis from the on-going TIPS-2 and POP studies, respectively, will be recruited.

The intervention

The intervention is best described in terms of organization on the one, and content on the other hand, both of which the quality and quantity will be scored according to the scale.
Organization: The intervention will be offered within the framework of mental health care. A main guiding principle of the intervention is that supporting people in attaining their educational goals is therapeutic and therefore, a treatment intervention in itself. Further, the main target group is people with severe mental illness, in need of close monitoring and support from mental health care. Case loads should be small, giving the mental health care worker the opportunity to offer standard mental health care in combination with vocational or educational support, and at the same time collaborating closely on an individual level with educational or vocational facilities. Close collaboration is ensured through frequent face-to-face meetings, and telephone/internet contacts with employers or educational facilities, treating clinicians and mental health care teams, as well as the participant him- or herself. Ample time and effort should be put into creating employment and educational opportunities by the supported employment/education worker. The adapted fidelity scale specifies percentage of time spent on this part of the intervention. The supported employment/supported education teams should be integrated into the mental health care teams.
Content: The content of the intervention can be described as delivering highly individualised work or education plans, taking into account individual preferences and resources as well as possibilities or challenges in the client's environment.
In order to do so, a thorough assessment including both strengths but also barriers to work/education, is necessary. Barriers may involve warning signs or symptoms, impairment of cognitive functions, or side effects of medication, hence, close collaboration and integration with mental health care is important. Follow-along support on-site, that is, at the work place or educational facility, is offered throughout the intervention period, which ideally should be time-unlimited. The team should be able to, where needed, offer encouragement, basic psychological interventions such as anxiety management, or social skills training. In sum, the intervention comprises flexible, individualised expert work or education support as an integral part of mental health treatment for severe mental illness aimed at improving functioning and quality of life.

Assessments

Assessments are planned at inclusion (baseline), 6 months, 12 months, and 24 months. They will be carried out by the TIPS/POP and School- and JobPrescription teams oin collaboration with the PhD student. The assessment protocol consists of: gender; age; symptoms (Positive and Negative Syndromes Scale for Schizophrenia, PANSS) [33]; diagnosis (Structural Clinical Interview for the DSM-IV, SCID) [34]; and remission defined according to the International Working group on Schizophrenia criteria: No score of 4 or higher on any of the following PANSS-items: Delusions; disorganized thought; hallucinatory behavior; blunted affect; passive/apathetic withdrawal; lack of spontaneity/flow of conversation, mannerisms and posturing, or unusual thought content, for the last 6 months. Ultra high risk states are assessed using the Structured Interview for Prodromal Syndromes (SIPS) [35]. Prior education will be operationalized in the following way because of the large age span and differences across participating countries resulting in naturally occurring differences in premorbid academic attainment: Young adults 18-21 having completed high school/secondary education equivalents receive a score of "2" (maximum score). Having partly completed high school/secondary education equivalent yields a score of "1", and not having attended or completed any of high school/secondary school equivalent a score of "0". Youth 16-18 - high school/secondary school age- are given a score of "2" if they are on schedule academically; a score of "1" if they lag behind more than half a school year, and a score of "0" if they have

dropped out. For adults over 21, a higher education (bachelor degree or equivalent, or higher) yields a score of "2", high school/secondary school diploma/trade school a score of "1", and no diploma from high school/secondary school or equivalent a score of "0".
The Drake Clinician Alcohol/Drug Use Rating Scale [36] was used for assessing substance use. The Cannon-Spoor Assessment of Premorbid Adustment (PAS) will be used for premorbid functioning[37].
Outcome measures: For employment and educational outcomes a score of 3 or 4 on the Strauss Carpenter Level of Functioning Scale will be used [38] in which "employment last year" means employment 20hrs/week or more. A score of 1 or 2 means employment less than 20hrs/week, and a score of 0 no employment. For education, the same cut-offs were used on the item "meaningful activity last year". In addition, information on education enrolment in ordinary educational facilities yes/no; hours of competitive employment per week, last two months; academic achievement measured by grades obtained; percentage of classes attended last 2 months; number of class days missed last 2 months. Change in grades per subject and percentage of exams/tests completed successfully will be collected through academic records and participant interviews. The Strauss-Carpenter Scale also provides information on hospital admissions, housing situation, and contact with friends last year. Recovery is operationalized as being in stable remission according to the Andreasen Working Group Criteria mentioned above, in addition to a score of 3 or 4 on the items regarding employment or meaningful activity (here: education) for the last 12 months. Fidelity scores on the adapted IPS fidelity scale will be used to assess the degree to which participants receive the intervention as intended. Fidelity scoring will be conducted by external raters not part of the study or any of the teams. All clinical assessors (TIPS/POP/School- and JobPrescription) including the PhD student will be part of the same training and reliability program with access to collaborators covering necessary research skills. TIPS has regular interrater-reliability assessments and trainings for clinical assessments.

Data analyses
For the quantitative part of the study, finding predictors and association, data will be analysed using appropriate statistical software including SPSS and R. Multivariate and mediation analyses will be applied: Dependent longitudinal variables of the multivariate analyses will be employment/educational attainment, and independent predictors and covariates will include demographics, diagnosis, symptoms, substance/alcohol use, and prior education/employment. This type of longitudinal analyses will be conducted using linear mixed effect models with fixed (i.e. group, site) and random (individual-specific) factors. In order to answer the question who benefits from the intervention, fidelity scores can be analysed as a mediator between predictors (certain individual and/or site characteristics) and outcome. For the qualitative part, exploring working elements of the intervention, a semi-structured interview guide [39] will developed based on a literature review on factors facilitating recovery in psychosis and in collaboration with service-user co-researchers recruited from the Stavanger University Hospital co-research school. The interviews will be reviewed using a participatory thematic analytic approach [40-43] within an interpretative-phenomenological epistemological and ontological framework. This is a method that has previously been used by our research group [44].

4.2 Organization and collaboration: This study is a collaboration between The TIPS network for clinical research in Psychosis of Stavanger University Hospital; School- and JobPrescription at the clinic for Child and Adolescent Mental Health Care and Addiction; and the Faculty of Health sciences at the University of Stavanger; the University of California Los Angeles, USA; the University of Tilburg, the Netherlands; King's College London, UK; Landspitali University Hospital of Reykjavik, Iceland; Vivantes health care providers connected with the University of Berlin, Germany; the University of Melbourne and the EPPIC centre for early intervention in Psychosis, Australia; and Yale Medical School, Dept, of Psychiatry and the STEP treatment for early psychosis program, USA. All sites have

specialized early intervention mental health teams working. The teams in Iceland, UK, the Netherlands, Germany and Norway have already been trained in the method; the Netherlands and Iceland having received their training at the Dartmouth Psychiatric Research Center- where the IPS method for people with severe mental illness originated. At Yale, a site visit training will be organized by the advisory board of the study. All members of this international group are highly regarded experts in their field. The multi-disciplinary School- and JobPrescription team consists of eight mental health care workers with backgrounds as psychiatric nurses or clinical social workers in Stavanger, and two in Helse Fonna. They receive supervision from the main supervisor of this project and from their team leader. The lead and main supervisor of the PhD study applied for here will be Dr Wenche ten Velden Hegelstad, PI of the TIPS group in Stavanger and founder and PI of the JobPrescription- SchoolPrescription group and - study. The day-to-day management of the study will be handled by an executive group, consisting of the applicant, the main supervisor, and with the support of professor Jan Olav Johannessen.

4.3 We will apply for funds for a PhD-student. The PhD-student is unable to start work before July 2018 due to maternity leave. We hope to either start her compensation then and extend until the summer of 2021. We also apply for financial compensation for the service-user co-researcher and for reimbursement of travel costs for study participants coming in for assessments.

4.4 Time frame and dissemination plan for PhD study: The study will continue follow-up of participants for two years. As a two-year follow-up is not feasible within a time frame of a PhD study, this will focus on follow-up after one year. Teams at all sites are in place by December 2017. The adapted fidelity scale has been translated into German, Norwegian, and Dutch and will be translated into Icelandic. The scale has been piloted and tested. The inclusion of participants has started in the Netherlands and Germany; the other sites including Stavanger and Haugaland DPS start in January 2018. A common data base will be created in the first half of 2018. The School- and JobPrescription team in collaboration with the TIPS and POP teams will carry out data collection at the Norwegian site, coordinated by the PhD student on return from maternity leave in summer 2018. Inclusion of participants will continue throughout 2018 at all sites. The qualitative interview will be developed by PhDs student, supervisors and service users in the third quarter of 2018. Interviews will be conducted the last quarter of 2018 and the three first of 2019, transcription process parallel to interviewing. One-year follow-up assessments will be carried out through 2019. Data analyses and writing will take place from mid 2019-end 2020 with extension into mid 2021 due to applicant's maternity leave.

For the PhD study the following papers are planned for dissemination of main results:

1. Fidelity to an innovative integrated IPS intervention for employment and education: Associations with educational and employment outcomes and recovery in psychosis and ultra high risk states at one year follow-up.
2. Individual and contextual predictors of benefit from an integrated IPS intervention for employment and education for psychosis and ultra high risk states.
3. What works and what doesn't, when helping persons with first episode psychosis or ultra high risk states gain or regain employment or education. A qualitative interview study.

4.5 Plan for implementation: The knowledge from this study will be used to improve mental health treatments for young persons with psychosis or ultra high risk by transgressing the barriers between first-line and specialist health care and employment/education support. Further, it will heighten the awareness and focus on functional outcome as central to treatment in mental health care, beside symptom outcomes. Better functional outcomes mean less dependence on expensive health care and economical benefit, and an improved

quality of life- ultimately the end goal of all mental health care, as we see it. Results will be implemented through the already existing School- and JobPrescription team counting eight mental health workers specialized within this field in Stavanger and two in Helse Fonna. Results will also help in advocating the need for such interventions. The project is innovative in that it transgresses boundaries between mental health care, employment services, and educational support services; barriers that traditionally have been obstructing or delaying adequate help for patients.

5. Service user involvement: Stavanger University Hospital has a pool of service user co-researchers. They are attending a two-year course on research methods and are invited to co-develop, co-deliver and co-analyse in research projects. In this study, a young member of the group has been invited to participate in creating the semi-structured interview aimed at eliciting the working elements of the intervention studied from a service-user perspective, and to analyse the interviews when they have been conducted. She will assist in interpreting the results from this, and the quantitative part, of the study. They will also contribute with fine-tuning or adding research questions if they see needed, as they are the experts on patients' needs, and interpreting and disseminating results.

6. Ethics: All participants at all sites will have to have signed informed consent. Ethical approval in in place at sites USA, Germany, and Norway (REK nr 2012/299). An application for prolongation and adaptation to new research questions -as this approval concerns the original School- and JobPrescription pilot study will be submitted). In Iceland, application for ethical approval is under preparation. All data will be de-identified and stored according to regulations. There are no intrusive methods applied in this study. Participants in Norway will be recruited via the existing, approved, TIPS/POP system (REK 2011/1198 and 2009/949, respectively), and School- and JobPrescription (2012/299, valid until 31.12.2017) for which necessary extensions will be applied.

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