

THE ROLE OF SCHOOL PSYCHOLOGISTS IN PARTIAL HOSPITALIZATION  
PROGRAM-TO-SCHOOL TRANSITIONS

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## ABSTRACT

Children and adolescents transitioning from partial hospitalization programs-to-schools have both mental health and educational needs. As the leading mental health experts in schools, school psychologists are uniquely suited to address the needs of these students. However, their role in this transition process has yet to be explored. This study begins to fill the gap in the empirical literature by investigating the actual role and function of school psychologists in partial hospitalization program-to-school transitions, the perceived barriers to successful transitions, and the school psychologist characteristics that predict involvement in the transition process. In addition, school psychologists' perceptions of the sufficiency of their training and the effectiveness of their current transition procedures were explored.

Seventy-one school psychologists practicing around the country who had at least one student on their caseload attend a partial hospitalization program during the previous two years participated in an anonymous, internet-based survey. Results indicate that school psychologists had high levels of involvement in partial hospitalization program-to-school transitions, most frequently engaging in activities related to special education services (i.e., IEP meetings, psychoeducational assessments) and consultation with teachers. School psychologists with smaller caseloads had significantly higher levels of involvement than those with larger caseloads. The strongest barrier to successful transitions was insufficient communication among schools and partial hospitalization programs. School psychologists who served on a team specifically designed to address the needs of students transitioning from a hospital-to-school setting perceived their procedures to be more effective than non-team members.

Overall, school psychologists perceived their training to transition students from partial hospitalization programs-to-school to be moderately sufficient; however, they perceived their current procedures to be moderately ineffective. Recommendations to improve the effectiveness of partial hospitalization program-to-school transitions are provided.

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## TABLE OF CONTENTS

	Page
ABSTRACT.....	ii
ACKNOWLEDGEMENTS.....	v
LIST OF TABLES.....	vii
CHAPTER	
1. INTRODUCTION.....	1
2. LITERATURE REVIEW.....	8
3. METHODOLOGY.....	32
4. RESULTS.....	35
5. DISCUSSION.....	46
REFERENCES CITED.....	67
APPENDIX	
A. RECRUITMENT MESSAGE.....	73
B. SURVEY.....	74

## LIST OF TABLES

	Page
1. Demographic Characteristics.....	36
2. Total Involvement vs. Partial/No Involvement.....	38
3. Frequency of Transition Activities.....	40
4. Barriers to Successful Partial Hospitalization Program-to-School Transitions.....	42
5. Team Members vs. Non-Team Members.....	43
6. Frequency Distribution of Responses on Perceived Sufficiency of Training.....	44
7. Frequency Distribution of Responses on Perceived Effectiveness of Current System.....	45
8. Correlation of Years of Experience with Perceived Sufficiency of Training and Effectiveness of Current System.....	45

## CHAPTER 1 INTRODUCTION

The traditional role of school psychologists has been to conduct psychoeducational assessments to determine eligibility for special education services (Bramlett, Murphy, Johnson, Wallingsford, & Hall, 2002; Hosp & Reschly, 2002; Reschly & Wilson, 1995; Sheridan & Gutkin, 2000). However, the National Association of School Psychologists (NASP) advocates for an expanded role and scope of practice for school psychologists through the publication *School Psychology: A Blueprint for Training and Practice III (Blueprint III)* (Ysseldyke, Burns, Dawson, Kelley, Morrison, Ortiz, et al., 2006). The authors write,

School psychologists should be the leading mental health experts in schools who are knowledgeable about development in social, affective, and adaptive domains and are able to identify and apply sound principles of behavior change within these domains in order to help design and implement prevention and intervention programs to promote wellness and resiliency (Ysseldyke et al., 2006, pg. 31).

The high incidence of mental health disorders among children and adolescents makes it critical to have experts in mental health in the schools. According to the United States Department of Health and Human Services (USDHHS), approximately one in five children and adolescents meet the diagnostic criteria for a mental health disorder, with 5% of all children experiencing “extreme functional impairment” (USDHHS, 1999, p. 17). Merikangas, He, Brody, Fisher, Bourdon, and Koretz (2010) provide the most recent prevalence data in the first study of mental health disorders in a nationally representative probability sample of U.S. children and adolescents ranging in age from eight to fifteen.

The sample of 3,042 children and adolescents was obtained from cross-sectional surveys conducted between 2001-2004 by the National Health and Nutrition Examination Survey (NHANES). Results indicated that one in eight met the diagnostic criteria for one of the disorders included in the survey. Twelve-month prevalence data indicated that 8.6% met the diagnostic criteria for attention-deficit/hyperactivity disorder (ADHD; 4.3% for attention deficit, 2.0% for hyperactivity, 2.0% for attention deficit and hyperactivity combined type), 3.7% for mood disorders (2.7% for major depressive disorder, 1.0% for dysthymic disorder), 2.1% for conduct disorder, 0.7% for anxiety disorders (0.3% for generalized anxiety disorder, 0.4% for panic disorder), and 0.1% for eating disorders (0.1% for anorexia and 0.1% for bulimia). Merikangas and colleagues also note that these data are likely underestimates of the true population base rates because the most common childhood mental health disorders (separation anxiety disorder and phobias) were not included in the surveys.

Although approximately 20% of children and adolescents meet the criteria for a mental health disorder, they are not all receiving treatment services. Merikangas and colleagues (2010) found that less than one-half of children and adolescents with mental health disorders sought professional treatment, while the USDHHS (1999) found that less than one-third received treatment. The children and adolescents who do receive mental health services do so in a setting that is contingent on the severity of their symptoms. Mental health services fall on a continuum of care, ranging from the least restrictive to the most restrictive: outpatient counseling, intensive outpatient counseling, partial hospitalization, acute inpatient hospitalization, and residential or long-term hospitalization.

Children and adolescents attending partial hospitalization programming, sometimes referred to as day-treatment, require more intensive services than those offered in an outpatient setting; however, they do not need the full-time care and monitoring provided in a residential or inpatient facility. Pennsylvania state regulations define partial hospitalization programs as:

A nonresidential treatment modality which includes psychiatric, psychological, social and vocational elements under medical supervision. It is designed for patients with moderate to severe mental or emotional disorders. Partial hospitalization patients require less than 24-hour care, but more intensive and comprehensive services than are offered in outpatient treatment programs. Partial hospitalization is provided on a planned and regularly scheduled basis for a minimum of 3 hours, but less than 24 hours in any 1 day. (55 Pa. Code §5210.3)

Approximately 11,000 children and adolescents attend partial hospitalization programs each year in Pennsylvania alone (Pennsylvania Departments of Education and Public Welfare [PDE & DPW], 2007). Partial hospitalization programming generally entails a combination of individual counseling, group counseling, family therapy, medication management, and social work services. Because children and adolescents attending partial hospitalization programs receive services during the school day, education services are also provided.

Unfortunately, the education services provided can vary substantially by partial hospitalization program (PDE & DPW, 2007). By nature of their design, partial hospitalization programs serve children and adolescents of varying ages, educational levels, and school districts, which, in turn, have varying school curricula. Because of this

variability, children and adolescents may not receive the same quality of educational services they would receive in their regular school setting. Further complicating the issue is that the persons providing the educational services may not be certified to teach in the academic areas taught. Because children and adolescents can attend partial hospitalization programs for weeks or even months, they may find themselves at an academic disadvantage when they transition back to school. This gap in education can lead to academic failure, grade retention, or delayed graduation. As a result, these children and adolescents may need to participate in assessments when they return to school to determine their current skill levels and the extent to which their skills have regressed.

To better understand the actual amount of educational services provided to children and adolescents attending partial hospitalization programs, the Education Law Center surveyed partial hospitalization programs in Pennsylvania on three separate occasions. Results indicated that, in 1998, children received an average of 3.4 hours of education per day. In 1999, 81% of partial hospitalization programs reported fewer than three hours per day. In 2003, 50% of partial hospitalization programs reported fewer than three hours per day of educational programming (Education Law Center, 2004; PDE & DPW, 2007). Clearly, children and adolescents attending partial hospitalization programs are receiving fewer hours of instruction than they would if they were attending their regular school program. The minimum length of the school day in Pennsylvania is five hours per day for elementary school students and 5.5 hours per day for middle and high school students (22 Pa. Code §11.3). However, many school districts provide longer

school days. An appropriate education program during partial hospitalization can help to provide a more seamless transition back to school.

The partial hospitalization program-to-school transition can be difficult not only because of differences in educational services, but also because of inadequate communication, a lack of coordinated planning, and insufficient knowledge about each player's roles (i.e., school district, partial hospitalization program, parents) in the transition process (Education Law Center, 2004; Education Law Center, n.d.; PDE & DPW, 2007). The PDE and DPW attempt to address these barriers to a successful partial hospitalization program-to-school transition by providing partial hospital programs and schools with transition guidelines through multiple publications (PDE & DPW, 2007; DPW, 2008; PDE, 2007). For example, PDE and DPW clarified that a representative from a patient's local education agency (LEA or school district) should be involved in planning during the course of treatment in a partial hospitalization program (DPW, 2008). However, the clarifications from PDE and DPW only address roles when a student is attending a partial hospitalization program. There are no formal guidelines regarding roles in the transition process after a student returns to school. Therefore, additional barriers to a successful transition may exist following school reentry.

As the leading mental health experts in the schools (NASP, 2008; Sheridan & Gutkin, 2000; Ysseldike et al., 2006), school psychologists should, logically, have a role in the partial hospitalization program-to-school transition. However, the role of school psychologists in this process has yet to be explored. Understanding the current practices of school psychologists, it is anticipated that the primary role of school psychologists in the partial hospitalization program-to-school transition will be conducting

psychoeducational assessments to determine eligibility for special education services. School psychologists' involvement in partial hospitalization program-to-school transitions may be further influenced by training level, size of caseload, and the disability classifications of students served.

A review of the literature reveals little information about partial hospitalization program-to-school transitions in general. Only two articles specifically addressing the transition from psychiatric hospitalization-to-school were found. One article addresses the roles of inpatient hospital-based personnel in the transition process (Simon & Savina, 2005) and the other addresses a school-based transition program (White, Langman, & Henderson, 2006). As a result of the paucity of literature regarding hospital-to-school transitions for children and adolescents receiving mental health care, possible roles for school psychologists in partial hospitalization program-to-school transitions will also be drawn from the more established literature surrounding hospital-to-school transitions for children and adolescents with other health disorders including traumatic brain injuries (TBI) and chronic illnesses.

### Research Questions

To begin to fill the gap in the empirical literature, this project investigated what roles school psychologists play in partial hospitalization program-to-school transitions. In addition, the barriers to successful partial hospitalization program-to-school transitions were explored. Specifically, this study addressed the following research questions:

Research Question 1: What roles do school psychologists play in partial hospitalization program-to-school transitions?

Research Question 2: Which school psychologist characteristics predict involvement with the partial hospitalization-to-school transition process?

Research Question 3: What are school psychologists' perceived barriers to successful partial hospitalization program-to-school transitions?

Research Question 4: Do school psychologists who work within hospital-to-school transition teams differ from those who do not when transitioning students from partial hospitalization programs-to-school?

Research Question 5: Do school psychologists believe that they have sufficient training to work with students transitioning from partial hospitalization programs-to-school?

## CHAPTER 2 LITERATURE REVIEW

Children and adolescents who attend partial hospitalization programs for psychiatric reasons have both mental health and educational needs. For the most part though, the programs designed to address these needs are not fully integrated because partial hospitalization programs and schools work in isolation from one another. For example, in Pennsylvania, partial hospitalization programs are administered by the Department of Public Welfare (DPW) as treatment programs, not as educational placements, and educational placements are provided and funded by the Pennsylvania Department of Education (PDE). Because each of these systems has different regulations within the Pennsylvania code, clarifications about how much education children in partial hospitalization programs should receive, which school district is responsible for determining what the child needs, and which school district is responsible for funding the education services were needed (Education Law Center, 2004). The PDE and DPW began to address the educational needs of children and adolescents attending partial hospitalization programs through a joint publication and subsequent publications from each individual department (PDE & DPW, 2007; DPW, 2008; PDE, 2007).

DPW's Office of Mental Health and Substance Abuse Services distributed a bulletin in January 2008 partly to address the "lack of coordinated planning between school districts and partial hospitalization programs for reentry into schools when children are discharged from partial programs" (DPW, 2008, p. 1). A standard process for interagency collaboration and planning was created and presented in this bulletin to ensure that children and adolescents attending partial hospitalization programs receive

necessary education and special education services and that behavioral health and educational services are not interrupted at discharge (DPW, 2008).

This reentry process is intended to apply to enrollments in partial hospitalization programs that are expected to last longer than three school weeks (DPW, 2008).

According to data for the 2005 calendar year (collected by DPW), 37% of partial hospitalization program patients received treatment for less than 30 days, 19% received treatment for between 31 and 90 days, 7% for between 91 and 120 days, 16% for between 121 and 240 days, and 22% for between 241 and 365 days (PDE & DPW, 2007).

Therefore, this standard reentry process applies to the majority of children and adolescents enrolled in partial hospitalization programs.

The reentry process designed by DPW is as follows. First, to facilitate collaboration between educational and mental health service providers, a Letter of Agreement should be created which “clearly define[s] the roles and responsibilities of each entity” (DPW, 2008, p.3). Then, an Interagency Team composed of the child, parent(s) or guardian(s), a representative from the County MH/MR program, providers who are providing or will provide services to the child, and a representative of the school district (LEA) where the child resides, holds a meeting to discuss clinical evaluations and recommendations. In addition, the child’s educational program, including the child’s Individualized Education Program (IEP), would be discussed. The educational program should be designed to allow the child or adolescent to continue to make sufficient progress in the subjects needed for grade promotion or graduation (DPW, 2008).

If the child has not previously been identified as a student with a disability, and also eligible for special education services or a Service Agreement under Section 504 of

the Rehabilitation Act of 1973 (504 Plan), the family should be advised to request an evaluation from the child's home school district. Finally, a discharge plan is created and includes a plan to transition the child or adolescent from the partial hospitalization program to the recommended school placement. The discharge plan is implemented when the partial hospitalization program treatment goals and objectives have been met, when the program is no longer the least restrictive, or when the parent or child (age 14 or older) chooses to withdraw from the program (DPW, 2008).

Although PDE and DPW have clarified the school reentry process for children and adolescents who attend partial hospitalization programs, they did not go so far as to make specific recommendations in identifying which school-based employees should play a role in the transition process. Because school psychologists are the mental health experts in schools, it follows that they should play an active role in the partial hospitalization program-to-school transition process. Unfortunately, the role of the school psychologist in partial hospitalization program-to-school transitions has also not been specifically addressed in the literature. However, a possible role can be posited from the current practices of school psychologists, which have been examined by the National Association of School Psychologists (NASP).

#### *Current Practices of School Psychologists*

Every five years, NASP conducts a survey to assess the demographic characteristics, employment conditions, and professional practices of school psychologists. The most recent data are from the 2004-2005 academic year (Curtis, Lopez, Castillo, Batsche, Minch, & Smith, 2008). One thousand three hundred ninety-eight school psychologists practicing full-time in a school setting were surveyed. Results

indicated that school psychologists spent 80.4% of their time involved in special education activities. In addition, 74.2% of surveyed school psychologists participated in the development of 504 Plans. Section 504 of the Rehabilitation Act of 1973 (Section 504) is a piece of civil rights legislation that protects individuals from discrimination on the basis of their disability. Individuals with disabilities are defined as persons with a physical or mental disability that substantially limits one or more major life activities. Under Section 504, students with a disability that limits a major life activity (e.g. learning) are eligible for accommodations through a service agreement, also called a 504 Plan.

This most recent estimate of time spent in special education activities is noticeably higher than previous estimates. Hosp and Reschly (2002) surveyed school psychologists in 1997 and found that they spent between one-half and two-thirds of their time in activities related to special education eligibility (i.e., assessments, IEP meetings). Similarly, Bramlett, Murphy, Johnson, Wallingsford, and Hall (2002) surveyed school psychologists in 1999 and found that the majority of their time was spent on assessment (46%). The rest of their time was spent in other roles including: consultation (16%), interventions (13%), counseling (8%), conferencing (7%), supervision (3%), inservicing (2%), research (1%), parent training (1%), and other (3%).

Although surveys have consistently found that school psychologists spend the majority of their time in the traditional role of conducting psychoeducational assessments to determine eligibility for special education services, other research indicates that school psychologists actually prefer to engage in non-traditional roles such as direct interventions, consultation, systems change, and research (Hosp & Reschly, 2002;

Reschly & Wilson, 1995). This is further supported by the fact that in a survey of school psychologists, five out of the six most frequent continuing professional development activities were not assessment related (Curtis et al., 2008).

In spite of the recent push for the field of school psychology to move away from the traditional medical model and toward the ecological model of service delivery, which focuses on prevention, intervention, collaboration, and consultation (Sheridan & Gutkin, 2000), the traditional assessment role persists. This is partly because school psychologists' primary role of assessment is directly influenced and supported by Federal legislation and the local interpretation of this legislation. In fact, it has been argued that the local interpretation of Federal mandates limits school psychologists to the role of "testing and placement" (Sheridan & Gutkin, 2000, p. 487). Students with disabilities may be eligible for services and accommodations through two separate pieces of Federal legislation: the Individuals with Disabilities Education Improvement Act (IDEIA) and Section 504 of the Rehabilitation Act of 1973 (Section 504).

When a child or adolescent attends a partial hospitalization program, he or she is experiencing significant mental health needs that are interfering with his or her daily functioning and may be considered a student with a disability. Under IDEIA, each state must have policies and procedures to ensure that all children and adolescents with disabilities, who are in need of special education services and related services, are identified, located, and evaluated (§300.111 (a) (1) (i)); this includes children and adolescents who attend partial hospitalization programs. Local interpretations of IDEIA further influence the roles of school psychologists. For example, in Pennsylvania, a school psychologist is required to be involved in the assessment process for the majority

of the disability categories, including: autism, emotional disturbance, mental retardation, multiple disabilities, other health impairment, specific learning disability and traumatic brain injury (PA Code §14.123 (a)). Even if a child or adolescent is not found eligible for special education services under IDEIA, he or she may be eligible for accommodations through Section 504. Because of their expertise in assessment, school psychologists are often involved in the evaluation of eligibility for and development of a 504 Plan. If a student's mental health is interfering with his or her ability to benefit from the general education program or to perform a major life activity, he or she may be eligible for an Individualized Education Plan (IEP) under IDEIA or a 504 Plan and will, subsequently, need to be evaluated by a school psychologist.

Many times, though, children and adolescents attending partial hospitalization programs have previously been identified as students with disabilities and already have an Individualized Education Program (IEP) or a 504 Plan. According to a survey of partial hospitalization programs in Pennsylvania in 2004, 54% of children referred to the programs had IEPs prior to admission (PDE & DPW, 2007). In these cases, it may be necessary to revise the IEP or to complete a Reevaluation with consideration of the new information about the student's mental health once they are discharged from the partial-hospitalization program; again, requiring the involvement of a school psychologist.

Given the current legislation guiding the activities of school psychologists, it is expected that their primary role in the partial hospitalization program-to-school transition will be conducting assessments to determine eligibility for special education services or a 504 Plan. In addition, knowing that school psychologists prefer an expanded role, school psychologists may also engage in other roles such as consultation or medication

monitoring. Unfortunately, this information is not yet available. This study sheds light on the exact roles and activities taken on by school psychologists in this process across the United States.

### *Expanded Role of School Psychologists*

In a position statement on the importance of mental health services, the NASP highlights that school psychologists are “uniquely qualified to provide comprehensive, cost-effective, mental health services” (NASP, 2008, p.2). Similarly, Nastasi (2003) notes that, because of their expertise in both mental health and education, school psychologists are “uniquely qualified to understand the educational implications of mental health and to facilitate the integration of public education and public health” (p. 51). As the leading mental health experts in the schools (NASP, 2008; Sheridan & Gutkin, 2000; Ysseldike et al., 2006), school psychologists can play a key role in the partial hospitalization program-to-school transition. Their expertise in consultation, behavioral intervention plans, counseling, assessment, and crisis interventions (NASP, 2008) supports the mental health of all students.

### *Confidentiality*

Also impacting the role of school psychologists in partial hospitalization program-to-school transitions are the legal and ethical obligations of confidentiality. In order for children and adolescents to transition from a partial hospitalization program-to-school, personal information needs to be shared between the partial hospitalization program and the school. Two Federal statutes regulate how personal information is shared in these settings, the Health Insurance Portability and Accountability Act (HIPAA) (P.L. 104-

191) and the Family and Educational Rights and Privacy Act (FERPA; 20 U.S.C. § 1232g; 34 CFR Part 99).

In addition to the ethical obligation of mental health treatment providers to maintain confidentiality, the HIPAA Privacy Rules dictate how protected health information, including admission and discharge dates, can be disseminated. The HIPAA Privacy Rules indicate that entities cannot release protected health information without consent. For mental health treatment, the age of consent is 14 years of age. Therefore, in order for partial hospitalization programs and school districts to collaborate and create a transition plan, the parent or adolescent (14 years or older) must give consent for the release of this information.

FERPA is designed to protect the privacy of educational records and it applies to all schools that receive U.S. Department of Education funds (i.e., public schools). According to FERPA, schools cannot release educational records, including special education documents, such as evaluations, reevaluations, or IEPs, without the consent of parents. Education records, particularly special education records, are an important part of the partial hospitalization program-to-school transition process. Consequently, it is necessary to obtain consent to release information to the school district, in addition to the consent to release information to the partial hospitalization program, so that entities can communicate effectively.

A lack of communication between entities has been identified as a primary barrier to the transition process (Education Law Center, 2004; Education Law Center, n.d.; PDE & DPW, 2007). The proper releases of information are the first step in the partial hospitalization program-to-school transition process. Because of the rules of

confidentiality, parents can and have enrolled their children in partial hospitalization programs without notifying the school district (Education Law Center, 2004; PDE, 2007). When children have short stays in the partial hospitalization program, this may not interfere with their educational progress. However, when children have extended stays, communication, particularly about the partial hospitalization program-to-school transition, is essential. To address this issue, PDE and DPW clarify that the partial hospitalization program is responsible for obtaining a release of information and notifying the school district of the enrollment (PDE, 2007). If releases of information are not obtained, the partial hospitalization program-to-school transition is hindered and supports and services may not be adequately offered to or implemented for students when they return to school.

### *Medication Monitoring*

Many school psychologists already engage in roles that may be beneficial to successful partial hospitalization program-to-school transitions. Specifically, monitoring the effects of medication on mood or behavior is necessary to ensure that children and adolescents continue to make progress toward their educational and behavioral health goals. This is especially true when students transition from partial hospitalization programs-to-school as they may be taking new medications or new dosages of previously used medications as a result of their treatment.

In 2005, Gureasko-Moore, DuPaul, and Power surveyed school psychologists about their medication monitoring practices for children with Attention-Deficit/Hyperactivity Disorder (ADHD). The survey focused on four areas: 1) the self-reported use of procedures for monitoring the effects of medication on ADHD, 2) training

in medication monitoring techniques, 3) perceived effectiveness, acceptability, and feasibility of medication monitoring techniques, and 4) perceived facilitators and barriers to medication monitoring.

Results indicate that 54.5% of the sample engaged in medication monitoring as part of their role as school psychologists, spending, on average, 5.1% of their time on such tasks. In addition, there was moderate agreement that school psychologists should be engaged in this role (mean=3.84; 1=strongly disagree to 5=strongly agree). Teacher rating forms, direct observations, and teacher interviews were viewed as the optimal medication monitoring methods, followed by parent rating forms and interviews. Forty-two percent of the sample indicated that they received formal training in medication monitoring techniques, mostly through graduate training (14.3%) and workshops (18%). School psychologists with training in medication monitoring techniques spent significantly more time engaged in medication monitoring with a greater number of students than untrained school psychologists. Barriers to medication monitoring included time, accessibility of physicians, and physician's perceptions of the school psychologists' role in medication monitoring. The greatest facilitator to medication monitoring was found to be teacher support.

Although not all students who attend partial hospitalization programs have diagnoses of ADHD, the same principles of medication monitoring can be applied to children and adolescents with other psychiatric diagnoses. Therefore, medication monitoring may be an appropriate role for school psychologists in the partial hospitalization program-to-school transition process.

### *Consultation and Collaboration*

Whether a child or adolescent has been hospitalized for physical or mental health problems, a collaborative team approach is widely supported and encouraged when transitioning from the hospital to the school setting (Farmer & Peterson, 2005; Glang et al., 2004; Hooper et al., 2001; Kaffenberger, 2006; Shaw, Clayton, Dodd, & Rigby, 2004; Shaw & Woo, 2008). Collaborative communication between school psychologists and other adults in the childrens' and adolescents' lives is necessary for transition services to be successful (Sheridan & Gutkin, 2000). The National Association of School Psychologists has emphasized the importance of collaboration between school psychologists and the medical teams that treat students. In fact, a chapter in *Best Practices in School Psychology V* is dedicated to the best practices when collaborating with medical professionals (Shaw & Woo, 2008).

Shaw and Woo (2008) present the following strategies for the effective collaboration of school psychologists with other health providers: respecting professional boundaries (i.e., not recommending medications or diagnoses to medical personnel), inviting participation, using liaisons, communicating in a jargon-free acronym-free manner, and engaging the parents and child. Because information needs to be shared between multiple systems and among multiple professionals, a single contact person, or liaison, can coordinate systems and services and share information between home, school, and hospital. Since school psychologists have expertise in interpersonal and collaborative relationships, they could potentially serve as liaisons (Nastasi, 2000; Prevatt, Heffer, & Lowe, 2000; Sheridan & Gutkin, 2000) in the partial hospitalization program-to-school transition.

### *Medical Transition Teams*

Because children and adolescents attending partial hospitalization programs have multiple adults involved in their transition, it may be necessary for roles and responsibilities of school personnel to be clarified. Shaw, Clayton, Dodd, and Rigby (2004) suggest that schools develop Medical Transition Teams because of the likelihood that school personnel will encounter children and adolescents with significant medical or mental health problems during their careers. A clearly defined Medical Transition Team is important because skills among school-based personnel are not always distinct. Defining roles is difficult when knowledge, training, and even professional guidelines, overlap. A review of the literature revealed hospital-to-school transition guidelines for school counselors working with children with chronic illnesses (Kaffenberger, 2006) and for school social workers working with children with burns (Badger, 2008). The information presented is surprisingly similar to and sometimes identical to the suggested roles of school psychologists; however, the school psychologist is absent from both of these discussions. For example, Kaffenberger (2006) suggests that school counselors provide families with information about special education and 504 plans, an area of expertise of school psychologists.

### *Roles in Hospital-to-School Transitions*

Additional roles of school psychologists in the partial hospitalization program-to-school transition can be further drawn from guidelines in the literature surrounding hospital-to-school transitions for students with health disorders such as traumatic brain injury (TBI) or chronic illness. Like children and adolescents with mental health

disorders, children and adolescents with TBI and chronic illnesses have unique needs when transitioning from the hospital to the school setting.

*Roles in the Transition Process for Children and Adolescents with Chronic Illnesses*

Although school reentry programs for children with chronic illnesses have primarily been hospital-based (Prevatt et al., 2000; Sexson & Madan-Swain, 1993; Worchel-Prevatt et al., 1998; Weil, Rodgers, & Rubovits, 2006), information about the roles of school psychologists can be gleaned from these programs. It is estimated that 10-15% of children and adolescents have a chronic illness (Clay, 2004). Chronic illnesses are long-term medical conditions that impact functioning such as asthma, cancer, cystic fibrosis, HIV infection, juvenile rheumatoid arthritis, and diabetes (Clay, 2004; Shaw & McCabe, 2008). Children and adolescents with chronic illnesses experience not only symptoms related to their medical condition but also symptoms of their treatment. As such, they may have poor attendance, fatigue, changes in cognition, or difficulty with attention or concentration (Shaw & McCabe, 2008). Therefore, children and adolescents with chronic illnesses may be eligible for special education services (IEP) or a Section 504 Plan. Given that school psychologists are predominantly involved in assessment for eligibility for special education services or a 504 Plan, it is expected that the school psychologist's primary role in hospital-to-school transitions for children and adolescents with chronic illness will be to conduct assessments to determine eligibility for services or accommodations.

Sexon and Madan-Swain (1995) suggest that, when notified that a child or adolescent with a chronic illness is transitioning back to school, school psychologists should conduct an assessment that includes measures of cognition, memory, attention,

academics, social-emotional functioning, and behavior. In addition, school psychologists should consult with medical staff to better understand how medications or treatments can impact school functioning, help other school personnel understand the transition process, and monitor the student's educational performance. Prevatt, Heffer, and Lowe (2000) suggest a similar role because school psychologists have training and expertise in assessment, consultation, acting as liaison between school, parents, and medical personnel, counseling, and working with classroom peers. Shared characteristics of reentry programs include interventions for: 1) the child, 2) family members, 3) teachers and other school personnel, 4) the child's peers, and 5) medical personnel (Prevatt et al., 2000). A designated liaison and multidisciplinary teams are also frequently suggested (Sexon & Madan-Swain, 1993; Shaw & McCabe, 2008; Worchel-Prevatt et al., 1998). *Roles in the Transition Process for Children and Adolescents with Traumatic Brain Injury (TBI)*

According to the National Institute of Neurological Disorders and Stroke of the National Institutes of Health (NINDS), symptoms of traumatic brain injury include "headache, confusion, lightheadedness, dizziness, blurred vision or tired eyes, ringing in the ears, bad taste in the mouth, fatigue or lethargy, a change in sleep patterns, behavioral or mood changes, and trouble with memory, concentration, attention, or thinking" (NINDS, 2010, n.p.). Considering these sequelae to TBI, children and adolescents with TBI will likely require supports and accommodations when they return to school following injury.

Since 1990, children and adolescents with TBI have been eligible for special education services under the Individuals with Disabilities Education Act and its

reauthorizations: IDEA 1997 and IDEIA 2004. Still, although children and adolescents with TBI may be eligible for special education services, it remains a low-incidence disability in special education (Farmer & Peterson, 1995; Glang, Tyler, Pearson, Todis, & Morvant, 2004). Because TBI is a high-incidence medical event, with approximately 475,000 children aged 0-14 experiencing a TBI each year (Langlois, Rutland-Brown, & Thomas, 2006), students with TBI may be underidentified for special education services (Glang et al., 2004; Langlois et al., 2006). Of course, some of these students with TBI may be receiving school supports through a Section 504 Service Agreement; however, these data are not available.

As with children and adolescents transitioning to school from partial hospitalization programs, it is expected that school psychologists' primary role will be assessments to determine eligibility for special education services. Farmer and Peterson (1995) outline guidelines for school psychologists to consider when assessing students with TBI. The use of an ecological model of assessment that focuses not only on the student but also on his or her environment (i.e., teacher qualities, instructional setting, peer interactions, etc.) is encouraged. Four key assessment strategies are presented to support school reintegration following a TBI: 1) neuropsychological orientation, 2) a multidisciplinary approach, 3) periodic and ongoing evaluation, and 4) contextual assessment.

For children and adolescents with a TBI, a neuropsychological assessment is recommended as IQ and achievement tests alone are not sufficient to determine the impact and extent of the injury (Farmer & Peterson, 1995). It is further suggested that this neuropsychological assessment is just one component of the assessment and that

additional contextual information (e.g., peer relationships or classroom functioning) should be gathered through a multidisciplinary approach. The school psychologist should team with other school-based professionals, including general and special education teachers, speech and language pathologists, social workers, school counselors, school nurses, and school administrators, to gather information and plan interventions. Information about the student's functioning should be gathered periodically on an ongoing basis. It is also recommended that the student's IEP be reviewed every 3-6 months for the first 18-24 months following injury or until improvements begin to plateau. (Farmer & Peterson, 1995)

#### *Training for School Psychologists and Other School-Based Personnel*

Unfortunately, some school psychologists may not understand TBI or its educational implications (Glang et al., 2004), and may, therefore, require additional training. To address this issue in North Carolina, the North Carolina State Department of Public Instruction (DPI) created a training model that focused on training school psychologists about TBI (Hooper, Walker, & Howard, 2001). The authors indicate that school psychologists were chosen for several reasons 1) the cost of outside evaluations was prohibitive, 2) because school psychologists are involved in assessment they would be in the position to follow-up on students with TBI, acting as case managers and coordinating services, and 3) because they know the school environment, school psychologists can effectively arrange services.

These rationales for choosing to train school psychologists about students with TBI can also be the rationales for training school psychologists to work with students attending partial hospitalization programs. Insufficient training of school psychologists

about mental health disorders may be a barrier to successful partial hospitalization program-to-school transitions. Although leadership within the field of school psychology advocates for the role of the school psychologist as mental health expert, it is not clear that school psychologists view themselves as mental health experts. According to Merrell, Ervin, and Gimpel (2006) this may be partly because a school psychologist may not have received the appropriate training. How school psychologists view their ability to implement mental health services may additionally impact their role in the partial hospitalization program-to-school transition.

The training model created by Hooper and colleagues (2001) was composed of two levels. First, school psychologists received 42 hours of training through didactic workshops focused on assessment and school performance and, second, they participated in 30 hours of clinical case supervision. At the conclusion of the training, school psychologists were added to a “Registry of Approved Providers.” In order to work with students with TBI, school psychologists must be on this registry or risk losing state funding for the education of that student. Hooper and colleagues (2001) reported that participants positively rated the workshops and supervision groups and that the program improved school-based services for students with TBI. However, no data are provided to confirm these assumptions and no follow-up studies have been conducted to evaluate student outcomes.

In addition to training for school psychologists, training for other school-based employees is necessary. Glang and colleagues (2004) described statewide consulting teams being implemented in Iowa, Kansas, and Oregon and designed to address educators’ lack of knowledge and training in TBI. These teams provide support for

educators, in the form of information, capacity building, and access to expert assistance. TBI Consulting Teams were composed of individuals with TBI, parents, general and special education teachers, speech and language pathologists, school counselors, physical therapists, occupational therapists, school nurses, school psychologists, and school administrators. Similar to the trainings described by Hooper and colleagues (2001), team members participated in trainings designed to increase knowledge, skills, and confidence and additionally received the support of a mentor. Following training, team members were available to consult with school personnel from districts across the state regarding students with TBI.

Glang and colleagues (2004) outlined the advantages of TBI Consulting Teams over other models, such as itinerant consultants, hospital-based consultants, or out-of-district placements. The authors argued that TBI Consulting Teams: 1) ensure easy access to needed resources for both educators and medical personnel, 2) provide ongoing professional development for team members, 3) foster enhanced collegiality and networking, 4) build statewide capacity to meet the unique needs of children with TBI, 4) provide needed support for parents, 5) raise awareness of TBI, 6) allow for widespread dissemination of TBI materials, and 7) augment state efforts to collect accurate data on this population and its needs. Some of the challenges to the implementation and effectiveness of the TBI Consulting Team model were described as follows: 1) the lack of a systematic evaluation of the model, 2) difficulty arranging for release time for training and consultation, 3) the geographic distance between team members can impede coverage for all communities, and 4) receiving funding for on-going trainings for team members (Glang et al., 2004).

Although this approach appears to be effective in training team members and is viewed as an effective model by program participants, there is limited information on the impact of the TBI Consulting Model on student outcomes. However, Glang, Todis, Thomas, Hood, Bedell, and Cockrell (2008) found that both the severity of the injury and the provision of a hospital-to-school transition plan were correlated with identification for formal educational services (IEP or 504 Plan).

In spite of this limited evidence of an impact on student outcomes, state-wide consulting teams are being developed across the country to address the needs of students with TBI. For example, building on programs designed and implemented in other states, the Brain Injury Association of Pennsylvania, in conjunction with the Pennsylvania Department of Health and the Pennsylvania Department of Education, developed a school re-entry program for children and adolescents with TBI called BrainSTEPS (Strategies Teaching Educators, Parents, and Students; Brain Injury Association of Pennsylvania, n.d.). BrainSTEPS provides information to educators about brain injury and the educational implications of TBI, as well as interventions that can support students through graduation. BrainSTEPS Teams receive ongoing training and are composed of educators, medical rehabilitation professionals, and family members of persons with TBI. Team members provide presentations to school personnel on the following topics: “training and consultation regarding identification, school re-entry planning, IEP development, intervention selection and development, and long-term monitoring of students” (Brain Injury Association of Pennsylvania, n.d., n.p.). After data are gathered on the effectiveness of these school-based transition teams, these programs could

potentially be used as models for transition teams for children and adolescents attending partial hospitalization programs.

*Roles of Inpatient Hospital Based Employees in Hospital-to-School Transitions*

Roles in the psychiatric hospitalization-to-school transition is beginning to be explored. Simon and Savina (2005) investigated the transition practices of inpatient psychiatric hospital-based therapists. Mental health therapists that handle transition planning were recruited by sending survey packets to the clinical directors of the 65 public psychiatric hospitals listed as providing services to children in the Substance Abuse and Mental Health Services Administration's National Mental Health Information Center in 2003. Twenty-two of the facilities were later excluded as they responded that they no longer provided services for children. The final sample consisted of 49 mental health therapists from 13 states representing 21 of the 43 remaining facilities. The survey was created by the authors and consisted of a total of thirteen questions related to demographics of the provider, demographics of the children served, and transition practices.

Results indicated that the majority of transition practices were completed prior to discharge with 87.8% of therapists meeting with parents or caregivers in person, 67.3% consulting with parents or caregivers by telephone, 75.5% consulting with school personnel by phone, and 32.7% meeting with school personnel in person. In addition, 59.2% of therapists notified school personnel that the student was returning to school by telephone, 46.9% mailed or faxed a discharge summary to school personnel, and 22.4% mailed or faxed a discharge summary to parents or caregivers. After discharge, 28.6% of therapists consulted with parents or caregivers by phone, 24.5% consulted with school

personnel by phone, 16.3% met with parents in person, and 18.4% met with school personnel in person. Only four respondents indicated that the hospital held a transition meeting with both parents and school personnel prior to discharge.

Although this survey revealed that hospital-based employees were contacting school personnel, it is not clear which specific personnel were contacted (i.e., school psychologist, school counselor, school social worker, principal, etc.). Each of these service providers has distinct and overlapping roles and skills within the school environment; therefore, clarification about roles seems necessary. In addition, communication about discharge occurred primarily with parents. Because the hospital-based employees did not always inform school employees that the student was being discharged, communication between the parents and school is also essential. These findings emphasize the need for a designated liaison to communicate with the hospital, parents, and school. As the mental health experts in schools, school psychologists could adequately fill this role. Simon and Savina (2005) note that they are working on research that investigates the transition practices of school-based personnel. However, a search of the literature indicates that this research has yet to be conducted and/or published. The search did reveal a school-based transition program for adolescents returning to school following psychiatric hospitalization, substance abuse treatment, a serious medical event, or incarceration (White et al., 2006), which will be described below.

#### *Model School-Based Hospital-to-School Transition Program*

White and colleagues (2006) created and implemented a program in Brookline, Massachusetts that provided intensive school-based support and care coordination to 99 adolescents after discharge from psychiatric hospitalization, substance abuse treatment, a

serious medical event, or incarceration from October 2003 through November 2005. The program included a “home base” classroom staffed by two master’s level social workers, or clinician coordinators, and a classroom aide. The clinician coordinators served six to eight students at a time and provided, as needed, assessment, counseling, family support, case management, care coordination, and educational planning. The clinician coordinator met with the students and their families before school reentry and worked together with parents, mental health providers, teachers, and administrators to plan short-term goals which included: schedule changes, referrals to mental health or medical services, educational assessment, and tutoring. While the student was in school, the clinician coordinator facilitated communication between all parties involved including school personnel, mental health and substance abuse treatment providers, pediatricians, court personnel, and staff from outside agencies. The classroom aide assisted in helping students organize and complete assignments and communicated with teachers about the students’ current level of functioning. In addition, the program offered parent support and a psychoeducational group.

After three months in the program, 88 students remained in the community while 11 were rehospitalized (White et al., 2006). The Child and Adolescent Functional Assessment Scale (CAFAS) was used to assess student functioning at admission to the program. After a three month period, the total CAFAS score significantly decreased from a mean of 89 at admission to a mean of 64 ( $t=6.00$ ,  $df=44$ ,  $p<.01$ ; range of possible total CAFAS scores: 0 to 240). In addition, parents reported “that having a single, reliable, and accountable point of contact, consistent communication, and assistance in negotiating complex systems of care resulted in substantial lessening of stress and improved their

relationships with the school and the agencies involved (White et al., 2006, p. 1211). It is unclear from the article how these data were collected. White and colleagues (2006) do not provide data regarding the rehospitalization and drop-out rates for adolescents returning to school before their program was implemented. So, although the students' functioning improved on average, it is unclear if this program resulted in a decrease in recidivism.

In this transition program, school psychologists seem to play a peripheral role, conducting educational assessments only. However, because of their expertise, school psychologists are ideally suited to help students successfully transition from hospital to school and should play a more central role in this transition process.

*Ideal Role of School Psychologists in Partial Hospitalization Program-to-School  
Transitions*

Based on the current practices, preferred roles, and suggested roles in hospitalization-to-school transitions, an ideal role for school psychologists in partial hospitalization program-to-school transitions can be extrapolated. Because the traditional role of school psychologists has been to conduct psychoeducational assessments to determine eligibility for special education services, it is logical that school psychologists' primary role should be to use these skills to meet the needs of students transitioning from partial hospitalization programs. Additionally, because of their expertise in assessment, school psychologists should also determine eligibility for a service agreement under Section 504.

Knowing that the leadership in the field of school psychology advocates for an expanded role and scope of practice and that school psychologists prefer to engage in

non-traditional roles, school psychologists should further meet the needs of students transitioning to school from partial hospitalization programs by collaborating with parents, partial hospitalization program staff, and school personnel, monitoring the effects of medications, consulting and teaming with school personnel, coordinating planning, and facilitating communication by acting as liaison between the partial hospitalization program and school. These expanded roles can help to limit the identified barriers of confidentiality rules, inadequate communication, insufficient training, and undefined or overlapping roles.

This study explicitly explored the actual roles of school psychologists in the partial hospitalization program-to-school transition and the perceived barriers to successful transitions. In addition, this study explored which school psychologist characteristics predict involvement in partial hospitalization program-to-school transitions. Finally, whether school psychologists believe they have sufficient training to adequately transition students from partial hospitalization programs-to-school was also investigated.

### CHAPTER 3 METHODOLOGY

#### *Participants*

School psychologists who work in schools across the country were targeted for participation. One hundred thirteen school psychologists participated in the survey. Ninety-four participants provided complete responses. Of the complete responses, 71 participants (75.5%) had at least one student attend a partial hospitalization program during the previous two years. Because the research questions of this study relate to the role of school psychologists in partial hospitalization program-to-school transitions, the 71 participants in this group served as the sample for this study.

#### *Materials*

Participants completed an anonymous, internet-based survey created by the author (see Appendix B) via SurveyMonkey. The survey consisted of three sections including: 1) an introduction to the study, 2) items related to demographic information, and 3) questions regarding partial hospitalization program-to-school transitions. Survey items were adapted from other research on the demographic characteristics of school psychologists (i.e., Curtis et al., 2008), previous research regarding hospital-to-school transitions, and this author's experiences transitioning students from partial hospitalization programs-to-school.

Participants were asked to provide demographic information about their gender, ethnicity, level of education, years of practice, number of and age-group of children on their caseload, state, and work setting (i.e., urban, suburban, rural). In addition, they were

asked to provide demographic information about the students they serve, including the ethnicity, socio-economic status, and educational classification of their students.

Participants' roles in the partial hospitalization-to-school transition process were investigated. Specifically, participants were asked how many students on their caseload (both general and special education students) attended a partial hospitalization program for psychiatric reasons during the previous two years. Questions then explored how many cases they were involved with, if they were members of a transition team, and in which transition activities they participated. Participants then identified perceived barriers to the partial hospitalization program-to-school transition process. (If a participant did not have at least one student on their caseload attend a partial hospitalization program during the previous two years, they were asked to skip these questions). Finally, participants rated how effectively they believe their current partial hospitalization program-to-school procedures meet students' needs as well as how sufficiently they believe they have been trained to work with students transitioning from partial hospitalization programs.

### *Procedures*

After approval from the Temple University Institutional Review Board (IRB) was obtained, a recruitment message (see Appendix A) explaining the purpose of the research and containing a hyperlink to the survey was sent electronically to potential participants through several avenues. The recruitment message was posted on the Association of School Psychologists of Pennsylvania (ASSP) website as well as multiple listservs including the school psychologist state associations of Connecticut, Vermont, and New Hampshire and the Temple University Association of School Psychologists (TASP). Also, the recruitment message was sent via electronic mail to the professional contacts of

this author. Participants were also encouraged to share the recruitment message with their colleagues.

As was articulated in the recruitment message, participation was voluntary and participants could discontinue the survey at any time. It was anticipated that the survey would take approximately 10 minutes to complete. There was no risk of harm and deception was not employed. Clicking on the hyperlink to the questionnaire and completing the survey served as consent to participate.

An incentive to participate was offered to potential participants through the chance to win a \$50 gift card to Amazon.com. Awarding of the incentive was confidentially processed through the SurveyMonkey website. Identifying information used for the chance to win the incentive was not linked to survey responses and a winner was randomly chosen at the conclusion of the data collection period.

The data collection period lasted for three months. The recruitment message was posted every four weeks after the initial posting to further encourage participation. Data collection discontinued when a minimum of 70 school psychologists who had at least one student on their caseload attend a partial hospitalization program during the previous two years completed the survey. The participants' responses were electronically gathered and compiled through SurveyMonkey into a spreadsheet to facilitate data analysis with SPSS. Confidentiality of the data was maintained as only the study investigator had password protected access to the survey data.

## CHAPTER 4 RESULTS

### *Demographic Characteristics*

Participants were predominantly female (73.2%) and Caucasian (91.5%), with an average of 8.77 ( $SD=8.23$ ) years of experience. The majority of participants were from Pennsylvania (60.6%) with the next most frequently cited state being Connecticut (12.7%). Participants were most often employed in suburban settings (69.0%) with less than 25% of students described as racial/ethnic minorities (54.9%) or eligible for free/reduced lunch (44.9%). The average school psychologist to student ratio was found to be approximately 1:570 ( $SD=618.51$ ; range=10-2500). The most frequently endorsed level of education was a Master's degree plus 30 credits (54.9%) followed by a doctorate degree (40.8%). During the previous two years, participants reported an average of 7.90 ( $SD=14.14$ ; range=1-80) of their students attended a partial hospitalization program for psychiatric reasons. Details of the demographic characteristics of this sample can be found in Table 1.

### *Data Analysis*

Due to skewness of the demographic data, several variables were recoded to facilitate data analysis: ethnicity, level of training, school setting, and state. Ethnicity was recoded as "Caucasian or non-Caucasian", level of training was recoded as "Master's/Master's +30 or Doctorate", setting was recoded as "urban or suburban/rural", and state was recoded as "PA or Other States." The recoded variables were used to answer all research questions.

Table 1. Demographic Characteristics

Demographic	Percentage
<b>Gender</b>	
Male	26.8%
Female	73.2%
<b>Ethnicity</b>	
Caucasian	91.5%
African American	1.4%
Hispanic	7.0%
Asian/Pacific Islander	0.0%
Alaskan Native/Native American	0.0%
Other	0.0%
<b>Level of Training</b>	
Masters	4.2%
Masters +30/Specialist	54.9%
Doctorate	40.8%
<b>Setting</b>	
Urban	25.4%
Suburban	69.0%
Rural	5.6%
<b>State</b>	
PA	60.6%
CT	12.7%
NJ	8.5%
MA	4.2%
CA	4.2%
DE	2.8%
MD	2.8%
TX	1.4%
FL	1.4%
AZ	1.4%
<b>Racial/Ethnic Minorities Served</b>	
Less than 25%	54.9%
25% but less than 50%	11.3%
50% but less than 75%	12.7%
75% of more	21.1%

Students Eligible for Free/Reduced Lunch	
Less than 25%	44.9%
25% but less than 50%	17.4%
50% but less than 75%	14.5%
More than 75%	23.2%

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### *Roles of School Psychologists in Partial Hospitalization Program-to-School Transitions*

To understand the roles of school psychologists in partial hospitalization program-to-school transitions, a frequency count of the transition activities that school psychologists engaged in with at least one student who attended a partial hospitalization program was calculated (see Table 2). Results indicated that the most frequent transition activities were attending IEP meetings, consulting with teachers, and conducting assessments to determine eligibility for special education services. School psychologists participated in no transition activities more frequently than they participated in creating discharge plans, developing or revising 504 Plans, or monitoring medication effects.

### *Involvement with the Partial Hospitalization Program-to-School Transition Process*

Participants reported that a total of 561 students attended a partial hospitalization program for psychiatric reasons in the previous two years. An analysis of their involvement with the partial hospitalization program-to-school transition revealed that they were involved with an average of 86.6% ( $SD=28.59$ ) of the students who attended partial hospitalization programs. Results indicate that 74.6% of participants were involved in some way with 100% of the students on their caseload who attended a partial hospitalization program and 5.6% of school psychologists were involved with none of the students who attended a partial hospitalization program. If they were not involved with the partial hospitalization program-to-school transition process, participants ( $n=34$ )

Table 2. Frequency of Transition Activities

Transition Activity	n	Percentage
Attended an IEP Meeting	50	70.4%
Provided Teacher Consultation	49	69.0%
Evaluation to Determine Eligibility for Special Education	47	66.2%
Initial Evaluation (ER)	33	46.4%
Reevaluation (RR)	37	52.1%
Discussed Educational Plan while Student Attended a PHP	43	60.5%
Served on a School-Based Transition Team	42	59.1%
Created a Positive Behavior Support Plan (PBSP)	40	56.3%
Created an Initial PBSP	29	40.8%
Revised an Existing PBSP	25	35.2%
Gave Parent Information about an IEP/504 Plan	39	54.9%
Served as Liaison Between Parent and PHP	26	36.6%
Transition Meeting with Parents and PHP	26	36.6%
Prior to Discharge	18	25.4%
Following Discharge	17	23.9%
None	18	25.4%
Developed a Discharge Plan	15	21.1%
Created a 504 Plan	13	18.3%
Developed an Initial 504 Plan	9	12.7%
Revised an Existing 504 Plan	10	14.1%
Conducted Medication Monitoring	6	8.5%

indicated that the school employee primarily involved was the school counselor (61.8%), followed by the school social worker (14.7%), school administrator (8.8%), classroom teacher (5.9%), school nurse (2.9%), and unknown (5.9%).

To determine whether any differences existed between the school psychologists who were involved with all of the students who attended partial hospitalization programs and the school psychologists who were not involved or were partially involved, Pearson Chi-Squares were computed. There was no significant difference across gender; thus, both male and female school psychologists were as likely to participate in the transition of their students from partial hospitalization programs back to school ( $\chi^2(1) = .253, p = .615$ ). Similarly, there was no significant difference in ethnicity ( $\chi^2(1) = 2.226, p = .136$ ), level of training ( $\chi^2(1) = .836, p = .360$ ), state ( $\chi^2(1) = .376, p = .540$ ), school setting ( $\chi^2(1) = .125, p = .724$ ), responsibility for students classified as having an emotional disturbance ( $\chi^2(1) = .105, p = .745$ ), percentage of racial/ethnic minorities served ( $\chi^2(3) = 1.613, p = .657$ ), or percentage of students eligible for free/reduced lunch served ( $\chi^2(3) = 2.023, p = .568$ ).

However, school psychologists who were involved with all of the students who attended partial hospitalization programs and the school psychologists who were not involved or were partially involved differed with respect to the grade levels served. School psychologists who work in middle schools were less likely to be involved with all of the students on their caseload transitioning from partial hospitalization programs-to-schools ( $\chi^2(1) = 4.669, p = .031$ , Cramer's  $V = .256$ ). School psychologists serving preschool ( $\chi^2(1) = .237, p = .627$ ), elementary school ( $\chi^2(1) = 3.013, p = .083$ ), and high

school ( $\chi^2(1) = 1.046, p = .306$ ) students were as likely to participate in the transition of their students from partial hospitalization programs back to school.

Table 3. Total Involvement vs. Partial/No Involvement

Variable	Mean	SD	F	Significance
Years of Experience			3.890	.053
Total Involvement	7.60	6.91		
Partial/No Involvement	12.19	11.14		
Size of Caseload			6.393	.014
Total Involvement	473.12	552.08		
Partial/No Involvement	912.75	753.65		
Sufficiency of Training			1.658	.203
Total Involvement	3.74	1.05		
Partial/No Involvement	4.13	1.03		
Current System Effectiveness			8.426	.005
Total Involvement	2.84	.96		
Partial/No Involvement	2.06	.85		

A MANOVA was used to compare those who were involved with all cases to those who were partially or not involved with transitioning students on the following variables: years of experience, size of caseload, perceived sufficiency of training, and perceived effectiveness of current transition system (see Table 3). Those who were involved with all of the students who attended partial hospitalization programs were found to have smaller caseloads ( $M = 473.12, SD = 552.08$ ) than those who were not involved or were partially involved ( $M = 912.75, SD = 753.65; F(1,66) = 6.393, p = .014$ , partial eta squared = .091). In addition, those who were always involved believed they had a more effective system for transitioning students ( $M = 2.84, SD = .96$ ) than those who were not involved or were partially involved ( $M = 2.06, SD = .85; F(1,66) = 8.426, p =$

.005, partial eta squared=.116). Although not statistically significant, school psychologists who were involved with all cases had fewer years of experience ( $M= 7.60$ ,  $SD= 6.91$ ) than those with partial or no involvement ( $M= 12.19$ ,  $SD= 11.14$ ;  $F(1,66) = 3.890$ ,  $p = .053$ ). The groups did not differ in how sufficient they believed their training was to work with students transitioning from partial hospitalization programs-to-school ( $F(1,66) = 1.658$ ,  $p= .203$ ).

#### *Barriers to Successful Partial Hospitalization Program-to-School Transitions*

Participants rated potential barriers to successful partial hospitalization program-to-school transitions on a Likert-type scale with 1=Not a Barrier and 5=Strong Barrier. The mean responses were calculated and can be found in Table 4. All potential barriers were rated to be moderate to strong barriers to successful partial hospitalization program-to-school transitions. The strongest barrier to successful transitions was found to be insufficient communication between partial hospitalization programs and school staff ( $M=4.01$ ,  $SD=1.083$ ) followed by unclear staff roles in the transition process ( $M=3.51$ ,  $SD=1.191$ ). Insufficient communication among school employees ( $M=3.39$ ,  $SD=1.203$ ) and a lack of releases of information ( $M=2.88$ ,  $SD=1.482$ ) were also rated as barriers to successful partial hospitalization program-to-school transitions.

#### *Transition Team Members vs. Non-Team Members*

Although 42 participants (59.1%) indicated that they teamed with other school-based professionals when transitioning students from a partial hospitalization program-to-school, only 15 participants (21.1%) indicated that their schools had school-based teams specifically designed to address hospital-to-school transitions. Of these, 14 school

Table 4. Barriers to Successful Partial Hospitalization Program-to-School Transitions

Barrier	Mean	SD
Insufficient Communication between PHP and school <sup>b</sup>	4.07	1.083
Unclear roles in the transition process <sup>b</sup>	3.51	1.191
Teachers had insufficient knowledge of mental health disorders <sup>a</sup>	3.39	1.203
Insufficient communication between school and parent(s) <sup>a</sup>	3.30	1.142
Lack of coordination of school-based services <sup>c</sup>	3.16	1.333
Parent/Student unwilling to share confidential information <sup>c</sup>	3.01	1.308
I didn't know the student attended a PHP <sup>d</sup>	3.00	1.655
Insufficient Communication among school employees <sup>b</sup>	2.97	1.349
Lack of Releases of Information <sup>b</sup>	2.88	1.482

Note: <sup>a</sup> n=69. <sup>b</sup> n=68. <sup>c</sup> n=67. <sup>d</sup> n=66.

psychologists (19.7%) were members of the team and one school psychologist was not a member of the team.

To understand whether the school psychologists who worked within organized hospital-to-school transition teams significantly differed from those who did not, several analyses were conducted. First, Pearson Chi-Squares were computed. School psychologists did not statistically differ across gender ( $\chi^2(1) = 2.305, p = .129$ ), meaning that school male and female school psychologists were as likely to be team members. Similarly, there were no significant differences in terms of ethnicity ( $\chi^2(1) = .039, p = .844$ ), level of training ( $\chi^2(1) = .029, p = .864$ ), school setting ( $\chi^2(1) = .989, p = .320$ ),

state ( $\chi^2(1) = .815, p = .367$ ), percentage of racial/ethnic minorities ( $\chi^2(3) = 4.203, p = .240$ ), and percentage of students eligible for free/reduced lunch ( $\chi^2(3) = .721, p = .868$ ).

Next, a MANOVA was used to compare hospital-to-school transition team members and non-team members on the following variables: years of experience, size of caseload, perceived sufficiency of training, and perceived effectiveness of current transition system. Results can be found in Table 5. Team members were found to perceive their current system as more effective at transitioning students from partial hospitalization programs-to-school ( $M=3.38, SD=1.044$ ) than non-team members ( $M=2.47, SD=.890; F(1,66) = 10.258, p=.002, \text{partial eta squared}=.138$ ). Team members and non-team members did not statistically differ on any other variables.

Table 5. Team Members vs. Non-Team Members

Variable	Mean	SD	F	Significance
Years of Experience			.301	.585
Team Members	9.85	8.204		
Non-Team Members	8.43	8.347		
Size of Caseload			2.476	.121
Team Members	336.08	445.242		
Non-Team Members	639.45	657.170		
Sufficiency of Training			.117	.733
Team Members	3.92	.954		
Non-Team Members	3.81	1.075		
Current System Effectiveness			10.258	.002
Team Members	3.38	1.044		
Non-Team Members	2.47	.890		

*Perceived Sufficiency of Training and Current Procedures*

Participants rated how sufficient they believed their training was to work with students transitioning from partial hospitalization programs to school on a Likert-type scale, with 1=Insufficient and 5=Sufficient (see Table 6 for distribution of responses). Results indicated that participants believed that their training was moderately sufficient ( $M=3.77$ ,  $SD=1.098$ ). Although they believed that their training was sufficient, participants still rated their current system for transitioning students from partial hospitalization programs-to-school as moderately ineffective ( $M=2.66$ ,  $SD=1.048$ ), with 1=Not Effective and 5=Very Effective (see Table 7 for distribution of responses).

To understand whether years of experience influenced perceptions of the sufficiency of training or the effectiveness of current procedures, Pearson correlations were computed. Results indicate that participants with more years of experience perceived their training to work with students transitioning from partial hospitalization programs-to-school as more sufficient (see Table 8).

Table 6. Frequency Distribution of Responses on Perceived Sufficiency of Training

Response	Frequency	Percentage
1	3	4.2
2	5	7.0
3	19	26.8
4	22	31.0
5	22	31.0

Table 7. Frequency Distribution of Responses on Perceived Effectiveness of Current System

Response	Frequency	Percentage
1	10	14.1
2	21	29.6
3	25	35.2
4	11	15.5
5	3	4.2

Table 8. Correlation of Years of Experience with Perceived Sufficiency of Training and Effectiveness of Current System

		Years of Experience	Sufficiency of Training	Effectiveness of Current System
Years of Experience	Pearson Correlation	1	.489	-.030
	Significance		.000	.806
Sufficiency of Training	Pearson Correlation	---	1	.132
	Significance			.278
Effectiveness of Current System	Pearson Correlation	---	---	1
	Significance			

## CHAPTER 5 DISCUSSION

This study serves as an initial investigation into the actual role and function of school psychologists in partial hospitalization program-to-school transitions. Not only do the results highlight previously uninvestigated roles in this process, but they also identify school psychologist characteristics that predict involvement and clarify the barriers to successful partial hospitalization program-to-school transitions. From this information, recommendations for improving the effectiveness of partial hospitalization program-to-school transitions can be drawn.

Knowing that 20% of students meet the diagnostic criteria for a mental health disorder (USDHHS, 1999), school psychologists are likely to encounter students receiving mental health care in a partial hospitalization program setting. In fact, this initial investigation revealed that 75.5% of participants who provided complete responses (N=94) had at least one student attend a partial hospitalization program for psychiatric reasons during the previous two years, with individual school psychologists reporting an average of 7.90 students attending a partial hospitalization program within the previous two years. Because school psychologists are considered to be the mental health experts in schools (NASP, 2008; Sheridan & Gutkin, 2000; Ysseldyke et al., 2006), it follows that they would play an active role in this transition process. However, until now, their actual role and function in this process was yet to be explored.

### *Roles of School Psychologists in Partial Hospitalization Program-to-School Transitions*

Based on the current practices of school psychologists, it was hypothesized that school psychologists' primary role in partial hospitalization program-to-school transitions

would be conducting psychoeducational assessments to determine eligibility for special education services. Results indicated that, although not primary, this traditional role continues to be emphasized.

The most frequent roles of school psychologists in the partial hospitalization program-to-school transition process were participating in IEP meetings, consulting with teachers, and conducting evaluations to determine eligibility for special education services. The high frequency of participation in IEP meetings and evaluations to determine eligibility for special education services is not surprising considering that school psychologists report spending 80.4% of their time engaged in special education activities (Curtis et al., 2008). However, the high frequency of teacher consultation indicates that current practices are extending beyond the traditional role to align with the expanded roles delineated in *Blueprint III* (Ysseldyke et al., 2006) and the NASP Practice Model (NASP, 2010). Further supporting this role in partial hospitalization program-to-school transitions is that consultation is a preferred activity of school psychologists (Hosp & Reschly, 2002; Reschly & Wilson, 1995).

Consultation with teachers is an essential component of partial hospitalization program-to-school transitions. After all, teachers are the school employees who have frequent, direct, and on-going interactions with students. When students transition back to school following a partial hospitalization, they are likely to have social, emotional, behavioral, and academic needs. Through consultation with the school psychologist, teachers can aid the transition process by regularly monitoring a student's adjustment back to school and implementing needed interventions and/or accommodations.

For a successful transition to occur, teachers need to possess accurate and meaningful information about mental health disorders. School psychologists indicated that teachers' insufficient knowledge about mental health disorders was a primary barrier to successful partial hospitalization program-to-school transitions. This lack of knowledge may lead to anxiety about how to best interact with or help a student with significant mental health needs and school psychologists can allay these fears. Because of their expertise, school psychologists can inform teachers about a particular mental health disorder, including the expected symptoms and possible medication side effects, while also suggesting strategies for effectively working with a student.

In addition to consultation, school psychologists support the role of teachers in partial hospitalization program-to-school transitions through the development of IEPs and Positive Behavior Support Plans (PBSP). Results indicate that developing IEPs was the most frequently cited role of school psychologists with more than half of school psychologists creating or revising a PBSP. These special education documents offer a clear structure for the supports that teachers and other school personnel should provide for students transitioning from a partial hospitalization program-to-school. They outline the necessary specially designed instruction, or accommodations, a student requires while also providing procedures for measuring student progress. This is especially important since, depending on their length of stay in a partial hospitalization program, a student's academic skills may have regressed and they may have missed significant portions of the curriculum.

Of all the transition activities considered, school psychologists least frequently engaged in medication monitoring. It was hypothesized that this role would occur at a

higher frequency than was found because previous research showed that 54.5% of a sample of school psychologists engaged in medication monitoring for students with ADHD (Gureasko-Moore et al., 2005). Although not all students who attend partial hospitalization programs have diagnoses of ADHD, the same medication monitoring principles could be applied to other psychiatric diagnoses. Yet, only 8% of the school psychologists in this sample engaged in medication monitoring for a student returning to school following admission to a partial hospitalization program. Considering that children and adolescents may return to school taking new medications or new doses of previously prescribed medications, monitoring of possible side effects is an important part of successful transitions, especially if the medication side effects can impact school functioning and achievement. However, results indicate that, contrary to previous findings, this role is not widely practiced by school psychologists.

Due to their expertise in assessment, it was also predicted that school psychologists would spend more time developing or revising 504 Plans than was actually found. This difference may be due to the fact that a different school employee is responsible for the development of 504 Plans (i.e., school nurse, school counselor). However, more likely, given the high number of IEP meetings attended, the reason for the infrequent development of 504 Plans may be that eligibility for special education services under IDEIA was established, making the implementation of a 504 Plan redundant and unnecessary.

One-fifth of school psychologists participated in the development of a discharge plan, a process that requires cooperation and collaboration with partial hospitalization program staff. Because a discharge plan is designed to address a student's needs

following discharge, it is presumed that the creation of the discharge plan occurred prior to discharge from a partial hospitalization program. Survey results indicated that one-quarter of school psychologists held a transition meeting with partial hospitalization program staff and parents prior to discharge. This indicates that some school psychologists collaborated with partial hospitalization program staff but they were not always involved in the development of a discharge plan.

Discharge plans tend to be oriented towards mental health treatment and include medical information and recommendations related to medication dosages and follow-up care. School psychologists may have limited involvement in this process because partial hospitalization program staff may view participation in discharge planning as outside the scope of practice of school psychologists. However, discharge plans would be more effective if they included recommendations for the school setting. Due to their expertise in mental health and education (NASP, 2008; Nastasi, 2003), school psychologists are ideally suited for this role.

Collaboration with other professionals is an inherent component of the process of conducting an evaluation to determine eligibility for special education services. Given the high frequency of evaluations to determine eligibility for special education services, it was anticipated that school psychologists would frequently engage in collaboration with parents and other professionals. School psychologists were found to collaborate with others in the partial hospitalization program-to-school transition process; however, the rates of collaboration varied depending on whether they were collaborating with school personnel, parents, or partial hospitalization program staff.

Only two-fifths of school psychologists held a transition meeting with partial hospitalization program staff and parents. Usually, the meeting was held either prior to or following discharge; however, some school psychologists attended a meeting both prior to and following discharge. School psychologists had higher levels of communication and collaboration with parents and school-based personnel than with partial hospitalization program staff. Slightly more than half of school psychologists indicated that they collaborated with school-based personnel during partial hospitalization program-to-school transitions and shared information with parents in the form of information regarding IEPs and 504 Plans at a similar rate. These higher rates of collaboration may primarily be the result of proximity, as school psychologists, other school-based personnel, parents, and students regularly interact within the school setting.

It has been suggested that having a single contact person, or liaison, can improve collaboration among parents and professionals. This is especially necessary when cooperation among professionals from multiple organizations is required. Serving as a liaison is a recommended role for school psychologists because they have expertise in interpersonal and collaborative relationships (Nastasi, 2000; Prevatt et al., 2000; Shaw & Woo, 2008). Results show that 36.6% of school psychologists engaged in the role of serving as a liaison between the parents, school, and partial hospitalization program staff. This is an important finding because, as Sheridan and Gutkin (2000) suggest, collaborative communication between school psychologists and other adults is necessary for transition services to be successful.

Therefore, school psychologists should have higher rates of collaboration during the partial hospitalization program to school transition than was found. In particular,

greater collaboration between partial hospitalization program staff and school personnel is needed. It is considered best practice to collaborate with medical professionals during hospital-to-school transitions (Shaw & Woo, 2008) because students return to school with mental health needs, limited academic experiences, and a possible regression of skills. Moreover, a lack of communication between partial hospitalization programs and school staff was found to be the primary barrier to successful transitions.

#### *Involvement with the Partial Hospitalization Program-to-School Transition Process*

To best understand the role of school psychologists in partial hospitalization program-to-school transitions, knowing the particular professional activities that school psychologists engage in is not sufficient.. It is also necessary to identify the characteristics that predict involvement in the partial hospitalization program-to-school transition process. School psychologists demonstrated high levels of involvement in partial hospitalization program-to-school transitions, participating in transition activities with an average of 86.6% of the students on their caseload returning to school following a partial hospitalization. Furthermore, three-quarters of school psychologists were involved in the transition of all of the students on their caseload who attended a partial hospitalization program. These high levels of involvement indicate that participation in partial hospitalization program-to-school transitions is a well-established role for school psychologists.

Although the vast majority of school psychologists were involved in partial hospitalization program-to-school transitions, some school psychologists continued to not be involved or to be only partially involved. Comparisons of these groups indicated that school psychologists who were involved with 100% of the students on their caseload who

attended partial hospitalization programs did not differ from those who were not involved or were partially involved in terms of gender, ethnicity, level of training, state, school setting, racial/ethnic and socioeconomic status of students, or perceived sufficiency of training. However, they did differ in important ways.

School psychologists who were involved with 100% of the students who attended a partial hospitalization program had significantly smaller caseloads than those who were not involved or were partially involved. This finding lends support to the recommended school psychologist to student ratios provided by the National Association of School Psychologists (NASP). NASP (2010) recommends that, in general, the school psychologist to student ratio should not exceed 1:1000; however, when school psychologists are providing comprehensive services that include evaluations, consultation, behavioral interventions, and counseling, the ratio should not exceed 1:500-700. Unfortunately, many school psychologists had caseloads that well exceeded the recommended ratios. These high ratios make it difficult for school psychologists to provide comprehensive services to students beyond the traditional “test and place” role.

Under IDEIA, each state must have policies and procedures to identify, locate, and evaluate all children and adolescents with a disability (§300.111 (a) (1) (i)). This federal legislation, along with the subsequent local interpretation of this legislation, directly influences the role of school psychologists. This is especially true at the elementary and middle school levels as many disabilities are first identified when children are exposed to the demands of the general education curriculum. Therefore, it was expected that school psychologists practicing in elementary and middle schools would have high levels of involvement in partial hospitalization program-to-school

transitions. However, contrary to expectations, school psychologists who worked in middle schools were found to be statistically less likely to be involved with all of the students on their caseload transitioning from partial hospitalization programs-to-schools. Rather, they were more likely to be only partially involved or not involved at all.

School psychologists practicing at the middle school level may be involved with only some or none of the students attending partial hospitalization programs because many students attending partial hospitalization programs are already identified as eligible for special education services. The high frequency of IEP meetings paired with the number of reevaluations, rather than initial evaluations, completed by the school psychologists in this sample suggests that many of the students attending partial hospitalization programs were identified as students with a disability prior to hospitalization. This is consistent with data from the Pennsylvania Departments of Education and Public Welfare, which found that 54% of students referred to partial hospitalization programs had IEPs prior to admission (PDE & DPW, 2007).

If a student was recently identified as a student with a disability, it may be unnecessary to complete an additional evaluation, thus negating a primary role of school psychologists. As a result, the particular transition needs of these students may be handled by a different school-based employee; likely the school counselor, who was identified as the school employee most frequently involved in transition process when it was not the school psychologist him/herself. Additionally, because of their obligation to find all children with disabilities, school psychologists working at the middle school level may not have availability in their schedules to engage in non-traditional roles with students transitioning from partial hospitalization programs who have already been

identified as students with a disability. Instead, their job description may be heavily weighted toward completing psychoeducational evaluations to determine eligibility for special education services for previously unidentified students.

Nevertheless, school psychologists employed at the middle school level should have greater involvement in partial hospitalization program-to-school transitions. This is especially true since school psychologists with greater involvement rated their current procedures as statistically more effective than those who were less involved. For students experiencing mental health symptoms severe enough to warrant admission to a partial hospitalization program at these young ages, it is essential that they have effective transition services and on-going monitoring by a school psychologist. Early involvement and comprehensive school-based services provided by the school psychologist may lead to better long-term outcomes.

#### *Barriers to Successful Partial Hospitalization Program-to-School Transitions*

Although school psychologists demonstrate high levels of involvement in partial hospitalization-to-school transitions, overall they rate their current transition procedures as moderately ineffective. Clearly, there are barriers that interfere with successful transitions. Previous literature has identified confidentiality rules (i.e., FERPA, HIPAA), inadequate communication (Education Law Center, 2004; Education Law Center, n.d.; PDE & DPQ, 2007), and undefined or overlapping roles (Shaw et al., 2004) as barriers in hospital-to-school transitions. Consistent with these findings, current results indicate that school psychologists perceive these barriers as having a moderate to strong impact on partial hospitalization program-to-school transitions.

By far, the highest rated barrier to successful partial hospitalization program-to-school transitions was insufficient communication between partial hospitalization program and school staff. It is not surprising that a lack of communication between partial hospitalization programs and schools was a barrier to successful transitions. After all, students returning from partial hospitalization have both mental health and educational needs. Not only are they coping with significant mental health needs but they must also cope with the additional burden of missing academic instruction and needing to reintegrate themselves into an established social system. Information regarding a student's educational experience while attending a partial hospitalization program, as well as recommendations for mental health supports in the school, are necessary components of successful transitions.

This lack of communication between partial hospitalization programs and schools has previously been identified as a primary barrier to the transition process (Education Law Center, 2004; Education Law Center, n.d.; PDE & DPW, 2007). In fact, the lack of coordinated planning between partial hospitalization programs and local education agencies in Pennsylvania was severe enough to warrant the attention of the Education Law Center. As a result of advocacy from the Education Law Center, the Pennsylvania Departments of Public Welfare and Education jointly issued a standard procedure for interagency collaboration that was designed to minimize barriers (DPW, 2008).

Despite this suggested procedure, a lack of communication between partial hospitalization programs and school districts remains. Current survey results indicate that only 25.4% of school psychologists participated in a transition meeting with partial hospitalization program staff and parents prior to discharge and 23.9% participated in a

transition meeting following discharge. From these data, it appears that the suggested procedures are not being translated into practice. However, it is possible that a school-based employee other than the school psychologist was involved in an interagency meeting.

It will be difficult to make changes unless these recommendations are enforced within the legal code. As it stands, partial hospitalization programs are administered and regulated by the Department of Public Welfare and educational programs are administered by the Department of Education. The isolation of these systems within the legal code prohibits seamless, collaborative, and fully participative communication. Obviously, more advocacy for the needs of students attending partial hospitalization programs is needed at the governmental level.

In addition to insufficient communication between partial hospitalization programs and schools, unclear roles in the transition process was also seen as a strong barrier to successful transitions. Without clearly established roles, the transition process can be chaotic for students and adults alike. Parents may be unsure of who to contact with questions or concerns about the transition process. In addition, they may be overwhelmed by having to repeat information when contacted by multiple school professionals. To reduce this barrier, having a liaison, or single contact person, is recommended (Nastasi, 2000; Prevatt et al., 2000; Shaw & Woo, 2008). School psychologists have the expertise to adequately fill this role; however, currently, it is only being practiced by two-fifths of practitioners.

Unclear or undefined roles in the transition process can also result in professionals duplicating tasks completed by others or avoiding tasks because it is assumed that a task

is the responsibility of another professional. This can especially happen when areas of expertise overlap. To address unclear or overlapping roles, Shaw and colleagues (2004) suggest the implementation of Medical Transition Teams. The structure of a transition team clearly defines each member's role and function, thus minimizing this barrier.

As previously discussed, teachers' insufficient knowledge of mental health disorders can be minimized through consultation with the school psychologist. This is important because insufficient knowledge of mental health disorders among teachers was rated to be a moderately strong barrier to successful partial hospitalization program-to-school transitions. Consultation with teachers should emphasize providing accurate information about mental health disorders, expected symptoms, and necessary interventions or accommodations, while also correcting preexisting misperceptions and misunderstandings.

#### *Transition Team Members vs. Non-Team Members*

When transitioning students from a hospital to a school setting, a collaborative team approach is widely supported and encouraged (Farmer & Peterson, 2005; Glang et al., 2004; Hooper et al., 2001; Kaffenberger, 2006; Shaw et al., 2004; Shaw & Woo, 2008). Given the likelihood that school psychologists will encounter students with significant medical or mental health needs that require hospitalization, Shaw and colleagues (2004) recommend that schools develop Medical Transition Teams. Despite this recommendation, only one-fifth of school psychologists indicated that their schools have teams specifically designed to transition students from the hospital-to-school setting. Encouragingly, though, nearly all transition teams had a school psychologist

member. It is important to note that some of these school psychologists may work within the same school districts.

School psychologist team members and non-team members did not differ in terms of their gender, ethnicity, level of training, school setting, state, racial/ethnic and socioeconomic status of student body, years of experience, size of caseload, or perceived sufficiency of training. However, a significant difference was found in perceptions of the effectiveness of current transition procedures. Team-members believed that their procedures for transitioning students from partial hospitalization programs-to-school were statistically more effective than school psychologists who did not serve on teams specifically designed to transition students from hospital-to-school settings. This statistically significant difference in perceived effectiveness provides additional support for the implementation of a team approach to partial hospitalization program-to-school transitions.

Team-members may perceive their procedures as more effective than non-team members for several reasons. First, a transition team approach brings all key players together in an organized manner and includes the student, parents, partial hospitalization program staff, and school staff. More than half of school psychologists indicated that they collaborated with other school-based employees; however, the transition team approach extends the group to include stakeholders outside the school setting. This allows for all student needs to be identified whether mental health, academic, or behavioral and for individual team members to share their specific areas of expertise.

Second, a transition team approach provides a clear structure that minimizes barriers to partial hospitalization program-to-school transitions. Most immediately, the

identified barriers of unclear roles and responsibilities, insufficient communication among school employees, and a lack of coordinated school-based services are diminished. Once these barriers are removed, the structure of a team further facilitates opportunities for communication with partial hospitalization program staff and parents. Third, the formality of an established transition team, which presupposes support from the school administration, gives legitimacy to the hospital-to-school transition process. This may additionally increase the likelihood that teachers will be open to consultation and parents and students may be more willing to share confidential information.

Although team-members perceive their procedures as more effective, it is important to emphasize that, overall, they only viewed their procedures as moderately effective. This indicates that team procedures do not remove all barriers to successful partial hospitalization program-to-school transitions. This may be because team members attempt to collaborate with partial hospitalization program staff and parents, but receive little cooperation. However, given that this was not explicitly asked on the survey, there may also be unidentified barriers that interfere with the partial hospitalization program transition process. Still, a team approach provides the structure necessary to remove certain barriers and should be adopted when transitioning students from partial hospitalization programs-to-school.

#### *Perceived Sufficiency of Training and Effectiveness of Current Procedures*

School psychologists believe that they have moderately sufficient training to work with students transitioning from partial hospitalization programs-to-school. A positive opinion regarding the sufficiency of their training is expected considering that the most frequently cited roles in the transition process were related to determining eligibility for

special education services (e.g., evaluations, IEP meetings). This role has long been the traditional role of school psychologists (Bramlett et al., 2002; Hosp & Reschly, 2002; Reschly & Wilson, 1995; Sheridan & Gutkin, 2000) and school psychology training programs emphasize these skills.

However, it is important to note that school psychologists view their training to work with students transitioning from partial hospitalization programs as only moderately sufficient, signifying that a gap in training exists. Although NASP has begun to advocate for an expanded role and scope of practice for school psychologists, suggesting that school psychologists should be the leading mental health experts in schools (NASP, 2008; Ysseldyke et al., 2006), this may not have translated into effective changes in training programs. In addition, these changes only affect recent graduates, meaning that experienced practitioners may not have been exposed to this shift in role and function during their training.

Currently, there is tension between the school psychologist role required by federal legislation and the expanded and comprehensive role advocated for by NASP through *Blueprint III* (Ysseldyke et al., 2006) and the NASP Practice Model (NASP, 2010). To address this tension, school psychology training programs may cover the expanded role, yet continue to stress the skills that will be used most frequently in daily practice (i.e., assessment) over other skills. Further influencing the curriculum of training programs is the orientation and research interests of the faculty members. If faculty members do not view themselves as the mental health experts in schools, it is unlikely that this perspective will be transferred to students. The result is that school psychologists

may not exit training programs prepared to view themselves as the mental health experts in schools.

Still, in general, school psychologists viewed themselves as prepared to transition students from partial hospitalization programs-to-school. No significant differences in perceptions were found between school psychologists with total involvement and those with partial or no involvement or between transition team members and non-team members. However, this finding is not unexpected, as school psychologists' perceptions of the sufficiency of their training are directly influenced by their anticipated role and function in partial hospitalization program-to-school transitions.

This identified gap in training needs to be addressed via multiple routes. First, training programs need to emphasize the needs of students attending partial hospitalization programs and provide pre-service school psychologists with the skills they need to fulfill an expanded role and scope of practice. Next, with the same goal, continuing professional development needs to be provided for school psychologists already practicing in the field. Specific training in how to effectively transition students from partial hospitalization programs-to-school is also necessary.

Unfortunately, the practices and procedures for partial hospitalization program-to-school transitions that are currently in place in schools are rated to be moderately ineffective. So, although school psychologists believe that, in general, they have sufficient training, these skills are not being translated into effective practice. However, certain subsets of school psychologists view their procedures to be more effective than others. School psychologists who were involved with 100% of the students on their caseload who attended a partial hospitalization program believe their procedures are more

effective than those involved with some or none of the students transitioning from a partial hospitalization program setting. In addition, school psychologists who transitioned students as a member of a team designed to specifically address hospital-to-school transitions perceived their procedures as more effective than non-team members.

*Recommendations for Improving the Effectiveness of Partial Hospitalization Program-to-School Transitions*

As the leading mental health experts in the schools, school psychologists are encouraged to advocate for the needs of students transitioning from partial hospitalization program-to-school by leading systems change within their school districts. Drawn from the current findings, the following recommendations are suggested to increase the effectiveness of partial hospitalization program-to-school transitions.

1. Establish a Hospital-to-School Transition Team

School psychologists who serve on a team specifically designed to transition students from a hospital-to-school setting perceive their procedures as more effective than non-team members. Hospital-to-School Transition Teams provide a clear structure that minimizes the identified barriers of insufficient communication, unclear or overlapping roles, and a lack of coordinated services. Additionally, the formality of established teams, along with support from school administration, provides legitimacy to the transition process, which may subsequently increase the participation of all stakeholders in the transition process.

## 2. Increase Involvement in the Partial Hospitalization Program-to-School Transition Process

School psychologists who were involved with all of the students on their caseload who attended a partial hospitalization program perceived their transition procedures as more effective than those who were not involved or were only partially involved. In addition, school psychologists who were involved with all of the students who attended a partial hospitalization program had significantly smaller caseloads than those with no or partial involvement. Therefore, within their school districts, school psychologists should advocate for the NASP recommended school psychologist to student ratio of 1:500-700.

## 3. Serve as a Liaison

Insufficient communication among parents, school-based employees, and partial hospitalization program staff was found to be a primary barrier to successful transitions. Having a single contact person, or liaison, can improve collaboration among parents and professionals. Due to their expertise in mental health, education, and interpersonal and collaborative relationships, school psychologists are ideally suited to fill this role.

## 4. Provide Teacher Consultation

Insufficient knowledge about mental health disorders among teachers was rated as a strong barrier to partial hospitalization program-to-school transitions. For successful transitions to occur, teachers need accurate and meaningful information about a particular mental health disorder, the expected symptoms and possible medication side effects, and suggested strategies for working effectively with a student. Through consultation with the school psychologist, teachers can aid the transition process by regularly monitoring a student's adjustment and implementing interventions and/or accommodations.

## 5. Seek Out Professional Development Activities

Through advocacy from NASP, school psychology training programs have begun to emphasize an expanded role and scope of practice for school psychologists. However, school psychologists view themselves as only moderately prepared to transition students from partial hospitalization program-to-school settings. Due to the changing role and function of school psychologists, school psychologists should seek out continuing professional development activities to expand their training and acquire the skills necessary to serve as the mental health experts in schools.

### Limitations

While this study serves as an initial investigation into the role and function of school psychologists in partial hospitalization program-to-school transitions, the findings must be interpreted with caution. For the purposes of this study, a convenience sample, rather than a nationally representative, randomly selected sample, was employed. Therefore, results cannot be generalized to school psychologists on the whole.

To understand the current practices of school psychologists, the sample was limited to school psychologists who had at least one student attend a partial hospitalization program within the previous two years. Although this procedure allows for the investigation of transition activities currently employed, it limits the understanding of perceptions of training and anticipated barriers to successful partial hospitalization program-to-school transitions. A complete and meaningful understanding of partial hospitalization program-to-school transitions is not possible without input from partial hospitalization program staff, parents, and students.

## Future Research

Future research should include school psychologists who have yet to have a student on their caseload attend a partial hospitalization program and school psychologists who have had a student attend a partial hospitalization program more than two years in the past. The inclusion of all school psychologists will result in more accurate information for practitioners as well as school psychology training programs. In addition, future research should investigate partial hospitalization program-to-school transitions from the perspective of other stakeholders including partial hospitalization program staff, parents, and students. This information can then be incorporated with the current findings to further enhance and improve partial hospitalization program-to-school transitions. Finally, future research should further explore the training experiences of school psychologists as related to partial hospitalization program-to-school transitions in order to inform school psychology training programs as they develop their course sequence and curriculum.

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APPENDIX A  
RECRUITMENT MESSAGE

The Role of School Psychologists in Partial Hospitalization Program-to-School  
Transitions

This study will examine the role of school psychologists in partial hospitalization program-to-school transitions. We are looking for school psychologists who are practicing in schools to complete a brief survey about their current roles in this process. If you would like to participate in this anonymous survey, please click on the hyperlink below. Please complete the survey by March 31, 2010. The survey should take no longer than 10 minutes to complete. After completing the survey, participants will have the opportunity to enter a drawing for the chance to win a \$50 gift card. Identifying information used for this purpose will not be linked to survey responses.

Clicking on the link below implies your consent to participate in the study. Participation is voluntary and you can discontinue at any time by exiting the browser.

<https://www.surveymonkey.com/s/X99F3CQ>

This study has been approved by the Temple University IRB as project number 13451.

Please contact the investigators below if you have any questions about this research.

Sincerely,

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APPENDIX B  
SURVEY

School psychologists who are currently practicing in schools are invited to complete this survey about partial hospitalization program-to-school transitions. First, brief demographic information will be collected followed by questions related to partial hospitalization program-to-school transitions.

**Demographics**

1. What is your gender?
  - Male
  - Female
  
2. What is your ethnicity?
  - Caucasian
  - African American
  - Hispanic
  - Asian/Pacific Islander
  - Alaskan Native/Native American
  - Other
  
2. What is your level of training?
  - Masters
  - Masters +30/Specialist
  - Doctorate
  
3. How many years experience do you have as a school psychologist? \_\_\_\_\_
  
4. In what setting is the school(s) you work in located?
  - Urban
  - Suburban
  - Rural
  
5. In which state do you work? \_\_\_\_\_
  
6. What age groups do you serve? (check all that apply)
  - Preschool
  - Elementary School
  - Middle School
  - High School

7. Approximately how many students are on your caseload? Please include both general education and special education students. \_\_\_\_\_

8. Please indicate what percentage of the students you serve are racial/ethnic minorities.

Less than 25% of students served are racial/ethnic minorities

25% but less than 50% of students served are racial/ethnic minorities

50% but less than 75% of students served are racial/ethnic minorities

More than 75% of students served are racial/ethnic minorities

9. Please indicate what percentage of the students you serve receive a free or reduced lunch through the National School Lunch Program.

Less than 25% of students served receive a free or reduced lunch

25% but less than 50% of students served receive a free or reduced lunch

50% but less than 75% of students served receive a free or reduced lunch

More than 75% of students served receive a free or reduced lunch

10. Are you responsible for students classified as having an emotional disturbance?

Yes

No

## Transitions

1. During the previous two years, approximately how many students on your caseload attended a partial hospitalization program for psychiatric reasons? (Please include both general and special education students. If none, please enter 0. If none, the survey will conclude.).

2. For each student who attended a partial hospitalization program, in which transition activities did you participate? (Check all that apply).

Student One:

- None
- Served on a school-based transition team
- Attended a transition meeting with parent(s) and partial hospitalization program prior to discharge
- Attended a transition meeting with parent(s) and partial hospitalization program following discharge
- Discussed the student's educational plan for while he/she attended the partial hospitalization program
- Participated in the development of a discharge plan
- Shared information with parent(s) regarding IEPs or 504 Plans
- Initiated an Initial Evaluation (ER)
- Initiated a Reevaluation (RR)

- Attended an IEP Meeting
- Initiated an Initial 504 Plan
- Initiated a Revised 504 Plan
- Created an Initial Positive Behavior Support Plan
- Revised an existing Positive Behavior Support Plan
- Served as liaison between partial hospitalization program and school
- Conducted medication monitoring
- Provided Teacher Consultation
- Other:

Student Two:

- None
- Served on a school-based transition team
- Attended a transition meeting with parent(s) and partial hospitalization program prior to discharge
- Attended a transition meeting with parent(s) and partial hospitalization program following discharge
- Discussed the student's educational plan for while he/she attended the partial hospitalization program
- Participated in the development of a discharge plan
- Shared information with parent(s) regarding IEPs or 504 Plans
- Initiated an Initial Evaluation (ER)
- Initiated a Reevaluation (RR)
- Attended an IEP Meeting
- Initiated an Initial 504 Plan
- Initiated a Revised 504 Plan
- Created an Initial Positive Behavior Support Plan
- Revised an existing Positive Behavior Support Plan
- Served as liaison between partial hospitalization program and school
- Conducted medication monitoring
- Provided Teacher Consultation
- Other:

Student Three:

- None
- Served on a school-based transition team
- Attended a transition meeting with parent(s) and partial hospitalization program prior to discharge
- Attended a transition meeting with parent(s) and partial hospitalization program following discharge
- Discussed the student's educational plan for while he/she attended the partial hospitalization program
- Participated in the development of a discharge plan
- Shared information with parent(s) regarding IEPs or 504 Plans

- Initiated an Initial Evaluation (ER)
- Initiated a Reevaluation (RR)
- Attended an IEP Meeting
- Initiated an Initial 504 Plan
- Initiated a Revised 504 Plan
- Created an Initial Positive Behavior Support Plan
- Revised an existing Positive Behavior Support Plan
- Served as liaison between partial hospitalization program and school
- Conducted medication monitoring
- Provided Teacher Consultation
- Other:

ETC.

3. If you were not involved, which school employee was primarily involved with the partial hospitalization program-to-school transition process?

- Principal
- Teacher
- School Counselor
- School Nurse
- School Social Worker
- Other:
- I don't know

4. Please rate the following by how strongly you believe each is a barrier to partial hospitalization program-to-school transitions.

None

I didn't know the student attended a partial hospitalization program

1	2	3	4	5
Not a Barrier		Neutral		Strong Barrier

Insufficient communication between partial hospitalization program and school

1	2	3	4	5
Not a Barrier		Neutral		Strong Barrier

Insufficient communication among school employees

1	2	3	4	5
Not a Barrier		Neutral		Strong Barrier

Insufficient communication between school and parents

1	2	3	4	5
Not a Barrier		Neutral		Strong Barrier

Lack of coordination of school-based services

1	2	3	4	5
Not a Barrier		Neutral		Strong Barrier

Unclear roles in the transition process

1	2	3	4	5
Not a Barrier		Neutral		Strong Barrier

Teachers had insufficient knowledge of mental health disorders

1	2	3	4	5
Not a Barrier		Neutral		Strong Barrier

Lack of Releases of Information

1	2	3	4	5
Not a Barrier		Neutral		Strong Barrier

Parent/student unwillingness to share confidential information about treatment

1	2	3	4	5
Not a Barrier		Neutral		Strong Barrier

Other:

5. Does your school have a team designed to specifically address hospital-to-school transition needs?

Yes

No

5a. If so, are you a member of the team?

Yes

No

6. How sufficient do you believe your training is to work with students transitioning from partial hospitalization programs-to-school?

1	2	3	4	5
Insufficient		Neutral		Sufficient

7. Do you feel that your current system for transitioning students from partial hospitalization programs to school are effectively meeting the students' needs?

1	2	3	4	5
Not Effective		Somewhat Effective		Very Effective