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PSYCHIATRIC HOSPITALIZATION TO SCHOOL TRANSITIONS: EXAMINING PROFESSIONAL PERCEPTIONS OF EFFECTIVENESS AND FIDELITY

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Abstract

The present study examined the effectiveness of adolescent psychiatric hospitalization-to-school transitions from the perspective of hospital and school-based mental health providers. Twenty-four school-based mental health professionals were surveyed to gain a better understanding of their experiences of reintegrating students to school following brief psychiatric hospitalization, including collaborations with hospital-based providers and contact with students' parents during and after hospitalization. Fourteen hospital and school mental health providers completed written narrative responses based upon a case vignette to identify ideal transition processes, and also participated in a semi-structured interview to identify barriers to successful transition plan implementation. Data was gathered and examined from a "fidelity of implementation" perspective. The study served three primary purposes, including 1) to provide general knowledge on school mental health staff's preparedness and competence to implement student transition plans, 2) to identify hospital mental health professionals' perceptions of important elements of the school transition plan, and 3) to compare the perspectives of hospital and school based mental health professionals regarding the hospital-to-school transition. A mixed-methods approach included analyses utilizing SPSS and NVivo to identify important themes and domains related to the psychiatric hospitalization-to-school transition. Results suggest that hospital and school providers' confidence in successful transition plan implementation is directly related to the number of available hospital and school resources. There were no differences in the ideal transition plans created by hospital and school providers. Finally, potential transition plan success was directly related to the presence of important transition plan elements, as well as the quality of supports available to ensure implementation as designed.

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CHAPTER 1

Introduction

Statement of the Problem

There is a dearth of current literature on best practices for transitioning adolescents back to school following a psychiatric hospitalization. Although there has been extensive research on effective methods for transitioning students back to school following a chronic illness and its resulting side effects, much less has been researched specifically regarding psychiatric hospitalization (Simon and Savina, 2007, 2010). Furthermore, available literature frequently references the entire span of childhood and was conducted prior to the new millennium. In covering the entire span of childhood, disorders are often aggregated together across ages and therefore issues specific to the adolescent period are not clearly or adequately addressed. Of further concern, is that although older studies provide helpful information they do not accurately reflect the manner in which our current health care system operates. The invention of managed care has drastically changed psychiatric hospitalizations in terms of length of stay, as well as opportunities for exposure to the school environment while remaining hospitalized (Shaw and McCabe, 2008), and therefore makes earlier studies less informative regarding contemporary service delivery.

This lack of clearly relevant research leaves hospital and school-based professionals to develop their own processes by which to address patient/student transition. This problem is compounded by the fact that hospitals and schools operate independently of one another and use different language when classifying, discussing,

and managing mental health disorders. Therefore, even when excluding additional barriers to effective transition within each individual setting, the likelihood of developing a streamlined process by which hospitals and schools can collaborate efficiently to manage adolescent needs is diminished, and will be fragmented at best. Additionally, much speculation exists about the source of differences in the practices of hospital and school-based mental health professionals when transitioning a teenager from one setting to another (Clemens et al., 2011). Families cannot and should not be expected to have to navigate this process without the assistance of mental health providers across settings, but are often placed in a position to do so due to underdeveloped collaborative systems (Simon & Savina, 2007).

Finally, school-based mental health professionals can come from a plethora of backgrounds, with substantial diversity in their academic and practical training (Center for Mental Health in Schools, UCLA, 2013). Differences in training and work expectations have the potential to create problems related to transitioning students back to school post-psychiatric hospitalization as well as providing them with the level of care necessary for them to progress in school. Lack of preparedness to manage ongoing psychiatric needs in school may include mental health needs that fall outside of the realm of a traditional school mental health professional's role, limited school resources that would allow for the creation of effective programming, and the absence of a formalized process for reintroducing students to the school environment after hospitalization.

Adolescence and Mental Health

An estimated 20% of adolescents ages 13-18 experience symptoms related to a diagnosable mental health disorder in any given year (U.S. Department of Health and Human Services, National Institute of Mental Health, Revised 2009) with nearly 10% of children and adolescents suffering from serious emotional and mental disorders that cause significant functional impairment in their day-to-day lives at home, in school and with peers according to the US Surgeon General (The National Alliance of Mental Illness, 2013). Adolescence is the developmental period during which children are most likely to develop and experience mental health problems for the first time (Giedd, Keshavan, & Paus, 2008). The Centers for Disease Control published a report on children and adolescent mental health from 2005-2011 and found that rates of mental health difficulties increased with age. In fact, half of all lifetime cases of mental illness begin by age 14 (Kessler et al., 2005). In addition to continued brain maturation during this period, the number of social and academic demands that take place during adolescence often result in a level of stress never before experienced (Giedd, Keshavan, & Paus, 2008). For students with an increased vulnerability to depression, anxiety, and/or eating disorders, there is an increased likelihood of experiencing problems during this period that may require some level of clinical intervention. One important context to monitor for adolescents experiencing mental health problems is our nation's schools, where nearly universal contact with adolescents is feasible. In recent years, this type of universal monitoring has often been within the purview of school psychologists, who increasingly are called on to screen for a variety of problems commonly experienced by children and adolescents (Greenwood & Kim, 2012; Doll, Spies, & Champion, 2012).

The body of literature on child and adolescent mental health needs has grown substantially within the past ten years. A short list of researched topics have included the impact of mental illness on physical and cognitive development (Giedd, Keshavan, & Paus, 2008), the long-term impact of unmet mental health needs as someone approaches adulthood (Best, Hauser, Gralinkski-Bakker, Allen, & Crowell, 2004), the importance of reducing stigma related to mental illness in our overall communities (Doll, Spies, and Champion, 2012), combining the efforts of community agencies and schools to screen for mental health needs and to protect identified children outside of school hours (Greenwood & Kim, 2012), and improving access to mental health services for underrepresented and marginalized communities (Sinclair, Christenson, & Thurlow, 2005). Although these studies have identified and proposed solutions for a large number of issues plaguing today's youth and challenging even the most seasoned mental health professionals, the implementation aspect of evidence based treatments and services continues to have numerous loopholes that prevent children and adolescents from gaining appropriate access to services or maintaining gains that have been achieved during treatment. Furthermore, these studies have not addressed the potential hurdles faced by statewide mandates of mental healthcare provision, where definitions of coverage and available benefits vary by state (National Conference of State Legislatures , 2014). Although a review of the literature is summarized in the following sections, a full review of the literature can be viewed in Appendix I-A.

Adolescence and Psychiatric Hospitalization

The number of adolescents involved in psychiatric hospitalization on a yearly basis is nearly 1000 per 100,000, an increase of almost 300 per year since the mid-1990s

(Blader, 2011). Although over a quarter million students are involved in short-term psychiatric hospitalizations each year where they receive mental health treatment, many are transitioned back into a traditional school setting (Simon & Savina, 2010). Psychiatric hospitalizations make up 7% of all pediatric and adolescent hospitalizations, and approximately 2.5% of adolescents were treated through inpatient psychiatric hospitalizations in 2008 (Substance Abuse and Mental Health Services Administration, 2009). The current average duration of psychiatric hospitalizations is 5-7 days (Balkin & Roland, 2007). This relatively short duration of hospitalization is significantly lower than durations occurring in the 1980s and 1990s, at which time psychiatric hospitalizations lasted from 11-44 days (National Association of Psychiatric Health Systems, 1987, 2002). In fact, Blader (2011) reviewed psychiatric hospitalization data from 1996 to 2007 and found that the number of hospitalization days approved (going from 52% to 22%) by private insurance companies for teenagers declined substantially. The prevalence and relatively short duration of psychiatric hospitalizations point to the need to involve school-based professionals in the planning of follow-up treatment upon discharge.

Reviews of the available literature suggest a need to focus upon adolescents' utilization of aftercare services post-psychiatric hospitalization such as counseling, medication management services, factors leading to discontinuation of care, and recidivism (Clemens et al., 2010, 2011; Simon and Savina, 2007, 2010). Equally researched are transition needs and concerns for students returning to school following hospitalization for physical conditions and diseases such as cancer, HIV, diabetes, and asthma (Shaw & McCabe, 2008). Recent reviews by Simon and Savina (2007, 2010) of the available literature on the hospital-to-school transition post psychiatric

hospitalization, unfortunately found a limited number of dated articles from the 1960s and 1980s emphasizing the importance of this transition. Additionally the existing body of research is more limited and narrow in scope than the literature on reintegration to school following chronic illness. While the heavily researched physical conditions are important for school aged children and adolescents, the potentially devastating outcomes resulting from one or more psychiatric hospitalizations during adolescence are equally deserving of careful professional attention and research. In 2004, Best and colleagues researched early adulthood outcomes for adolescents with prior psychiatric hospitalizations. In an 11 and 20 year post-hospitalization follow-up, they found that adolescents aged 12-15 that met criteria for psychiatric hospitalization were significantly: less likely to complete high school, attend college and graduate school; more likely to experience significant emotional distress, and more prone to mortality at an early age when compared to same age peers without these psychiatric symptoms (Best, Hauser, Gralinkski-Bakker, Allen, & Crowell, 2004). It is important to note that youth included in the aforementioned study were given state-of-the-art psychiatric treatment, which was defined by the American Medical Association as: treatment at a university teaching hospital, psychoeducational testing, family therapy, and extensive discharge planning. Therefore, the unfortunate outcomes experienced by these adolescents were significant despite appropriate and comprehensive treatment.

Hospital to School Transition

Shaw and McCabe (2008) discussed the difficulties of navigating the hospital-to-school transition for children with chronic illnesses throughout an evolving healthcare system and made the following statement in their literature review.

> "There is a significant body of literature describing and evaluating hospital-to-school transition programs [for children with chronic illnesses]. Most programs prepare the child with chronic illness, family, peers, and school personnel for transition back to a school environment after an extended hospital stay… [using] a prototypical three-phase model, wherein phase one involves initiation of community supports, arranging hospital and homebound instruction, and educating peers; phase two involves hospital-school communication, development of an instructional support plan, preparing for absences, and anticipating psychosocial adjustment issues; and phase three involves hospital-school-family follow-up communications. Such a model is effective for facilitating the transition to school for students with chronic illness" (p. 77).

Unfortunately, in an effort to reduce medical costs, there has been an evolution in healthcare to provide the majority of treatment through outpatient services. This is the case for chronic illness as well as mental health conditions (Shaw & McCabe, 2008) The body of literature defining best practices within the current health system for hospital to school transition for students with chronic illnesses is well developed. Although the body of literature for hospital-to-school transition for adolescents experiencing psychiatric illnesses is less developed, much can be garnered from existing literature on chronic illness regarding best practices through understanding the necessary elements of the transition process. Although many teenagers with psychiatric illnesses may receive inpatient treatment followed by an outpatient program prior to returning to school, there are also a large number of teens that do not meet the criteria for inpatient admissions, and participate in psychiatric day treatment only. Psychiatric day treatment programs provide

a significant level of support during weekday hours, but offer less supervision than 24/7 inpatient settings, and are also relatively brief in duration, averaging only 2-4 weeks of treatment. For these individuals, hospital professionals are challenged with achieving psychiatric stabilization in addition to assisting their patients in managing their home lives, and establishing effective coping mechanisms and functional strategies for successful reintegration into their school settings.

Resources referenced by Simon and Savina from the 1990s support the necessity of quality communication between hospital and school professionals during students' transition from one setting to another. However, this can be difficult for a number of reasons, most notably due to family requests for privacy. In their 2007 and 2010 studies, Simon and Savina, as well as Clemens and colleagues (2010, 2011) substantially contributed to the literature on the perspectives of school professionals in the hospital-to-school transition including mental health therapists working in dual settings (hospital and school), and special educators. These authors describe in detail the manner in which mental health counselors and special educators can be utilized in the transition process to promote improved achievement for previously hospitalized students. While this information is very important and helpful regarding students currently receiving special education services, it is less applicable to students that were previously ineligible for special education and those currently not supported by individual education plans (IEPs) or section 504 services (Rehabilitation Act of 1973), because these students often have little to no relationship with mental health counselors, and do not have regular access to special educators.

Overview of the Current Study

The current study was undertaken to address the lack of a uniform transition process for adolescents returning to school following psychiatric hospitalization. It is intended to be the first study known to compare the professional perspectives of hospital-based and school-based mental health clinicians on the transition process, beginning from the first day of hospitalization until the child returns to school. The study explored potential barriers that exist across and within hospital and school settings, which have the potential to reduce the effectiveness of post-hospitalization transitions plans.

Purpose of Study

This study is intended to build upon Simon and Savina's (2010) research on the hospital-to-school transition post psychiatric hospitalization. Previous studies have assessed the knowledge of dual setting (hospital and school) mental health clinicians related to the hospital-to-school transition, as well as the role that special educators can play in making this transition successful. Information gathered from these prior studies was fundamental in establishing a set of current and relevant hospital-to-school transition research. However, many transitions take place for students who are not currently receiving special education services, and these students often are being supported by school support staff that may not have expertise in managing the needs of students with complex psychiatric situations. For example, guidance counselors with little mental health training are often the initial contact when hospital staff inquires about any academic or social concerns in the school setting. Other contacts may include school social workers, adjustment counselors, school psychologists, and the school nurse.

Consequently, while Simon and Savina (2007) researched dual setting mental health clinicians' perspectives on the hospital-to-school transition, these clinicians are less likely to be handling the majority of individual student transitions. For this reason, it is imperative that researchers learn more about the support needs of school mental health staff as they transition teenagers back to their school environments post-hospitalization. Therefore, the current study will measure school mental health staff's ratings of their competence and ability to successfully implement students' discharge and transition plans. Additionally, rating scales will be completed by hospital mental health staff addressing their perspectives on critical features of the hospital-to-school transition.

Finally, this study is intended to extend Simon and Savina's hospital-to-school transition research by addressing the fidelity of implementation gap. This gap refers to the difference between what hospital and school mental health providers conceptualize as the "ideal" transition process, compared to what they are realistically able to practice in their settings due to barriers such as financial and staff resources, and administrative pressures on the time and activities of professionals. It is important to gain an accurate understanding of the fidelity of implementation gap in order to bridge communication among various mental health providers. Therefore, information gathered from this study may begin to distinguish between "true" differences in perspective of the hospital-to-school transition process, compared to variation in administrative and fiscal pressures.

In discussing fidelity of implementation throughout the transition process, several layers of fidelity will be considered (Harn, Parisi, & Stoolmiller, 2013). *Structural* fidelity refers to objectively measuring inclusion of central components of the transition (e.g. identification of needs and resources), time allocation, and intervention completion

(during creation of the transition plan and dissemination of the plan upon returning to school). Each of these components can be measured through direct report of the clinicians. *Process* fidelity refers to the quality of transition and transition plan delivery, and the quality of patient-clinician, and student-clinician interactions throughout the transition process. *Process* fidelity is more difficult to measure solely utilizing questionnaires and rating scales (O'Donnell, 2008), and will thus be identified utilizing qualitative interviews in combination with rating scales. While both structural and process dimensions are important to this research study, *process* elements are essential to understand, because they can provide necessary information and insight on the effectiveness (or lack thereof) of an intervention (Harn, Parisi, & Stoolmiller, 2013).

In sum, the purpose of the study was threefold: 1) to generate knowledge on school mental health staff's preparedness and competence to implement student transition plans, 2) to identify hospital mental health professionals' perceptions of important elements of the school transition plan, and 3) to compare the perspectives of hospital and school based mental health regarding the hospital-to-school transition. The transition will be discussed in terms of *structural* and *process fidelity.* It is intended that information gathered from this study will be utilized to inform the improvement of collaboration between hospital and school based professionals throughout the adolescents' hospitalization and discharge to create the highest potential for a positive outcome post-hospitalization.

Hypotheses

1) School mental health staff's perceived preparedness to effectively manage student transition plans will increase as the number of available resources (hospital & school) increases.
2) The ideal transition process proposed by school and hospital mental health staff participants will be dissimilar across professional setting, and perceived likeliness for successful implementation will vary between groups.
    a. Differences noted between hospital and school mental health staff will pertain to the person(s) responsible for implementation, and "active ingredients" of the transition plan.
3) School mental health staff's perceived levels of structural and process fidelity will have an impact on their confidence in successfully implementing the transition plan, such that high levels of fidelity will result in higher perceived levels of transition plan success.

CHAPTER 2

Methodology

Methodology Overview

This study focused on the hospital-to-school transition from the perspective of mental health and educational professionals involved in the transition process. For this study, transition was defined as the process through which hospital and school staff persons communicate to understand concerns in the school setting prior to hospitalization, progress that is made throughout the hospitalization, and remaining concerns for the student as he or she returns to the school environment post hospitalization. It included the initial school contact, any phone calls or meetings that take place while the client is hospitalized, and final dissemination of the discharge plan (Clemens et al., 2010).

A mixed-methods approach was utilized to capture information related to professionals' years of experience in transitioning youth back to school following psychiatric hospitalization, as well as to explore facilitators and barriers in communication between those professionals involved in providing support to hospitalized youth on both sides of the transition. Quantitative inquiry was used to gather descriptive data about the participants including the following information: current work title, number of years in the profession, number of students with whom they've worked that have been hospitalized for psychiatric concerns, pre- and post-hospitalization contact with parents, and specific types of follow-up requested.

Qualitative inquiry was utilized to explore and compare professional perceptions on transition from hospital-based and school-based mental health professionals. This information was gathered and analyzed from a "fidelity of implementation" perspective (O'Donnell, 2008). The most commonly accepted definition of this term is "the degree to which a treatment or intervention is implemented as intended" (Moncher & Prinz, 1991; Yeaton & Sechrest, 1981). Due to the complex environment of schools and psychiatric hospitals, two forms of fidelity were considered: *structural* and *process*. *Structural*, or *surface fidelity*, represents an objective look at whether important pieces of the intervention were delivered. Harn and colleagues (2013) provided several examples of the dimensions of *structural fidelity* which can be measured via direct observation or self-report, including the following: measuring (a) central components or active ingredients of the intervention (i.e., program adherence), (b) time allocation, and/or (c) intervention completion (e.g., expected material was covered, number of lessons completed; Durlak & DuPre, 2008; Gersten et al., 2005; Power et al., 2005). *Process fidelity* is concerned with the quality of intervention delivery and is much more difficulty to measure objectively (Harn et al., 2013). For this study, potential dimensions of *process fidelity* were developed based upon the information provided by participants. Current literature discusses the importance of utilizing a multidimensional approach when assessing the fidelity of intervention implementation, rather than treating structural and process dimensions as dichotomous. To date, the limited research available on hospital-to-school transitions has yet to address the *process* elements of the hospital-to-school transition, which makes utilizing a multidimensional approach impossible to implement effectively.

Participants

Participants included staff members from two different settings: licensed hospital mental health staff (n=7), and school mental health professionals servicing Rhode Island and Southeast Massachusetts middle and high schools (n=24). The hospital mental health staff from a local psychiatric day treatment program serve in the capacities of individual and family based social workers (n=3), clinical psychologists (n= 2), psychiatrists (n=1), and nurses (n=1). Male staff comprised 28% (n=2) of the sample and females represented the majority of the sample (72%, n=5). School mental health staff had varying titles as defined by each individual district, but each staff member participant self-identified as being an initial contact and/or responsible transition agent for students post-hospitalization. These positions by title included guidance counselors (n=2), school psychologists (n=7), clinical psychologists (n=1), social workers (n=7), adjustment counselors (n=4), and school counselors (n=3). Despite their specific titles, some held multiple roles or positions within their given schools (i.e. school psychology/special education department chair/504 coordinator; school psychologist/school adjustment counselor). All school participants were female.

All participating professionals (hospital and school) identified as Caucasian and held the appropriate professional license or credential for practice in their fields. Among school-based staff, 29% (n= 7) held doctorates in their field, and 71% (17) held Master's degrees plus appropriate licensure. Additionally, of the school-based staff, 79% (n=19) worked predominantly in high schools, 16% (n=4) worked predominantly in middle schools, and 5% (n=1) were responsible for both high school and middle school students.

Recruitment

Institutional Review Board approval was obtained before recruitment. Hospital-based participants were recruited from a local adolescent day treatment program that emphasizes treatment of teenagers with mental health disorders/concerns. Purposive sampling was utilized during recruitment due to the small number of such staff and limited programs in the area. Although a second local day treatment program was contacted in an attempt to diversify the sample, no response was received. Hospital staff received an initial e-mail explaining the study and its intent. Next, the researcher attended a hospital staff meeting to explain the study in further detail and answer any questions about participation and the process. Paper copies of consent forms and the hospital-based survey were provided to potential participants during the meeting. Consistent with the Dillman (1998, 2006) method, a follow-up e-mail was sent one week later to secure willing participants and to provide additional copies of study materials electronically. A third e-mail was sent to potential participants two weeks after the second e-mail, and the researcher conducted follow-up phone calls to secure the final number of participants. Once participants agreed to complete both portions of the study, paper copies of the second portion of the study were disseminated to each individual who demonstrated initial interest via e-mail, phone, or during the initial recruitment meeting. A $5 Dunkin Donuts gift card was provided to each participant along with the survey materials as an incentive for participation. A total of 7 hospital-based participants were generated from recruitment strategies, with 7 individuals completing the initial survey and 6 participants completing both the quantitative and qualitative portions of the study. One hospital-based

professional declined completion of the narrative response and interview portion of this study, because her job duties did not include the information being requested.

School mental health staff participants were recruited from schools in Rhode Island and Southeastern Massachusetts. Contact information was gathered from district websites and a school counselor listserv. Anyone listed as a mental health staff/support person as well as school nurses were contacted via e-mail. The e-mail contained a brief description of the project, an estimate of time requirements, and instructions for participation. The full contents of the recruitment materials can be viewed in the Appendices II-A – II-B. A total of 282 staff were contacted over the course of three e-mails, in accordance with the Dillman method (Schaeffer & Dillman, 1998). Representatives from two schools expressed a high level of interest in the study and extended an invitation for an in-person description of the study to answer any questions and to provide paper copies of survey materials. Five individuals responded stating that they were newer to their position and districts, and could not provide the requested information. Two additional individuals replied stating that they dealt exclusively with college counseling concerns, and were not responsible for mental health. A total number of 24 school mental health individuals participated in the survey. A total of five school mental health participants provided additional comments that they felt were important related to the hospital-to-school transition and will be discussed in the results and discussion session of this write-up.

To secure school mental health participants for the qualitative portion of this study, it was intended that 5 participants with the most and 5 with the least experience (by number of students) transitioning students would be contacted to complete the

qualitative section of this study. However, due to varied response rates and lack of availability of other participants to be interviewed, a selection of staff with varying years of experience in their professions, as well as number of transitions were contacted via e-mail to complete the second portion of the study. In the end, a total of nine school mental health professionals were interviewed and completed the interview portion of the study. The sample size for which both hospital and school staff were recruited follow Hill and colleagues' (1997) recommendation for qualitative research methods of a sample of 8 to 15 participants, with a sample on the larger end when a large amount of variability is anticipated in the participant's experience relative to the topic.

Procedures

Participants completed a combination of written surveys, narrative reports, and interviews. Questionnaires specifically targeted the previous experiences of school and hospital mental health staff as they have transitioned students from the hospital to school setting. Hospital participants completed the survey, narrative report, and semi-structured interview portion of the study. Whereas 24 participants completed the survey, only 9 staff completed the narrative report and interview portion of the study. The number of students that they transitioned from hospital to school varied from 1 to 40. Additionally, they reported working in their profession for a range of years (1-3=3; 4-7=2; 12 or more=3). For this study, "transition" is defined as the process through which hospital and school staff persons communicate and collaborate to understand concerns in the school setting prior to hospitalization, progress that is made throughout the hospitalization, and remaining concerns for the student as he or she returns to the school environment post hospitalization. It includes the initial school contact, any phone calls or meetings that take

place while the client is hospitalized, and final dissemination of the discharge plan (Clemens et al., 2010).

Data Collection

Upon consent to participate, participants completed a questionnaire documenting their experiences within the last five years transitioning adolescents back into school following psychiatric hospitalization. Following completion of the survey, the remaining 16 participants, a combination of hospital-based and school-based mental health staff, were asked to read the "Sarah" vignette and to then respond to a number of questions. Next, a hospital-to-school transition logic model was explained to each participant and they were asked to reconsider their responses to the "Sarah" vignette and make any changes or additions to their original responses. The final portion of the study was an in-person interview to collect more detailed information about the participant's perceived barriers to a successful hospital-to-school transition.

Measures

Demographic information. Demographic information assessed from participants included professional background (e.g. school psychologist, guidance counselor, social worker), number of years employed in the profession, and approximate number of students he/she has been responsible for transitioning back to school post psychiatric hospitalization. Similarly, hospital mental health staff identified their profession (e.g. school psychologist, social worker, clinical psychologist, nurse), number of years working in psychiatric hospital settings, and approximate number of students he/she has assisted in transitioning from hospital to school environments.

School mental health staff questionnaire. This questionnaire (Hospital to School Transitions: School Mental Health Staff Survey) has been adapted from Simon and Savina's 2010 study on special educators' knowledge of the hospital-to-school transition, for application to school mental health staff (see Appendix II-E). The eight survey items assess four issues: (a) roles of mental health staff in the hospital-to-school transition (4 items), (b) knowledge, skills, and resources needed by school mental health staff in the transition process (2 items), (c) behaviors of adolescents following hospital discharge (2 items), and (d) critical time period during which children re-adjust to the school setting following hospitalization (1 item). Two additional items requested information about number of years of experience in his/her position, and number of children with whom the participant has worked that have been reintegrated to school following psychiatric hospitalization. A copy of the questionnaire is contained in Appendix II-C.

Day-program transitions questionnaire. This questionnaire was adapted from Simon and Savina's (2007) research with hospital-based therapists. Hospital mental health staff completed the survey which examined (a) which of 11 actions they take when transitioning students from the hospital setting into school, (b) how and when they communicate with parents/caregivers and school staff, (c) level of receptiveness for each group (i.e. parent, school staff) to participants' form of communication, (d) type of consultation provided to parents/caregivers and school staff, (e) concerns and problem behaviors that students are likely to display prior to and immediately following their return to school, and (f) participants' satisfaction with the current transition process at their facility. A copy of the questionnaire can be viewed in Appendix II-D

"Sarah" vignette and narrative report. Participants were asked to provide a narrative as to how they would approach the "Sarah" vignette from start to finish. Hospital and school staff then described the ideal steps in creating the student's transition plan, specifically defining: (a) time of initial school contact, (b) who would be contacted, (c) what information they would gather about school, (d) when the transition meeting would ideally take place, (e) who should be involved, and (f) specific ideas for follow-up. Participants were then asked to define how many resources they would need, what the resources would be, and who would provide them. Next, they were asked to create an ideal transition plan for "Sarah" and to rate its potential effectiveness for successful re-entry if the plan was to be offered for implementation in local school districts (school staff will be asked to specifically discuss effectiveness for *their* district only). Responses from the school interview were compared to answers on the School Mental Health Staff Questionnaire to examine consistency. The body of the "Sarah" vignette is included below and a full view of the form can be viewed in Appendix II-E.

Figure 1: "Sarah" Vignette

Sarah is a 16 year old sophomore at a local high school. She has attended her local schools since the 6th grade, when her family relocated to the area from the Midwest. Sarah has a history of anxiety, for which she has been working with an outpatient therapist for the last 6 months, as well as depression that began within the last two months. Her depression began following the death of her uncle, with whom she had a strong relationship. Sarah's hospitalization resulted from an attempted suicide, whereby she took 10 Benadryl in an effort to "make the pain disappear". Her parents are also concerned, because her mother has recently discovered numerous cuts on Sarah's legs, which Sarah minimizes and describes as "accidental scrapes from shaving". Her academics began to suffer prior to her uncle's sickness, and continued to decline following his death.

Sarah's anxiety and depression have made it very difficult for her to get through an entire school day, with her frequently arriving at school 1-2 hours late, and she has already missed 26 days of school, even though it is only January. Sarah reports that she has some friends, but she often smokes marijuana with them after school, and her parents

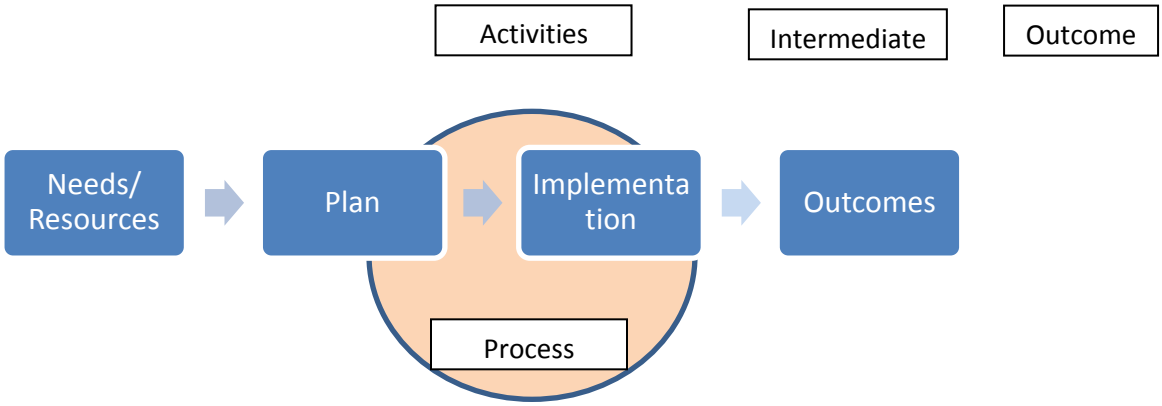
do not view them as positive influences in her life. Sarah and her family's relationship with her high school has diminished within the last month, because the family feels that school hasn't effectively assisted Sarah in catching up on the material that she has missed, as well as providing her with coping strategies to function effectively throughout the school day.

Sarah has met with her guidance counselor and school nurse on several occasions, but there is no formal plan in place at this time. Additional mental health staff persons at the school include a school psychologist and school social worker, both of which are at the high school 2.5 days weekly.

The "Sarah" vignette was developed from a combination of actual cases encountered during the researcher's previous work at a psychiatric day treatment program. Two staff from the psychiatric treatment facility were contacted to review the scenario and ensure that it accurately represented cases that they encountered on a regular basis. Details were updated and corrected based upon their feedback. The vignette was then presented to two mental health professionals who are currently doctoral students in a school psychology program as a pilot study to ensure that all questions were clear and answerable as intended by the researcher. During the study, participants were asked to review each question attached to the vignette prior to responding and were provided with clarification as needed.

Finally, the examiner presented and described a potential transition plan and logic model for successful re-entry following short term psychiatric hospitalization based upon best-practices derived from the literature on school re-entry following hospitalization for chronic illness, as well as information gained from previous psychiatric hospitalization studies (Hysing et al., 2009; Clemens et al., 2010; Simon & Savina, 2007, 2010; CSMH, UCLA, 2014). Participants were asked to update their re-entry plan based upon the information presented in the logic model, as well as to provide an explanation for their changes.

Figure 2: Hospital-to-School Transition Plan



The transition plan (Figure 2) represents the process beginning with identification of the adolescent's needs and current natural and community-based resources prior to beginning plan development. The activities area represents program activities that take place in the day-treatment program, as well as ideas for activities generated during creation of a discharge plan among stakeholders. Implementation of the plan (which begins while the adolescent is still hospitalized) overlaps with the program activities, and is followed by outcomes (intermediate and long-term). The terminology "intermediate" and "outcome" is consistent with formative program evaluation literature (Patton, 2002). *Intermediate* outcomes refer to changes that can be noted in the adolescent immediately following his or her discharge through the first 6 weeks following re-integration. *Outcome* refers to the individual's long term (after 6 weeks) functioning after psychiatric hospitalization.

Additionally, the logic model (Figure 3) was also formulated in accordance with program evaluation literature (Patton, 2002) and begins with identification of risk and protective factors relative to the adolescent's overall functioning followed by a list of hospital-based program activities that address each of the risk and protective factors listed

in the first column. Finally, the third and fourth columns provide details regarding short and long-term outcomes relative to each of the risk and protective factors as they were addressed by program activities. The logic model was explained in detail to all participants, who were then given time to review the model, and then ask any additional questions. If participants had any additional questions, they were able to contact the researcher via e-mail or by phone for clarification. Finally, the researcher clarified any statements made regarding participant updates to the transition plan based upon the logic model, prior to beginning the interview portion of the study.

Figure 3: Hospital-to-School Transition Logic Model

Risk/protective factors	Program activities	Intermediate Outcome	Outcome
Biological predisposition	Psychiatry	+ capacity to "function"	Successful re-entry
Family support	Family therapy	+ family relationships + parent-teacher contact	Successful re-entry, - recidivism
Social connectedness/ Peer influences	Milieu groups; individual therapy	+ peer relationships	Successful re-entry + relationship building
Academic abilities	Tutoring/Assessment	+ knowledge of school materials/confidence	Successful re-entry
Intrinsic Motivation	Individual Therapy	+ effort in school/ self-advocacy	+ help seeking Successful re-entry
School staff relationships	Post-program meetings	+ School climate	+ help seeking Successful re-entry

Interviews. The final step was a semi-structured interview where hospital and school participants were asked to verbally describe their current perception of the hospital-to-school transition process for teenagers with mental health needs. Specifically, what areas of the process need to be improved, who should be responsible for these improvements, how long it will likely take before the ideal transition process can be implemented in their hospital or school settings, and existing barriers across settings (i.e. between hospital, school, and community providers).

Researcher

The primary researcher for this study was a doctoral student in a school psychology Ph.D. program. She has experience working with adolescents and their families in outpatient clinics, partial-hospital day programs, residential treatment settings, as well as traditional and specialized school settings. During the conceptualization phase of this study, the researcher identified and discussed biases that may have impacted the study design or analysis of the data with supervisors and clinicians from each of the aforementioned settings. The researcher believed that collaboration among hospital and school providers is essential to student success following short or long-term psychiatric hospitalization. The researcher anticipated participants would describe communication across hospital and school professionals as a significant challenge and barrier to successful transition. It was also expected that school-based participants have not had an overall positive experience working with hospital-based providers following adolescents' discharge from the hospital.

Trustworthiness and Authenticity

Ensuring the trustworthiness of a study enables researchers to establish the credibility and transferability of qualitative research findings (Creswell, 2007). The researcher promoted several techniques to promote the trustworthiness of participant reported information and subsequent findings. Techniques used during data collection in Simon and Savina (2007, 2010) as well as Clemens and colleagues (2010, 2011) research were replicated as an attempt to utilize consistent qualitative methods in the development of hospital-to-school transition literature. As a follow-up to prior research, it is important to briefly revisit previously explored questions and to then expand inquiry into the areas of future research as identified in prior studies. Secondly, the researcher enlisted participants to review the accuracy of data through a member check. Following each narrative report and semi-structured interview, the researcher asked participants to clarify any unclear statements and verbally informed them what had been written to capture each portion of their interview. Participants provided clarification where necessary and were encouraged to contact the researcher with any clarifying statements should they arise after the interview was completed. Patton (2002) referenced specific criteria to improve the trustworthiness of qualitative data, including:

> objectivity of the inquirer (attempts to minimize bias), validity of the data, systematic rigor of fieldwork procedures, triangulation (consistency of findings across methods and data sources), reliability of coding and pattern analyses, correspondence of findings to reality, generalizability (external validity), strength of evidence supporting causal hypotheses, [and] contributions to theory (p. 544).

Lincoln and Guba (2000) consider these benchmarks to be "parallel criteria" to validity and reliability criteria utilized in quantitative research.

Additionally, Patton, Lincoln and Guba (2002, 2000) discussed the importance of *authenticity* as an additional facet to *trustworthiness* in qualitative research. *Authenticity* criteria, or *intrinsic* criteria, are deemed as equally important as trustworthiness (Morrow, 2005) and include fairness, ontological authenticity, educative authenticity, and catalytic authenticity. Morrow defined these terms concisely in her 2005 article on trustworthiness and authenticity in qualitative research.

> *"Fairness* demands that different constructions be solicited and honored. In *ontological authenticity,* participants' individual constructions are improved, matured, expanded, and elaborated. *Educative authenticity* requires that participant' understandings of and appreciation for the constructions of others be enhanced. *Catalytic authenticity* speaks to the extent to which action is stimulated. p.252"

The reader is referred to Morrow (2005) for a detailed description of these terms and their impact on qualitative research. Therefore, in accordance with the guidelines set by Patton (2002), Lincoln and Guba (2000), and Morrow (2005) the following activities were completed. Information gathered during the interview portion of data collection was compared to participant responses on the surveys for consistency. Feedback from the interview and survey portions of the study was integrated prior to data analysis. Findings were then compared to the results of previous qualitative studies during the data analysis process.

Data Analysis

School Mental Health Staff Questionnaire

The non-parametric Kruskal-Wallis statistic was utilized instead of a two-way ANOVA due to the small sample size, as well as unequal group sizes. A One-way between-subjects Kruskal-Wallis test was calculated to assess the relationship between the number of years of experience in school mental health, and the amount of knowledge, skills, and resources requested by them; as well as the relationship between numbers of students for whom they have facilitated hospital-to-school transitions and the amount of knowledge, skills, and resources requested.

Day Program Transitions Questionnaire

A One-way between-subjects Kruskal-Wallis test was initially proposed in order to assess the relationship between self-rated satisfaction with the transitions process (1-3, 4-7, 8-10) and the content of consultation provided to school personnel (behaviors, academic performance, interpersonal relationships); as well as self-rated satisfaction with transition process compared to method (face-to-face or phone) and timing (prior to discharge/following discharge) of consultation. Due to similar ratings across participants and descriptions for ratings that were outside of the direct control of hospital-based clinicians, any information gathered from this statistical test would have likely been a misrepresentation of results. For this reason, information gathered from the hospital-based survey was incorporated into qualitative analysis only.

Qualitative Analysis

Several participants reported discomfort with having the interviews audio recorded, but did consent to the researcher writing down their key statements and occasional quotations. For this reason, all interviews were conducted in this manner. Responses from the semi-structured interviews were typed and then de-identified for participant anonymity. Pseudonyms were used to protect the anonymity of participants when direct quotations were utilized in thematic analysis. Transcripts were created and themes were identified, and defined for clarity. The researcher became immersed in the data, completing multiple readings of each narrative report, interview, and additional comments from surveys prior to developing an initial list of possible themes or domains. The semi-structured and narrative interviews were entered into NVivo (QSR International, 2013); a software program designed to facilitate organization and analysis of text based data, and organized by topic and theme utilizing word and concept frequency analyses. Two auditors, who are also school-psychology graduate students, one with extensive work in psychiatric hospital units and both with expertise in working with school providers, reviewed theme definitions for clarity. Unclear themes and domains were revised and renamed based upon auditor feedback. Following the identification of overall themes, all data was coded into the various domains.

The qualitative interviews produced details regarding hospital-school communication prior to student transition, as well as school mental health staff concerns related to implementing the transition plan and services post-discharge. A comparative analysis was completed to determine points of relatively trouble-free and relatively problematic interactions, and provided information for future collaboration across

providers. Finally, NVivo was also used to complete a cross-analysis, generating frequency data that assessed the representativeness of categories across the sample.

CHAPTER 3

Results

Overview

The data reported in this section is intended to 1) provide general knowledge on school mental health staff's preparedness and competence to implement student transition plans, 2) to identify hospital mental health professionals' perceptions of important elements of the school transition plan, and 3) to compare the perspectives of hospital and school based mental health regarding the hospital-to-school transition. Specifically, this results section will also answer the research questions posed. First, does school mental health staff's perceived preparedness to effectively manage student transition plans increase as the number of available hospital and school-based resources increases? Secondly, does the ideal transition process differ among hospital and school-based mental health professionals, and do they rate potential levels of success differently? Finally, do perceived levels of structural and process fidelity impact school mental health providers' confidence in successfully implementing their designed transition plans?

A mixed-methods approach was utilized to capture information related to professionals' years of experience in transitioning youth back to school following psychiatric hospitalization, as well as to explore facilitators and barriers in communication between those professionals involved in providing support to hospitalized youth on both sides of the transition. Quantitative inquiry was used to gather descriptive data about the participants from questionnaires. The quantitative data was analyzed using SPSS to provide descriptive statistics regarding participant backgrounds and non-parametric statistics to determine any group differences among school-based staff related

to their number of years in the profession and experience with transitioning students back to school following brief psychiatric hospitalization. Qualitative inquiry was utilized to explore and compare professional perceptions on transition of hospital-based and school-based mental health professionals. This information was gathered and analyzed from a "fidelity of implementation" perspective. Specifically, qualitative information was gathered from narrative reports that contained responses to the "Sarah" vignette and responses to the logic model (Figure 3 in the narrative section of the methods chapter and is also available in appendix II-E). Additional qualitative information was gathered from the semi-structured interview conducted with all willing participants. Information from narrative reports and semi-structured interviews was analyzed using NVivo software, which allowed for identification of common themes and domains. Themes and domains were cross-checked by two auditors for consistency.

This results section is separated into quantitative and qualitative areas. Information is presented in the order that materials were presented to participants. Specifically, data from questionnaires and associated analyses are presented first, followed by information gathered from the narrative reports. Finally, barriers to successful implementation are discussed by most common domains and themes.

Quantitative Analysis

School Mental Health Staff questionnaire

A total of 24 school-based professionals answered the School Mental Health Staff questionnaire. Data pertaining to years of experience in school mental health can be viewed in Table 1, with information regarding the number of students transitioned in Table 2. The majority of participants (n=13, 54%) have worked in school mental health

for more than 12 years. The remainder of participants had a range of experience, between 1 and 11 years. Participants were asked to identify the number of students that they had personally reintegrated to school following psychiatric hospitalization. The range varied greatly from 1 to more than 100 students (Table 2). Despite this range, the majority of participants had transitioned fewer than 20 students, with 30% responsible for fewer than 5 student transitions.

Hospital contact. The first section of the questionnaire assessed contact with hospital based providers *pre* and *post* student psychiatric hospitalization. Whereas almost all participants (*n*=23, 96%) reported having contact with hospital professionals prior to discharge on at least one occasion in their overall experience with transitions, this was not a regular occurrence. In fact, almost half of the participants (*n*= 10, 42%) reported being contacted prior to discharge less than 50% of the time. Although some (*n*= 6, 25%) reported receiving contact prior to discharge on every transition they have encountered, 80% of these individuals work in settings that have strict policies necessitating a discharge meeting with all providers prior to the student's return to school. The number of professionals reporting post-discharge contact with hospitals was significantly lower than those reporting contact prior to discharge (*n*= 10, 42%). Several participants indicated "requesting discharge summary" as the primary reason for this contact, which was mostly initiated by the school professional. Only 12% (*n*= 3) of participants reported any form of post-discharge contact with the hospital in 30% or more of their transitions.

Table 1:

 # Years in School Mental Health

		Frequency	Percent
Valid	1 to 3 years	5	20.8
	4 to 7 years	5	20.8
	8 to 11 years	1	4.2
	12 + years	13	54.2
	Total	24	100.0

Table 2:

 # Students Reintegrated

		Frequency	Percent
Valid	1-4	7	29.2
	5-9	4	16.7
	10-19	5	20.8
	20-39	5	20.8
	40-100	3	12.5
	Total	24	100.0

Parent contact. Professionals' contact with parents, both during and after hospitalization was the focus of the next section. School mental health professionals were more likely to have contact with parents during hospitalization than with the hospital staff providing care, with 83% (*n*= 20) of participants reporting pre-discharge parental contact that occurred in more than 75% of cases. Post-discharge parent contact was similar to pre-discharge parent contact in many cases (*n*=16, 67%), although slight increases in post-discharge contact compared to pre-discharge was reported by some participants (*n*= 6, 25%). Two participants indicated no pre- or post-hospitalization contact with parents, but reported that they were not the primary professional responsible for student reentry in their districts.

Critical re-integration period. Next, participants were asked to identify the critical time period in which to help a student become reestablished in school following psychiatric hospitalization. Whereas more than half (*n*= 13, 54%) of participants indicated the first three days as the critical time period for school reintegration, others (*n*= 8, 33%) defined the first week post-discharge as the critical period. Only a few participants (*n*= 3, 12%) identified an extended (i.e., longer than one week) critical period of re-integration.

Emotional/behavior difficulties upon return. Participants were asked to what extent their students returned to school with continuing emotional and behavioral problems upon their reintegration into school, as well as to define the nature of student difficulties by selecting responses from a number of options. The majority of participants (*n*= 19, 79%) reported ongoing student difficulties upon their return from psychiatric hospitalization. Of those with reported difficulties, more than 90% identified anxiety and withdrawn behavior as the two most common student problems upon returning from hospitalization, followed by "off task behavior" (*n*= 13, 68%). Other categories of difficulties (e.g., manipulative behavior, aggression, rule breaking behavior) were endorsed by fewer than 50% of participants, and have thus been omitted from this discussion, but can be viewed in the appendices.

School resources requested. The Kruskal-Wallis nonparametric statistic was calculated to investigate two hypothesized relationships: 1) the extent to which the number of years working in school mental health was related to or correlated with knowledge/resources requested by school mental health professionals (Table 3; $\chi^2(3, N=24) = 5.12$, $p = .164$), and 2) the extent to which the number of students for whom the individual has facilitated the hospital-to-school transition was related to the knowledge, skills, and resources requested (Table 4; $\chi^2(4, N=24) = 2.88$, $p = .578$). The correlation for neither relationship was found to be statistically significant. In fact, there was no distinguishable pattern in the number of resources or type of resources that were requested among school mental health providers. The most commonly requested resource was the hospital discharge plan (n= 23, 96%), with behavior management information

and consultation with other school personnel being the least requested resources (n= 14, 58%; n=13, 54%).

Table 3:
Relationship Between Years in Profession and Resources Requested

	Total Resources
Chi-Square	5.108
Df	3
Asymp. Sig.	.164

Table 4:
Relationship Between Number of Student Transitions and Resources Requested

	Total Resources
Chi-Square	2.880
Df	4
Asymp. Sig	.578

Overall results from the School Mental Health questionnaire suggest that school-based professionals are more likely to have contact with hospital mental health staff during hospitalization than following discharge, although some participants reported inconsistent contact with hospital-based providers altogether. Reported contact with parents, both during and following hospitalization was similar, with nearly 70% of participants indicating contact with parents throughout the transition process. Although there was not an overall consensus on the critical timeframe for student reintegration, more than half of the participants identified the first three days as the most important time period for students to be successfully reintegrated into the school setting.

Summary of School Questionnaire Results

Eighty percent of participants reported on-going difficulties with students after they returned from hospitalization, such as anxiety, being withdrawn, and off-task behavior. Data analysis found no significant difference in number or type of resources requested by school-mental health staff regardless of number of years in the school mental health profession or number of students transitioned. Most participants requested the majority of resources available from hospital-based staff, yet they mostly reported no

contact or inconsistent contact with hospital-based providers after students are discharged. Results from the School Mental Health questionnaire provide foundational knowledge to the status of hospital-school contact during the transition process and provides an understanding of the types of resources requested and needed by school-based staff regardless of their professional experience.

Day Program Questionnaire

A total of seven hospital participants completed the Day Program Questionnaire. Their responses to most items were very similar, as all participants worked for the same program. None of the participants disclosed mailing a copy of the patient's discharge plan to the home, indicating that the discharge plan is provided directly to the parents at the time of discharge. However, nearly half (n= 3, 43%) indicated that they would provide the school with a copy of the discharge by parent request or with parent permission. All but one participant indicated that they contact the patient's school prior to discharge (n= 6, 85%). The one exception was the hospital nurse who is not directly responsible for making contact with schools unless specifically requested by the primary family clinician.

With the exception of the hospital nurse, the remaining six participants responded exactly the same on the remainder of questions regarding parent and hospital contact. They all endorsed consultation with parents and schools prior to student discharge, as well as face-to-face meetings with parents prior to discharge. When requested and with parent permission, the six providers would also have face-to-face meetings with school personnel when possible. By participant report, all consults and face-to-face meetings ceased with parents and schools following a patient's discharge from the hospital.

However, 57% (*n*= 4) of hospital clinicians stated that they would engage in some monitoring of the student's mental health status when the request is initiated by the family or school. These respondents indicated that such contact is rare and generally no post-discharge monitoring is completed.

Hospital consultation. When asked to describe the nature of consultation provided by hospital staff during the patient's hospitalization, 85% (*n*= 6) checked all available boxes on the questionnaire (i.e. Behaviors related to child's disorder, Academic performance related to child's disorder, Interpersonal relationships of child with parent/caregiver, Interpersonal relationships of child with school personnel, Interpersonal relationships of child with peers). The seventh participant rated her consultation as directly related to any medical concerns that caregivers or school personnel may have for the patient/student's safety post-discharge. Only two participants reported family members and school personnel to be more than "adequately receptive" to their methods of communication. The remaining participants indicated that their attempts are "adequately" received.

Satisfaction with transition planning. A total of 57% (*n*=4) of participants reported being *somewhat* to *adequately* satisfied with transition planning at their facility. Remaining participants indicated that they were *very satisfied* with transition planning at their facility. Finally, 71% of participants (*n*= 5) indicated that withdrawn behavior, anxiety, and off-task behavior were most likely to be exhibited after patients return to school following psychiatric hospitalization.

Summary of Day Treatment Questionnaire Results

Overall results from the Day Program questionnaire indicated that all hospital staff responsible for student transitions contact schools prior to discharge as a common practice. These same professionals reported availability for consultation with school providers, as well as face-to-face meetings with them when parent permission is granted. Overall, hospital participants reported that school-based providers were adequately receptive to information provided during consultations, but they all reported that contact with school and family providers ceased following student's discharge. However, more than half of hospital participants indicated willingness to reinforce the transition plan when contacted by schools and families after discharge.

These results also suggest that hospital providers predict similar post-discharge problems to those reported by school-based staff (i.e., anxiety, withdrawn behavior, off-task behavior). The resources requested by school staff were in sync with consultation reportedly provided by hospital-based staff. However, both school and hospital staff report lack of hospital contact following the patient/student's discharge from the hospital. In fact, for the 57% of hospital staff reporting "somewhat to adequate" satisfaction with the transition process, they all cited lack of post-discharge follow-up as the reason for their lower ratings. The results indicate that hospital providers are available to meet the consultation needs of school-based professionals, but the contact among providers is inconsistent.

Narrative Report: "Sarah" Vignette

A total of fourteen participants (8 school, 6 hospital) were provided with a case study vignette (as described in the "narrative report" section of the methods chapter and

found in appendix II-D) and were asked to design a transition plan from beginning to end for Sarah. They were instructed to include several elements that will be discussed in the following sections and asked to rate the potential success of their plan. Finally, they were asked to predict and explain the potential success, or lack thereof, for the developed transition plan.

Timing of initial school contact. Fifty-eight percent (*n*=8, school-hospital) of participating individuals indicated that Sarah's school should be contacted within three days of her arrival to the hospital program. Two participants (14%, school-based) indicated that an initial school contact need not be made until a few days prior to discharge, with an additional two (14%, school-hospital) not specifying a timeframe, but indicating that school contact should be made prior to discharge. The final two participants (14%, hospital-based) indicated that school contact should be initiated with parent assistance or permission once an initial assessment of the patient's needs had been assessed.

Table 5:
Timeframe of initial school contact

Initial Contact	Number/Percentage
1-3 days after arrival	8/58%
A few days prior to discharge	2/14%
No specific timeline	2/14%
Parent permission only	2/14%

Initial school person contacted. There was a great deal of variation on who should be contacted initially at Sarah's school. Only one participant indicated a single individual (i.e. guidance counselor) as the primary contact. Twenty-eight percent (*n*= 4, school-

hospital) of respondents indicated that the guidance counselor and principal should be contacted by default. Whereas 50% (*n*= 7, school-hospital) stated that the hospital should contact the provider who knows Sarah best per Sarah and family report 28% (*n*=4, school-hospital) stated that the initial contact should be someone with decision making power and/or is responsible for school counseling services. Additionally, 21% (*n*= 3, hospital) listed several people (e.g., social worker, school psychologist, nurse, guidance, teacher) as potential contacts, discussing the fact that appropriate contacts vary according to the school district.

School information to be gathered. All participants (*n*= 14) wanted to gain information about available mental health resources at Sarah's school. Although 58% (*n*= 8) of respondents felt it was necessary to gather information about the school (i.e. school size, Sarah's schedule, school environment/climate), a greater proportion of school-based professionals reported this concern (*n*=6, 69%) compared to hospital-based professionals (*n*=2, 28%). The majority of participants (*n*=11, 79%, school-hospital) wanted information regarding her current academic performance and any academic and mental health supports she was receiving prior to hospitalization. Only 28% of participants (*n*= 4) requested information about Sarah's peer connectedness prior to hospitalization, with the majority of such requests coming from hospital-based professionals (*n*= 3, 50%) compared to school professionals (*n*=1, 12.5%). Finally, 58% (*n=8*, school-hospital) of participants requested additional information about available support services that Sarah has not utilized in the past. Results are summarized below.

Table 6:

School Information Requested

School Information Gathered	Number/Percentage
Available mental health resources	14/100%
School environment	8/58%
Utilized academic & emotional supports	6/69%
Peer connectedness	2/28%
Available academic & emotional supports	8/58%

Timing of transition meeting. Whereas 29% (*n*= 4) of respondents indicated that the transition meeting should take place at least one week prior to scheduled discharge, 21% (*n*= 3) indicated that a meeting should take place within the final few days of hospitalization, but not on the last day. However, half of all participants did not specify a timeline (*n*=7, 50%), but just indicated that one should take place prior to discharge. Despite the lack of specificity, all participants noted the importance of a transition meeting taking place prior to discharge, with some (*n*= 6, 42%) discussing the major problems associated with the plan not being implemented immediately upon discharge.

Transition meeting attendees. All participants indicated that Sarah, her parents, a school representative, and a hospital clinician should be present at this meeting, but the definition of "school representatives" varied among respondents. Seventy-one percent (*n*=10) of mental health professionals specifically stated that "guidance counselors, school psychologists, and social workers" should *all* be in attendance at the meeting, with several participants describing how each one would provide a different service for Sarah's transition. Whereas only four participants (28.5%) mentioned that the teacher should attend the transition meeting, seven participants (50%) discussed the importance

of the school principal or administrator attending the meeting. Finally, 12.5 % (*n*= 2) identified the school nurse as an important attendee at the transition meeting.

Follow-up items. As the final part of planning Sarah's transition process, participants were asked to describe "follow-up" areas to be discussed at the transition meeting. Seventy-one percent (*n*=10) of professionals (school and hospital) indicated that Sarah should have "centralized" care upon her return to reduce anxiety and eliminate confusion about her re-integration to school. Fifty percent (*n*= 7) specified the importance of developing a comprehensive safety-plan for Sarah with administrative support to improve her chances for a successful transition. Furthermore, these individuals discussed the importance of ensuring that Sarah's plan can be implemented with fidelity based upon resources being included in the safety plan. Fifty percent (*n*= 7) of respondents noted the importance of providing on-going family support when Sarah returns to school from school and community providers. Almost all participants (*n*= 12, 85.7%) discussed Sarah's slow reintegration into school, with tutoring assistance to catch her up on missed work. More than half (*n*=9, 64%) felt that she would best be served through the addition of a school accommodation plan based on Section 504 of the Rehabilitation Act of 1973 or Individualized Education Plan (IEP). Similarly, other participants indicated the need for referral to outside providers to manage Sarah's on-going needs (*n*= 8, 57%). Finally, the majority (*n*= 10, 71%) of participants stated that Sarah's developed plan should include on-going collaboration among school, family, and outpatient providers after Sarah's discharge from the hospital.

Table 7:

Discussion items for transition meeting

Follow-up Items	Number/Percentage
Centralized care	10/71%
Safety plan with admin support	7/50%
Ongoing family support	7/50%
Tutoring assistance	13/86%
504 plan or IEP	9/64%
Referral to community providers	8/57%
School-Family-Outpatient collaboration	10/71%

Provision of services post-discharge. The penultimate section of the narrative response asked participants to identify and define necessary services for Sarah upon her return to school, as well as who should be responsible for implementing the service. The majority of participants (*n*= 12, 85.7%) stated that school mental health professionals (i.e. social worker, school psychologist, guidance, school adjustment counselor) are the main ones responsible for Sarah's reintegration to school. In fact, 78.5% (*n*= 11) of participants assumed that there was more than one individual available at Sarah's school and defined the nature of service provision for Sarah. Only two participants placed any responsibility on school administration and classroom teachers for Sarah's reentry. A small number (*n*= 4, 28.5%) discussed the importance of collaboration between school and community providers to improve chances for Sarah to be successful. Nearly 43% of participants (*n*= 6) included the school nurse as an important resource in Sarah's reintegration, as well as teacher investment (*n=5,* 36%). Lastly, half of the respondents indicated that peer connectedness following Sarah's discharge is significantly related to her successful reintegration.

Table 8:

Individuals responsible for student reintegration

Responsible Professional	Number/Percentage
School Mental Health Prof.	12/~86%
School Administration	2/14%
Teachers	2/14%
School-Community collaboration	4/28%
School Nurse	6/43%

Success of developed transition plan. Participants were asked to rate the potential success of their developed transition plan on a 10-point Likert scale, where 1= *not successful* and 10= *very successful*. Hospital participant ratings ranged from 6 to 10, with a median of 7, *adequately successful.* School participant ratings ranged from 5 to 9, with an average rating of 7.37, *adequately successful*. Most participants (*n*=10, 71%) based their ratings on the chances for the plan to be implemented with fidelity. For example, one school participant with a low rating of success stated:

> "The availability of the mental health staff at the school could pose an issue. Daily check-ins might be helpful but these individuals are not available 5 days per week."

Similarly, a hospital participant with a *"very successful"* rating indicated that the prescribed plan would be successful, because it would continue to be "tweaked" until implemented as designed. The remainder of participants commented on concerns related to the high-risk nature of Sarah's case and difficulty managing some of her mental health needs in the traditional school, family ability to ensure Sarah attends school following

hospital discharge, and the school's ability to implement the plan as designed immediately upon Sarah's return to school.

Logic model changes. The final task related to the "Sarah" vignette was a review of best transition practices as developed from school reintegration following hospitalization for chronic-illness. The majority of hospital participants (*n*= 5, 83%) indicated that they would add post-discharge follow-up to their plans, and some would devise specific plans to improve family-school relationships (*n*=2*).* School providers indicated that they would improve opportunities for peer connectedness in and outside of school (*n*= 2), and increase collaboration with community providers (*n*=3).

Summary of "Sarah" Vignette and Logic Model Responses

The information gathered from the narrative response section answer the first two research questions. Specifically, school mental health professionals did rate the potential success of implementing their designed transition plans based upon the availability of hospital and school resources available to them. Interestingly, hospital participants also rated the success of their plan based upon the availability of these resources. Next, inconsistent with the second hypothesis, there were not differences in ideal transition practices among hospital and school providers. Both hospital and school providers identified similar key components in a successful transition plan, with the majority of hospital and school participants identifying school mental health providers as the individuals primarily responsible for student reintegration following psychiatric hospitalization. Finally, school and hospital participants identified structural and process fidelity elements as important to the success of the transition plan, which is consistent

with the third hypothesis. Specifically, both groups reported that certain elements are important to the formation of an effective transition plan, but the success of the plan is largely dependent upon the quality of implementation.

Interview: Barriers to Successful Transition

For the final portion of the study, participants were asked to identify and discuss barriers to successful school transitions following psychiatric hospitalization, including hospital and school factors. Participant descriptions were captured during the semi-structured interview and were reviewed and categorized into domains. Participant responses were recorded in a written fashion due to several individuals' refusal to be audiotaped. These participants wanted to remain anonymous due to the potential ramifications of sharing sensitive information related to their work environments and collaboration with outside professionals. Five domains emerged from the participant descriptions of "Sarah's" reentry to school following psychiatric hospitalization as well as identified barriers during a final semi-structured interview. Participants were asked to consider their responses to the "Sarah" vignette and their daily work and respond to the following question: "What are the barriers to successful hospital to school transition? Please be sure to consider both hospital and school factors." The five domains that emerged from the data were: *school mental health resources and expectations, professional collaboration during hospitalization, transition meeting and re-entry, student/family dynamics,* and *insurance problems.* A total of 12 main categories were identified utilizing NVivo software to code all responses into subcategories by using frequency and word queries to identify commonalities in responses. These subcategories were reviewed by the researcher and combined into larger categories. These categories

were further examined and divided within these five domains. Two auditors were consulted to ensure trustworthiness of coding and categories, and domains and themes were updated and renamed in accordance with group consensus. A full list of domains and associated categories is provided in Table 9.

Table 9:

Barrier Domains and Categories

School MH resources & Expectations	Professional Collaboration during hospitalization	Transition meeting & Re-entry	Student/Family Dynamics	Insurance Problems
Availability of MH resources	Hospital-school collegiality	Location of meeting	Family relationships with school	Length of Hospital Stay
Preparedness of MH staff	Regularity of contact across settings	Meeting attendees	Student-school connectedness	Lack of Hospital Follow up
Dual Mental Health professional roles	Information Exchange	Fidelity of Implementation	Family support & collaboration post-discharge	Rough Transition to Community Services

School Mental Health Resources and Expectations

Every participant noted concerns related to the availability of school mental health professionals. These concerns were reflected throughout additional comments on the school mental health survey, narrative responses, and the semi-structured interview. Specifically, mental health clinicians are not always hired as full time employees and often have a very high student-to-clinician ratio when they are available. Despite their limited available, school mental health professionals are expected to fulfill a number of roles, including: provision of counseling services, to act as liaisons between family and community resources, and to monitor on-going school-wide mental health initiatives.

This is an on-going concern for individuals who do not receive the necessary training and/or support to manage high-risk student needs.

> "Here [specialized school] we are given a level of experience or training to manage mental health needs. In regular education settings, they're less prepared to handle what will be needed to transition kids back."

Furthermore, this training is extremely important because school mental health personnel are called upon to provide on-going consultation to teachers and support staff who may not understand the impact of mental health issues on student performance.

> "Oftentimes there is difficulty understanding what the student can't control and won't control so students are seen as acting out and being disrespectful. Or there is fear and overreaction when it becomes known that a child is struggling."

School-based participants reported that such demands are overwhelming as more students with increasingly demanding mental health needs enter our schools.

Professional Collaboration during Hospitalization

This domain includes the areas of *hospital-school collegiality, regularity of contact across settings,* and *information exchange*. Only categories identified by more than half of participants will be discussed in this section. Hospital and school participants alike indicated that mental health professionals in the opposite setting often misunderstand how the other's setting operates. Due to time barriers on both ends, hospital staff are often left wondering who to contact "…hospital staff need to know who the important players are at each school," and school staff are often times unaware of

what takes place in the hospital setting or how the student is responding to hospital programming. On some occasions, school providers are never contacted while the student is hospitalized.

> "Often (as you'll see in my responses), hospitals do not even make contact with the schools while the students are hospitalized, and I feel by doing that, they are missing a very important perspective (hear what the school has to say) and also missing a critical opportunity for collaboration to help the student's transition."

An area of concern identified by several school participants was the lack of collegiality they receive when contacting hospital-based professionals.

> "Hospital professionals talk to school provides as though they're idiots, because they're calling from a school. They're not very collegial… I think we are wanting the same thing… I often think what key words I will use to help them understand my proficiency/competency through the phone… I have to identify myself as the LICSW or clinical social worker at the school, NOT as a guidance counselor, not as the adjustment counselor, because they don't respond to that either"

This was reported even by clinicians who work in a therapeutic-day school setting with similar credentials to those working in the hospital setting. Although some clinicians reported mutual respect when conversing with hospital staff, they indicated that teachers are less likely to receive mutual respect due to lack of clinical credentials.

Information exchange was identified as an area of concern for both hospital and school staff. Hospital staff must search for the best person to contact at a patient's school if this information isn't provided by the patient or his parents. Sometimes the individual

identified by the family is not responsible for the student's ongoing care upon returning to the school. School professionals indicated a lack of hospital responsiveness to requests for information during the hospitalization, while the hospital is "quick to demand information from the school." The most frequently identified issue with information exchange is the notification of, invitation to the meeting, and dissemination of discharge summary results. It is "quite difficult to get discharge summaries, and I feel those are very important for schools to see, as they will often explain why the student was hospitalized in the first place (providing school personnel with ideas about triggers, risk factors, etc.).

Transition Meeting and Re-entry

There are many events related to successful discharge and successful re-integration of students post discharge. Categories in this domain include *location of meeting*, *meeting attendees*, and *fidelity of implementation.* Hospital and school participants discussed the importance of information garnered during the transition meeting. They both identified location of the meeting and individuals present at the meeting as the two most important factors in creating a "smooth" transition plan. Both hospital and school participants noted the value of having a transition meeting at the school…

> "I've never had [the] hospital offer to do a meeting at the school, nor to view the setting where the kid is to see if it's appropriate."

Although hospital staff agreed with the school location, "[a] School meeting at the school for complicated school issues is a must", they openly discussed the time barriers

associated with doing so. “Going out to school meetings takes up the entire afternoon. This can be a “programmatic barrier: it’s valuable to me, I have freedom to do it…that’s the tradeoff, I still have to get my work done after I get back or before I go.” However, holding a discharge meeting at the hospital can result in “school representatives being more guarded against making decisions.” One hospital staff person stated that recommendations are easier to provide at an in person meeting “…schools sometimes doesn’t grasp all of the recommendations during the meetings and then say “uhoh.” I think it helps that I go to school meetings and they know who I am.” Doing so assists with the student’s transition after the discharge meeting is completed.

All hospital participants identified lack of appropriate school representatives as a barrier to successful transition planning. They reported that school representatives are sent to discharge planning meetings, but often have no power to provide the approval necessary for creating certain student transition plans.

> “Schools need all of their people to make decisions…can we please have all of the important players when we are having a meeting?”

School staff also indicated the need for administrative representation at meetings, especially when the creation of a 504 plan or IEP is warranted. Furthermore, all of the stakeholders involved in the student’s transition should be involved in the transition meeting if it is going to work well.

> “Teachers are expected to carry through a plan that doesn’t make sense to them or they disagree with it, or don’t think it will work.”

This finding was noted during hospital and school interviews.

Finally, *fidelity of implementation* refers to the likelihood that a created transition plan will be implemented as designed and reviewed for effectiveness immediately following student discharge. Hospital and school staff reported concerns in this area. School staff stated hospital discharge plans often contain recommendations that are not actually enforceable in the school environment due to educational policies, or due to staff availability. Additionally, they show a lack of understanding about the specific school setting attended by the patient, as well as a misunderstanding about what resources were provided prior to hospitalization as summarized by one school participant.

> "They don't understand what we do… we're looking for more than what was recommended… we were already doing that before the student was hospitalized!"

Hospital staff reported that schools occasionally "stall" provision of additional, more expensive services by failing to send "key decision-makers" to meetings. Schools also "only want the mental health stuff" and will "often demand things form the hospital" in terms of a placement decision. This ultimately impacts the potential success of any plan, because the two sides aren't effectively working together.

Student/Family Dynamics

Although this study focused primarily on hospital and school provider relationships, the role that students and families play in successful reintegration into school cannot be ignored. This domain includes such areas as *family relationships with the school, student-school connectedness,* and *family support and collaboration post-discharge.* Hospital staff are bound by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and therefore cannot contact school providers

without the permission of family members. If a patient and/or her family have an adversarial relationship with school providers, this immediately limits the hospital's ability to gain neutral information about the student's difficulties at school. Conversely, strong family-school relationships can result in faster and more effective hospital-school collaboration, as stated by one hospital participant

> "…success largely depends on how willing/able family and school are to work together to come up with a plan… [they can] talk about the value of the school clinician being involved during hospitalization and at discharge."

Furthermore, school staff may be able to gain or provide more information to the hospital when their relationship is well developed,

Student-school connectedness refers to the student's engagement with and feelings of belonging in her school environment *pre* and *post* hospitalization. Connectedness has been defined to include attendance at school, relationships with peers, relationships with teachers, and engagement in school based activities. Peer connectedness is a barrier that was identified by several hospital and school staff, especially after viewing the presented logic model.

> "My background is attachment… kid's need relationships at school… without this they will fail…we have at times had the best discharge plans, but the kid still refused to go to school."

Finally, student-family enmeshment reduces the student's connectedness to school and can be a large barrier to the student's ability to successfully return to school.

Family support and post-discharge collaboration refers to ensuring that families have ongoing support after the student's discharge. The majority of hospital staff and several school staff discussed the negative impact of on-going family-school adversarial relationships after discharge takes place. Several hospital clinicians indicated that they try to address these difficulties prior to the patient's discharge to improve opportunities for successful collaboration once the hospital staff is no longer connected to the family.

> "Sometimes the school and parents are hostile, pointing fingers at each other for the child's difficulty. I find it to be a good use of my time to help the parent and school determine this difficulty."

Additionally, there will be times when the school mental health clinician's attempt to protect the self-advocacy or self-determination of their student conflicts with parent wishes, this barrier can have at a tremendous impact on the student's decision to return to school and return to optimal functioning.

Insurance Problems

The final domain contains all issues related to insurance and managed care limitations. All hospital staff identified time limits on hospitalization as a major barrier for the potential success of students returning to school. Often times students are hospitalized for several weeks and receive very little time to "try out" school and fully process any remaining difficulties. Hospital staff stated that students could benefit from attending school for some portion of the day with hospital milieu staff to observe how the student functions in his or her school environment. This would allow staff to make several observations of the student and process events in the hospital setting to encourage

the student to respond differently during next school interaction. One school provider noted difficulties in obtaining outpatient services for students prior to being discharged from the hospital due to insurance regulations.

This delay in service provision can result in an "unsmooth transition" that leaves the student open to "falling through the cracks" upon discharge from the hospital. Additionally, treatment allowance "is not based upon student diagnosis, but rather time limitations." Another major insurance barrier is directly related to the hospital's lack of follow-up post discharge. There are no programs in place that allow for the student to maintain contact with hospital providers as they become reintegrated to their school setting. This lack of follow-up was identified by all hospital providers as the most consistent hospital-based barrier towards successful student transition.

Summary of Barriers and Overall Findings

The barriers presented by hospital and school participants were consistent with information gathered in the questionnaire and narrative response sections of the study. For example, communication barriers between hospital and school professionals reportedly prevent them from working collaboratively, despite school professionals' need for resources and hospital staff's willingness to provide consultation. The barriers and narrative reports combined provide a wealth of information related to the research questions and will be discussed below in further detail.

Results Summary

Preparedness to Manage Student Transitions

Results from the narrative and interview section of this study are consistent with the first hypothesis, which posed that school mental health staff's preparedness to manage student transitions will increase as the availability of hospital and school resources increases. Hospital and school providers offered that school mental health providers are primarily responsible for students' successful reintegration to school. They also rated the potential success of created transitions plans based upon the availability of resources to assist the school mental health professional in implementing the plan. These resources have been identified as collaboration with hospital professionals, staff support, financial support, professional development and training, and administrative support. When these resources are in place, school mental health staff reported increased preparedness to successfully manage student transition plans.

Ideal Transition Process

Results were inconsistent with the second hypothesis that ideal transition processes would differ between hospital and school providers. Responses were similar across hospital and school participants, with each group identifying professional collaboration, availability of school mental health resources, importance of transition planning with the key stakeholders present at the discharge meeting, and family-school dynamics as important elements to consider in adolescent transitions. However, hospital staff heavily emphasized the impact of managed care on their ability to engage in effective transition planning and practices. Insurance companies fund the day treatment program and therefore heavily influence the daily practices of hospital-based staff. This unfortunately disallows staff to engage in practices that may be in an adolescent's best interest (e.g., sending the patient to school for brief exposure earlier in their

hospitalization). School providers are also faced with barriers that may not be in the best clinical interest of the student, such as the inability of a school mental health provider in a public school to have twice daily check-ins with a student returning from psychiatric hospitalization.

Fidelity and Transition Plan Success

Finally, the third hypothesis posed that school mental health staff's perceived levels of structural and process fidelity will have an impact on their confidence in successfully implementing the transition plan. Results are consistent with this hypothesis, as evidenced by participant reports in their narratives and interviews. Participants revealed two levels of transition planning: 1) ensuring that a transition plan has the appropriate elements and involves the correct stakeholders during plan creation, and 2) ensuring that the plan can actually be implemented with fidelity and with support from necessary resources. For example, a student returning to school who requires daily check-ins will require school administrators to ensure that another staff person is available to assist the school mental health clinician in providing appropriate check-ins, or by working with other students, so that the school clinician is more available to the transitioning student. Unfortunately, barriers in the availability of mental health staff and lack of post-discharge follow-up among hospital providers, as well as difficulties in ensuring that students and families utilize community-based resources will impact school mental health staff's confidence in their ability to successfully implement transition plans regardless of the investment and creation of a quality transition plan.

Overall results will be discussed in detail in the following section. Implications of these results for hospital and school-based collaboration in the psychiatric hospitalization to school transition process will be considered. Finally, ideas will be generated for the potential role of school psychologists in improving professional collaborations to ensure that students with transition needs are served effectively in our schools and that staff receive the necessary support to ensure that these transition plans are implemented with fidelity.

CHAPTER 4

Discussion

Discussion Overview

Briefly, the results of the present study indicate that (1) school mental health staff's perceived preparedness to manage school transitions increased as the number of available hospital, school, and community-based resources increased; (2) hospital and school based staff created ideal transition plans with similar key components and identified school mental health providers as primarily responsible for student reintegration following brief psychiatric hospitalization; and (3) school mental health staff's reported confidence in successfully implementing student transition plans, as well as hospital mental health staff's confidence that they will be implemented successfully, was based upon the presence of a well-developed plan with input from all involved stakeholders and support to ensure that the plan is implemented with fidelity. These results are consistent with the first and third hypotheses stated in the introduction and results sections, but inconsistent with the second hypothesis. In the following sections, the results will be interpreted relative to their significance, the extent to which the obtained results are similar and different from related previous work, and general implications for school mental health services. Finally, limitations of the present study will be discussed, along with directions for future research.

Significance of Study

School-based mental health professionals. As the role of school-based mental health professionals constantly evolves and expands beyond the traditional school setting, it is important that research extends to clinical and community settings, where the

greatest cross-collaborative interactions among mental health and educational professionals take place. School psychologists are in a particularly strong position to assist clinical, education, and community providers in improving the creation and implementation of transition plans as hospitalized students transfer from the hospital to school and community settings. The training that school psychologists receive in communicating with a multidisciplinary team of individuals, as well as creating and assessing the effectiveness of individual plans to improve student success, allows for better identification of barriers that may impede successful execution of transition plans once applied to real world settings. Guidance counselors and school nurses are often expected to manage a large variety of student concerns, but as the number of students with mental health concerns increases, schools must ensure that all personnel that are required to manage student mental health needs are provided with the necessary professional development that allows them to do their jobs effectively. The results of the present study have the potential to identify some of those needs and also to raise some related concerns for school administrators.

General Application

Gaining an understanding of the barriers that exist between ideal transition processes and those actually being implemented in Rhode Island and Southeastern Massachusetts schools has the potential to initiate dialogue regarding collaboration among mental health professionals in various settings. Identifying areas of agreement and points of disagreement among these professionals in terms of an ideal transition process creates opportunities for professionals to better understand how other professionals perceive their current transition activities. Further, this information could be of use to

administrators in hospital and educational settings to inform and/or streamline the transition process for the benefit of all students.

Previous Findings and Current Study

Previous Literature

This study was conducted to expand the literature on psychiatric hospitalization-to-school transitions. Prior to 2005 the literature on student reintegration following psychiatric hospitalization focused predominantly on individual factors within the adolescent that impacted his or her ability to return to school. Available literature discussing the roles of hospital, school, and community providers was more heavily emphasized for students returning to school following hospitalization for chronic illness. Although some information on best-practices for hospital-to-school transition following chronic illness can inform best practices for psychiatric hospitalization-to-school transition (e.g. Prevatt et al., 2000; Deidrick and Farmer, 2005; Kaffenberger, 2006), there are several major differences that cannot be ignored. These include the stigma surrounding mental illness and its impact on the student's embarrassment surrounding hospitalization (Corrigan et al., 2005), and limitations or loss of hospital staff contact following hospitalization (Balkin and Roland, 2007). Additionally, issues surrounding access and acceptance of community-based aftercare services (Leichtman and Lechtman, 2002; Daniel et al., 2004; Goldston et al., 2003), and questions regarding student eligibility for special-education services following psychiatric hospitalization (Simon and Savina, 2010) must also be recognized.

Recent Literature

Recent studies have asked mental health professionals to discuss barriers impacting successful student transition including academic, social, and emotional factors once an adolescent returns to the school environment (Clemens et al., 2010), practices of hospital based therapists and their roles in the psychiatric hospital-to-school transition (Simon & Savina, 2007), and the potential role of special educators in facilitating student reintegration (Simon and Savina, 2010). Additionally, a qualitative study exploring potential barriers to successful school re-entry from the perspective of inpatient, outpatient, and school mental health professionals recently was conducted as part of a larger study on adolescent perceptions of school reentry following psychiatric hospitalization (Clements et al., 2011). More than 60% of the concerns generated during this study focused upon school-based factors and school provider communication with outside resources (i.e. hospital and community based), as well as the "smoothness" of reentry. These alarming results warranted further exploration of school-based professionals' involvement in psychiatric hospital and their communication with hospital mental health professionals.

Current Study

To gain a better understanding of the transition process and associated communication among hospital and school-based providers, the current study was conceptualized and designed. Instead of surveying inpatient and outpatient providers, the focus was narrowed to specifically identify practices of providers in a hospital-based day treatment program and school-based mental health professionals. Doing so eliminated

differences among hospital providers who may have had differing experiences based on their ability to transition students to a "step-down" program prior to school reentry. Step-down programs are designed to provide patients with a less intense level of care than provided within an inpatient psychiatric admission, but still provide support beyond what is typically available in the school setting. Participants were asked to respond to the same case-vignette to uncover any differences in development of a transition plan from start to finish.

Overall Findings

Overall results were consistent with the findings from qualitative studies referenced above, but provided additional information that was garnished from the addition of the "Sarah" case-vignette. For example, in a manner similar to results found by Clemens and colleagues (2011) the present results indicated that lack of collaboration among hospital and school providers stifles effective transition planning for students. Also similar to previous work by Simon and Savina (2007), the present work indicated that hospital based staff were invested in transition planning, but had difficulty being present for the entire transition due to insurance policies that disallow follow-up after patients were discharged. Not all findings were consistent with previous research, however.

Specifically, inconsistent with expectations from the second hypothesis, there were no overall differences in the development of an *ideal* transition process among hospital and school providers (*structural fidelity)*, but systemic, environmental, and financial barriers that resulted in differences in their daily practices (*process fidelity)*,

which is consistent with the idea of "fidelity of implementation gap." School and hospital providers identified similar key components to a successful transition plan (e.g., having all stakeholders present at the transition meeting, professional collaboration throughout the hospitalization process, developing and maintaining a supportive relationship with families), but each group reported barriers that prevented these elements from being present on a regular basis in their practices. The lack of these necessary components prevents transition plans from being implemented as designed.

There were no differences found in the number and types of supports requested by school-based professionals neither in relation to their number of years in school mental health nor in relation to their experience transitioning students back to school following psychiatric hospitalization. However, school providers' ratings of transition plan effectiveness were specifically related to the number and type of available hospital and school resources (Hypothesis 1). In fact, hospital professionals' rating of transition plan success was similarly tied to the availability of resources. Specifically, both groups rated their likelihood of success in relation to the development of a transition plan would be related to the input and agreement of hospital, school, and family members. Moreover, the majority of all participants discussed the need for a school administrator with the authority to approve transition plan ideas, and a regular school presence to ensure follow through of the developed plan, to be present at the discharge meeting (Hypothesis 3). These findings are especially important given that 86% of all participants identified school mental health professionals as the main individuals responsible for implementing the developed transition plan in the "Sarah" vignette, which was inconsistent with the second hypothesis.

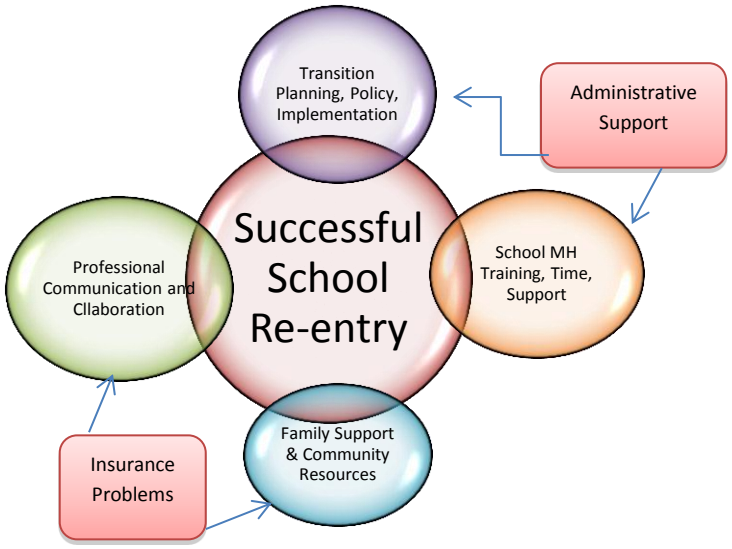
Importance of Findings

All mental health professionals have one goal in mind, which is to assist their patients and clients in developing and maintaining their emotional and physical well-being. However, to ensure that a smooth transition occurs when adolescents are transitioning from hospital to school environments, hospital and school providers must be united in terms of their collaboration from the beginning of hospitalization through the student's reintegration into the school environment, professional collegiality, and assisting the adolescent and their family to feel prepared to manage the school transition once he or she is discharged. According to the findings of the present student, successful school reentry following psychiatric hospitalization is dependent upon the following structural and process factors (Figure 4): a) effective and consistent communication and collaboration among all stakeholders (*process)*, b) when school mental health professionals have the training, time, and administrative support necessary to complete the demands of their job (*structural* and *process*), c) when schools and hospital providers become educated about services provided by each location (*process*), d) when transition planning and policy becomes an important initiative in hospital and school programs (*structural* and *process*), e) when insurance provides *flexible* benefits for adolescents with delicate mental health needs during hospitalization and upon discharge (*structural* and *process*), and f) when families are provided with community-based supports to manage on-going care (*structural)* that cannot or should not be provided in the school setting (i.e. trauma therapy, substance abuse management, therapeutic mentoring).

These factors are depicted in Figure 4, which is arranged as a series of interlocking Venn diagrams. The figure has been arranged to depict the four most

important elements to successful school transition as described by participants in the present study, as well as from the findings of previous research (i.e. Clemens et al., 2011; Simon & Savina, 2007). Administrative support and insurance problems are placed outside of the Venn diagrams, as they are very important to the transition, but are outside of the direct control of school and hospital based providers.

Figure 4: Visual Representation of Factors Related to Successful School Re-entry



Effective Communication

Stern (2006) defines the concept of *interprofessional professionalism* as "consistent demonstration of core values evidenced by professionals working together, aspiring to and wisely applying principles of, altruism and caring, excellence, ethics, respect, communication, accountability to achieve optimal health, and wellness in individuals and communities." This concept is significantly related effective collaboration among hospital and school-based providers regarding hospital-to-school

transition planning. Communication is most effective when involved individuals feel that they will receive mutual respect regarding their credentials and competence in their respective professional fields. Additionally, involved individuals must take time to understand the nature of each person's work setting, or be willing to learn more information about what services are being provided and those that are available or cannot be provided in a given setting (respect and accountability). Taking the time to learn what services are provided in the hospital setting as well as a student/patient's school setting, as well as the appropriate individuals to contact at each setting at the beginning of hospitalization can save valuable time when stakeholders are preparing to create a transition plan (Simon & Savina, 2010; Clemens et al., 2011). Failure to do so may lead to increased frustration among all stakeholders and perpetuate stereotypes that hospital and school providers are not invested in the transition process, when in reality, there are structural fidelity barriers, mainly time allocation and administrative support, which negatively impact effective collaboration.

School Mental Health Resources

Although interprofessional professionalism is an important element of successful transition planning, sufficient school mental health resources must exist to implement the plan. In a follow-up article from the 2002 Futures in School Psychology Conference, Dawson and colleagues (2003) summarized some of the immediate changes that needed to take place in the field of school psychology based on the alarming trend of dropout and underachievement occurring in schools across the United States. Two of the identified themes were a call for action based and qualitative research to complement quantitative research, in order to discover presenting issues in our schools; and the second was an

emphasis on home-school-community collaboration as a manner to identify and remediate academic and behavioral concerns. It would be impossible to manage these tasks without the expertise of support professionals, which include school psychologists, social workers, school adjustment counselors and guidance counselors. However, our nation's schools continue to lack a sufficient number of mental health professionals to service student mental health needs (Center for Mental Health in Schools, UCLA, 2013). This problem is only exacerbated when students returning to school following psychiatric hospitalization require a high level of follow-up and mental health professionals are identified as the central people responsible for their successful reintegration.

Every member of a student's academic team, family members, and community providers will be needed to fully achieve the goals suggested in the 2002 Futures Conference. The movement from a medical-model to a public-health model in schools has created opportunities for other school professionals to become involved in students' overall well-being. The medical model focused on the individual student and his or her "pathology", rather than focusing on the system at large that may be creating or maintaining the student's difficulty. In contrast, a public health framework pushes educators to focus on the *whole* student and how factors such as poverty, physical illness, and family stress can result in poor academic outcomes (Gutkin, 2012), additional factors can be noted in Appendix IV-A. Shifting from a traditional medical model to a public health framework requires all school professionals to consider the environment in which their students are learning and being asked to demonstrate ability, home and school, when evaluating their needs. This model emphasizes greater levels of intervention by school

professionals such as special educators (Simon & Savina, 2010) and nurses (Center for School Mental Health, 2013).

Although not all students returning from psychiatric hospitalization will qualify for special education services, many will have contact with the school nurse (Center for Mental Health in Schools, UCLA, 2013). In fact, the Center for School Mental Health (CSMH) at UCLA has created a series of trainings for school professionals, including nurses, to have a clearer understanding of their specific roles in managing student mental health needs. The full curriculum for nurses is available on the CSMH website and an outline of the proposed model can be found in Appendix IV-B and C. This center and an additional one at the University of Maryland were formed in 1995 by the Health Resources and Services Administration, Bureau of Maternal and Child Health, Office of Adolescent Health out of government recognition that mental health care should indeed be provided, in some part, by our nation's schools.

Ensuring that school mental health professionals are able to successfully implement student transition plans requires a number of resources, some of which go beyond the local school district. Identifying the need for additional school mental health resources, establishing a literature base for the need, and securing funding are only part of the issue. The following project is an example of national support to improve and increase the number of mental health resources available to our nation's adolescents, which can have a significant impact on the ability of school-based mental health professionals to implement hospital-to-school transition plans with fidelity.

In 2013, President Obama created the "Now Is the Time (NITTS)" project to reduce gun violence in our nation's schools. The government funded project will result in $150 million towards the hiring of 1,000 additional school-based mental health professionals and school resource officers. Additional funding is being provided to provide "mental health first-aid" training for teachers and school professionals, to increase mental health care access for 750,000 students, with an emphasis on students aged 16 to 24, and to train an additional 5,000 mental health professionals on working with adolescents and young adults. Despite this tremendous governmental backing, students will not receive the full benefit of these services without a specific plan to ensure that all students receive necessary mental health care commensurate to their individual needs. The CSMH at UCLA and School Mental Health Project at University of Maryland are actively working on initiatives to streamline these processes. An example of school-wide assessment and provision of services with varying levels of mental health needs can be viewed in Appendix IV-D. These school services cannot be maximally effective without support from home and community-based resources (Appendix IV-E). These last two examples provide specific information that can be useful when school systems are trying to provide services for students returning to school following psychiatric hospitalization.

Transition Planning and Policy

Although only four participants explicitly stated the need for actual "transition plan policies" at schools and hospitals, all of them discussed concerns related to individuals in attendance at transition meetings and fears related to the fidelity of plan implementation once it was created. In previous studies (Clemens et al., 2011; Simon & Savina, 2007) the emphasis of re-entry planning focused upon the student's self-advocacy

and self-determination, rather than on professionals' collaboration to ensure a successful plan was created or the school district's ability to implement the plan with fidelity. One hospital participant identified lack of hospital policy on setting up and attending school meetings as a primary reason for extensive differences in practices among hospital providers. Similarly, several school providers identified the existence of specific policies and processes for reintegration of students returning from hospitalization as the primary reason for high degrees of contact with hospital providers during student hospitalization, the receipt of discharge materials, and hospital provider attendance at school-based transition meetings. Conversely, several school interviewees listed their lack of transition policy as being partially responsible for inconsistent contact with hospital providers, lack of discharge summaries, and sometimes never being informed of a student's hospitalization.

Clemens and colleagues (2011) discussed the implementation of a "reentry coordinator" to assist in creating more effective hospital-to-school transitions, as this person would be the primary school-based contact for parents and students during the hospitalization and reentry process. They further stipulate that this person should not be the primary person responsible for implementing the transition plan, but should coordinate with hospital and community-based stakeholders to ensure all stakeholders' expertise is incorporated into a student's transition plan. Many participants in this study identified the need for a central person to manage "Sarah's" needs during the transition process, but also discussed the lack of school administrators or multidisciplinary team coordinators' frequent absence at discharge meetings as a frequent barrier to successful transition planning. Additionally, these individuals are often unavailable to ensure plans

are implemented with fidelity and that families are utilizing after-care services as suggested by hospital providers, which is a known barrier in the transition literature (Daniel et al., 2004).

Furthermore, it is often difficult to identify a "key" person responsible for student transition, as schools are faced with the dilemma of appointing the individual who knows the student best or the person who is responsible for student well-being as the primary person responsible for a student's reintegration. Some students returning from psychiatric hospitalization were not previously eligible for special education services or a 504 plan, nor were they on the "radar" for service provision from school mental health providers or the school nurse. When the precipitating factors for hospitalization were related to home or community-based environmental factors, schools may not receive information until after the hospitalization has taken place. Thus, the idea of a reentry coordinator (Clemens et al, 2011) or utilizing a special educator (Simon & Savina, 2010) will not always be possible. In these cases, effective transition planning and fidelity of implementation are even more crucial because the school will have less time to learn important information about the student related to their mental health needs. The initial plan may require updates to meet the need of the student within the crucial time period for successful student reintegration. Similarly, a student reintegration policy would allow school and hospital collaboration, as well as introduce the family to available services in the school and provide them with information about community-based resources that they may have otherwise not known.

The Influence of Managed Health Care on Transitions

Although the Affordable Care Act and Massachusetts' Community Behavioral Health Initiatives mandate that all children and adolescents have access to mental health benefits, these benefits vary in duration and quality. As stated by all hospital-based providers in this study, limits in the number of half-days patients have at the hospital setting, whereby they attend their schools for a portion of the day and then return to the hospital setting to process their concerns in returning to the school environment, make successful transition more difficult. Patients arrive to hospital day-programs for a number of reasons, some of which are accompanied by lengthy school refusal or families that have allowed students to be absent for long period of time due to their mental health difficulties. These students simply cannot be expected to "warm up" to a school environment that they have not attended for a long time, or when they are being transferred to different schools to accommodate their needs.

Similarly, insurance does not pay hospital programs for "after-care" that would allow hospital providers to remain involved in their patients' lives during a transitional period whereby the adolescent and their families can work with hospital providers on problems that were identified during the hospitalization. If is often very upsetting for families to have to explain what occurred during hospitalization to outpatient providers, especially if these providers were not previously involved in the adolescent's life. Furthermore, many community-based agencies are not allowed to begin service provision while a higher level of care is still involved (National Wraparound Initiative, 2013). This break in service provision was reported by hospital and school participants as a major barrier to successful and smooth hospital-to-school transitions, especially when the primary reason for hospitalization was triggered by home or community-based factors.

Limitations of the Current Study

This study provided an exploration of the perspectives of hospital-based and school-based mental health clinicians on the hospital-to-school transition process involving adolescents hospitalized with mental health problems. The results presented in this study do not represent an exhaustive list of the numerous barriers facing today's mental health clinicians in their work settings. The hospital staff that agreed to participate in this study all worked in the same setting, which may have resulted in a more narrow focus of barriers related to their specific work setting. It is possible that these participants had specific barriers that they felt were necessary to share to improve transition methods within their work setting. A more heterogeneous sample may have uncovered additional barriers that are not present in the current participants' work setting, or may have identified similar barriers, which would suggest that the same hospital-based barriers exist across settings.

Due to challenges in obtaining school-based mental health staff, the number and variety of school based participants was smaller than initially intended. The low number of participants resulted in a lack of power that may have been able to detect differences related to the first hypothesis. Therefore, this study may not be an accurate representation of the true state of affairs regarding hospital-to-school transitions. Additionally, this study may not fully represent some of the needs being requested by certain school-based professionals, including guidance counselors and school nurses, who are the professionals most likely to be negatively impacted by an underdeveloped collaborative with hospital staff due to their expanding roles in the school setting. The lack of guidance counselors and school nurses may have resulted in an understatement of barriers existing in middle

and high schools related each of the domains identified in the present study. Additionally, they may have identified different components of an ideal transition plan, which would provide more information about potential differences among school-based providers in transition planning.

This study is also limited in that it does not address a professional's preparation in graduate school to manage adolescent psychiatric crises, nor does it provide information about staff members who may work in dual settings (i.e. private practice or community mental health centers), which may impact an individual's exposure or level of expertise in managing post-psychiatric hospitalization transitions, and not necessarily reflect the level of support that a staff member receives from his or her school administration. Any levels of training or exposure (coursework or applied experiences) can significant impact the nature of resources requested or needed by school-based mental health providers. It is important to include information about the helpful experiences that school-based providers have had related to the hospital-to-school transition to inform researchers and consumers of available resources that can improve overall practice. Additionally, some school districts may not be adequately represented due to a lack of e-mail addresses available on the district's website. Participants were recruited based upon school-district websites, and some sites did not identify or provide contact information for their mental health providers.

In terms of school-based interviews, several of the school staff work in the same school, which may have resulted in similar opinions regarding building-level barriers. Finally, some individuals were uncomfortable with having their voices recorded, and therefore all semi-structured interviews were recorded by hand. The tone and inflection

that convey messages when recorded in audio-format were unavailable for analysis. In summary then, the present work is limited in several ways, including limited samples of participants, homogeneity within samples, and a potential underrepresentation of the existing barriers facing the most vulnerable school-based mental health providers.

Directions for Future Research

This study has contributed to the qualitative literature on hospital-to-school transitions and has identified specific constructs contributing to the "fidelity of implementation gap" from the perspective of hospital and school professionals who are directly involved in the development of transition plans. Directions for future research include quantitative investigations of the degree to which these individual factors affect stakeholder collaboration, as well as the development of transition plans, and finally the fidelity of plan implementation after adolescents are discharged from the hospital and reintegrated in their school districts. For example, quantitative investigations on stakeholder collaboration might utilize the "interprofessional professionalism" concept (Stern, 2006) and survey how communication, respect, altruism and caring, excellence, ethics, and accountability individually impact the nature and quality of collaboration among hospital and school-based mental health providers. The Interpersonal Professionalism Collaborative (IPC) has been created to create an assessment instrument to measure these behaviors, and should be considered as a valuable resource when studying stakeholder collaboration.

Additionally, research that specifically focuses on the development of hospital-to-school transition plans should be conducted utilizing a mixed-methods approach. The potential contributions include: 1) how to approach the development of the plan, 2) how

to ensure that all stakeholders are involved in the plan, and 3) how to ensure that the plan is reviewed on a regular basis with input from school, family, and community stakeholders. The design of specific plans for student re-integration utilizing the public-health framework warrant attention, as current plans identify service provision for students with different levels of mental health needs, but do they do not specify the manner in which students enter, leave, or move among the tiers of service provision.

Conclusion

Reintegrating students into school following psychiatric hospitalization is a process that can be overwhelming for students, families, and school mental health providers alike. Despite this difficulty, there are several factors that can facilitate the transition for all stakeholders, with adolescents receiving the greatest potential for successful reintegration. Consistent with previous literature, the results of this study indicated that stakeholder communication and collaboration throughout the hospitalization and reintegration process, developing and implementing a transition plan with input from all stakeholders, and referral for and utilization of aftercare services following hospitalization are all imperative for successful student reintegration. Additionally, improving mental health benefits and making them more flexible to meet the delicate mental health needs of adolescents experiencing brief psychiatric hospitalization will allow hospital-based providers to complete their jobs more effectively and allow for a better continuum of care where hospital providers are able to consult with families until their adolescents are successfully reintegrated into the school setting. Finally, providing school mental health providers with the necessary administrative and teacher support, as well as opportunities for professional development in necessary areas

of mental health will ensure that school-based professionals are able to manage their multiple responsibilities, delegate when necessary, and provide students with the best school-based mental health care possible.

Appendix I-A

Review of Literature

Adolescents with Mental Health Needs

An estimated 20% of adolescents ages 13-18 experience symptoms related to a diagnosable mental health disorder in any given year (U.S. Department of Health and Human Services, National Institute of Mental Health, Revised 2009), with nearly 10% of children and adolescents suffering from serious emotional and mental disorders that cause significant functional impairment in their day-to-day lives at home, in school and with peers according to the US Surgeon General (The National Alliance of Mental Illness, 2013). Adolescence is the developmental period during which children are most likely to develop and experience mental health problems for the first time (Giedd, Keshavan, & Paus, 2008). The Centers for Disease Control published a report on children and adolescent mental health from 2005-2011 and found that rates of mental health difficulties increased with age. In fact, half of all lifetime cases of mental illness begin by age 14 (Kessler et al., 2005). In addition to continued brain maturation during this period, the number of social and academic demands that take place during adolescence often result in a level of stress never before experienced (Giedd, Keshavan, & Paus, 2008). For students with an increased vulnerability to depression, anxiety, and/or eating disorders, there is an increased likelihood of experiencing problems during this period that may require some level of clinical intervention. One important context for monitoring for adolescents experiencing mental health problems is our nation's schools, where nearly universal contact with adolescents is feasible. In recent years, this type of universal monitoring is often within the purview of school psychologists, who

increasingly are called on to screen for a variety of problems commonly experienced by children and adolescents (Greenwood & Kim, 2012; Doll, Spies, & Champion, 2012).

The body of literature on child and adolescent mental health needs has grown substantially within the past ten years. A short list of researched topics have included the impact of mental illness on physical and cognitive development, the long-term impact of unmet mental health needs as someone approaches adulthood, the importance of reducing stigma related to mental illness in our overall communities, combining the efforts of community agencies and schools to screen for mental health needs and to protect identified children outside of school hours, and improving access to mental health services for underrepresented and marginalized communities. Although these studies have identified and proposed solutions for a large number of issues plaguing today's youth and challenging even the most seasoned mental health professionals, the implementation aspect of evidence based treatments and services continue to have numerous loopholes that prevent children and adolescents from gaining appropriate access to services or maintaining gains that have been achieved during treatment. Furthermore, these studies have not been able to address the potential hurdles faced by statewide mandates of mental healthcare provision, where definitions of coverage and available benefits vary by state (National Conference of State Legislatures, 2014).

Adolescence and Psychiatric Hospitalization

The number of adolescents involved in psychiatric hospitalization on a yearly basis is nearly 1000 per 100,000, an increase of almost 300 per year since the mid-1990s (Blader, 2011). Although over a quarter million students are involved in short-term

psychiatric hospitalizations each year where they receive mental health treatment, many are transitioned back into a traditional school setting (Simon & Savina, 2010). Psychiatric hospitalizations make up 7% of all pediatric and adolescent hospitalizations, and approximately 2.5% of adolescents were treated through inpatient psychiatric hospitalizations in 2008 (Substance Abuse and Mental Health Services Administration, 2009). The current average duration of psychiatric hospitalizations is 5-7 days (Balkin & Roland, 2007). This relatively short duration of hospitalization is significantly lower than in the 1980s and 1990s, at which time psychiatric hospitalizations lasted from 11-44 days (National Association of Psychiatric Health Systems, 1987, 2002). In fact, Blader (2011) reviewed psychiatric hospitalization data from 1996 to 2007 and found that the number of hospitalization days approved by private insurance companies for teenagers had declined substantially (going from 52% to 22%). The prevalence and relatively short duration of psychiatric hospitalizations point to the need to involve schools in the planning of follow-up treatment upon discharge.

Reviews of the available literature suggest a need to emphasize adolescents' utilization of aftercare services post-psychiatric hospitalization such as counseling, medication management services, factors leading to discontinuation of care, and recidivism (Clemens et al., 2010, 2011; Simon and Savina, 2007, 2010). Equally researched are transition needs and concerns for students returning to school following hospitalization for physical conditions and diseases such as cancer, HIV, diabetes, and asthma (Shaw & McCabe, 2008). Unfortunately, Simon and Savina (2007; 2010) reviewed the available literature on the hospital-to-school transition post psychiatric hospitalization and found a limited number of dated articles from the 1960s and 1980s

emphasizing the importance of this transition. Additionally the existing body of research is more limited and narrow in scope. While the heavily researched physical conditions are important for school aged children and adolescents, the potentially devastating outcomes resulting from one or more psychiatric hospitalizations during adolescence are equally deserving of careful professional attention and research.

In 2004, Best and colleagues researched early adulthood outcomes for adolescents with prior psychiatric hospitalizations. In an 11 and 20 year post-hospitalization follow-up, they found that adolescents aged 12-15 that met criteria for psychiatric hospitalization were significantly: less likely to complete high school, attend college and graduate school; more likely to experience significant emotional distress, and more prone to mortality at an early age when compared to same age peers without these psychiatric symptoms (Best, Hauser, Gralinkski-Bakker, Allen, & Crowell, 2004). It is important to note that youth included in the aforementioned study were given state-of-the-art psychiatric treatment, which was defined by the American Medical Association as: treatment at a university teaching hospital, psychoeducational testing, family therapy, and extensive discharge planning. Therefore, the unfortunate outcomes experienced by these adolescents were significant despite appropriate and comprehensive treatment.

Hospital to School Transition

Shaw and McCabe (2008) discussed the difficulties of navigating the hospital-to-school transition for children with chronic illnesses throughout an evolving healthcare system and made the following statement in their literature review.

> "There is a significant body of literature describing and evaluating hospital-to-school transition programs [for children with chronic illnesses]. Most programs prepare the child with chronic illness, family, peers, and school personnel for transition back to a school environment after an extended hospital stay… [using] a prototypical three-phase model, wherein phase one involves initiation of community supports, arranging hospital and homebound instruction, and educating peers; phase two involves hospital-school communication, development of an instructional support plan, preparing for absences, and anticipating psychosocial adjustment issues; and phase three involves hospital-school-family follow-up communications. Such a model is effective for facilitating the transition to school for students with chronic illness" (p. 77).

Unfortunately, in an effort to reduce medical costs, there has been an evolution in healthcare to provide the majority of treatment through outpatient services. This is the case for chronic illness as well as mental health conditions. The body of literature defining best practices within the current health system for hospital to school transition for students with chronic illnesses is well developed. Although the body of literature for hospital-to-school transition for adolescents experiencing psychiatric illnesses is less developed, much can be garnered from chronic illness literature regarding best practices through understanding the necessary elements of the transition process. Although many teenagers with psychiatric illnesses may receive inpatient treatment followed by an outpatient program prior to returning to school, there are also a large number of teens that do not meet the criteria for inpatient admissions, and participate in psychiatric day treatment only. Psychiatric day treatment programs provide a significant level of support

during weekday hours, but offer less supervision than 24/7 inpatient settings, and are also relatively brief in duration, averaging only 2-4 weeks of treatment. For these individuals, hospital professionals are challenged with achieving psychiatric stabilization in addition to assisting their patients in managing their home lives, and establishing effective coping mechanisms and functional strategies for successful reintegration into their school settings.

Simon and Savina reference several resources from the 1990s supporting the necessity of quality communication between hospital and school professionals during students' transition from one setting to another. However, this can be difficult for a number of reasons, most notably due to family requests for privacy. In their 2007 and 2010 studies, Simon and Savina, as well as Clemens and colleagues (2010, 2011) substantially contributed to the literature on the perspectives of school professionals in the hospital-to-school transition including mental health therapists working in dual settings (hospital and school), and special educators. These authors describe in detail the manner in which mental health counselors and special educators can be utilized in the transition process to promote improved achievement for previously hospitalized students. While this information is very important and helpful regarding students currently receiving special education services, it is less applicable to students that were previously ineligible for special education and those currently not supported by individual education plans (IEPs) or section 504 services, because these students often have little to no relationship with mental health counselors, and do not have regular access to special educators.

Current State of Mental Health Services in Schools

The discussion of school-based mental health care has been controversial for quite a bit of time, with differing opinions on whether traditional mental health services should be provided during school hours, by school based professionals. There are many justifications for providing mental health services in schools, which can be summed up by the following statement: "...mental health is inexorably linked with general health, child care, and success in the classroom and inversely related to involvement in the juvenile justice system" (US DHHS, 1999). Additionally, students may experience mental health problems for a variety of reasons, including biological predisposition, academic and social difficulties in the school environment, home and community stressors, or a combination of these factors. It is estimated that nearly 70% of youth and adolescents with diagnosable mental health disorders are untreated (Gutkin, 2012). For nearly half of the children with serious emotional disturbances who do receive mental health services, the school system has been the sole provider (Feinberg & Cash, 2009). Additionally, in their presentation entitled *School Mental Health: From Understanding to Action,* Feinberg and Cash (2009) summarized the literature on reasons to provide mental health services in schools through three brief statements:

1) Schools are the optimal place to develop psychological competence and to teach children about making informed and appropriate choices concerning their health and many other aspects of their lives because schools are the only organization in our society to which virtually all children and adolescents are consistently exposed for extended periods of time. Schools are vital and central community institutions.
2) As multidisciplinary entities, schools are the best places to integrate and to coordinate the efforts of teachers, families, mental health service providers, and administrators to foster the mental health of students.
3) Accessible, affordable mental health services are most easily and consistently provided in the educational setting. Problems of transportation, accessibility, and stigma are minimized when such services are provided in schools.

There is a strong literature base supporting the use of an ecological perspective to creating the greatest potential for student success, which includes providing access to school-based mental health services for all students. Doll and colleagues (2012) explain that there are three ecological principles toward student success: multiple tiers of influence, holistic perspectives of the person, and transactional influences across systems. However, the process involved in implementing these principles remains an on-going challenge for school systems nationwide. Systematic changes must be proposed prior to addressing the individual components necessary to achieve the three ecological principles mentioned above. The following sections will provide a brief discussion of two of the barriers and challenges faced in implementing school-based mental health services.

Education as the primary mission. Many opponents of school-based mental health services do not deny the fact that students are facing an ever-increasing number of barriers to academic success, including factors that cannot be controlled within the school environment. The debate focuses on the following question "what is the primary mission of schools?" The answer to that question is undeniably education. However, the manner in which education is defined and structured varies among school professionals and administrators. Teachers and support staff are under a tremendous amount of pressure to conform to standards and curricula that are often times measured through high-stakes testing, whose scores are used an overall representation of teacher and student success. This model leaves teachers with very little time to be concerned with individual student mental health needs, even if they are negatively impacting the student in the classroom. Additionally, mental health staff is often hired to complete specific tasks (i.e. mandated

IEP services, educational/psychological testing) for a large number of students relative to the amount of time that they are available during the school day.

Current provision of mental health services. School-based mental health professionals are viewed as supplementary providers (Adelman & Taylor, 2003), who are not fundamental for the success of all students. Therefore, providers are often splitting their time among several settings and to provide pre-designated assignments. This set-up does not leave any time for providers to engage in activities, such as program development, ongoing teacher consultation, and teaching social-emotional curricula that would benefit students and employees alike. The lack of school-wide prevention and screening initiatives, as well as lack of integration into the educational curriculum allows for students with emerging or established mental health needs to go undetected until a potentially dangerous situation, such as self-harm or hospitalization occurs. To be more effective, "preventative" rather than "reactionary" mental health interventions need to be devised and implemented on an on-going basis (Shinn & Walker, 2010). To address the definition of "education" and resolve the manner in which services are provided, legislative as well as district based changes are necessary to have the greatest impact and most consistent changes.

National and Department of Education Funding

Although there is a strong body of research suggesting the necessity of school-based mental health services for students who are at-risk for developing mental health problems, as well as those requiring a substantial amount of care, a systematic process for implementing these services is necessary in order to have the greatest impact. However until recently, there were relatively few federally funded programs that are concerned

with the advancement of a systematic approach to mental health care in schools. These programs will be described briefly below. In 1995, the *Center for School Mental Health* was established with federal funding from the Health Resources and Services Administration to focus on "advancing school mental health policy, research, practice, and training at local, state, and national levels" (CSMH, 2014). In a joint initiative with the IDEA Partnership (a Community of Practice that unites stakeholders from over 50 national organizations around the issues they share), CSMH facilitates the "National Community of Practice on School Behavioral Health", launched in 2004, to address 12 specific issues related to school-based mental health practices within the system of care. Readers are directed to the initiative's website to learn about specific practices (www.sharedwork.org).

The U.S. Office of Special Education Programs is spearheading a national initiative founded by President Obama called "Now Is The Time (NITT)." It was created as a response to the numerous school shootings that have taken place, in an effort to reduce gun violence in our schools and communities. One of its four tenets includes ensuring that students and young adults receive treatment for mental health issues. As of June 2013, a proposed $25 million was allocated to "Project Prevent" to help schools address pervasive violence, allowing funding to be used on providing mental health services to students and young adults with trauma anxiety (U.S. Department of Education, 2014). Additionally, "Project AWARE (Advancing Wellness and Resilience in Education)" has been allocated $55 million to reach 750,000 young persons through mental health screenings and early referral. Major training initiatives include training all teachers in "Mental Health First Aid," as well as supporting individuals aged 16-25 at

high risk for mental illness, training 5,000 additional mental health professionals to serve students and young adults, and have launched a national conversation to increase understanding about mental health (WhiteHouse.gov, 2013). Most importantly, the NITT initiative will provide funding for up to 1,000 more school resource officers and counselors in schools, as well as allowing school districts to decide what type of support they need most (i.e. school resource officer or a mental health professional).

Although the previous two initiatives are very important steps in improving school-based mental health services and the discussion of collaboration, they do not specifically address the process by which schools begin to work collaboratively with outside providers. *Integration of Schools and Mental Health Systems* is a grant funded program that was established in 2005 by the Department of Education. The mission listed on their website states

"this program provides grants to SEAs, LEAs, and Indian tribes for the purpose of increasing student access to quality mental health care by developing innovative programs that link school systems with local mental health systems. More specifically, a funded program must include all of the following:

- Enhancing, improving, or developing collaborative efforts between school-based service systems and mental health service systems to provide, enhance, or improve prevention, diagnosis, and treatment services to students;
- Enhancing the availability of crisis intervention services, appropriate referrals for students potentially in need of mental health services, and ongoing mental health services;
- Providing training for the school personnel and mental health professionals who will participate in the program;
- Providing technical assistance and consultation to school systems and mental health agencies, and families participating in the program;
- Providing linguistically appropriate and culturally competent services;
- Evaluating the effectiveness of the program in increasing student access to quality mental health services, and making recommendations to the secretary of education about sustainability of the program" (DOE, 2011).

This project was one of the first federal attempts to assist school administrators nationwide to create an infrastructure that is designed to manage a broad array of mental health care needs within the school environment. This can be achieved through direct school-based services, collaborating with local mental health clinics to provide services either outside of school or within the school, or through the creation of school-based mental health clinics that provide a complete set of mental health services.

At its inception, the federal government noted the importance of providing a framework for school-based mental health services that is derived on a public-health, instead of a medically based model. As stated by the National Advisory Mental Health Council's Workgroup on Child and Adolescent Mental Health (2003) "The extent, severity, and far-reaching consequences of mental health problems in children and adolescents make it imperative that our nation adopt a comprehensive, systematic, public health approach to improving the mental health status of children."

Redefining the Role of School Psychologists in a Public Health Model

For many decades, school psychologists have traditionally been the only, or one of two support professionals in schools that have training in remediating the needs of students with mental health disorders and behavioral problems. By the nature of their training, school psychologists are aware of the myriad social, emotional, and psychiatric conditions that can impede a child's development not only at school, but also at home and in the community. Furthermore, their training provides them with the competence to collaborate with a number of educational and mental health professionals in order to design and develop curricula and interventions that promote social and emotional development, reduce behavioral problems, and thus increase the potential for all children and adolescents to achieve academic success. School psychologists are integral

stakeholders in the improvement of educational outcomes for students, because they understand the importance of holistic development. The intersection between social and emotional competence and academic success must be recognized and addressed within the school environment.

In a follow-up article from the 2002 Futures in School Psychology Conference, Dawson and colleagues (2003) summarized some of the immediate changes that needed to take place in the field of school psychology based on the alarming trend of dropout and underachievement occurring in schools across the United States. Identified themes included: a movement away from traditional IQ assessments to those guided by evidence based practices, which utilize data collection to make decisions; a call for *action* based and qualitative research to discover true presenting issues in our schools; and an emphasis on home-school collaboration as a manner to identify and remediate academic and behavioral concerns.

It would be impossible to manage these tasks without the expertise of support professionals, which include school psychologists, social workers, and guidance counselors. However, every member of a student's academic team, family members, and community providers are needed to fully achieve the goals suggested in the 2002 Futures Conference. The importance of developing student support teams is important for all children, but is especially important for students facing difficult transitions, such as returning from brief or long-term hospitalizations.

As the role of all mental health providers change, the model by which services are provided and from whom must also change. For example, in their roles school-based

clinicians may be expected to run social groups for children identified with behavior disorders through their individual education plans (IEP), provide individual counseling for special education students, meet with special education teachers to discuss progress for their shared students, and facilitate IEP or 504 plan meetings with parents. While these services are necessary, they do not prevent the number of students engaging in unsafe behaviors in their classrooms, decrease teacher frustration, reduce the number of office referrals, or promote success for students that haven't been identified as needing special education.

A primary initiative that would allow school psychologists to achieve their role of being interventionists and problem solvers for students is the change from utilizing a medical model in schools to utilizing a public health framework. Gutkin (2012) discusses the cons of utilizing the medical model, stating that school psychologists in their traditional roles have been asked to focus on the individual student and his or her "pathology", rather than focusing on the system at large that may be creating or maintaining the student's difficulty. In contrast, a public health framework pushes educators to focus on the *whole* student and how factors such as poverty, physical illness, and family stress can result in poor academic outcomes. Shifting from a traditional medical model to a public health framework requires all school professionals to consider the environment in which their students are learning, as well as home and school when evaluating their needs.

In their commentary on utilizing a public health framework in schools, Adelman and Taylor (2003) caution school psychologists from expecting school administrators and policymakers to be excited about the change without first explaining why it is necessary,

and how their job fits into the updated framework. They suggest that school psychologists must first engage these administrators in a conversation around what society expects schools to accomplish, acknowledging that schools are responsible for all students, not just those with problems. Achievement accountability is what drives school systems, and school psychologists must discuss the reason for which they have been hired in the first place (i.e. promoting the achievement and success of all students). Once this has been accomplished, and administrators understand that school psychologists play a fundamental role in student success, progress is more likely to be achieved (Adelman & Taylor, 2003).

The October 2012 Futures in School Psychology Conference webinar discussed the role of school psychologists as leaders in their professional environments, especially as leadership pertains to promoting evidence based initiatives that will improve the development and functioning of all students. The importance of understanding how each student interacts with his or her educational, home, and community environment and the associated impact on educational achievement has been supported by numerous articles (Doll et al., 2012; Gutkin, 2012; Reschly & Christenson, 2012). Known as an *ecological* or *systems* approach, achievement is determined by the interaction among various levels of a system including: the individual student; people or places with whom the child interacts directly on a regular basis, and subsequently how those systems interact with each other; societal factors with which the student doesn't have contact with on a daily basis, but directly impacts the student; and finally, general environmental factors that the student cannot control. Utilizing an ecological systems approach to remediate behavioral and academic problems requires the involvement of school officials, family members,

and community providers (e.g. mental health, recreational, religious). They can develop joint plans of action to address the multiple instructional, social, emotional, and behavioral needs presented by students in our schools. This shift in perspective will allow educators and school mental health staff to identify emerging problems at an early stage, thus decreasing the percentage of avoidable anxiety, sadness, and other emotions that can lead to more serious mental health problems.

School Interventions for Students with Mental Health Disorders

Unfortunately, despite mental health professionals' efforts to stabilize at-risk students in school and outpatient settings, some students will require hospitalization for medical, as well as mental health concerns. Over 50 percent of students with a mental health condition age 14 and older who are served by special education drop out−the highest dropout rate of any disability group (US Department of Education, 2006). These adolescents will need structured and organized assistance from school mental health staff and educators to successfully transition back to school following their hospitalization or illness if they are to be successful and remain in school. Successful re-entry also requires these professionals to work collaboratively with hospital clinicians, outpatient providers, and family members.

With early action and appropriate interventions, teenagers with mental health diagnoses and disabilities can successfully complete high school, benefiting from the maturation and social interactions that are commonplace among this group. For example, Sinclair, Christenson, and Thurlow (2005) researched the effectiveness of utilizing the *Check & Connect* intervention program with students experiencing mental health disabilities. *Check & Connect* bridges available school resources and engages the student,

family, school staff, and community providers to promote success in all areas of the adolescent's life by providing an individual "monitor" that follows a student's progress across settings. Sinclair and colleagues (2005) found that students with mental health disabilities who participated in the *Check & Connect* program were significantly more likely to remain in high school longer, and were more likely to have an updated Individualized Education Plan (IEP) with articulated transition goals as compared with similar peers that were not receiving the intervention. The results of this study suggest that having a central person or case manager to identify and address student strengths and needs across settings is an integral part of academic success for students with mental health disabilities. This may be especially important when adolescents are returning to school following psychiatric hospitalization.

Continuum of Care

The "continuum of care" refers to the complete range of programs and services available to improve the mental health care of children and adolescents. It includes services provided in a home, school, clinic, acute or short-term hospital unit, residential treatment setting, and long-term hospital units (Simon & Savina, 2007). For adolescents that have already received in-patient services, the continuum of care should "maintain improvements realized while the child was institutionalized and postpones, or even prevents, readmission" (Foster, 1999). Previous transition research supports the idea that the continuum is most effective when there is a seamless transition from the hospital to a less restrictive setting, as well as when there is not a significant lag in time between hospitalization and an appropriate level of aftercare (Simons, Petch, & Caplan, 2002). Aftercare should address all components of an adolescent's life, including home, school,

and community environments. The concept of "wraparound" services provided through the *systems of care* perspective is able to address many of these factors (NWI, 2014), but often takes time to implement prior to reaching maximum effectiveness. Adolescents are most vulnerable for re-hospitalization within three months of their discharge (Fontanella, 2003). Therefore, long-term student success without recidivism is incumbent upon careful planning and collaboration among providers that are most likely to be stable resources in the adolescent's life. Given the ever-changing environmental factors that impact the adolescents and families in today's society, hospital and school providers are the only guaranteed resources available. For this reason, collaboration among hospital and school providers is essential to the success of adolescents transitioning from the hospital to school setting.

Collaboration and the Transition Process

The need for outlining the transition process for students returning to school following psychiatric hospitalization has received little attention in the medical and educational literature. Previous researchers (Simon & Savina, 2007, 2010; Clemens et al., 2010, 2011) have discussed the gap between literature on transitioning students back to school who were hospitalized for chronic illness and traumatic brain injury, compared to that on individuals returning from psychiatric hospitalization. While some of this literature can inform best practices on the psychiatric hospitalization-to-school transition, such as involvement of teachers, nurses, and paraprofessionals in managing student needs, as well as on-going contact with medical professionals, there are a number of different factors for the psychiatric hospitalization-to-school transition. For example, most students with chronic illnesses return to school with a number of medical professionals who are willing to provide on-going collaboration to school providers, as

well as some have personal care attendants in the school environment. Additionally, these children are more likely to qualify for 504 or IEP services for their on-going conditions. Adolescents returning from a psychiatric hospitalization are not guaranteed to have aftercare services, nor do they always qualify for special education services.

Peacock and Collett (2010) wrote a book that describes the importance of and process by which effective home/school collaborations can be created and maintained. At this time, no formal guidelines exist on the process of creating effective hospital and school collaboration. However, Trickett and Rowe (2012) suggest some preliminary steps in their article titled *Emerging Ecological Approaches to Prevention, Health Promotion, and Public Health in the School Context: Next Steps From a Community Psychology Perspective.* They stated that ‘‘an ecological approach invites consideration of the joint impact of two or more settings or their elements. This is the requirement, whenever possible, of analyzing interactions between settings.” This statement provides credence to the necessity of hospital and school based professionals to understand how their institutions function, as well as how these functions can interact in an effective manner to produce the greatest outcomes for their clients/students. Thus, the transition process is not only one determined by individual environments functioning separately, but rather, the collaboration between the two. This collaboration can be discussed from the *fidelity of implementation* viewpoint.

Fidelity of Implementation Gap

Fidelity of implementation refers to “the degree to which an intervention is implemented as intended” and is referenced in the school literature due to a gap in implementation (O’Donnell, 2008). This gap refers to the difference between what

hospital and school mental health providers conceptualize as the "ideal" transition process, compared to what they are realistically able to practice in their settings due to barriers such as financial and staff resources, and administrative pressures on the time and activities of professionals. It is tremendously important to gain an accurate understanding of the fidelity of implementation gap in order to bridge communication among various mental health providers. This concept will be discussed in greater detail in the methodology section.

Purpose of Current Study

This study is intended to build upon Simon and Savina's (2010) research on the hospital-to-school transition post psychiatric hospitalization. Previous studies have inquired about the transition practices of hospital based therapists (Simon & Savina, 2007), assessed the knowledge of dual setting (hospital as well as school) mental health clinicians related to hospital-to-school transition (Clemens et al., 2010), as well as the role that special educators can play in successfully transitioning students back to their school environments (Simon & Savina, 2010). Information gathered from these prior studies was fundamental in establishing a set of current and relevant hospital-to-school transition research. However, many transitions take place for students who are not currently receiving special education services, and they are often being supported by a group of school support staff that may not have expertise in providing and/or coordinating services for students with psychiatric needs. For example, guidance counselors are often the initial contact provided when hospitals staff inquire about any academic or social concerns in the school setting. Other contacts may include school social workers, school psychologists, and the school nurse, but best practices for working

collaboratively and efficiently are still in the developing stages. This study will examine the transition practices of hospital and school-based mental health staff, with an emphasis on barriers to effective communication and collaboration when transitioning students from the hospital to school settings.

Appendix II-A

School mental health professional recruitment letter

THE
UNIVERSITY
OF RHODE ISLAND
COLLEGE OF
ARTS AND SCIENCES

THINK BIG WE

DEPARTMENT OF PSYCHOLOGY
Chafee Hall, 142 Flagg Road, Kingston, RI 02881 USA p: 401.874.2193 f: 401.874.2157 uri.edu/artsci/psy

REQUEST FOR PARTICIPATION IN DISSERTATION PROJECT

Jacqueline Tisdale, M.A., School Psychology Intern

October 1, 2013

Dear School Counselor,

My name is Jacqui Tisdale and I am a School Psychology doctoral student at the University of Rhode Island. I am contacting you because your school district website identifies you as a counselor or mental health clinician by profession. I am currently conducting a study that strives to create a better understanding of the communication gap between school and community providers, specifically emphasizing the needs of adolescents with mental health disabilities and problems. **I am the principal student investigator for this study at the University of Rhode Island and can be reached at jtisdale@my.uri.edu, 508-904-8918. Supervising faculty member, Dr. Gary Stoner, can be contacted at gstoner@uri.edu.**

My dissertation project is entitled "*Psychiatric hospitalization to school transitions: Examining professional perceptions regarding effectiveness and fidelity*". The project is exploratory, utilizing qualitative inquiry to compare perceptions of school and hospital based mental health staff regarding the *ideal* transition process from time of hospital entry to moment of reintegration in each adolescent's school setting.

For this study, "transition" will be defined as the process through which school and hospital mental health personnel communicate to understand concerns in the school setting prior to hospitalization, progress that is made throughout the hospitalization, and remaining concerns for the student as he or she returns to the school environment post hospitalization. It includes the initial school contact, any phone calls or meetings that take place while the client is hospitalized, and final dissemination of the discharge plan.

Participation in my study is anonymous, and data will be coded in a manner to protect confidentiality. I will be asking you to: 1) complete a questionnaire regarding current transition planning habits and demographic information, 2) read a sample case vignette and derive a written narrative identifying the ideal transition planning process for the student, and 3) verbally describe current perception of the hospital-to-school transition process for teenagers with mental health needs. Specifically, what areas of the process need to be improved, who should be responsible for these improvements, how long it will likely take before the ideal transition

process can be implemented in their school settings, and existing barriers across settings (i.e. between school, hospital, and community providers).

If you would be willing to participate in my study, I would greatly appreciate your time and would disseminate project results to you upon completion of my study. I estimate that participation in the study will require roughly 30-45 minutes of your time, and would be scheduled with me directly.

I hope to schedule interviews with individual staff members throughout October and November, at your convenience. My e-mail is jtisdale@my.uri.edu and phone number is 508-904-8918. I am happy to answer any questions that you may have about participation in my study, as well as the content of the study itself. I will be contacting you individually via e-mail to schedule appointments based upon your availability.

Thank you in advance for your time and consideration.

Sincerely,

Jacqueline Tisdale, M.A.

School Psychology Intern

Doctoral Candidate

School Psychology Program

University of Rhode Island

Appendix II-B

Hospital mental health professional recruitment letter

THE
UNIVERSITY
OF RHODE ISLAND
COLLEGE OF
ARTS AND SCIENCES

THINK BIG WE DC

DEPARTMENT OF PSYCHOLOGY
Chafee Hall, 142 Flagg Road, Kingston, RI 02881 USA p: 401.874.2193 f: 401.874.2157 uri.edu/artsci/psy

REQUEST FOR PARTICIPATION IN DISSERTATION PROJECT

Jacqueline Tisdale, M.A., School Psychology Intern

November 1, 2013

Dear APHP Staff,

It has been my great pleasure to work with all of you during the 2012-2013 school year as one of the program's first School Psychology interns. The opportunity has allowed me to hone my group therapy, consultation, and community-school collaboration skills. Additionally, I was able to learn more about the inner workings of Bradley Hospital and appreciated the opportunity to work with such a professionally diverse array of staff.

My ongoing research interests are related to understanding and bridging the communication gap between school and community providers, specifically emphasizing the needs of adolescents with mental health disabilities and problems.

My dissertation project is entitled "*Psychiatric hospitalization to school transitions: Examining professional perceptions regarding effectiveness and fidelity*". The project is exploratory, utilizing qualitative inquiry to compare perceptions of hospital and school based mental health staff regarding the *ideal* transition process from time of entry to moment of reintegration in each adolescent's school setting. **I am the principal student investigator for this study at the University of Rhode Island and can be reached at jtisdale@my.uri.edu, 508-904-8918. Supervising faculty member, Dr. Gary Stoner, can be contacted at gstoner@uri.edu.**

For this study, "transition" will be defined as the process through which hospital and school staff persons communicate to understand concerns in the school setting prior to hospitalization, progress that is made throughout the hospitalization, and remaining concerns for the student as he or she returns to the school environment post hospitalization. It includes the initial school contact, any phone calls or meetings that take place while the client is hospitalized, and final dissemination of the discharge plan.

Participation in my study is anonymous, and data will be coded in a manner to protect confidentiality. I will be asking you to: 1) complete a questionnaire regarding current transition planning habits and demographic information, 2) read a sample case vignette and derive a written narrative identifying the ideal transition planning process for the student, and 3) verbally

describe current perception of the hospital-to-school transition process for teenagers with mental health needs. Specifically, what areas of the process need to be improved, who should be responsible for these improvements, how long it will likely take before the ideal transition process can be implemented in their hospital or school settings, and existing barriers across settings (i.e. between hospital, school, and community providers).

If you would be willing to participate in my study, I would greatly appreciate your time and would disseminate project results to the APHPs upon completion of my study. I estimate that participation in the study will require roughly 30-45 minutes of your time, and would be scheduled with me directly.

I hope to schedule interviews with individual staff members throughout October and November, at your convenience. My e-mail is jtisdale@my.uri.edu and phone number is 508-904-8918. I am happy to answer any questions that you may have about participation in my study, as well as the content of the study itself. I will be contacting you individually via e-mail to schedule appointments based upon your availability.

Thank you in advance for your time and consideration.

Sincerely,

Jacqueline Tisdale, M.A.

School Psychology Intern

Doctoral Candidate

School Psychology Program

University of Rhode Island

Appendix II-C

The University of Rhode Island
Department of Psychology: School Psychology
Chafee Hall
10 Chafee Road
Kingston, RI 02881

Psychiatric hospitalization to school transitions: Examining professional perceptions regarding effectiveness and fidelity

CONSENT FORM FOR RESEARCH

You have been invited to take part in a research project described below. The researcher will explain the project to you in detail. You should feel free to ask questions. Jacqueline Tisdale is the student investigator and Professor Gary stoner, Ph.D. is the URI supervising faculty member. If you have more questions later, Jacqueline Tisdale, jtisdale@my.uri.edu, (508) 904-8918, will discuss them with you.

Description of the project:

The purpose of the study is threefold: 1) to generate knowledge on school mental health staff's preparedness and competence to implement student transition plans, 2) to identify hospital mental health professionals' perceptions of important elements of the school transition plan, and 3) to compare the perspectives of hospital and school based mental health regarding the hospital-to-school transition.

What will be done:

If you decide to take part in this study here is what will happen: Participants will complete a combination of written surveys, narrative reports, and semi-structured interviews. A questionnaire will specifically target the previous experiences of school and hospital mental health staff as they have transitioned students from the hospital to school setting. Surveys should take no longer than 2 minutes, narrative reports no longer than 25-30 minutes, and a 5 minute interview. Participants will first be asked to submit survey and narrative responses electronically, and will then have a separate interview with the researcher (who will contact you individually to discuss a convenient time via phone or in-person).

Risks or discomfort:

Potential risks for school mental health staff include potential embarrassment if you disclose that you do not feel adequately prepared to perform the transitional responsibilities of your job, and/or may have concerns for administrative reprimand if you disclose that you are not receiving the amount of internal support or professional development necessary to remain current in best practices in your field. Hospital mental health staff may feel also uncomfortable when discussing the gap between "ideal" service

provisions compared to what you are actually practicing at this time (whether due to administrative or time constraints).

Benefits of this study:
This study will require hospital and school staff to consider their strengths and weaknesses as professionals who have been or will be responsible for transitioning teenagers with emotional difficulties back to their middle and high school environments. The exercise will help you identify what you need for professional development and administrative support, to be more effective your daily work. Participants may choose to share this information with their director supervisors and have the potential to receive the support needed in individual work environments.

Confidentiality:
Your participation in this study is confidential. None of the information will identify you by name. All records collected electronically will be maintained in a password protected electronic file. All paper files will be maintained in a locked folder within the researcher's office.

Decision to quit at any time:
The decision to take part in this study is up to you. You do not have to participate. If you decide to take part in the study, you may quit at any time (including after electronic submission). If you wish to quit, simply inform Jacqueline Tisdale, jtisdale@my.uri.edu of your decision.

Rights and Complaints:
If you are not satisfied with the way this study is performed, you may discuss your complaints with Jacqueline Tisdale jtisdale@my.uri.edu, (508) 904-8918 or with Dr. Gary Stoner (401) 874-4234, gstoner@uri.edu, anonymously, if you choose. In addition, if you have questions about your rights as a research participant, you may contact the office of the Vice President for Research, 70 Lower College Road, Suite 2, University of Rhode Island, Kingston, Rhode Island, telephone: (401) 874-4328.

You have read the Consent Form. Your questions have been answered. Your signature on this form means that you understand the information and you agree to participate in this study. Please check the appropriate box below, indicating your consent to participate in this project and return the form in-person during the follow-up interview or electronically to jtisdale@my.uri.edu.

I agree ☐ do not agree ☐
to participate in this
research study

_____
Signature of Researcher

_____
Name

_____
Name

_____
Date

_____
Date

Appendix II-D

Day Program Transition Questionnaire (adapted from Simon and Savina, 2007)

Responses to the following questions will improve professionals' understanding of the practices initiated by hospital-based mental health service providers when adolescents (ages 12-18 years) transition from psychiatric day-program placements to their regular school. Since data from this study will only be described as a group, please answer the questions as honestly as possible.

1. When you transition a child from the hospital to his/her regular school, which of the following do you usually do? (Check all that apply)
_____ Mail/fax discharge summary to parent/caregiver
_____ Mail/fax discharge summary to school personnel
_____ Phone call to school to notify that child is returning
_____ Consult with parent/caregiver on phone prior to child's discharge
_____ Consult with parent/caregiver on phone after child's discharge
_____ Consult with school personnel on phone prior to child's discharge
_____ Consult with school personnel on phone after child's discharge
_____ Meet face-to-face with parent/caregiver before child's discharge
_____ Meet face-to-face with parent/caregiver after child's discharge
_____ Meet face-to-face with school personnel before child's discharge
_____ Meet face-to-face with school personnel after child's discharge
_____ Other _____

2. In general, how receptive are parents/caregivers to your methods of communication reported in Item #1? Circle one number.

1	2	3	4	5	6	7	8	9	10
Not receptive		*Somewhat receptive*			*Adequately receptive*			*Very receptive*	

3. In general, how receptive are school personnel to your methods of communication reported in Item #1? Circle one number.

1	2	3	4	5	6	7	8	9	10
Not Receptive		*Somewhat receptive*			*Adequately receptive*			*Very receptive*	

4. How do you typically monitor the child's mental health condition after discharge? Check all that apply and provide time frame for each that you check.
_____ Contact child ___ days/___weeks after discharge.
_____ Contact parent/caregiver ___ days/___weeks after discharge.
_____ Contact school personnel ___ days/___weeks after discharge
_____Other _____

5. If you provide consultation to parent/caregiver or school personnel

prior to a child's discharge, what are the consultations typically focused on?
_____Behaviors related to child's disorder
_____ Academic performance related to child's disorder
_____ Interpersonal relationships of child with parent/caregiver
_____ Interpersonal relationships of child with school personnel
_____ Interpersonal relationships of child with peers
_____ Other _____

6. Based on your clinical experiences, what kinds of concerns or fears do children typically exhibit just before they return to their regular school? Check all that apply.
_____ Academic performance
_____ Peer relationships
_____ Relationships with parent/caregiver
_____ Relationships with school personnel
_____ Personal coping skills
_____ Other _____

7. Based on your clinical experiences, what kinds of behavior problems do children usually experience after they have returned to their regular school? (Check all that apply)
_____ Withdrawn behavior
_____ Off-task behavior
_____ Aggression
_____ Disruptive behavior
_____ Rule breaking behavior
_____ Anxiety
_____ Inattention
_____ Argumentativeness
_____ Manipulative behavior
_____Other _____

8. Rate your satisfaction with transition planning in your facility. (Circle one number)

1	2	3	4	5	6	7	8	9	10
Not Satisfied			*Somewhat satisfied*			*Adequately satisfied*			*Very satisfied*

Please provide the following demographic information
1. How long have you worked as a mental health service provider?
_____ 1-3 years _____ 4-7 years _____ 8-11 years _____ 12+ years

2. What is your area of training?
_____ Psychiatry
_____ Clinical psychology
_____Counseling psychology
_____School psychology
_____ Nursing
_____ Social work
_____Other _____

3. What is the average number of children your facility serves in each Capacity (monthly)?

_____ Acute or short-term treatment (3 days to 2 weeks)
_____Residential or long-term treatment (More than 2 weeks)

4. What is the approximate percentage of children served by your facility who are re-hospitalized after they were discharged?

_____Initial stay: Acute or short-term treatment (3 days to 2 weeks)
_____Initial stay: Residential or long-term treatment (More than 2 weeks)

5. What are the approximate percentages of children served by your facility in each of the following ethnic categories?

_____African American	_____Asian American/Pacific Islander
_____Caucasian	_____ Latino/Latina
_____Native American	_____ Other

Thank you for your participation in this research study!

Appendix II-E

Hospital to School Transitions: School Mental Health Staff Questionnaire (adapted from Simon and Savina, 2010, *Hospital to school transitions: Special education teacher survey)*

1. How many years have you been practicing your current profession?

____ 1–3 years ____ 4–7 years ____ 8–11 years ____ 12 / more years

What is your title? _____

2. Have you had any experience(s) with a student who has returned to school after being discharged from a hospital where he/she received mental health services?

____ Yes. With how many such children have you worked? _____ (**Please continue.)**

____ No. **Stop here**. Thank you for your help! Please return this survey via e-mail to jtisdale@my.uri.edu

3. For any such children with whom you have worked, did you have any contact with hospital personnel before the child returned to school?

____ Yes. With how many children have you experienced such contact? _____

____ No

4. For any such children with whom you have worked, did you have any contact with hospital personnel after the child returned to school?

____ Yes. With how many children have you experienced such contact? _____

____ No

5. For any such children with whom you have worked, did you have any contact with the child's parents before he/she returned to school?

____ Yes. With how many children have you experienced such contact? _____

____ No

6. For any such children with whom you have worked, did you have any contact with the child's parents after he/she returned to school?

____ Yes. With how many children have you experienced such contact? _____

____ No

7. Based on your experience, what is the crucial time to help a child

become reestablished in school after a hospitalization? (Check only one)

____ First – third day ____ First week ____ First two weeks ____First month

8. Did the child/ren have any behavioral problems for which he/she was referred to your office upon his/her return?

____ Yes ____ No

9. If you answered "Yes" to Item #8, please check type(s) of behavioral problems present

____ Withdrawn behavior ____ Anxiety

____ Off-task behavior ____ Inattention

____ Aggression ____ Argumentative behavior

____ Disruptive behavior ____ Manipulative behavior

____ Rule breaking behavior

____ Other: _____

10. Please check what particular knowledge, skills or resources might assist you in managing a child who has recently been discharged from a hospital setting.

____ Information about his/her disorder

____ Discharge Summary from hospital

____ Behavioral management skills

____ Consultation with other school personnel

____ Consultation with parents

____ Consultation with hospital personnel

____ Other: _____

Thank you for your participation in this research study!

Appendix II-F

"Sarah" Vignette

Sarah is a 16 year old sophomore at a local high school. She has attended her local schools since the 6th grade, when her family relocated to the area from the Midwest. Sarah has a history of anxiety, for which she has been working with an outpatient therapist for the last 6 months, as well as depression that began within the last two months. Her depression began following the death of her uncle, with whom she had a strong relationship. Sarah's hospitalization resulted from an attempted suicide, whereby she took 10 Benadryl in an effort to "make the pain disappear". Her parents are also concerned, because her mother has recently discovered numerous cuts on Sarah's legs, which Sarah minimizes and describes as "accidental scrapes from shaving". Her academics began to suffer prior to her uncle's sickness, and continued to decline following his death.

Sarah's anxiety and depression have made it very difficult for her to get through an entire school day, with her frequently arriving at school 1-2 hours late, and she has already missed 26 days of school, even though it is only January. Sarah reports that she has some friends, but she often smokes marijuana with them after school, and her parents do not view them as positive influences in her life. Sarah and her family's relationship with her high school has diminished within the last month, because the family feels that school hasn't effectively assisted Sarah in catching up on the material that she has missed, as well as providing her with coping strategies to function effectively throughout the school day.

Sarah has met with her guidance counselor and school nurse on several occasions, but there is no formal plan in place at this time. Additional mental health staff persons at the school include a school psychologist and school social worker, both of which are at the high school 2.5 days weekly.

Sarah Vignette Response

Dear Participant,

Now that you have read Sarah's story, please use the lines below to answer the following:

A) Ideal steps in creating the student's transition plan, specifically defining:
   a. timeframe of initial school contact
   b. who should be contacted
   c. information to be gathered about school
   d. when the transition meeting would ideally take place
   e. who should be involved
   f. specific ideas for follow-up.

B) Define how many resources will be needed, what would they be, and who should provide them.

C) Please rate the potential success of the transition plan that you have created if it were to be (a) implemented in your school setting OR (b) passed along for implementation at your patients' schools upon discharge, utilizing the following scale.

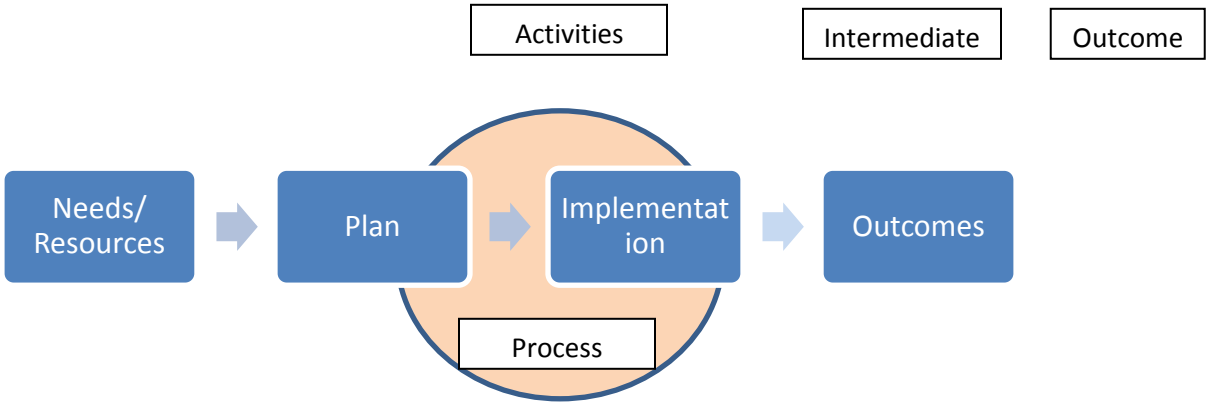
1	2	3	4	5	6	**7**	8	9	10
Not Successful		*Somewhat successful*			*Adequately successful*			*Very successful*	

Explanation of rating (*please provide a written description of your explanation for this rating)*:

D) Logic model changes

Appendix II-G

Hospital-to-School Transition Plan



Hospital-to-School Transition Logic Model

Risk/protective factors	Program activities	Intermediate Outcome	Outcome
Biological predisposition	Psychiatry	+ capacity to "function"	Successful re-entry
Family support	Family therapy	+ family relationships + parent-teacher contact	Successful re-entry, - recidivism
Social connectedness/ Peer influences	Milieu groups; individual therapy	+ peer relationships	Successful re-entry + relationship building
Academic abilities	Tutoring/Assessment	+ knowledge of school materials/confidence	Successful re-entry
Intrinsic Motivation	Individual Therapy	+ effort in school/ self-advocacy	+ help seeking Successful re-entry
School staff relationships	Post-program meetings	+ School climate	+ help seeking Successful re-entry

Appendix IV- A

Public Health Model factors to consider for student mental health needs

Center for School Mental Health at UCLA, accessed 1/23/2014

Stop, Think, Discuss

What are some major barriers you think must be addressed so that students will learn and perform appropriately at school?

Outlined below are some common barriers usually identified as interfering with learning/ parenting/ teaching. Think about and perhaps discuss with your colleagues which of these you see everyday and what others you would add to the list.

Deficiencies in basic living resources and opportunities for development

- dearth of food in the home
- inadequate clothing
- substandard housing (incl. being homeless)
- lack of transportation
- income at or below the poverty level (e.g., due to unemployment or welfare status)
- lack of after-school supervision for child
- lack of youth recreation and enrichment
- immigration-related concerns (e.g., limited English proficiency, legal status)
- lack of home involvement in schooling
- lack of peer support
- lack of community involvement
- lack of school support services
- lack of social services
- lack of physical, dental, and mental health services

Psychosocial problems

- physical health problems
- school adjustment problems (incl. school avoidance, truancy, pregnancy, and dropouts)
- relationship difficulties (incl. dysfunctional family situations, insensitivity to others, social withdrawal, peers who are negative influences)
- deficiencies in necessary skills (e.g., reading problems, language difficulties, poor coordination, social skill deficits)
- abuse by others (physical and sexual)
- substance abuse
- Overreliance on psychological defense mechanisms (e.g., denial, distortion, projection, displacement)
- eating problems
- delinquency (incl. gang-related problems and community violence)
- psychosocial concerns stemming from sexual activity (e.g., prevention of and reactions to pregnancy or STDs)
- psychopathology/disabilities/disorders

General stressors and underlying psychological problems associated with

- external stressors (objective and perceived) and deficits in support systems
- competence deficits (low self-efficacy/self-esteem, skill deficits)
- threats to self-determination/autonomy/control
- feeling unrelated to others or perceiving threats to valued relationships
- emotional upsets, personality disorders, mood disorders and other psychopathology

Crises and emergencies

- personal/familial (incl. home violence)
- subgroup (e.g., death of a classmate or close colleague)
- school-wide (e.g., earthquake, floods, shooting on campus)

Difficult transitions

- associated with stages of schooling (e.g., entry, leaving)
- associated with stages of life (e.g., puberty, gender identity, job and career concerns)
- associated with changes in life circumstances (e.g., moving, death in the family)

Note: The severity and pervasiveness of all the problems addressed may be mild, moderate, or severe; they also may be narrow or pervasive in terms of how broadly they are manifested.

Appendix IV-B

School professionals that may be involved in managing student mental health needs

Center for Mental Health in Schools, UCLA, accessed 12/20/2013

Types of interveners who might play primary or secondary roles in counseling, psychological, and social service activity

Instructional professionals
(e.g., regular classroom teachers, special education staff, health educators, classroom resource staff and consultants)

Health office professionals
(e.g., nurses, physicians, health educators, consultants)

Counseling, psychological, and social work professionals
(e.g., counselors, health educators, psychologists, psychiatrists, psychiatric nurses, social workers, consultants)

Itinerant therapists
(e.g., art, dance, music, occupational, physical, speech-language-hearing, and recreation therapists; psychodramatists)

Personnel-in-training for the above roles

Others
- Aides
- Classified staff (e.g., clerical and cafeteria staff, custodians, bus drivers)
- Paraprofessionals
- Peers (e.g., peer/cross-age counselors and tutors, mutual support and self-help groups)
- Recreation personnel
- Volunteers (professional/paraprofessional/ nonprofessional)

Appendix IV-C

Potential roles of school professionals providing student mental health care

Center for Mental Health in Schools, UCLA, accessed 12/20/2013

Types of functions provided

Direct services and instruction
(based on prevailing standards of practice and informed by research)

- Identifying and processing students in need of assistance (e.g., initial screening, gatekeeping and triage, client consultation, referral, initial monitoring of care)
- Indepth assessment (individuals, groups, classroom, school, and home environments)
- Crisis intervention and emergency assistance (e.g., psychological first-aid and follow-up; suicide prevention; emergency services, such as food, clothing, transportation)
- Primary prevention through protection, mediation, promoting and fostering opportunities, positive development, and wellness (e.g., guidance counseling; contributing to development and implementation of health and violence reduction curricula; placement assistance; advocacy; liaison between school and home; gang, delinquency, and safe-school programs; conflict resolution)
- Transition and follow-up (e.g., orientations, social support for newcomers, follow-thru)
- Treatment/therapy/counseling, remediation, rehabilitation (incl. secondary prevention)
- Increasing the amount of direct service impact through ongoing management of care multidisciplinary teamwork, consultation, training, and supervision

Coordination, development, and leadership for programs, services, resources, systems

- Needs assessment
- Coordinating activities (e.g., participating on resource coordinating teams to enhance coordination across disciplines and components; with regular, special, and compensatory educ.; in and out of school)
- Mapping and enhancing resources and systems
- Developing new approaches (incl. facilitating systemic changes)
- Monitoring and evaluating intervention for quality improvement, cost-benefit accountability, research
- Advocacy for programs and services and for standards of care in the schools
- Pursuing strategies for public relations and for enhancing financial resources

Enhancing connections with community resources

- Strategies to increase responsiveness to referrals from the school
- Strategies to create formal linkages among programs and services

Appendix IV-D

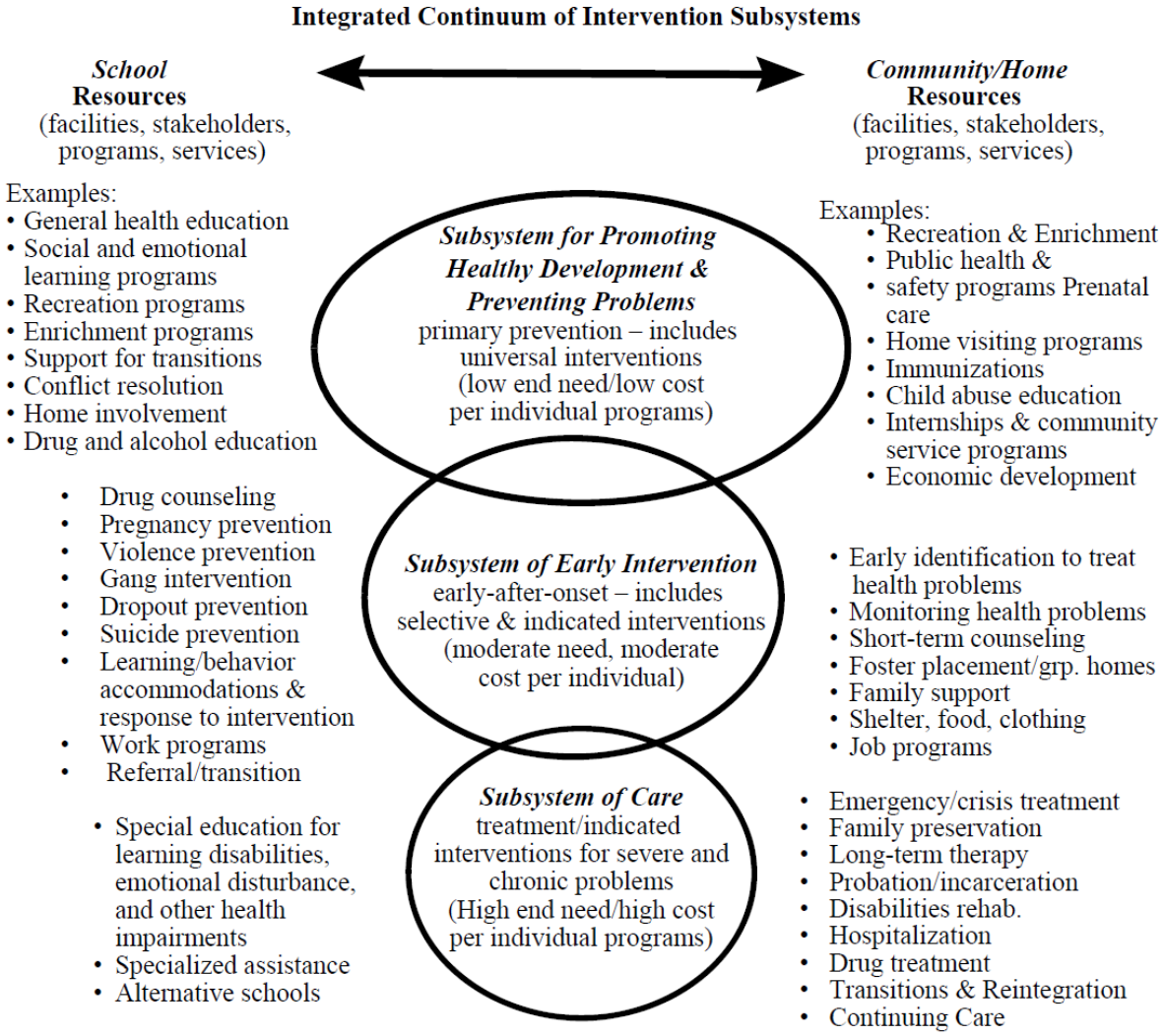
Center for Mental Health in Schools, UCLA, accessed 2/20/2013

From Primary Prevention to Treatment of Serious Problems: A Continuum of Community-School Programs to Address Barriers to Learning and Enhance Healthy Development

Intervention Continuum	*Examples of Focus and Types of Intervention* (Programs and services aimed at system changes and individual needs)
Primary prevention	1. Public health protection, promotion, and maintenance to foster opportunities, positive development, and wellness • economic enhancement of those living in poverty (e.g., work/welfare programs) • safety (e.g., instruction, regulations, lead abatement programs) • physical and mental health (incl. healthy start initiatives, immunizations, dental care, substance abuse prevention, violence prevention, health/mental health education, sex education and family planning, recreation, social services to access basic living resources, and so forth)
Early-after-onset intervention	2. Preschool-age support and assistance to enhance health and psychosocial development • systems' enhancement through multidisciplinary team work, consultation, and staff development • education and social support for parents of preschoolers • quality day care • quality early education • appropriate screening and amelioration of physical and mental health and psychosocial problems
	3. Early-schooling targeted interventions • orientations, welcoming and transition support into school and community life for students and their families (especially immigrants) • support and guidance to ameliorate school adjustment problems • personalized instruction in the primary grades • additional support to address specific learning problems • parent involvement in problem solving • comprehensive and accessible psychosocial and physical and mental health programs (incl. a focus on community and home violence and other problems identified through community needs assessment)
	4. Improvement and augmentation of ongoing regular support • enhance systems through multidisciplinary team work, consultation, and staff development • preparation and support for school and life transitions • teaching "basics" of support and remediation to regular teachers (incl. use of available resource personnel, peer and volunteer support) • parent involvement in problem solving • resource support for parents-in-need (incl. assistance in finding work, legal aid, ESL and citizenship classes, and so forth) • comprehensive and accessible psychosocial and physical and mental health interventions (incl. health and physical education, recreation, violence reduction programs, and so forth) • Academic guidance and assistance • Emergency and crisis prevention and response mechanisms
	5. Other interventions prior to referral for intensive and ongoing targeted treatments • enhance systems through multidisciplinary team work, consultation, and staff development • short-term specialized interventions (including resource teacher instruction and family mobilization; programs for suicide prevention, pregnant minors, substance abusers, gang members, and other potential dropouts)
Treatment for severe/chronic problems	6. Intensive treatments • referral, triage, placement guidance and assistance, case management, and resource coordination • family preservation programs and services • special education and rehabilitation • dropout recovery and follow-up support • services for severe-chronic psychosocial/mental/physical health problems

Appendix IV- E

Center for School Mental Health at UCLA, accessed 4/1/2014



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