CAMMARANO, ALEXANDRIA S. Ph.D. Learning to Be STRATEGIC: A Training Evaluation on the Student Reentry Process Following Psychiatric Hospitalization. (2024)
Directed by Dr. Carrie Wachter Morris. 179 pp.

For the last decade, psychiatric hospitalization rates for children and adolescents have significantly increased, taking many students out of school to receive appropriate care (Clemens et al., 2011; Hall & DuBois, 2020; Leeb et al., 2020). Furthermore, recent trends show that students experience considerably shorter psychiatric stays focused on intense treatment modalities, leading many to rely on outpatient services post-discharge (Blader, 2011; Preyde et al., 2021; White et al., 2017). As a result, students and their families turn to school services as an accessible source for support services during the reentry process (Marraccini et al., 2019). However, schools struggle to ease the transition, with many school support personnel reporting few to no policies, procedures, or training for handling the student reentry process following psychiatric hospitalization (Iverson, 2018; Marraccini et al., 2021; Tisdale, 2014).

The reentry process is critical for students as they work towards meeting academic, social, and emotional demands, navigate new routines, manage symptoms, and face mental health stigma (Preyde et al., 2021; Savina et al., 2014). Although there is an abundance of recommendations regarding the reentry process, only a limited number of researchers created programs or models to address this phenomenon, and the few that exist lack the feasibility, funding, and staff considerations needed to achieve their promising results in schools nation-wide (Midura et al., 2023). Moreover, community considerations play a large influence in how schools and larger systems handle student mental health. For example, rural school districts face unique challenges that are a part of larger systemic issues, such as a lack of a consistent definition of “rural,” shortage of specialists, and fewer protocols and policies around the student reentry process (Anderson et al., 2013; Blackstock et al., 2018; Marraccini et al., 2021). The

study detailed in this dissertation proposal presented an eight-step training informed by researchers' recommendations, community considerations, and includes a tangible document to promote individualized reentry planning.

This study sought to evaluate the Learning to Be STRATEGIC training based on the areas of training evaluation and school counselors' experiences of the training. Additionally, the study examined school counselor's self-efficacy and multi-tiered systems of support (MTSS) skills and knowledge before and after implementation of the training. The researcher utilized an experimental design consisting of pre- and post-tests, a treatment group, and a waitlist control group. The researcher also used live feedback questions during the training, and open-ended questions during the second time point to gather qualitative data on the implementation of the training. Data analysis included descriptive statistics, thematic analysis, and repeated measures ANOVAs to answer each of the research questions. Results from the study indicated significant differences across participants' scores for self-efficacy and MTSS knowledge and skills after the implementation of the Learning to Be STRATEGIC training. Furthermore, the training was shown to have high participant scores across Kirkpatrick's four areas of training evaluation indicating participants were satisfied with the training and found its applications useful within their working environments. The researcher only found significant differences based on treatment condition for the organization results area of the Q4TE, suggesting further research may be needed to better address the long-term outcomes of the training. The results from this study demonstrate the development of the Learning to Be STRATEGIC model and training may prove to be a significant and feasible tool for school support personnel facilitating the student reentry process following psychiatric hospitalization.

LEARNING TO BE STRATEGIC: A TRAINING EVALUATION ON THE STUDENT REENTRY PROCESS FOLLOWING PSYCHIATRIC HOSPITALIZATION

by

Alexandria S. Cammarano

A Dissertation
Submitted to
the Faculty of The Graduate School at
The University of North Carolina at Greensboro
in Partial Fulfillment
of the Requirements for the Degree
Doctor of Philosophy

Greensboro

2024

Approved by

Dr. Carrie Wachter Morris
Committee Chair

DEDICATION

This project is dedicated to all the students struggling with their mental health and the school support personnel doing their best.

You are not alone.

APPROVAL PAGE

This dissertation written by Alexandria S. Cammarano has been approved by the following committee of the Faculty of The Graduate School at The University of North Carolina at Greensboro.

Committee Chair

Dr. Carrie Wachter Morris

Committee Members

Dr. Connie Jones

Dr. Rebecca Mathews

Dr. Andrea Hunter

April 24, 2024

Date of Acceptance by Committee

April 24, 2024

Date of Final Oral Examination

ACKNOWLEDGEMENTS

I am deeply grateful for the endless amount of support I received throughout this process. Pursuing a doctoral degree wasn't initially part of my plan, but it has turned out to be one of the most rewarding decisions of my life. I would not have been able to get through this process without the help of many people. While completing dissertation marks reaching the final milestone, I cannot put into words what my time at UNCG and CED has meant to me. I will forever cherish the guidance, words of wisdom, sense of belonging, and people who have made my journey unforgettable.

First and foremost, I express my deepest gratitude to my wonderful committee, whose invaluable support and mentorship made this project a reality. To my chair, Dr. Carrie Wachter Morris, thank you for not only supporting the ambitious aspirations of this project, but for providing me opportunities to work alongside you since my first year as a doctoral student. You are an incredible counselor educator and I hope you never stop advocating for school counselors everywhere. Dr. Connie Jones, thank you for our countless meetings filled with laughter, empathy, and your mentorship. I hope you know how much your presence and support mean to students; I consider myself fortunate to have had the chance to know and learn from you. Dr. Rebecca Mathews, thank you for generously sharing your expertise on child and adolescent development, your time, and the warm, supportive energy you brought throughout every step my dissertation journey. To my cognate chair, Dr. Andrea Hunter, thank you for dedicating your time for collaboration sessions during my independent study, our shared commitment towards advancing advocacy efforts for schools, and your dedication to ensuring this model fully supported *all* students.

To the exceptional faculty and staff in CED, thank you for your unwavering dedication to the profession and your continued efforts to our commitment of making the counseling field a better place. To the master's students I had the opportunity to meet and work with, thank you for allowing me the privilege to learn and grow from you all. Our shared experiences have shaped me into a better supervisor, counselor, and educator. I have no doubt the next generation of counselors is one of the best yet to come. Finally, to my fellow ghostbusters, thank you for being the most supportive and inspiring cohort I could have envisioned to share this journey with. You have become my second family and friends I hope to have for life.

I have been blessed and fortunate to have an incredible support system of friends and family throughout my life. To my husband Joe, thank you for being my anchor, offering unconditional love, support, and compassion through every major milestone. As my best friend and chief advocate, I could not have imagined completing this phase of my life without you. To my family, I cannot thank you enough for your encouragement, grace, and sacrifice for allowing me to accomplish my dreams. Words cannot do justice how much your support has shaped my life, and I am deeply grateful to have become the person I am today because of each of you. I love you all tons!

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

CHAPTER I: INTRODUCTION

Children and adolescent populations account for an increasing proportion of psychiatric hospitalizations within the last two decades (Hall & DuBois, 2020; Leeb et al., 2020) and nearly twenty percent of youth in the United States report a mental health diagnosis (AHRQ, 2022). In 2021, the United States Surgeon General declared a mental health crisis among youth due to increased rates of suicidal behaviors, psychological distress, and psychiatric emergency room visits (Office of the Surgeon General, 2021). Commitment to psychiatric hospitalization usually requires that the student be placed in a medical setting for a length of time, therefore, temporarily taking the student out of their school setting. Although student absences due to medical reasons are generally excused, many state attendance policies require that students must return to school promptly following hospital discharge (Clemens et al., 2011). This leaves a short period of time for the student transition period back to school as well as limited planning time for the student's return by school support personnel. Several factors influence the student's perceived reentry experience including type of hospital admission, mental health stigma, geographic location, risk of readmission, their school's role or involvement, and school/district policies. Post-discharge, students must learn to adapt and change to meet the academic, social, and emotional demands as they reenter their school settings (Preyde et al., 2021; Savina et al., 2014).

Students with health conditions such as chronic illness and traumatic brain injury (TBI) remain the current focus of the school reentry literature (Clemens et al., 2011; Kaffenberger, 2006). While there are similarities between the literature on students reentering school following chronic illness and psychiatric hospitalization such as navigating symptom management and extended absences, students who struggle with mental illness often perceive higher levels of stigma and require different treatment modalities (Savina et al., 2014). Furthermore, youth report

mixed reactions from being hospitalized and name the type of hospital admittance as a key predictor to perceived experiences of the hospitalization (Salamone-Violi et al., 2015).

Regarding the student reentry process, community factors further represent the influence of staff retention, school funding, accessibility or availability of mental health agencies, cultural beliefs on mental health, and impact of significant events shared by the community (e.g., COVID-19 pandemic; Blackstock et al., 2018; Curfman et al., 2021). Students living in rural communities face additional barriers to a successful reentry such as poverty, lack of accessibility of resources, mental health provider shortages, and low treatment engagement (James et al., 2022; van Vulpen et al., 2018). Several school support personnel report school counselors as one of the primary leaders in the reentry process (Marraccini et al., 2019; Marraccini et al., 2021; Savina et al., 2014; Vanderburg et al., 2023); however, school counselors disclose a lack of training around students returning from psychiatric hospitalization and few – if any – policies or procedures around this process (Iverson, 2018; Marraccini et al., 2021; Tisdale, 2014). While researchers explored and recommended plan components for a successful student reentry following psychiatric hospitalization, few provided a formal model or procedure for this process, specifically with considerations for rural school districts.

Current Trends in Psychiatric Hospitalization

The Centers for Disease Control (CDC) state that children (5-11 years old) and adolescents (12-17 years old) have the highest rates of psychiatric emergency room visits within the 2019-2020 year (Leeb et al., 2020). Hall and DuBois (2020) found that the rates for psychiatric hospitalization among adolescents is increasing significantly, with a three hundred percent increase in mental health related hospital visits in the past two decades. While there has been an influx in psychiatric hospitalizations, the length of time patients stay at the hospital has

rapidly decreased over the past twenty years due to an increased use of medications, employment of cost-cutting health care approaches, and that longer hospital stays do not always necessitate better outcomes (Nash et al., 2021; Preyde et al., 2021, White et al., 2017). Therefore, the dependence on outpatient care has increased across students and families (Blader, 2011; Preyde et al., 2021; White et al., 2017). The length of stay for children and adolescents hospitalized for mental health concerns ranges between three to ten days based on the severity of the child's symptoms and priorities for treatment (White et al., 2017). Researchers have found that quick and informal reentry practices often lead to poorer school transitions post-discharge (Preyde et al., 2021; Savina et al., 2014). Additionally, many students in rural communities' face challenges and decisions post-discharge regarding their ability to continue treatment including obtaining referrals for specialists, transportation, and accessibility (van Vulpen et al., 2018). On top of geographic location challenges, these students also face difficulty with medication and symptom management, facing stigma, and returning to schools with little to no formal reentry protocols (Marraccini et al., 2021).

Geographic Location

Geographic area serves as a leading factor contributing to the accessibility and proximity to resources and specialists, availability of funding, and rates of school support personnel (Anderson et al., 2013; Blackstock et al., 2018). For example, rural communities face unique challenges that contribute to these factors including the variation in the definition of "rural" within federal and state organizations and policymakers, physical distance from specialists and transportation concerns, community cultural beliefs around mental health services, and shortage of school support personnel (Blackstock et al., 2018). As outlined in Marraccini et al. (2019), school personnel's most common requirements for reentry included meetings with families,

phone calls with hospital staff, and developing a reentry plan individualized to the student's needs. However, school systems with a lack of funding, access to resources, and staff training serve as barriers to creating successful student reentry (Tisdale, 2014). Furthermore, Marraccini et al. (2021) found that schools in suburban and metropolitan/urban communities were more likely to report having reentry plan protocols and policies when compared to schools in rural communities.

Role of School Counselors

School counselors have been identified and recommended among school staff and caregivers as the primary facilitators or reentry coordinators of the student reentry process following psychiatric hospitalization (Marraccini et al., 2019; Marraccini et al., 2021; Savina et al., 2014; Vanderburg et al., 2023). School counselors' specific training and knowledge of the social, academic, and emotional needs of students places them in an ideal position to facilitate the reentry process as a whole (e.g., chronic illness, psychiatric hospitalization; Kaffenberger, 2006). The American School Counseling Association (ASCA) states school counselors are essential in assisting students in developing skills and coping mechanisms to navigate changing expectations and environments, collaborating with all stakeholders, and providing resources or referrals within their recommendations for school reentry (ASCA, n.d.). Furthermore, ASCA outlines the ethical standards required of school counselors that apply to issues related to school reentry including A. Responsibility to Students, and B. Responsibility to Parents/Guardians, School and Self (ASCA, 2022).

Barriers to facilitating the reentry process include school administration's requirements of school counselors to complete duties not outlined in ASCA's standards (e.g., clerical responsibilities, proctoring tests, covering classes for teachers), high student caseloads, and

managing multiple crises (Marraccini et al., 2021). Additionally, Monteiro-Leitner et al. (2006) found that rural school counselors are more likely to spend time completing non-counseling duties and often do not meet the advised standards set by ASCA. In a study that surveyed school counselors' comfort and training around public-school mental health interventions, counselors reported feeling confident in their skills to handle student issues as they arise (Carlson & Kees, 2013). However, eighty-eight participants also stated they lack the time to provide needed services due to the demands of their role in a school setting (Carlson & Kees, 2013). As a result, students and caregivers heavily rely on school professionals, such as school counselors, to help facilitate the transition from psychiatric hospitalization to school, but often these professionals lack training, resources, and time to help follow through with reentry plans (Iverson, 2017; Tisdale, 2014).

Post-Discharge

Twenty-four to thirty-seven percent of youth readmission rates occur within one year of discharge, with students being at the highest risk for rehospitalization in the three-months post-discharge (Preyde et al., 2021). Regarding students' perceptions reentering school following psychiatric hospitalization, McBride and Preyde (2020) found that returning students reported they believed their difficulties transitioning back to school made it a lot harder for those around them (i.e., family and friends). When returning to school, students often reported high levels of discrimination, bullying, anxiety to complete missing work, and challenges dealing with mental health symptoms (Marraccini et al., 2022; Marraccini & Pittleman, 2022). Students also described protective factors during their reentry such as caregiver engagement, reconnecting with friends, finding a trusted school staff member, and frequent check-ins (Iverson, 2018; Marraccini & Pittleman, 2021).

Researchers continue to support identifying interventions and creating programs to assist students and their families in the school reentry process following psychiatric hospitalization, and many have shown the benefits to providing services during this phenomenon. Students who report poorer transitions perceive a lack of support at school and face unaddressed discrimination and stigma (Preyde et al., 2021). Lack of perceived support increases youth's risk of rehospitalization, higher levels of stress, lower levels of resilience, and in some cases, suicide-related behaviors (Marraccini & Pittleman, 2021; Preyde et al., 2021). Youth who received and engaged in support services post-discharge, including school counseling, reduced their rehospitalization risk by seventy-six percent over a thirty-month period (James et al., 2010).

Statement of Problem

While school staff, specifically school mental health personnel, complete risk assessments and provide referrals, researchers found that many feel they lack training or did not receive training on the reentry process following psychiatric hospitalization and only 16.5% of schools have a formal, written protocol in place for reentry (Marraccini et al., 2021). Throughout the literature, researchers agree to a cohesive plan approach that encompasses specific components to ensure a successful school reentry from psychiatric hospitalization. Furthermore, an exploration on community considerations prompted additional components that should be considered for all school districts.

In reviewing the literature, limited program models have been created to address the student reentry process. Weiss et al. (2015) created the School Transition Program (STP), a community-based intervention created to help promote communication and collaboration of all stakeholders during the three months after a student returns from psychiatric hospitalization. The program provides youth with coordination services, a transition plan, and check-ins with school

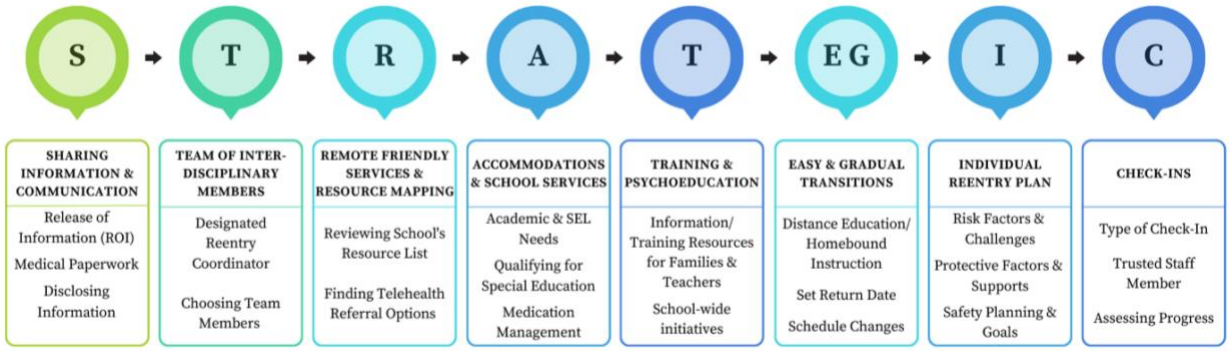
staff while caregivers receive a peer supporter (a graduated caregiver member of STP) and psychoeducation. Weiss et al. (2015) found that caregivers in their program reported lower levels of caregiver strain and increased sense of empowerment. White et al. (2017) examined the Bridge for Resilient Youth in Transition (BRYT) program where students receive a set of interventions focusing on improving youth functioning and the transition to a traditional school environment within eight to twelve weeks post-discharge. Stakeholders from schools and a mental health agency created the program to allow students to gradually reenter school through a designated classroom space with clinical and school support personnel, a transition plan, and school accommodations. Students who participated in the BRYT showed significant improvement in emotional scores, self-harm scores, school functioning, school attendance, and high school graduation rates (White et al., 2017). While these programs show promising results to the reentry process, they lack the feasibility to implement in schools nationwide due to funding and staff requirements (Midura et al., 2023). Additionally, there are not currently any research programs on the student reentry process following psychiatric hospitalization that specifically address community considerations.

The Learning to Be STRATEGIC Model

The following plan outlines the suggested components from the reentry literature for school mental health personnel through the STRATEGIC acronym and includes: (S) sharing information and communication between families, school staff, and hospitals, (T) team of interdisciplinary members lead by an identified reentry coordinator, (R) resource mapping and inclusion of remote-friendly services, (A) accommodations and multicomponent services, (T) training and psychoeducation provided to caregivers and school staff, (E-G) easy and gradual transitions back into school, (I) creation of an individualized reentry plan, and (C) frequent

check-ins with the student, their family, and members of the reentry team throughout the first three months of being back at school (Hall & DuBois, 2020; James et al., 2022; Marraccini et al., 2021; Savina et al., 2014; Tougas et al., 2022; van Vulpen et al., 2018). Order of the plan follows in accordance with a table of proposed reentry protocols for students returning with chronic health conditions outlined by Schilling and Getch (2018). A recent article outlining a framework and order of protocol recommendations for the student reentry process following psychiatric hospitalization further support the Learning to Be STRATEGIC model's original order (Tougas et al., 2023). The researcher created the model through combination of researchers' general recommendations and community considerations.

Figure 1. The Learning to Be STRATEGIC Model



Significance of Study

In reviewing the literature, there is a significant lack of procedures and protocols for school support personnel as they work with students returning from psychiatric hospitalization. This study evaluated the Learning to Be STRATEGIC training and obtain feedback around the training's effectiveness on the school reentry process post-psychiatric hospitalization and collect observations in general self-efficacy scores and school counselors' skills and knowledge around multi-tiered systems of support (MTSS). The significance of this study is to provide a model grounded in the literature to better guide school counselors, especially those in rural

communities, in the student reentry process from psychiatric hospitalization. Additionally, this model provides a tangible document that can be distributed across school staff, ensuring all school support personnel have access to reentry procedures in the event a school counselor is absent (see Appendix A). The Learning to Be STRATEGIC model highlights specific cultural and community components within the student reentry process, emphasizing the additional importance on the inclusion of remote-friendly services and school engagement in resource mapping.

Research Questions

Research Question 1 (R1): How effective is the Learning to Be STRATEGIC training for school counselors in the various areas of training evaluation (i.e., reaction, learning, behavior, and results)?

Research Question 2 (R2): Is there a difference on school counselors' self-reported scores of general self-efficacy after the implementation of the Learning to Be STRATEGIC training?

Research Question 3 (R3): Is there a difference on school counselors' skills and knowledge around multi-tiered systems of support (MTSS) after the implementation of the Learning to Be STRATEGIC training?

Research Question 4 (R4): What is school counselors' feedback on the implementation of the Learning to Be STRATEGIC training?

Research Question (R5): Is there a difference between the waitlist control group and treatment group self-efficacy, knowledge and skills of multi-tiered systems of support (MTSS), and training evaluation scores?

Definition of Terms

American School Counseling Association – A professional organization working to support school counselors, school counseling students/interns, school counseling program directors or supervisors, and school counseling educators in their efforts to assist all students on academic, social/emotional, and career development (ASCA, 2022).

Emergency hold – If a patient requests to be discharged, the hospital may hold the patient for up to 72 hours or until a mental health provider can evaluate and determine whether there are any safety concerns (NAMI, 2018).

Formal reentry policies - Policies or protocols that are written or documented at either the school or district level (Marraccini et al., 2019).

Informal reentry policies - Policies or protocols that are consistently followed at the school or district level but not documented in the school/district's handbooks (e.g., who are members of the reentry coordination team; Marraccini et al., 2019).

Involuntary admission – Admission into a psychiatric hospital/unit where the patient does not agree, is experiencing extreme mental health symptoms, or the mental health provider evaluates and determines the patient is a safety risk or danger to their selves or others. Laws around involuntary admission vary from state-to-state and age of the patient (NAMI, 2018).

Mental health crisis – Any situation in which a person's behavior puts them at risk of hurting themselves or others and/or prevents them from being able to care for themselves or function effectively in the community (NAMI, 2018, p. 5).

Multi-Tiered Systems of Support – evidenced-based, holistic and systematic approaches to improve student learning and social-emotional behavioral functioning…implemented in

educational settings including Response to Intervention (RTI) strategies across three tiers or levels (Sink, 2016, p. 204)

Tier 1 – universal or primary prevention that can includes providing support school-wide to students and staff (Goodman-Scott et al., 2023, p. 5)

Tier 2 – indicated or secondary prevention for students who present indicators of problem behaviors or concerns (e.g., small groups; Goodman-Scott et al., 2023, p. 6)

Tier 3 – intensive or tertiary prevention for students at significant risk or lack protective factors…implemented through specialized and individualized supports (Goodman-Scott et al., 2023, p. 6)

Professional School Counselor – The American School Counselor Association (ASCA, 2022) defines school counselors as "certified/licensed educators who improve student success for ALL students by implementing a comprehensive school counseling program" (p.1).

Psychiatric hospitalization – An overnight stay or longer in a psychiatric inpatient unit (excluding emergency room visits without an inpatient admission) for individuals with behaviors or symptoms that are likely to result in harm to themselves or others (NY Dept. of Health and Mental Hygiene, 2016, p. 1).

Rural – According to the National Center for Education Statistics (NCES, 2022), there are three ways school districts can be categorized as rural:

Fringe – Census-defined rural territory that is less than or equal to 5 miles from an Urbanized Area, as well as rural territory that is less than or equal to 2.5 miles from an Urban Cluster.

Distant – Census-defined rural territory that is more than 5 miles but less than or equal to 25 miles from an Urbanized Area, as well as rural territory that is more than 2.5 miles but less than or equal to 10 miles from an Urban Cluster.

Remote – Census-defined rural territory that is more than 25 miles from an Urbanized Area and also more than 10 miles from an Urban Cluster.

Self-efficacy - foundation for motivation, well-being, and personal accomplishment in all areas of life (Pajares, 2006; p. 339)

Urbanized area – Densely developed territory, and encompass residential, commercial, and other nonresidential urban land uses…with at least 50,000 people or more (U.S. Census Bureau, 2022, p.2).

Urban cluster – Developed territory encompassing a population of at least 2,500 to 50,000 people (U.S. Census Bureau, 2022, p.7).

Voluntary admission – Admission into a psychiatric hospital/unit where a person goes for a mental health evaluation and the mental health provider and patient agree the patient meets criteria for hospitalization and may benefit from the treatment plan (NAMI, 2018). For information on patient discharge for voluntary admission, please see *emergency hold* definition.

CHAPTER II: LITERATURE REVIEW

In Chapter I, the researcher provided a brief overview of the student reentry process following psychiatric hospitalization literature and researcher recommendations for guiding school support personnel. To address the lack of research outlining protocols and procedures designed to inform school staff personnel of this process, the researcher created the Learning to Be STRATEGIC model and training. In Chapter II, the researcher provided an in-depth exploration of the literature surrounding student reentry, rationale for specific community considerations, and detailed analysis of the Learning to Be STRATEGIC components.

Trends in Student Reentry

Psychiatric Hospitalization

Psychiatric hospitalization is a critical treatment for children and adolescents who need diagnostic assessments, safe and contained environments, psychopharmacology, stabilization, and immediate access to specialized professionals (Marraccini & Pittleman, 2022; Moses, 2011). Consequences of psychiatric hospitalization include abrupt transitions of students' daily routines and lives, and possible risk of strong negative reactions (e.g., shock, fear, and anxiety; Plemmons et al., 2018). Treatment engagement following psychiatric hospitalization is often low due to accessibility to outpatient resources, medical bills, inconsistent attendance, long wait lists, and premature termination (Brown & Jager-Hyman, 2014; Marraccini & Pittleman, 2021). Researchers found mixed reactions of youth's experience with psychiatric hospitalization. Some students reported feeling a sense of safety and relief due to peer support, feedback, and normalization in the hospital setting while others reported stress and anxiety due to perceived rigidity or confinement, lack of treatment responsiveness, and frightening/anxiety provoking experiences (i.e., witnessing others be restrained; Moses, 2011; Salamone-Violi et al., 2015).

Furthermore, Salamone-Violi et al. (2015) found that the type of hospital admittance impacted perceived experiences of the hospitalization. For example, youth admitted under an involuntary treatment order (ITO) were more likely to report negative experiences, such as fear and anger, whereas youth open to hospitalization perceived the experience as supportive. Therefore, students with negative or traumatic perceptions of the hospitalization process could potentially further the risk of not engaging in treatment post-discharge and lead to poorer transitions upon their return to school (Preyde et al., 2021).

Hospital and school systems operate at different models, leaving discrepancies between policies, procedures, and treatment options (Kaffenberger, 2006; Seehusen, 2021). Therefore, policies reinforcing a quick student reentry (e.g., school attendance) could cause potential challenges and not provide students enough time to find or gain access to resources recommended by the hospital setting (Savina et al., 2014). Many students report their initial transition back to school as difficult due to social, emotional, and academic demands (Preyde et al., 2021; Savina et al., 2014). Regarding social-emotional experiences, students identify interactions with peers and staff, managing psychiatric symptoms, accessing supports, and absences as perceived challenges within the reentry process.

McBride and Preyde (2020) found that returning students perceived their difficulties transitioning back to school as challenges and stress for those around them (i.e., family and friends). Students returning to school from psychiatric hospitalization not only consider the immediate challenges they will face but envision long term consequences. A student from one study exemplifies this notion by stating, “I am already quite behind in school and after returning I will be further behind; this will affect my marks which will affect my university admission” (Preyde et al., 2017, p. 521). The concept that students could potentially view themselves as a

burden and think critically about the long-term effects of hospitalization matches with other research findings on student's perceptions of balancing a desire of support while also experiencing feelings of isolation (Marraccini & Pittleman, 2022; McBride & Preyde, 2020). Students transitioning back to school from chronic/long-term illness, running away, or traumatic brain injury are focal points for most reentry literature (Clemens et al., 2011; Kaffenberger, 2006). Consequently, the research focus on the reentry process for students following psychiatric hospitalization, and the prevalence of school policies and procedures is limited. To better inform the creation of the Learning to Be STRATEGIC model, the researcher turned to literature focusing on reentry following chronic illness, school involvement in referrals, and community considerations.

Chronic Illness

According to the American Academy of Pediatrics (2020), twenty million children live with a chronic illness, and one third of these children experience school challenges upon reintegration. Chronic illness can be defined as severe injury or illness lasting longer than three months causing lifestyle disruptions and require various medical interventions (AAP, 2021; Schilling & Getch, 2018). Many of the school reintegration protocols and programs for students with chronic illness land in three categories: student-focused, school personnel-focused, and peer support programs (Wikel & Markelz, 2023). Each program serves a different purpose ranging from individualized programming (i.e., student-focused) to increasing knowledge of peers and staff members on chronic illness (school- and peer-focused). Student-focused reentry programs tend to be the most common and include the following components: establishing contact, collaborative communication across stakeholders on the child's condition, providing homebound instruction or multicomponent accommodations (e.g., IEP and 504 plans), and holding a school

reentry meeting prior to the student's return (Canter & Roberts, 2012; Hamlet et al., 2011; Schilling & Getch, 2018; Wikel & Markelz, 2023).

Students reentering school following chronic illness show similar difficulties to those who reenter following psychiatric hospitalization, such as somatization, anxiety, and psychological distress (Vanclooster et al., 2018). Furthermore, students reentering school from consistent absence often face challenges with their performance at school, personal functioning, and social interactions with their peers (Clemens et al., 2011; Vanclooster et al., 2018). Vanclooster et al. (2018) examined themes in the research for students returning to school following chronic illness. Their findings confirmed the desire for open communication among all stakeholders, a "school liaison" to monitor and adapt the student's reentry plan as needed, and training or educational workshops for school staff members. Researchers further recommend that reentry planning for students with chronic illness should begin immediately when the student and their family inform the school of an extended absence and focus on consistent communication across stakeholders to help facilitate the process (Hamlet et al., 2011; Hen, 2022; Kaffenberg, 2006; Schilling & Getch, 2018). Additionally, Hen (2022) found that mothers and teachers of chronically ill students reported observations of traumatic and difficult integrations back to school following the lack of communication during the illness. The desire for connection and support throughout a student's absence from school highlight the importance of active stakeholder engagement and appointment of a reentry coordinator to serve as the main liaison between settings (Hamlet et al., 2011; Schilling & Getch, 2018).

Homebound instruction is one of the primary services offered to chronically ill students during the interim period before school reentry (Shaw et al., 2014). Homebound instruction promotes communication across stakeholders, ensures the student receives supplemental learning

during their absence and can be provided online when necessary (Hamlet et al., 2011; Schilling & Getch, 2018). Other formal services the school offers for students during this process include considerations for an IEP or 504 plan to help identify educational support and remove barriers within a general education setting (Shaw et al., 2014). This process often includes thorough assessments of the student, eligibility determination, and individualized planning (Schilling & Getch, 2018; see IEP vs. 504 Plans section).

Many teachers and school support personnel express a lack of professional development or educational training around chronic illness to discuss the needs of their student who has been hospitalized. This often results in low levels of staff confidence and competence around this process (Hoffman, 2021; Kaffenberg, 2006; Schilling & Getch, 2018). Specifically, Hoffman (2021) found that teachers and support staff requested information around the student's confidentiality when it comes to relaying information to peers and HIPAA guidelines. Therefore, researchers recommend that further training or continuing education workshops related to students with chronic health problems should be provided at all levels to increase knowledge within the school community (Hoffman, 2021; Schilling & Getch, 2018; Wikel & Markelz, 2023).

Recommendations for the appointed reentry coordinator vary across the literature, and include school nurses, school counselors, and school psychologists (Hamlet et al., 2011; Hoffman, 2021; Kaffenberger, 2006; Schilling & Getch, 2018). School nurses often act as the liaison between the school and medical professionals due to their extensive medical knowledge and understanding of the school system (Hamlet et al., 2011). School counselors are often tasked with communicating the needs of the chronically ill student and their family with school staff, and helping students cope with the demands of returning to school (Hamlet et al., 2011;

Hoffman, 2021; Kaffenberger, 2006). Hamlet et al. (2011) found the student's grade and developmental levels impacted reentry services offered by the school counselors. For example, seventy-one of high school counselors reported services focusing on academic and self-advocacy skills, while elementary school counselors reported a focus mainly on keeping routines and social-emotional learning. Schilling and Getch (2018) point out that school psychologists may also be considered a qualified reentry coordinator due to their knowledge and training on psychological and developmental assessment. Examining the literature on the reentry process for chronically ill students can provide a better understanding of the protocols or procedures around reentry plans following psychiatric hospitalization and differences in treatment modalities between the two.

School Involvement in Psychiatric Referrals

School referrals account for twenty percent of child and adolescent psychiatric emergency room visits, and one out of every ten school risk assessments (e.g., suicide and threat assessments) lead to psychiatric hospitalization (Crepeau-Hobson, 2013; Soto et al., 2009). Additionally, Marraccini et al. (2019) found school psychologists reported up to forty student referrals for hospitalization occur within each school year. School mental health personnel report they often received training and had protocols around risk assessments, long absences, and behavioral issues. However, they lacked training or have not received training in the school reentry process from psychiatric hospitalization, and only a small number (16.5%) of schools had a formal, written protocol in place for reentry (Marraccini et al., 2019; Marraccini et al., 2021). Members of reentry coordination (i.e., school counselors, school psychologists, social workers, special education teachers, and administrative staff) frequently turn towards reactive, potential solutions rather than proactive methods for students. Quick and informal reentry practices may

be unsuccessful and problematic due to the differences in support, resources, funding, routines, expectations, and personnel available in hospitals versus school settings (Preyde et al., 2021; Savina et al., 2014).

School services are a leading, accessible source for mental health treatment post-hospitalization. According to the 2016 National Survey on Drug Use and Health, 13.1% (3.2 million) of adolescents in the U.S. reported receiving mental health services and treatment for psychiatric disorders in schools. Current components for youth reentry plans include addressing the academic, social, and emotional needs, accommodations to support student adjustment, teacher preparation, coping methods for addressing adverse reactions, safety planning, roles, and responsibilities of those within the students' support network, and contact information of the reentry coordination team (Marraccini & Pittleman, 2021; Savina et al., 2014; Tougas et al., 2022; White et al., 2017). Therefore, the importance of schools as a mental health source for adolescent recovery and early, proactive communication among reentry coordinators cannot be overemphasized (Marraccini et al., 2019).

Limitations to school as the sole source for mental health services include inconsistent attendance, legal and ethical considerations when working with minors, limited financial resources, high demands of staff, IEP and 504 plan restrictions, and legislation around education (Richter et al., 2022). Additional barriers to providing school mental health services during reentry include a lack of communication and collaboration across providers or agencies (Marraccini & Pittleman, 2021; Savina et al., 2014; Tougas et al., 2022). The most common school services available include on-site tutoring, check-in/check-out (e.g., regular check-ins with a trusted staff member), individual counseling, support for time management/work make-up, and self-monitored instruction (Marraccini et al., 2021). As a result, school counselors must

be able to utilize school resources, recommend appropriate accommodations when eligible, and possess knowledge of community-based referrals to provide students with a multisystem of support.

IEPs vs. 504 Plans

Another research area to note is the requirements for IEP and 504 plans that provide accommodations and specialized instruction to students. IEPs are a crucial component of the Individuals with Disabilities Education Act (IDEA) and provide students with a formal plan to adjust learning environments and specialized instruction. Students qualify for IEPs if they fall within one of the thirteen categories: autism, deaf-blindness, deafness, emotional disturbance, hearing impairment, intellectual disability, multiple disabilities, orthopedic impairment, other health impairment (OHI), specific learning disability (SLD), speech or language impairment (SLI), traumatic brain injury (TBI), and visual impairments (U.S. Dept. of Education, 2018). 504 plans are a component of Section 504 of the Rehabilitation Act and provide students with less formal plans to adjust support options and address barriers to student learning (Marraccini et al., 2021).

While 504 plans can allow for additional support and accommodations for the student, they cannot provide specialized instruction as listed in IEP plans (e.g., adapting the academic content of a class to support student goals; U.S. Dept. of Education, 2018). Regarding the transition process from psychiatric hospitalization, the following most common services listed in the prior paragraph required an IEP or 504 plan: reduced workloads, extended deadlines, additional time for tests, and traditional testing alternatives (Marraccini et al., 2021). Meeting the requirements for IEPs can be difficult during this transition. Most school support personnel report that unless a student had an IEP before hospitalization, they were often not considered for

IEP services when they returned to school (Marraccini et al., 2021). The complex nature of the IEP process consists of the cost, resources, and time that goes into making and altering these plans. Additionally, students and staff must evaluate whether the student has met or failed to meet their goals on a reoccurring basis. Therefore, there is an additional need among caretakers and stakeholders to advocate for students' needs and potential accommodations when they reenter school following psychiatric hospitalization.

Community Considerations

The researcher wanted to examine school district considerations to address the limited literature around the impact of communities on school mental health when shaping the Learning to Be STRATEGIC model. The community considerations for school districts further the training's goal of accessibility and feasibility by conceptualizing the literature of school reentry recommendation and protocols to be adaptable for *all* school locations (i.e., rural, suburban, and metropolitan/urban). The following section examines the history and discrepancies within various types of school districts to outline specific cultural factors for the student reentry process following psychiatric hospitalization.

Rural Community Considerations

Eighty-four percent of mental health practitioner shortages in the United States occur within rural counties, thus, children and adolescents within these communities are less likely to receive mental health care and evidence-based practices (Eiraldi et al., 2022). Researchers found that rural communities are more likely to have higher rates of childhood poverty, and lower levels of education attainment and help-seeking behaviors (Blackstock et al., 2018; O'Malley et al., 2018). Hesitancy within rural communities to receive mental health services encompasses three core beliefs: lack of trust in mental health providers, stigma, and community attitudes.

Across these three areas, Blackstock et al. (2018) found that people in rural communities had a lack of trust in "outside" mental health professionals (i.e., those who do not live in the same community as their practice), an overall stigma of pursuing mental health services due to the nature of the community (e.g., close-knit, small town), and attitudes that one should be able to deal with problems on their own. These beliefs compounded by the issues school counselors already face in rural communities (i.e., staff retention, lack of funding) limit the services available for students reentering school following psychiatric hospitalization (Blackstock et al., 2018).

Several barriers exist within rural communities and warrant further components in addition to the ones listed. Since the type of geographic area (i.e., rural, metropolitan/urban, suburban) impacts a school's access to funding, mental health practitioners, and community resources, researchers imply that rural schools should re-evaluate their referral lists through resource mapping to ensure their resources fit with the community's needs. Additionally, resource mapping provides families with a list of remote-friendly services (i.e., telehealth providers) to address lack of accessibility and transportation challenges (Anderson et al., 2013; Brenner, 2016; James et al., 2022; van Vulpen et al., 2018). Rural schools are less likely to require that newly hired social workers, school psychologists, and school counselors be licensed, certified, or credentialed by state agencies and licensing boards when compared to metropolitan communities (O'Malley et al., 2018). Researchers found that caregivers and school staff request psychoeducation or training on child and adolescent mental health concerns to acquire knowledge of trauma-informed care, awareness around the signs of rehospitalization, and address misconceptions of the mental health field (Hoffman, 2021; Kruczek, 2022; Vanderburg et al., 2023). These findings emphasize the country-wide shortage of school support personnel, a

need for trained professionals within rural schools, and a desire from stakeholders for psychoeducation.

The Many Definitions of "Rural"

Rural definitions often take into consideration aspects such as population density, land use, proximity to urbanized core (e.g., geographic isolation), and community size (Crockett et al., 2016). The U.S. Census Bureau and the Office of Management and Budget (OMB) are among the two primary government agencies with distinguished rural definitions to identify population size, density, and demographics (Crockett et al., 2016). Several policies and legislation aim to address disparities within rural communities, however, policymakers struggle with ambiguity around what designates an area as rural (Long et al., 2021). Discrepancies between rural definitions can impact the allocation of resources, health promotion and disease prevention, government funding, policymaking, and create misconceptions of rural culture (Childs et al., 2022). For example, Hart et al. (2005) found that close to eighteen percent of the country's population is classified differently based on which definition (i.e., U.S. Census Bureau or OMB) is used. The Health Resources and Services Administration (HRSA, 2022) notes that the inconsistency between these two definitions stem from the OMB undercounting rural areas and the U.S. Census Bureau overcounting them.

Long et al. (2021) studied eight different government organization rural definitions to assess which definitions identified the same areas as rural and to examine rural disparities across each definition. They found that there was no definition that exceeded others for predicting rural disparities and each definition provided greater insight into areas of demographics, health care measures, and accessibility. More importantly, they highlighted the importance of careful consideration around choosing a definition that will best fit the context and aim of the study

(Long et al., 2021). For the purpose of this study, the researcher chose to use the National Center for Education Statistics (NCES, 2022) definition of rural (see Definition of Terms section) due to its appropriateness, subcategories for rural schools, and use in education legislation. The Urban-Centric Locale Codes established by the NCES in 2007 classifies schools based on population size (for city and suburban assignments) and proximity to urban areas and clusters (for town and rural assignments; NCES, 2022). The NCES rural definition relies on the broader U.S. Census Bureau definition and helps determine schools' eligibility to receive funding from the Rural Education Achievement Program (REAP) under the Every Student Succeeds Act (ESSA; Brenner, 2016).

COVID-19 Pandemic

Regarding the student reentry process into schools, the COVID-19 pandemic proved to be a multifaceted endeavor, challenging public education systems to reconsider their approaches to addressing the social, emotional, and academic needs of their students and staff to promote overall wellbeing and safety (U.S. Dept. of Education, 2021). Researchers' findings of the impact on children and adolescents from the pandemic have shown to be extensive, with negative effects on physical and psychosocial health from trauma, loss, and fear of the unknown (Arslan et al., 2022; Chen et al., 2021). Furthermore, accessibility, effectiveness, and implementation of mental health interventions during the various stages of the pandemic proved to be difficult following school closures, pause on extracurriculars, and social distancing measures (Hoffman & Miller, 2020; Razai et al., 2020). As a result, nations swiftly embraced the widespread adoption of virtual platforms and telehealth services, offering people a sense of community, continuity of care, and heightened levels of unprecedented accessibility (Lau et al., 2021; Whaibeh et al., 2020).

Researchers emphasize the critical role telehealth serves, especially for children and adolescents who encounter substantial obstacles in accessing necessary care (Curfman et al., 2021). Many families have communicated a need for more mental health services, specifically telehealth or remote-friendly services, to promote community partnerships with schools, increase inter-agency communication, and increase development of school-based health centers (Fox et al., 2021; Watson et al., 2022). Furthermore, many medical researchers emphasize the promotion of telehealth services in underserved areas increases access to assessments, reduces costs, minimizes unnecessary hospital visits, and enhances client experience with health care systems (Ferro et al., 2021). However, a barrier surrounding the promotion of telehealth services is ensuring school mental health personnel are not furthering disparities in families with a lack of access to technological devices and data plans/platforms (i.e., Wi-Fi; Domlyn et al., 2024; Tolou-Shams et al., 2022).

Student Inequities and Considerations

One major critique of the current literature is the lack of cultural consideration of the student reentry process. In addition to the findings on student barriers to the reentry process, students of color, specifically Black and Latinx youth, are less likely to receive outpatient services post-discharge (Marraccini et al., 2019). Black and White youth have similar emergency department visits and inpatient hospitalization rates. However, Black and Latinx youth made 47% and 58%, respectively, fewer visits to mental health providers (Marrast et al., 2016). Several cultural and systemic factors may affect mental health disparities across minority youth and examine the different systems through a systemic lens. For example, reluctance to seek mental health services emerges as societal stigma (macrosystem), historical mistrust of the health

care system (chronosystem), accessibility to specialists and insurance (interaction between macro- and exo-systems) (Marrast et al., 2016; Mellin & Weist, 2011).

Ethnic minority youth are more likely to receive mental health interventions from school settings than clinic settings due to increased access to care and reduced stigma of receiving services in school settings (Mellin & Weist, 2011). However, ethnic minority youth are still less likely than Non-Hispanic, White youth to receive mental health treatment altogether (Mellin & Weist, 2011). Guo et al. (2014) studied the referral rates for Latinx and Asian American students to distinguish explanations for any observed differences in using school-based mental health services. Latinx youth was almost four and a half times more likely to be referred for mental health services. However, both groups had similar percentages of symptom self-reports, suggesting school gatekeepers may struggle with identifying the needs of their Asian American students (Guo et al., 2014). Cultural considerations play a large role when examining the social, emotional, and academic needs of students reentering following psychiatric hospitalization and represent a need for more individualized reentry planning.

Around 20% of youth with autism experience psychiatric hospitalization, and children with special needs who experienced disciplinary actions were more than three times more likely to experience psychiatric hospitalization (Matson & Cervantes, 2014; Turcotte et al., 2017). Furthermore, youth with special needs, specifically autism, display self-injurious and aggressive behaviors that can lead to being removed from the school environment (Matson & Cervantes, 2014). Turcotte et al. (2017) studied the intersectionality of school discipline, hospitalization, and police contact among students with autism spectrum disorder (ASD). The researchers found that students with autism ages 13 to 17 and from the lowest income households (< $39,000/year) had the highest likelihood of being hospitalized for mental health concerns. Additionally,

students with co-occurring ADHD or conduct disorder diagnosis had the highest risk for experiencing school discipline, psychiatric hospitalization, and contact with the police (Turcotte et al., 2017). Students with special needs have additional challenges and supports that should be considered when reentering school following psychiatric hospitalization and creating individualized plans for coming back to school.

Another area of student inequities to consider includes culturally and linguistically diverse (CLD) students, also known as English language learners. This group of students are often disproportionately placed in special education, have low mental health treatment engagement, and have a higher risk of receiving inadequate or inappropriate treatment interventions (Peterson et al., 2017). Researchers contribute these concerns with a shortage of school mental health personnel with CLD backgrounds, lack of school translation services, and compounding stressors (e.g., acculturation, immigration status, poverty) (Peterson et al., 2017; Vincent et al., 2011). Furthermore, CLD students are more likely to receive office discipline referrals instead of school mental health services for subjective judgement behaviors such as defiance, disrespect, and insubordination. As a result, these students are at a higher risk of more severe consequences for behavioral issues, such as being referred for psychiatric hospitalization when discipline interventions are not deemed as successful (Vincent et al., 2011). While school-based mental health services attempt to decrease disparities among students, research still needs to explore cultural considerations used in reentry following psychiatric hospitalization.

Theoretical Frameworks

Ecological systems theory (EST) remains a robust framework around the literature on the school reentry process following psychiatric hospitalization. Bronfenbrenner (1979) believed that our environment consists of various systems, relationships, and bi-directional interactions.

According to EST, the developing person is at the center of various systems (i.e., rings) with the closest interactions being within the microsystem. The microsystem consists of the person's immediate environment and addresses engagement with peers, family, school, and work (Bronfenbrenner, 1979). The next outer ring encompasses the mesosystem, where interactions between the developing person's microsystems occur (e.g., interactions between family and schools). The third ring extending outward includes the exosystem, where external environments impact the developing person without their involvement (e.g., a parent bringing home problems from work; Bronfenbrenner, 1979). Next is the fourth ring or system called the macrosystem which involves the impact of cultural elements (e.g., attitudes and values). Last is the final, outer ring called the chronosystem encompassing experiences the developing person encounters throughout time (Bronfenbrenner & Morris, 2006).

Regarding the reentry process, this theory serves as a guide to help school counselors better understand the impact of environmental factors and relationships within the systems on the student's experience as they transition back to school from the hospital. For example, EST can discuss the influence of peer interactions (i.e., microsystem) and communication across stakeholders (i.e., mesosystem) on the developing person (i.e., the student). The macrosystem differs from the other systems in that it includes cultures and subcultures (e.g., laws, social beliefs, and economic values) that mirror how the lower systems operate (Rosa & Tudge, 2013). However, current research fails to address proximal processes, biopsychosocial characteristics of the developing individual, and how students make meaning within their lives during the reentry process.

Bioecological Model

Bronfenbrenner transformed and developed the foundational components of EST into a more inclusive bioecological model that covers process, person, context, and time (PPCT) (Bronfenbrenner & Morris, 2006). Proximal processes refer to the reciprocal interactions (with others, objects, or symbols) in the developing individual's immediate environment such as parent-child interactions, peer interactions, group play, and learning new skills (Merçon-Vargas et al., 2020). Disturbances in proximal processes can hold long-term effects on child and adolescent development due to disruptions in routine and consistency (Navarro et al., 2022). For example, when students return to school following psychiatric hospitalization, they often struggle with social and emotional interactions with staff, their caregivers, and peers because these proximal processes are often not the same prior to hospitalization. Changes in these proximal processes could include caregivers overseeing medication management, the student navigating mental health symptomology, and bullying from classmates at school (Iverson, 2018; Marraccini & Pittleman, 2022).

Regarding academic achievement and performance, students reentering school often struggle with changes in assignments, tests, and homework due to an extended absence. Challenges with work completion and comprehension usually results in accommodations and sometimes special education services (Savina et al., 2014). Therefore, new, academic proximal processes further shape student development when accommodations are put into place such as altering the student's schedule, providing special education services, and changing the educational environment. School staff should ensure these accommodations involve activities with others, objects, or symbols, given on a fairly basis over an extended period, and get frequently checked and altered based on the individual’s development and needs. By doing this,

school staff will be able to follow the approach for multicomponent accommodations and guidelines for positive proximal processes by Bronfenbrenner and Morris (2006).

The concept of person best explains the student-focused approach for individualized reentry plans (Marraccini & Pittleman, 2022; Marraccini et al., 2022). According to Bronfenbrenner and Morris (2006), there are three types of person characteristics including force (i.e., traits that foster, sustain, or prevent proximal processes), resource (i.e., biological, experiential, or mental resources brought to proximal processes), and demand (i.e., observable factors that invite or discourage reactions). Furthermore, personal characteristics show up in the PPCT model at two different levels: antecedents to proximal processes and results of synergistic interactions (Bronfenbrenner & Morris, 2006; Navarro et al., 2022). For example, the student's antecedent characteristics could describe the student's level of social interactions prior to hospitalization.

Regarding reentry, the developing person of interest would be a student post-discharge from psychiatric hospitalization. Examples of the three types of person characteristics could include self-efficacy level (force), knowledge of coping skills (resource), and behaviors in class (demand). Each type of characteristic can assist or deter proximal processes, and the coexistence of characteristics demonstrates the intersectional nature of the developing person (Bronfenbrenner & Morris, 2006). Reentry plans should be individualized to students to identify characteristics, cultural considerations, and further understand the synergistic interactions (e.g., the connections between the student, school staff, and school climate).

When exploring the concept of context in this topic, it is essential to understand the factors influencing the bi-directional interactions among students and their various systems. The focus of researchers often centers on the micro- and meso-systems because these are the

immediate systems the student actively engages in daily life during the reentry process (Loeper, 2021). Thus, researchers can pinpoint potential barriers to treatment and the effectiveness of the student's support network. Since students in rural communities lack access to mental health providers and specialists within their mesosystems, rural children and adolescents are more likely to rely on prescribed medication from primary care physicians than receive counseling services (Anderson et al., 2013). Furthermore, the Rural Health Research Center indicates that only about thirty percent of rural counties have access to medication prescribers who are specifically trained in mental health concerns such as psychiatrist or psychiatrist nurse practitioners (Larson et al., 2016). Regarding the reentry process, researchers identified several challenges faced within the student's school and home life such as academic work completion, navigating social relationships, level of caregiver involvement, and coping with mental health symptoms (Loeper, 2021; Marraccini & Pittleman, 2022; Preyde et al., 2021). Understanding the context behind this phenomenon further supports researchers approaches to engage in resource mapping, offer families remote-friendly resources (i.e., telehealth providers), and provide psychoeducation or trainings of trauma-informed care to caregivers and school staff.

Time is another crucial factor within the bioecological model. For example, psychiatric hospitalization typically involves inpatient stays for around seven to ten days, interrupting proximal processes requirements in micro- and meso-time (Navarro et al., 2022; Preyde et al., 2021). As a result, the student's acts of learning new skills, continuing to participate in social interactions, and interactions with parents/caregivers shift to new proximal processes such as medication management, interactions with hospital staff, and treatment planning. This idea supports the researchers' recommendation of starting the reentry planning process as soon as the student leaves and being patient with students as they learn to engage in new routines during the

reentry process (Tougas et al., 2022). Additionally, researchers found that students often struggle with academic performance due to long leaves of absences, lack expectations on how and when their work should be completed, and report consequences to their mental health as they try to catch up in school (White et al., 2017). Plemmons et al. (2018) found that hospitalizations for suicide ideation and/or attempt occur most frequently in the fall and spring at children's hospitals. Predye et al. (2021) discovered the highest rates of rehospitalization among children and adolescents occur within the first three months post-discharge. These findings further emphasize the importance of time and support researchers' approach on implementing gradual transitions and frequent check-ins with the student in the first three months of being discharged.

One of the keys to a successful reentry according to researchers is collaboration and communication across all stakeholders, with the student serving as one of the prime decision-makers (Iverson, 2018). Researchers must consider the different stakeholders when examining the various systems and their interactions with the student. Members of the micro- and meso-systems include hospital staff, parents/caregivers, families, school support personnel, and community members. The microsystem consists of settings and communities where students spend most of their time forming relationships (i.e., school, home, neighborhood). Simultaneously, the mesosystem helps explain the interactions among two or more microsystems where the developing person actively participates (Bronfenbrenner, 1979). The component for an interdisciplinary team and information sharing/communication across stakeholders is best explained through context and synergy, or the collective interaction among agencies where the total effect exceeds the sum of all its parts (Bronfenbrenner & Morris, 2006; Navarro et al., 2022). Therefore, the total effect across all systems interacting and communicating will have a more significant impact than single effects from each microsystem acting alone. Increasing

interactions across all these microsystems encourages the chances for the student to adapt more efficiently when returning to school. This concept further supports the researcher's findings on increased continuity of care, treatment engagement, information flow, and student commitment when agencies work together (Savina et al., 2014; Tougas et al., 2022).

Phenomenological Variant of Ecological Systems Theory (PVEST)

Integrating the phenomenological variant of ecological systems theory (PVEST) with the bioecological model helped to understand the influence of culture, lived experience, individual's perceptions, and synergistic interactions contribution to the disparities in mental health among rural youth. PVEST incorporates developmental concepts, a sensitive focus on context, bi-directionality, and is process oriented to find a more inclusive way of examining a developing individual that challenges deterministic- and deficit-based thinking (Spencer, 2006). Upon examination of research from the top-down, researchers often fail to address systemic opportunities and inequities that are deeply rooted within our society and their impact in shaping synergetic interactions and the individual's social ecology (Spencer, 2006).

PVEST includes components that assist in helping understand development, psychosocial processes, and how individuals make meaning within their lives. These include (1) net vulnerability levels, (2) net stress engagement, (3) reactive coping methods, (4) emergent identities, and (5) life-stage specific coping outcomes (Spencer, 2006). Net vulnerability levels refer to the characteristics of the individual, family, and community that impact risk and protective factors. Additionally, Spencer (2006) notes that vulnerabilities do not occur within isolation, but rather embodied through a complex process of system interactions. For example, James et al. (2022) highlights that local churches are often the center for events and services within rural communities. Thus, when school districts build school-community partnerships with

churches (i.e., a protective factor), they are often able to do a better job of creating awareness around prevalent concerns and reaching the whole community. Regarding the reentry process and youth, interdisciplinary team members should consider the risk and protective factors as well as how to provide a better net balance of these factors through partnerships with local community resources (e.g., Boys and Girls Club and local churches), maintaining communication with the student's family, and providing accommodations and materials to assist in academic performance from the start of the return date.

The second component of PVEST refers to net stress engagement or perceived experiences of challenges and available supports that promote or infringe on an individual's wellbeing. Moreover, challenges and supports do not have to be experienced physically but can also be symbolically assessed and inferred (Spencer, 2006). One way to examine net stress engagement is through a rural, minority youth lens. Rural, Latinx youth face additional challenges that increase the risk for mental health concerns such as immigration, language barriers and discrimination (Ramos et al., 2022). More importantly, discrimination can be a crucial predictor for internalizing symptomology of disorders such as anxiety and depression (Benner et al., 2018; Cave et al., 2020). Family resilience serves as an essential support towards adaptive coping of stressors and aligns with the belief of *familismo* (family as the central role) within Latinx culture (Ramos et al., 2022). Regarding the reentry process, school staff may better support rural, Latinx students returning to school through careful consideration of their cultural beliefs, providing translators to address language barriers, promoting family involvement, and ensuring school as a safe space for immigrant families.

Thirdly, reactive coping mechanisms refers to problem-solving strategies that are either adaptive or maladaptive. These problem-solving strategies are a result of bidirectional interaction

of the challenges and available supports outlined within net stress engagement (Spencer, 2006). Regarding the reentry following psychiatric hospitalization, school mental health personnel should work with students to identify adaptive and maladaptive coping strategies through individual counseling, check-ins, and treatment planning. Additionally, through this PVEST component, school staff can better understand the risk for rehospitalization as some coping strategies are more comfortable and convenient than putting in the work to create new, adaptive solutions. Stable coping responses guide emergent identities as individuals continue to engage in coping strategies and self-appraisal. Emergent identities refer to how individuals perceive themselves within and between various contexts of their development (i.e., family, school, peer groups, neighborhood, and the community; Spencer, 2006). As students return to school following psychiatric hospitalization, they must face challenges of changes in student roles, school member interactions, and building self-efficacy (Savina et al., 2014).

Lastly, decision-making, and problem-solving behaviors that emerge from individual's self-appraisal of their identities can lead to productive or adverse (unproductive) life-stage specific coping outcomes. Common examples of productive coping outcomes include school engagement, low levels of risky behaviors, and positive family relationships whereas examples of adverse coping outcomes may include poor academic performance, school dropout, and lower levels of health (Spencer, 2006). Spencer (2006) notes that while individuals engage in the cyclical process of encountering stressors, expanding their coping reactions, and reshaping their emergent identities, their specific coping outcomes notably impacts how others may view the individual. The examination of the reentry process following psychiatric hospitalization through a PVEST lens further supports the findings on ensuring that reentry plans are individualized to consider the social, cultural, emotional, and academic lived experiences of students.

Multi-Tiered Systems of Support (MTSS)

Schools serve as one of the primary settings for developing and shaping students' knowledge, skills, and competency. Additionally, researchers have found that schools have a strong impact on child and adolescent social, emotional, and behavioral health (Goodman-Scott et al., 2023). MTSS operates under the three-tiered prevention logic, focusing on proactive and intervention-oriented approaches to help the students' educational development at different levels corresponding to their needs (Goodman-Scott et al., 2023; Sink, 2016). MTSS is naturally occurring within the Learning to Be STRATEGIC training due to model components that address school-wide (Tier 1), secondary interventions (Tier 2), and individualized support (Tier 3). For example, the individualized reentry planning process focusing on the student's risk factors, supports, and direct needs represent Tier 3 level interventions while providing psychoeducation on mental health awareness represents a Tier 1 intervention.

MTSS can be implemented through culturally responsive needs through prioritizing the student's voice and finding supports that can engage the student more within the school environment (Edirmanasinghe et al., 2022; Goodman-Scott et al., 2020). Regarding MTSS as an equitable intervention for all students, Edirmanasinghe et al. (2022) recommends a culturally responsive model for implementing antiracist practices within MTSS that may benefit in addressing school staff's perceptions on productive versus adverse coping outcomes of their students. This model includes (a) practitioner awareness of their own culture, practices with students, and biases, (b) hearing and prioritizing the voices, participation, and decision-making of stakeholders, and (c) using data to increase access, opportunities, and equity. Regarding the reentry process, school staff should consider this model when implementing services across the

tier levels to further promote and encourage productive coping outcomes for their students, specifically those within marginalized communities.

The Foundations of the Learning to Be STRATEGIC Model

S – Sharing Information and Communication

Across all areas of reentry literature (i.e., chronic illness and psychiatric hospitalization), researchers recommend that the reentry planning for students should begin immediately when the student and their family inform the school of the student's extended absence due to hospitalization (Hall & DuBois, 2020; Kaffenberger, 2006; White et al., 2017). Schools are often able to inform caregivers of how to report a hospitalization to the necessary school staff member(s) (e.g., school social worker and counselor) when they are presented expectations on attendance and reporting absences (Hall & DuBois, 2020). A common practice among school mental health personnel when informed of an extended absence due to hospitalization includes obtaining a release of information (ROI) to receive and provide necessary information to hospital staff on the student's treatment planning (Marraccini et al., 2022). Regarding reentry following psychiatric hospitalization, ROIs can help schools address basic information for reentry planning (e.g., student's intended return date and diagnosis), helpful resources provided in the hospital (e.g., coping mechanisms), ongoing treatment (e.g., medication, referrals for outpatient care), safety planning (e.g., triggers and stressors), and any school-related recommendations the hospital personnel may have for the student (Marraccini et al., 2021).

While ROIs support collaboration among school and mental health stakeholders, school staff members must ensure they are following the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Family Educational Rights and Privacy Act (FERPA)

when discussing information on a student's school and medical experiences. Vanderburg et al. (2023) found that caregivers often endorsed permission for the school to share information about the student's hospitalization but did not feel like they were kept in the loop about the context or the amount of information shared. Therefore, one way school staff can use ROIs appropriately is through conversations with the student and their family on what information they would like to be shared with their teachers and peers as well as what they would like to remain private (Marraccini et al., 2021). Marraccini and Pittleman (2022) found in their study on students' perceptions following hospitalization for suicide-related behaviors that students reported commonly hearing rumors and comments directed at them about their length of absences from school members (e.g., teachers and peers). One example of this behavior was a student recollection of a teacher stating that they forgot the student "was in a crazy hospital" when taking attendance (Marraccini & Pittleman, 2022). Researchers call on school mental health personnel to inform and remind school members (both staff and students) of confidentiality, privacy, and inclusive language during the sharing of information (Hoffman, 2021; Savina et al., 2014).

Medical documentation can be extremely helpful in determining accommodations, providing medication management at school, and identifying components for safety plans, but usually is rarely brought in (Marraccini & Pittleman, 2022; Marraccini et al., 2021). Therefore, the emphasis of obtaining ROIs must not be understated. It is also important to acknowledge the barriers to receiving ROIs and communication among stakeholders such as family denial of child's mental health state, fear of the department of social services (DSS) or child protective services (CPS), language barriers, and a lack of understanding caregiver rights in schools (Marraccini et al., 2021). For school staff who are encounter challenges or unable to obtain a

ROI, it is imperative to maintain communication with the student's caregiver as they become the liaison between the school and hospital (Loeper, 2021; Vanderburg et al., 2023).

Hospital staff report that communication between schools and hospitals often occurs with the purpose of gathering information on the student's needs and treatment plan instead of information sharing. An example of this includes hospitals having trouble obtaining academic work for a student and identifying what, if any, accommodations the student receives (e.g., an IEP or 504 plan; Loeper, 2021). Additionally, hospital staff reported that their involvement within the reentry meetings were uncommon and caregivers often needed support on knowing what to ask for to advocate for their child (Loeper, 2021). Lastly, barriers to collaboration and communication across all stakeholders may derive from power imbalances such as role hierarchies, power struggles, and stakeholder status. Therefore, it is crucial to acknowledge these power differentials and advocate towards a shift within interdisciplinary collaboration to create equitable spaces for all involved (Tougas et al., 2022).

T – Team (Interdisciplinary Members)

The second component of the plan includes organizing an interdisciplinary team lead by an identified reentry coordinator. Members of this team often include the student, their family, school administration (i.e., principal), school counselor, school psychologist, social worker, teacher(s), school nurse, and potentially a mental health professional (Hall & DuBois, 2020; Marraccini et al., 2021). Much of the literature around the reentry planning process focuses from the adult perspective such as school staff, caregivers, and hospital staff, thus, they often lack the student's perspective. Researchers emphasize the importance of highlighting the student as the primary voice within the interdisciplinary team (Iverson, 2018). Bronfenbrenner and Morris (2006) further connect this finding with concepts from the bioecological model reinforcing the

student/child/adolescent as the center and focus of proximal processes and systemic interactions from this phenomenon.

Open dialogues and communication are more likely to occur within the interdisciplinary team when a reentry coordinator or liaison is appointed (Helms et al., 2016; Schilling & Getch, 2018). Researchers found that the reentry coordinators for the student return following psychiatric hospitalization are often school counselors (Marraccini et al., 2021; Vanderburg et al., 2023). School counselors usually operate as a primary contact for staff, teacher, caregiver, and student referrals, and provide services that are common accommodations (see Accommodations section) during the reentry process (Carlson & Kees, 2013). While school counselors appear to be the most common staff member to serve as reentry coordinator, they are often constrained by large student-to-counselor ratios, non-counseling responsibilities and duties, and crisis management that limit the amount of time they can allocate to address reentry mental health needs (Carlson & Kees, 2013). Therefore, researchers suggest school psychologists or social workers as alternative options to fulfilling the reentry coordination when school counselors are unavailable or absent due to staff shortages (Marraccini et al., 2019; Marraccini et al., 2022; McBride & Preyde, 2020). School psychologists and social workers are equipped to handle the role due to their psychological education and training, and potential familiarity with students (McBride & Preyde, 2020; Schilling & Getch, 2018).

When configuring and coming together as a team, it is essential to understand and allow caregivers to voice their experiences with the school. During the beginning of the student's psychiatric hospitalization, caregivers report that they often experience high levels of strain, and lack of knowledge, social support, and psychological availability (Blizzard et al., 2016; Tougas et al., 2019). Furthermore, during times of heightened stress and anxiety, caregivers often

become the unofficial liaisons between the hospital and school (Blizzard et al., 2016). Regarding the reentry process, Blizzard et al. (2016) found that caregivers reported overall lower satisfaction with their student's school than the hospital with only half of participants reporting the school listened to their needs and forty percent providing the help they wanted. To help improve the caregiver's role within the interdisciplinary team, caregivers want more knowledge of resources on how to advocate for their child's needs and their own rights when working with hospital and school settings (Tougas et al., 2019).

Another important stakeholder perspective to consider within the interdisciplinary team are the student's teachers. Marraccini and Pittleman (2022) found that adolescents were able to describe helpful teacher techniques for assisting in work completion such as setting clear expectations, consistent communication, providing availability to support make-up work, development of work timelines, and keeping up with the student's accommodations. In the same study, students were also able to identify unhelpful approaches from teachers such as lack of communication around missing work and limited support in making up missed material. Regarding the reentry process, teachers reported feeling unsure of how to engage with the student and what information to expect when the student returned from psychiatric hospitalization but felt that it was the school's responsibility to support the mental health needs of its students and include the teacher as a crucial member of facilitating this process (Rager, 2015; Savina et al., 2014). Interdisciplinary teams for school districts could include all members listed above as well as behavioral health specialists and instructional coaches. These school support personnel ensure programs comply with guidelines and student goals, work with students experiencing emotional and behavioral challenges, and can also serve as mentors for teachers and staff to improve student learning.

R – Remote Friendly Services and Resource Mapping

The next component is specific to schools within rural communities and addresses the recommendation for resource mapping and providing families with remote friendly services. James et al. (2022) suggests that rural school districts engage in resource mapping to join forces with local community agencies and partners due to a lack of accessibility within these areas. Within this process, schools and members of the community identify policies, resources, and agencies that share a common goals, plans of action, and optimal outcomes for the priorities of the specific county. By partnering with organizations and agencies with a shared common goal, rural core beliefs limiting help-seeking behaviors can be reduced (Blackstock et al., 2018).

Through resource mapping, school personnel redefine their lists of referral resources and build strong collaborations with local community to connect their students and families with during the reentry process. A long-term goal of resource mapping includes creating awareness around a particular need or priority for the members of the county (James et al., 2022). Regarding the reentry process, a continuing goal of for this technique would be to slowly start creating awareness around student mental health concerns, provide information on ways community members can help to reduce stigma, and connect community members to local agencies. An example of resource mapping within rural school districts may include reconnecting with local agencies through staff site visits, working with local churches, in-services at the schools to provide information to caregivers, and inviting local mental health professionals to career and college fairs.

Another area of consideration for this approach includes offering students and their families remote friendly services. Due to the lack of accessibility and appropriateness of resources within rural communities, families often must travel miles away to nearby cities to

receive necessary services (Cyr et al., 2019). Factors such as government agencies and insurance policies can influence community member's access and delivery of care, further adding to the list of challenges faced by those living within rural communities (Cyr et al., 2019). Regarding the student reentry process, schools should build on their intentional referral lists to include providers that use telehealth methods and expand student options for receiving outpatient care when transportation is a major factor (van Vulpen et al., 2018). Telemental heath options are also a key strategy to increase student's access to specialists who have a greater chance of offering evidence-based interventions fitting the student's mental health needs (Myers, 2019). Examples of providing remote friendly services within rural school districts may include ensuring the student has access to a laptop and Wi-Fi at home, gathering referrals for mental health professionals who provide telemental health, and educating students and families on finding a telemental health practitioners using resources such as Psychology Today.

To utilize telemental health resources, a person will normally require, at the very least, access to a working phone, tablet, or computer with available Wi-Fi or a data plan to allow for services. Additionally, families may need assistance with technological literacy in being able to set up virtual services, such as learning how to access public Wi-Fi, navigating platforms, and understanding basic functions on their devices (Domlyn et al., 2024; Tolou-Shams et al., 2022). Therefore, researchers call on mental health personnel to consider the necessary factors when choosing to provide virtual services and consider the ways in which they can advocate for funding, provide technology trainings, and identify appropriate referral sources (Curfman et al., 2021; Domlyn et al., 2024; Tolou-Shams et al., 2022).

A – Accommodations and School Services

The fourth component to the reentry plan approach includes administering multicomponent accommodations and services. School mental health personnel must be able to fully utilize resources through knowledge of community-based referrals and apply appropriate accommodations for eligible students to provide a multi-tiered system of support. A main consideration within this component is distinguishing which services or specialized instruction require Individualized Education Plans (IEPs) or 504 plans. Marraccini et al. (2021) found that the most common school services for students returning to school following psychiatric hospitalization were on-site tutoring, check-in check-out (CICO; i.e., frequent check-ins with a trusted school staff member), individual counseling, time management and extensions for missing work, and self-monitoring instruction (e.g., study hall periods, online programs). Out of all the available accommodations, ones that required IEP or 504 plans include reducing workloads, extensions on deadlines, receiving additional time for tests/exams, and traditional testing alternatives (Marraccini et al., 2021).

Meeting the IEP requirements can be an especially difficult process for students returning to school with most school support personnel reporting that students were not often considered for IEP services following psychiatric hospitalization unless they had a plan prior to admission (Marraccini et al., 2021; Vanderburg et al., 2023). More often, students receive a 504 plan during reentry to provide accommodations that adjust support options and remove barriers to student learning in the general education setting (Marraccini et al., 2021; Hay et al., 2015). The complexities of the IEP process take up a great deal of time, cost, and resources that go into developing, checking, and altering services to assess whether students have met their goals (Marraccini et al., 2021). Thus, this provides an additional need during the reentry process that

tasks caregivers with advocating for their student's needs and potential eligibility for accommodations.

Marraccini et al. (2021) also noted accommodations that do not require special education services and are available to everyone such as CICO, individual counseling, and support with assignment completion and developing time management skills. Lastly, there are several pros and cons to the accommodation with the highest level of use by students – a universal pass to visit the counselor. Benefits to this accommodation included students using their autonomy to identify triggers or stressors, leave their current environment, and engage in help-seeking behaviors. However, as noted earlier, there is limited flexibility in school counselors' schedules given their job responsibilities and demands, thus students would often spend time waiting until the counselor was available or not receive one-on-one counseling at all (Marraccini et al., 2021; Marraccini et al., 2022).

During the hospitalization period, numerous caregivers reported their child struggling to keep up with make-up work and experiencing boredom because they did not receive schoolwork that was at an appropriate academic level for an extended absence (Vanderburg et al., 2023). Researchers of this study recommend appointing a reentry coordinator or liaison to ensure that the hospital and school can work cohesively to provide appropriate work to the student while they are gone and determining the amount of work on a case-by-case basis (Vanderburg et al., 2023). Marraccini and Pittleman (2022) found that most services provided to students returning from psychiatric hospitalization centered around academic accommodations, however, these were not always systematic and varied by teacher. The organized interdisciplinary team listed earlier should work together to ensure consistency across services and accommodations for the

student to help ensure a smoother reentry process and ability to keep up in their academic performance (Marraccini et al., 2021).

T – Training and Psychoeducation

The fifth component involves training and psychoeducation across all stakeholders. Mental health awareness trainings and psychoeducation improves mental health knowledge, attitudes, help-seeking behaviors, and reduces stigma when implemented in rural communities (Salerno, 2016). Regarding the reentry process, teachers expressed not feeling confident around current knowledge, lacking the ability to support a child returning to school following hospitalization, and do not feel they have the proper training to address a student's needs throughout this phenomenon (Hoffman, 2021). However, Hoffman (2021) found that teachers reported a willingness to learn and grow their skills through professional development, educational resources, and reviewing legal guidelines for information sharing. Similarly, school mental health personnel reported wanting more training within specific areas such as triggers, warning signs, reasons for hospitalizations, follow-up care, medication management, safety planning and guidelines around ROIs (Marraccini et al., 2021). Furthermore, these findings align with results from a study on school counselors' perceptions of their training and education. Carlson and Kees (2013) identified high levels of perceived competence in counseling theories, group counseling, career counseling, and ethics, but low levels of perceived competence in areas of pharmacology, advanced counseling skills, diagnosis, and crisis management. These findings warrant a focus on school staff's less confident areas for continuing education and professional development.

Caregiver's desire for psychoeducation highlighted trauma-informed care trainings, school-wide education on mental health awareness, instruction on coping mechanisms, and

social-emotional learning as key areas for working with students returning to school following psychiatric hospitalization (Vanderburg et al., 2023). Several researchers also noted the importance of implementing school-wide interventions and trainings. Loeper (2021) reported that overall schools can benefit from implementing universal interventions that promote ideal environments for learning, positive social responses, and address a variety of student mental health needs. Vanderburg et al. (2023) call on schools to continue to invest in evidence-based, low cost, and effective, comprehensive suicide prevention trainings to promote awareness on mental health and implement schoolwide suicide screenings as a proactive measure for students. Specific to the reentry process following psychiatric hospitalization, students recommend schoolwide psychoeducation on challenges of suicidal urges, and reducing stigma around mental health (Marraccini & Pittleman, 2022). These findings represent an abundance of topics/starting points for school districts to put time and energy into developing trainings regarding the reentry process and student mental health. Examples for school districts could include implementing a mental health awareness month throughout the school year encompassing some of the topics listed above and continuing to provide consistent social-emotional learning to all grade levels.

E – Easy and G – Gradual Transitions

A student's ability to adjust and adapt to a functional state post-discharge is a significant factor in rehospitalization within the first three months (Preyde et al., 2021). Post-discharge, students must address the social, emotional, and academics demands of school while learning to navigate new treatment planning and coping with psychological symptoms (Clemens et al., 2011; Savina et al., 2014; White et al., 2017). Researchers recommend a gradual transition back into school as students learn to reshape their social interactions, attendance, participation, and role within an education setting (Clemens et al., 2011; Preyde et al., 2021). Tougas et al. (2022)

define gradual transitions as a strategy for students and school staff to "progressively adjust the reality of the school setting" (p. 89). While it may feel imperative to have the student return to school immediately so they can catch up, poorer student transitions result in a perceived lack of support, higher levels of stress, lower levels of resilience, higher risk for rehospitalization, lack of ability to cope and address stigma, and sometimes engagement in suicide-related behaviors (Marraccini & Pittleman, 2021; Preyde et al., 2021). Thus, researchers and caregivers recommend allowing the student to start make-up work from home and utilize online, credit recovery programs or remote services offered by the school such as homebound instruction (Schilling & Gretch, 2018).

Homebound instruction is one of the primary services offered to chronically ill students throughout the transitional, interim period post-discharge, and can easily be adapted for students reentering following psychiatric hospitalization. Through homebound instruction, students receive supplemental learning and teaching by a school staff member within their home setting (Shaw et al., 2014). The benefits to homebound instruction such as increasing communication across stakeholders, allowing the student to pace their transition back to school, and can easily be provided online if necessary (Schilling & Getch, 2018; Shaw et al., 2014). Researchers studying reentry following psychiatric hospitalization recommend that the student's teachers remain active within the services provided by the school to foster positive student-teacher relationships during this time (Marraccini et al., 2022).

Other common services utilized by students to promote gradual transitions includes an abbreviated or modified school day for the student that includes hybrid and online courses (Marraccini et al., 2021). Weis et al. (2015) found that if expectations and tasks for attendance were too demanding too quickly, the student's risk for disengagement, distress and

rehospitalization significantly increase. Therefore, researchers recommend allowing the student to start off by choosing one or two classes to attend each day when they feel comfortable enough to attend in-person, and work with their interdisciplinary team to determine criteria for adding supplemental courses to their schedules (Hall & DuBois, 2020). Additionally, students should identify a home-base or trusted school staff member to locate when they experience psychological symptoms or need a break from the traditional classroom environment (Hall & DuBois, 2020; Marraccini et al., 2021).

Regarding expectations to complete missing work and catch up upon reentry from psychiatric hospitalization, Hall and DuBois (2020) recommend considering when within the academic year the student was absent to assist in determining expectations and having teachers identify the most important assignments that will need to be completed first. During the transitional period, school staff should understand the limitations of their competencies and school as the primary source for mental health services such as student attendance, miscommunication among stakeholders, legal and ethical considerations for working with minors, lack of financial resources, high demands of school staff, restrictions around accommodations, and the impact of legislation on education (Richter et al., 2022). Knowing and understanding these limitations may assist school mental health personnel in working with the student to identify attainable and realistic goals for returning to school. Examples of gradual transitions for students could include working with the student's family to ensure the student has all the school materials they need (e.g., notebooks, laptop, textbooks), providing homebound instruction and credit recovery programs, developing starting goals for attendance and work completion, and ensuring staff engaging with the student are aware of the student's safety plan (if applicable).

I – Individualized Reentry Plan

The seventh component encompasses developing and implementing an individualized reentry plan for students. Children and adolescents often return to school with varying treatment experiences, levels of engagement, social-emotional needs, and family engagement (Marraccini & Pittleman, 2022). Furthermore, youth often return to school with a number of these complex and individualized needs focused on behavioral and emotional stabilization instead of long-term goals centering on therapeutic treatment progress (Hall & DuBois, 2020). Iverson (2018) found that students perceived a more successful reentry and felt better about the transition when school staff organized formal reentry meetings committed to developing an individualized plan that addressed the students' specific needs, supports, and stressors.

Hall and DuBois (2020) suggest that individualized reentry plans cannot rely on a one-plan-fits-all concept and should highlight environmental factors, coping skills, academic and socio-emotional learning supports, length of time supports will be in place, in-school clinical support (i.e., counselors), SMART goals and focus areas, and gradual expectations. Individualized reentry plans should consider the components of the bioecological model and PVEST to further address individual characteristics and context of the student's situation in addition to the factors listed above. Additional factors to consider among these reentry plans stem from Bronfenbrenner and Morris's (2006) emphasis on person characteristics including force characteristics (i.e., traits that foster, sustain, or prevent proximal processes), resource characteristics (i.e., biological, experiential, or mental resources brought to proximal processes), and demand characteristics (i.e., observable factors that invite or discourage reactions). Therefore, school mental health personnel should consider traits that promote interactions with others and school material, student resources that may foster these interactions, and factors that

may provide opportunities or interfere with environmental reactions. An example of exploring these characteristics within rural school districts may include inviting the student to discuss interests, motivations, and extracurriculars that could be implemented throughout their reentry plan.

School members should also incorporate elements of PVEST to strengthen the reentry plan components for students, especially when considering cultural factors. Spencer (2006) defines the five components of PVEST (1) net vulnerability levels, (2) net stress engagement, (3) reactive coping methods, (4) emergent identities, and (5) life-stage specific coping outcomes. Recommendations that emerged from an examination of the reentry process within these components include considering the risk and protective factors, identifying challenges and supports, distinguish between maladaptive and adaptive strategies, examine the student's self-appraisal to assess how they could identify if they met their goals, and identify productive and adverse coping outcomes of the reentry plan (Spencer, 2006).

C – Check-Ins

The final component includes frequent check-ins with the student, their family, and members of the interdisciplinary team within the first three-months post-discharge. Researchers note that this intervention is especially important when reevaluating individualized reentry plans, examining the student's progress, and determining if the student is meeting their goals (Hall & DuBois, 2020). Blum and Libbey (2004) recommend school staff focus on improving perceived school connectedness and positive school relationships to promote student health and development throughout the reentry process. In a study completed by Marraccini and Pittleman (2022), students recommended that school staff monitor or check-in with those returning from psychiatric hospitalization during the initial period of their return. Students noted this was in

large part of wanting their teachers and other school staff members to get to know them, ask how they are, engage beyond an academic context, and wanted these adults to understand and use therapeutic terminology (Marraccini & Pittleman, 2022).

Additionally, check-ins serve as a way for members of the interdisciplinary team to identify barriers or risks for rehospitalization. Certain school factors linked to higher risk of rehospitalization include changes in special education services, difficulty with motivation, attention or concentration, and negative peer experiences such as bullying (Tossone et al., 2014). School staff members should also keep in mind the various discharge procedures and their lasting impact on the student as they return to school when they first check-in with the student. Discharge practices done inadequately or inappropriately are more likely to lead to poorer care coordination, higher risks of rehospitalization, and lower levels of patient health outcomes (Chen et al., 2020). Lastly, Weiss et al. (2015) found an increased risk for rehospitalization following discharge due to the students simultaneously coping with mental health symptomatology and environmental stressors. Frequent check-ins maintain accountability of stakeholders involved within the interdisciplinary team and may serve as a potential protective factor of rehospitalization (Marraccini et al., 2021). Researchers further imply that check-ins with student should be completed by school mental health personnel or another staff member that the student trusts (Marraccini et al., 2019; Marraccini et al., 2021).

Pedagogical Approaches to the Learning to Be STRATEGIC Training

The researcher utilized three different pedagogical and learning approaches to the training developed out of the Learning to Be STRATEGIC model. Two learning approaches to further enhance the training's effectiveness and participants' ability to keep the training in good memory include Schunk's (2016) model on Information Processing Theory (IPT) and Ambrose et

al.'s (2010) seven principles of the Science of Learning. IPT is a dynamic model that interprets the ways people process, store, and retrieve knowledge to transfer information from sensory and short-term (i.e., working) memory to long-term memory (Schunk, 2016). Given information first enters the brain through the use of senses, the researcher ensured the use of a simplistic background and incorporated visual models to illustrate the comparison between mental health levels of care to RTI. To demonstrate the transfer from sensory to short-term memory, the researcher incorporated Bloom's Taxonomy in the objectives, reported recent trends in the literature and broke down important concepts (e.g., psychiatric hospitalization, levels of care). To maintain short-term memory of the training's information, the researcher utilized components of maintenance rehearsal (e.g., repeating important components) and chunking (i.e., organizing the training's information using objectives and breaking down the STRATEGIC acronym; Schunk, 2016). To encourage the training's transfer to long-term memory, the researcher incorporated a case example demonstration and live feedback questions to address concepts of schemata organization (i.e., how mental representations are used to organize knowledge), encoding (i.e., making the material meaningful) and elaboration (i.e., linking prior knowledge to new information; Schunk, 2016).

Additionally, the researcher used a few of Ambrose et al.'s (2010) seven principles of the Science of Learning, to further demonstrate how participants can learn and retain the training's objectives. The first principle included the incorporation of prior knowledge using Response to Intervention (RTI) and MTSS concepts. A second principle includes organization of knowledge which the researcher addresses through using an acronym to detail the eight outlined steps within the training. To address another principle of assisting participants practicing and applying the training's components, the researcher created a case example demonstration breaking down

information to be applied within each step of the acronym in the corresponding reentry document.

The final pedagogical approach included adding in an aspect of Experiential Learning (Kolb, 1984), to promote motivation and provide participants an opportunity to demonstrate how they would use the model within their work as school counselors. In combination with Knoop's (1984) five step pragmatic problem-solving model, case scenarios have the ability to engage with each phase of the experiential learning process (Kreber, 2001). Although the training is completed through watching a pre-recorded video, the participants are walked through the demonstration by the researcher and prompted to (1) identify the student's reentry concerns, (2) distinguish these concerns through conceptualization of various factors, (3) generate multiple ways to approach the presenting concerns, (4) evaluate each approach using the Learning to Be STRATEGIC model, and (5) develop a documented reentry plan addressing the student's reentry. During the final step of this approach, participants input additional considerations to be included within the reentry plan document and highlighted lingering questions to promote the concept of convergent knowledge (Kolb, 1984).

CHAPTER III: METHODOLOGY

Student reentry following psychiatric hospitalization is a complex process involving multiple stakeholder perspectives, knowledge of school accommodations, and consistent collaboration between settings (Marraccini & Pittleman, 2022; Midura et al., 2023; Tougas et al., 2022). Additionally, the transition back to school is critical for students as they work towards meeting academic, social, and emotional demands, navigating new routines, and facing mental health stigma (Preyde et al., 2021; Savina et al., 2014). Post-discharge, educators and school support personnel struggle to ease the transition, with many schools reporting few to no policies or procedures for handling the student reentry process (Marraccini et al., 2019). Moreover, the few programs created to help address the student reentry process lack the feasibility, funding, and staff support to be implemented within any school district (Midura et al., 2023). To address a lack of policies and procedures for school support personnel on the student reentry process following psychiatric hospitalization, the researcher created the Learning to Be STRATEGIC model and reentry plan document.

Understanding the specific training needs of school counselors is critical to increasing counselor self-efficacy, motivation, and performance outcomes (Larson & Daniels, 1998). Regarding student reentry following psychiatric hospitalization, school staff reported wanting more training in the areas of triggers, warning signs, reasons for hospitalizations, follow-up care, medication management, safety planning, and guidelines around ROIs (Hoffman, 2021). Moreover, Carlson and Kees (2013) found that school counselors lack confidence in their ability and training on family counseling, treatment planning and crisis management. Researchers continue to highlight the need for professional development and programs on the student reentry

process to promote knowledge and confidence of school support personnel working with these students (Hoffman, 2021; Loeper, 2021).

MTSS is a leading prevention-based framework for interventions and evidence-based practices across schools nation-wide (Goodman-Scott et al., 2023). In a systematic literature review, Midura et al. (2023) found that school staff frequently reported a desire to help but a lack of knowledge around services to assist in the student reentry process. Creators of the programs built upon MTSS to address the student reentry process following psychiatric hospitalization found significant improvements in levels of empowerment, satisfaction, mood and emotions, school functioning, school attendance and graduation rates, but lack feasibility across all schools (Midura et al, 2023; Weiss et al., 2015; White et al., 2017). The researcher created the Learning to Be STRATEGIC model and reentry document as an accessible way for schools to utilize tier level interventions through the components, however, there is currently no support for the training's impact on MTSS knowledge and skills. Through the proposed purpose, research questions and definition of terms in Chapter I, the researcher examined the effectiveness of the training using an experimental design with a waitlist control group, and open-ended questions to obtain quantitative and qualitative data summarized in Chapter III.

Research Design

This study served as an initial examination of the effectiveness of the Learning to Be STRATEGIC training and its relationship to school counselor perceptions of self-efficacy and MTSS. The researcher utilized an experimental methodology with open-ended questions to collect a combination of qualitative and quantitative required to explore the effectiveness of the training intervention (Creswell et al., 2011). The study operated with a treatment group and waitlist control group design with pre- and post-test surveys at multiple time points to assess the

training's effectiveness across self-efficacy, MTSS skills and knowledge, and training evaluation constructs. The control group served as a waitlist control to ensure all participants receive treatment and help control for confounding variables. Four research questions guided the present study:

Research Question 1 (R1): How effective is the Learning to Be STRATEGIC training for school counselors in the various areas of training evaluation (i.e., reaction, learning, behavior, and results)?

Research Question 2 (R2): Is there a difference on school counselors' self-reported scores of general self-efficacy after the implementation of the Learning to Be STRATEGIC training?

Hypothesis: School counselors' self-reported scores of general self-efficacy will increase after the implementation of the Learning to Be STRATEGIC training.

Research Question 3 (R3): Is there a difference on school counselors' skills and knowledge around multi-tiered systems of support (MTSS) after the implementation of the Learning to Be STRATEGIC training?

Hypothesis: School counselors' skills and knowledge around multi-tiered systems of support (MTSS) will increase after the implementation of the Learning to Be STRATEGIC training.

Research Question 4 (R4): What is school counselors' feedback on the implementation of the Learning to Be STRATEGIC training?

Research Question (R5): Is there a difference between the waitlist control group and treatment group self-efficacy, knowledge and skills of (MTSS), and training evaluation scores?

Participants

Inclusion and Exclusion Criteria

To be eligible for the study, participants met the following criteria: (1) be at least 18 years old, (2) hold credentials/licensure as a professional school counselor in their corresponding state, (3) currently employed in a K-12 public school setting, and (4) work and live in the United States. Exclusion criteria included school counselors-in-training (SCITs) and school counselors working in private education. The researcher excluded SCITs since engaging in a master's program is a critical point in the development of counselor identity and generating self-efficacy (Mullen et al., 2015). Furthermore, the researcher excluded school counselors employed in private schools since the researcher cannot guarantee the use of the MTSS framework, and consistency among school organization, management, and support services.

Sample Size and Sampling Method

An a priori analysis was conducted using G*Power 3.1 to determine the minimum number of participants. Results from the F tests, repeated measures analysis of variance (ANOVA), within-between group interaction containing an effect size of 0.25, 0.05 alpha, two groups, and three measurements determined the targeted sample size would need to include a total of 28 participants (i.e., 14 in each group) to reach a power of 0.80 (Faul et al., 2007). Participants were recruited through convenience and snowball sampling. The researcher created recruitment materials (i.e., email write-up and flyer) to send out to members in her professional network, neighboring school districts, and school counseling organizations for the promotion of the study on social media. The email write-up and flyer included a clickable link and a scannable QR code to access the informed consent and first questionnaire. Since the researcher used social media to recruit participants, the researcher enabled the multiple submissions prevention and bot

detection features for each survey in Qualtrics to flag potential spam responses. The researcher offered an incentive as an opportunity to increase the likelihood of participant recruitment and time commitment towards the study. Participants received an incentive entry for each survey completed. The first 30 participants that completed the entire study (all surveys and the training) received a $15 Amazon gift card. Incentive winners received their gift cards electronically. Moreover, participants were permitted to keep the reentry plan document to better support their work with students post-study.

Measures

The present study consists of the following measures: (1) demographics questionnaire, (2) the General Self-Efficacy Scale (GSE; Schwarzer & Jerusalem, 1995), (3) the School Counselor Knowledge and Skills Survey for Multi-Tiered Systems of Support (SCKSS; Olsen et al., 2020), (4) the short form of the Questionnaire for Professional Training Evaluation (Q4TE; Grohmann & Kauffeld, 2013), and (5) scaling and open-ended questions requesting training feedback.

Demographics

The demographics questionnaire consists of six questions asking participants: (1) state location of their school, (2) their school level (i.e., elementary, middle, or high school), (3) school category (i.e., metropolitan/urban, suburban, or rural), (4) school referrals for psychiatric hospitalization, (5) student reentry protocols (i.e., formal, informal, or none), and (6) a description of the protocols if they picked formal or informal from the previous option. The researcher chose to exempt demographic questions around the participant's identity to help ensure anonymity. The demographics survey is provided in Appendix B.

General Self-Efficacy Scale (GSE)

The GSE assesses the level or strength of the participant's belief in their ability to respond or resolve challenges as they occur in everyday life. This measure consists of 10 items with self-efficacy statements rated on a 4-point Likert scale from 1 = *not at all true* to 4 = *exactly true*. Example items include: "I can always manage to solve difficult problems if I try hard enough" and "It is easy for me to stick to my aims and accomplish my goals." The higher the scores for each statement, the greater the individual's generalized beliefs of their self-efficacy (Schwarzer & Jerusalem, 1995). The GSE has strong internal reliability with Cronbach's alphas (α) between 0.79 and 0.90 (Luszczynska et al., 2005). Criterion validity is well documented for the GSE in correlation with emotion, optimism, and work satisfaction while anxiety, depression, burnout, stress, and health complaints contained negative coefficients (Schwarzer & Jerusalem, 1995). The GSE survey can be found in Appendix C.

School Counselor Knowledge and Skills Survey for Multi-Tiered Systems of Support (SCKSS)

The SCKSS is an adaptation of Blum and Cheney's (2009) Teacher Knowledge and Skills Survey (TKSS). The TKSS measured teacher's knowledge and skills of positive behavioral supports (PBS), but the authors soon realized the language within the TKSS was not appropriate for school counselors. Researchers worked with the authors of the TKSS to change the items' terms from *PBS* to *MTSS* and *teacher* to *school counselor*. Authors of the SCKSS also adapted item 6 from "I know how to access and use our school's counseling programs" to "I know how to provide access and implement our school's counseling programs" (Olsen et al., 2020).

The SCKSS contains 33 items rating participant's knowledge, skill level or awareness across areas: (1) individualized supports and practices, (2) schoolwide supports and practices, (3) targeted supports and practices, and (4) collaborative supports and practices. The SCKSS uses a 5-point Likert scale from 1 = *none or little* to 5 = *mastery* with a table outlining the rating scale's definitions such as explaining 1 = none or little as "I am not aware of the knowledge, policy, or skill, or I am slightly aware (e.g., heard of it) but have never practiced it or applied it" (Olsen et al., 2016). Examples items include: "I know our school's policies and programs regarding the prevention of behavior problems" and "Communicating regularly with parents/guardians about student's behavioral progress. The SCKSS has strong internal reliability ($\alpha = 0.95$) for the total score and a Cronbach's alpha range between 0.65 and 0.88 for each of the four factors. The measure's construct validity is also documented through high factor loadings and statistically significant coefficients above 0.50 suggesting item stability among the four factors (Olsen et al., 2020). According to the authors, each of the first three factors align with a tier level, for example, *individualized supports and practices* represents Tier 3 interventions, *schoolwide supports and practices* as Tier 1 universal interventions, and *targeted supports and practices* as Tier 2 interventions. The fourth factor, *collaborative supports and practices,* is associated with school counselors' cooperative efforts with all tier levels interventions and school staff consultation (Olsen et al., 2020). The SCKSS survey can be found in Appendix D.

Short Form of the Questionnaire for Professional Training Evaluation (Q4TE)

The Q4TE measures short- and long-term training outcomes through examination of Kirkpatrick's four areas of training evaluation: (1) reaction (i.e., satisfaction and utility), (2) learning (i.e., skills and knowledge acquisition), (3) behavior (i.e., application to practice), and (4) organizational results (i.e., individual, and global impact; Grohmann & Kauffeld, 2013). The

short form of the Q4TE consists of 12 items and an additional self-efficacy scale with two items rated on an 11-point Likert scale from 0 percent = completely disagree (coded as 0) to 100 percent = completely agree (coded as 10). Example items include: “I enjoyed the training very much” and “The training is very beneficial to my work” (Grohmann & Kauffeld, 2013). The Q4TE has strong internal reliability with Cronbach’s alphas ranging between 0.79 and 0.96 across the factors. Furthermore, the authors found strong support for differential and discriminate validity among the relationship between the scale application of the Q4TE and practice and transfer quantity (Grohmann & Kauffeld, 2013). Grohmann and Kauffeld (2013) outline the item list of the Q4TE short form in their article on the development and evaluation of the measure and can be found in Appendix E.

Scaling and Open-Ended Questions

The purpose of the scaling and open-ended questions in the Q4TE survey is to gain detailed feedback on the training. The questions ask the participants to reflect on the training’s format, expand on the implications of the training, and report areas they would still like more information on the student reentry process following psychiatric hospitalization. Additionally, the researcher asks participants if they have received any additional trainings/professional development since completion of the Learning to Be STRATEGIC training to assess the confounding variables that may attribute to the participants’ responses. Figure 2 provides the scaling and open-ended questions listed in the survey. These questions included a 1 to 10 scale and free response to gather the participants’ thoughts, feelings and missed opportunities from the training.

Figure 2. Survey Open-Ended Questions

SCALING AND OPEN-ENDED QUESTIONS

Training Time Point (TG – TP1, WCG – TP2)

1. What aspects of the training do you believe benefit your work as a school counselor?
2. What aspects of the training do you believe are not beneficial to your work as a school counselor?
3. What questions do you still have about the Learning to Be STRATEGIC training and the student reentry process following psychiatric hospitalization?

Time Point 3 (One-Week Post-Training)

1. Aspects of the training were easy to understand. (Scaling Question; 1-10)
2. Aspects of the training were difficult to understand or confusing. (Scaling Question; 1-10)
3. In what ways has the training impacted your work as a school counselor?
4. What do you still want to know about the student reentry process following psychiatric hospitalization?
5. Have you received any additional trainings or professional development since the completion of the training? If yes, please list them below.

Procedures

Once the principal investigator (PI) has obtained Institutional Review Board (IRB) approval to administer the study, the participant recruitment process began. All informed consent documents, measures, and data collection were through Qualtrics software. The informed consent (see Appendix H) explained the purpose of the study, anonymity, risks and benefits, the opportunity to withdraw from the study at any time, and an estimated time frame for how long each survey and the training takes to complete. Participants electronically chose their choice for the informed consent through Qualtrics prior to participation in the study. Once participants gave given consent, Qualtrics randomly redirected each participant to the treatment or waitlist control group survey flow.

Data collection occurred at four separate time points (see Figure 3) within the study design for the treatment group: (1) pre-test and training completion survey, (2) training evaluation survey sent one-week post-training, (3) GSE and SCKSS survey sent two weeks post-training, and (4) GSE and SCKSS survey sent three weeks post-training. The waitlist control group had an additional time point measuring the GSE and SCKSS prior to the delayed training (see Figure 4). Participants were asked to create and remember a four-digit code consisting of the first letter of their last name and last three numbers of their phone number (e.g., Smith and 012-345-6789 = S789) as the identifier for their responses across each survey and to ensure anonymity.

Figure 3. Study Time Points for Treatment Group

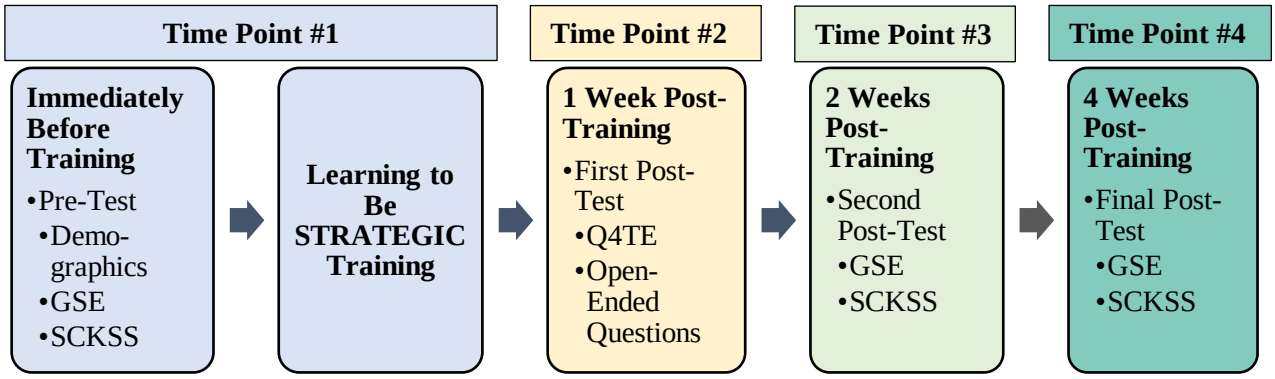
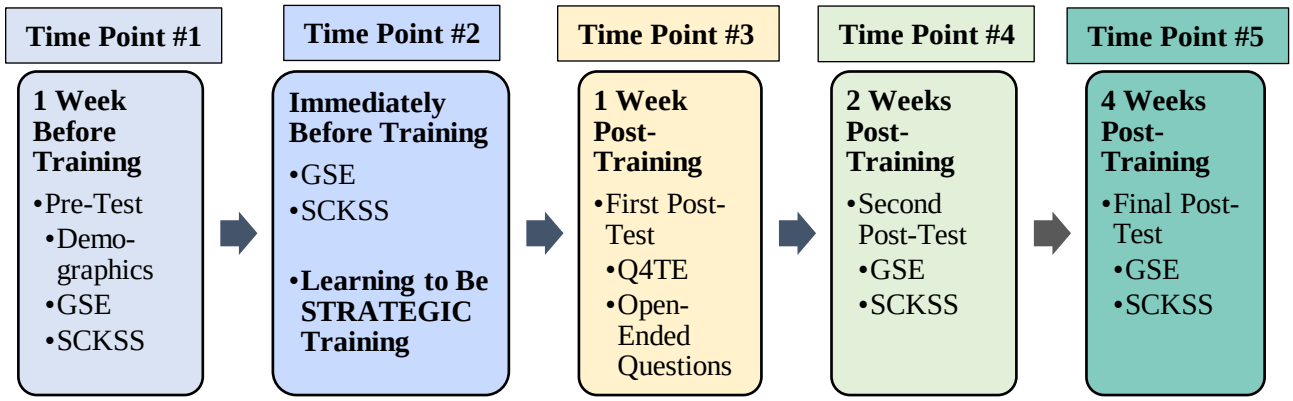


Figure 4. Study Time Points for Waitlist Control Group



Following the informed consent, Qualtrics randomly assigned participants to either the treatment or waitlist control groups survey flow. The treatment group were able to complete the pre-test and training within the first time point while the waitlist control group only completed the pre-test within the first time point. Demographics, GSE scores, and SCKSS scores were all collected in the pre-test prior to the training section of the survey to establish participant baseline across constructs. The training section of the surveys included an embedded video of the one hour long Learning to Be STRATEGIC training and corresponding documents (i.e., reentry plan document and training references; see Appendix F). The Learning to Be STRATEGIC training outlined the information and pedagogical approaches outlined in Chapter II. At the end of each completed survey, the participants automatically were redirected to a separate survey that collects their email address (see Appendix G). The separate collection of email addresses from the participants responses helped the researcher maintain anonymity and automated Qualtrics to send the following surveys at their corresponding time points.

One week after completion of the training, the participants received an automated email with the link to first follow-up survey focused on training evaluation. Scores from the Q4TE and feedback from the open-ended questions were collected during this time point. Post completion of the first follow-up survey, participants were redirected to a separate survey that asks them again for their email address to record for the gift card incentive and further automated survey emails. Two weeks post-training the participants received an automated email with the link to the second follow-up survey measuring GSE and SCKSS scores. Again, once completed, the participants were redirected to a separate survey where they input their email address for the gift card incentive entry and automated emails. Three weeks post-training the participants received a final automated email with the link to the last follow-up survey measuring GSE and SCKSS

scores. Once completed, the participants were redirected to a separate survey where they can input their email address for a final gift card incentive entry. Using the data from the email response surveys, the researcher sent reminder emails to participants to complete surveys; participants received no more than an initial and final reminder email. Once the data collection period ended for the study, the researcher identified the first 30 participants to complete the study to receive a $15 Amazon gift card. Incentive recipients received their gift cards electronically.

Data Analysis

The quantitative scores from the measures were analyzed through IBM® SPSS® Statistics Software while the qualitative data was coded separately. The researcher gathered descriptive statistics through SPSS for the demographic questions to identify the study's sample. Additionally, the researcher identified common language throughout the protocol descriptions in the demographics to create common themes to responses around formal and informal protocols/policies. To answer R1, the researcher gathered mean scores in the Q4TE areas to determine the effectiveness of the training. To answer R4, the researcher analyzed the open-ended questions around training evaluation following Braun and Clarke's (2006) six-step process for thematic analysis (TA) to examine patterns and meaning of the participant's training experiences through themes. The researcher chose thematic over content analysis due to its highly flexible approach aimed at describing the story or themes of the participants responses of their experiences.

The first step in TA involved the researcher familiarizing their self with the data through reading through transcriptions, immersing in the data, and jotting down initial ideas. The second step of TA included generating initial codes featuring both semantic and latent data. The third step of Braun and Clarke's (2006) six step process for TA consisted of the researcher searching

and theme development. To differentiate between participant meaning and researcher interpretation, the researcher bracketed biases early on, balanced subjectivity, and practiced reflexivity (Williams & Morrow, 2009). Next the researcher reviewed the themes and check to see if the themes work with initial codes and thematic mapping of the entire data set. The fifth step of TA included naming and defining the themes to enhance the analytical narrative of the data. Lastly, in the final phase of TA, the researcher wrote the final presentation of themes and overall story of the participant's experiences with the training (Braun & Clarke, 2006). Upon recommendations from Clark et al. (2015), the researcher's write-up contained a maximum of six final themes for each question, and a 30:70 ratio of data excerpts and analytic commentary. Lastly, the researcher established trustworthiness in conducting thematic analysis through Nowell et al.'s (2017) recommended outline encompassing reflexivity and triangulation throughout the six steps of TA.

Separate repeated measures ANOVA analyses were conducted to track changes over time within the treatment and waitlist control groups to answer R2 and R3. A repeated measures ANOVA is used to test a continuous dependent variable's effects measured over time (Lix & Keselman, 2018). For R2, the researcher hypothesized that GSE scores will increase after implementation of the training. For R3, the researcher hypothesized that scores around skills and knowledge of MTSS will increase after implementation of the training. For R5, the researcher conducted two separate repeated measures ANOVAs to analyze GSE and SCKSS scores across the three time points with a focus on between-subject interactions (i.e., treatment group and waitlist control groups). To observe the differences in mean Q4TE scores between the TG and WCG, the researcher started by implementing an independent t-test then conducted several one-way ANOVAs to identify significant differences between the mean Q4TE level scores (RL, LL,

BL-APP, and ORG) for the TG and WCG. The researcher checked the normal distribution of the dependent variable by examining skewness and kurtosis values and assess the assumption of sphericity through a Mauchly's Test of Sphericity. If the tests were found to be significant, the researcher conducted pairwise comparisons to assess where differences occur (Lix & Keselman, 2018).

Pilot Study

Since the newly developed Learning to Be STRATEGIC Model is the first of its kind within the reentry literature, the purpose of this pilot study was to obtain expert feedback on the model's training and factors that lead to a successful professional development. Expert reviewers received the Learning to Be STRATEGIC training created by the author along with a set of open-ended questions on evaluating the training and measures (Figure 4). One of the goals for the pilot study included establishing support for the Learning to Be STRATEGIC training by having experts in the school mental health field review the training and provide specific feedback on the components, appearance, and implementation. A second aim of the pilot study was to receive feedback on survey format, the selected measures, and time commitment to take each survey. Time commitment was a central area of the pilot study feedback to due to the multiple surveys included in the study's designs, considerations for survey fatigue, and decisions around appropriate compensation for participants. Lastly, the researcher wanted to ensure that the automated design set up within Qualtrics worked throughout the experts' completion of the surveys.

Figure 5. Pilot Study Open-Ended Questions

OPEN-ENDED QUESTIONS
Please answer the following questions based on your experience. 1. How many years of experience do you have working within the school counseling field? 2. How would you describe your current level of engagement with school settings? Please answer the following questions on the Learning to Be STRATEGIC training and training implementation. 1. How do you stay engaged during trainings? 2. What elements of the training felt easy to understand? 3. What elements of the training felt confusing or harder to understand? 4. How long did it take you to complete the pre-survey and training? 5. How long did it take you to complete the first follow-up survey? 6. How long did it take you to complete the final follow-up survey? 7. What general feedback would you like to provide about the training, surveys, or study design?

Expert Criteria and Sample Size

The following criteria were taken into consideration for the selection of the expert reviewers to provide a range of feedback, (a) type of school position, (b) years of experience, and (c) current level of engagement with school settings. The selected expert reviewers included three current counselor educators and a school psychologist. The researcher sought feedback from various school counseling perspectives and experience to align with one of the training's goals of being accessible to any school support personnel in the event a school counselor is not available. All experts identifying as counselor educators were former school counselors with one having previous experience working for the Department of Education in their state. In addition to being a school psychologist, the fourth expert served as a former director of mental health for a school district. Years of experience in the field ranged from 6 to 20+ years, and all experts

reported actively engaging with school settings. Answers for current level of engagement with school settings included conducting research, implementing grant-funded programs, fieldwork of their students, consultation, legislation, and full-time employment.

Measures

The researcher administered the same Qualtrics surveys to the pilot study experts that will also be distributed to participants in the larger, dissertation study. The surveys included a demographic questionnaire, GES, SCKSS, Q4TE, and open-ended training feedback questions. The researcher will review the experts' data from the pilot study to ensure Qualtrics is gathering and separating survey responses from email address collection.

Procedures

The researcher used convenience and purposive sampling to gain expert participants for the pilot study. The researcher utilized their connections and professional network to reach out to five school mental health professionals who met the criteria for the pilot study. Pilot study experts were recruited via email and phone invitation, and four out of the five professionals agreed to complete the pilot study. One potential participant could not agree to complete the pilot study due to time constraints. The researcher provided a general description of the study, and the following materials for the experts to review: (1) links to each survey, (2) open-ended questions outlined earlier in this section, (3) the Learning to Be STRATEGIC training PowerPoint, and (4) the corresponding reentry plan document. The researcher provided the experts with a recommended deadline for receiving feedback with the option to inform the researcher if they needed more time.

Results and Revisions

All four experts reviewed and provided feedback on the measures, training, and the open-ended questions outlined in Figure 4. The training feedback was generally positive and consistant across the four experts. Years of experience in the field varied; one expert held 6 years of experience, another held 12 years, and the final two experts both held over 20 years of experience. Experts' current level of engagement with school settings also varied to include areas of research, legislation, grant-funded programming, students' fieldwork placements, consultation, and for one expert, full time employment. One expert commented the usefulness of including these questions for the larger study's participants as well. Therefore, the researcher included the pilot study's questions asking about years of experience and engagement in school settings within the pre-test demographics section but specified part-time and full-time employment for the engagement question to further gather data on participants.

Experts reported they stay engaged during trainings through additional note sheets, having real-life examples or case studies, and a balance between material and application. Experts had generally positive feedback for the training content, graphics, and method. All reported that the acronym was useful in remembering the eight-step process, and the additional reentry plan document from the training was a feasible, useful tool to walk school staff through the student reentry process. Furthermore, several experts reported that they appreciated the common questions section as it helps, "address potential questions that could come up in a live training."

Regarding feedback for the surveys, the researcher added an "Unsure" option for the demographics questions asking the number of students referred to psychiatric care and geographic location based on multiple experts' recommendations. Experts suggested that

providing this option could give more insight into the percentage of school counselors unaware of this information for their school. The time commitment reported for the pre-test and training ranged between 45-50 minutes. One expert recommended the addition of a validation check question within the surveys to ensure participants are answering truthfully. The researcher considered this option and chose to add a validation within the pre-test and training survey since this time point has the largest time commitment. The time commitment reported for the follow-up surveys ranged between 5-10 minutes for each survey. One expert reported that they struggled with the directions of the SCKSS due to its length and language used in describing the item rating scale. The researcher reviewed and identified key components from the directions that appear useful for participants to know. The researcher adjusted the directions through simplification to the key components and replaced the rating scale table with general statements of each rating scale number. All four experts did not report any problems using Qualtrics, and the automated system set up by the researcher worked without any issues.

Following proposal and further consultation with the dissertation committee, the researcher decided to include a case study example (see Appendix I) to guide participants through the reentry plan document as quality assurance to verify participants engagement in the training and gain live, open-ended feedback for thematic analysis. The researcher will identify whether participants pass the quality assurance check through pre-written answers to questions and match these answers to participant's responses. See Appendix J for the case study questions and pre-written answers. Inclusion of the case study example extended the training's time from thirty minutes to one hour. As a result of this, the researcher separated the pre-test and training into two different surveys for treatment group participants to complete due to time constraints.

The training survey was provided to treatment group participants immediately upon the completion of the pre-test.

CHAPTER IV: RESULTS

The purpose of this study is to evaluate the effectiveness of the Learning to Be STRATEGIC training for professional school counselors on the student reentry process following psychiatric hospitalization through examination of self-efficacy, skills and knowledge on multi-tiered systems of support (MTSS), and professional training evaluation measures. Additionally, an exploration of the type of group (i.e., treatment and waitlist control) on GSE, SCKSS, and Q4TE scores were examined to further determine the training's effectiveness. This chapter will cover sample demographics, descriptive statistics, and results of analyses outlined in Chapter III.

Sample

As described in Chapter III, participants were recruited through convenience and snowball sampling. The researcher reached out to members within her professional network, each state school counseling association, neighboring school districts, and school counseling organizations on social media. The G*Power analysis for F tests, repeated measures analysis of variance (ANOVA), within-between group interaction containing an effect size of 0.25, 0.05 alpha, two groups, and three measurements yielded a proposed sample of size of 14 members per group (28 participants in total) to reach a power of 0.80 (Faul et al., 2007). A total of 66 school counselors consented to the study and completed the first time point. However, due to the rate of attrition and time constraint of the training, the researcher acquired a sample size of 27 with 14 participants in the treatment group and 13 participants in the waitlist control group. Table 1 reports the attrition rates across each time point. Overall, there was an attrition of 39 total participants across all time points and groups (n = 19 from the treatment group, and n = 20 from the waitlist control group). Responses flagged as a multiple submission and/or potential bots

from the features designed in Qualtrics were removed from the study to ensure validity of responses. The researcher implemented a case study example in the training survey to demonstrate how the reentry document would be completed. Additionally, the case study served as a quality reassurance check to ensure participants remained engaged with the training video, by identifying correct answers to the related questions. The case example questions and answers can be found in Appendix J.

Table 1. Attrition Rates Across Time Points

Group	TP1	Training	TP2 (Delayed Training)	TP3	TP4	TP5	Percent Attrition
Treatment (*n*)	33	15	-	15	14	14	57.6%
Waitlist Control (*n*)	33	-	14	14	13	13	60.6%
Total	66	-	29	29	27	27	59.1%

The researcher collected individual and school demographic information from all participants including state, school level, years of experience, type of employment, school category (i.e., rural, suburban, metropolitan/urban, unsure), an estimated number of students referred for psychiatric hospitalization the previous 2022-2023 academic year, and type of protocols for the student reentry process following psychiatric hospitalization (i.e., formal, informal, none). Table 2 outlines the descriptive statistics of the demographic data from the total sample size and distributed by each group.

Table 2. Sample Demographics (Total and Group)

	Total (*n* = 66)		Treatment Group (*n* = 14)		Waitlist Control Group (*n* = 13)	
State	AZ	1	AZ	0	AZ	0
	AR	3	AR	1	AR	1
	CA	2	CA	0	CA	0
	CT	1	CT	0	CT	0

	FL	1	FL	0	FL	1
	GA	5	GA	1	GA	0
	IN	1	IN	0	IN	0
	KS	1	KS	0	KS	0
	KY	1	KY	0	KY	0
	LA	1	LA	0	LA	0
	MI	2	MI	1	MI	0
	NH	1	NH	1	NH	0
	NY	11	NY	2	NY	2
	NC	2	NC	1	NC	0
	ND	1	ND	0	ND	1
	OH	11	OH	2	OH	1
	OK	3	OK	0	OK	1
	SC	1	SC	1	SC	0
	TN	6	TN	0	TN	3
	TX	4	TX	2	TX	0
	VT	1	VT	0	VT	0
	VA	4	VA	2	VA	2
	WI	2	WI	0	WI	1
Level	Elementary	18	Elementary	8	Elementary	2
	Middle	13	Middle	1	Middle	2
	High	35	High	5	High	9
Years of Experience (Mean, SD, Range)	(M = 8.61, SD = 7.656, Range = 26)		(M = 8.64, SD = 8.741, Range = 25)		(M = 8.85, SD = 9.017, Range = 26)	
Type of Employment	Full-Time	65	Full-Time	14	Full-Time	13
	Part-Time	0	Part-Time	0	Part-Time	0
	Other	1	Other	0	Other	0
School Category	Rural	25	Rural	4	Rural	5
	Suburban	24	Suburban	8	Suburban	4
	Metropolitan/ Urban	16	Metropolitan/ Urban	1	Metropolitan/ Urban	4
	Unsure	1	Unsure	1	Unsure	0
Referrals for Psychiatric Hospitalization	0-5	23	0-5	7	0-5	3
	6-10	24	6-10	5	6-10	5
	11-15	5	11-15	2	11-15	2
	15+	8	15+	0	15+	2

	Unsure	6	Unsure	0	Unsure	1
Protocols for Reentry	Formal	34	Formal	6	Formal	7
	Informal	25	Informal	7	Informal	4
	None	7	None	1	None	2

Of the total sample (*n* = 66), majority of respondents were from New York (*n* = 11) and Ohio (*n* = 11) with participant responses encompassing at least one state from each region of the United States. Almost all participants of the total sample identified as working full-time (*n* = 65) and in high schools (*n* = 35), apart from one participant who identified as working 0.8 FTE (80% as a full-time employee or 32 hours a week). Years of experience within the total sample ranged from one year to twenty-seven years, with a mean of 8.61 years. Among the entire sample, variations were observed for school category and referrals for psychiatric hospitalization the previous 2022-2023 academic year. Majority of participants identified their schools as rural (*n* = 25) and suburban (*n* = 24) with 0-5 (*n* = 23) and 6-10 (*n* = 24) referrals from the previous year, respectively.

The treatment group consisted of participants who were full-time (*n* = 14), employed at an elementary school (*n* = 8), working in a suburban area (*n* = 8), and had an average of 8.64 years of experience in the school counseling field. Treatment group states ranged across the board with most participants in New York (*n* = 2), Ohio (*n* = 2), Texas (*n* = 2), and Virginia (*n* = 2). Many participants in the treatment group (*n* = 12) reported anywhere from 0-10 psychiatric hospitalization student referrals from the previous academic year. Many of the treatment group participants (*n* = 13) also reported formal and informal protocols in place for the student reentry process. The waitlist control group consisted of participants who were full-time (*n* = 13), employed at a high school (*n* = 9), and had an average of 8.85 years of experience in the school counseling field. School category was fairly equal within the waitlist control group for rural (*n* =

5), suburban (*n* = 4), and metropolitan/urban (*n* = 4) areas. Participant states for the waitlist control group also varied with the most common state being Tennessee (*n* = 3), followed by New York (*n* = 2) and Virginia (*n* = 2). Similar to the treatment group, majority of participants in the waitlist control group (*n* = 8) reported anywhere from 0-10 psychiatric hospitalization student referrals from the previous academic year. Many of the waitlist control group participants (*n* = 11) also reported formal and informal protocols in place for the student reentry process.

Regarding protocols for the reentry process, 59 participants reported having some type of policy in place, either formal or informal, on how to handle the student reentry process following psychiatric hospitalization while other participants reported no protocols (*n* = 7). Table 3 shows a list of selected responses on the formal and informal policies identified by participants for their school/district; a table of all responses for formal and informal policies can be found in Appendix O. Participants who identified formal (i.e., written and documented) policies for their school/district reported having designated paperwork, clear expectations for the student's return (e.g., needing signed medical documentation), official reentry meetings with multiple staff members, safety planning, and referrals. Participants who identified informal (i.e., spoken or known, but not written) policies for their school/district reported a lack of set guidelines or paperwork with an emphasis on the school counselor developing protocols for the reentry process. In the responses on informal protocols, common services reported include frequent check-ins, coordination with medical personnel (if possible), requests for reentry meetings, determination of safety plans, and aligning school services based on recommendations from hospital personnel.

Table 3. Selected Examples of Formal and Informal Policies

Formal	Paperwork needs to be received from facility stating it is okay for student to return, re-entry meeting with parent, student, and social worker, counselor and social worker create safety plan for student and monitor student
	Student and parents come to a re-entry meeting prior to the student returning to the classroom. The meeting includes the student, parents, school counselor, social worker, assistant principal, and school psychologist. Parents are asked to bring documentation of the hospitalization (for attendance) and any safety plans that were put in place. We adapt the safety plan for the school setting. With parents' consent, teachers are informed with what information parents are comfortable sharing.
	Students require a doctor's note to return to school, the school holds a re-entry meeting with the school counselor, admin, and teachers, and there is a standardized safety plan worksheet (may be filled out by medical professional or during reentry meeting)
	Our school social worker or school psychologist has a document they use for students that return. Some questions include triggers, coping mechanisms, and people on campus student identifies as a safe space
	Student must have a signed copy of the state emergency notification form and must meet with the school counselor to establish a student safety plan.
	We have documentation of safety plan, depending on reason behind placement the student may be placed at our alternative school as a controlled environment due to have 2100+ students, meeting with teachers to assure adequate care.
Informal	Our district policies are more informal. Staff members are told to hold a meeting when the student gets back and whoever is in charge identifies who should be a part of the meeting. Any kind of services or accommodations usually depend on the situation, but the most popular seems to be CICO.
	Communicate with hospital as possible. Before reentry, we review the safety plan created by student while hospitalized. Meet with student upon morning of return. Follow up as decided or periodically to check on student.
	If we have notice of return of students and their absences was for a period of more than 2 weeks, we have a meeting with student and parent. We then discuss safety plans and get any releases signed.
	We loosely follow the protocols for reentry after home instruction or hospitalization for any other reason. We also evaluate the case to see if there are any special considerations. For example, a student might need to ease back into the classroom and attend for 1/2 days initially while building up to full days. They may also be exempted from certain long-term assignments or tests so that they can start fresh with a new topic/unit. Any grades obtained during the hospitalization are added into the average by the classroom teacher.
	Ask family for discharge summary and recommendations from facility for reentry. If applicable, and we find out before discharge, we ask facility to send grades, summary, recommendations, etc. we meet with student the day they return, evaluate, send email to teachers regarding any accommodations or advice, tell student we are available for them to visit as needed.

Preliminary Analysis

The researcher inspected for outliers using box plot analyses across all survey responses for GSE, SCKSS and Q4TE measures. No outliers were identified for GSE, and SCKSS scores across all responses. Three outliers were identified for the Q4TE measure across the Organization Results (ORG; $n = 1$), Individual Results Scale (IND; $n = 1$), and Global Results Scale (GLO; $n = 1$). Since IND and GLO are scales in the larger ORG level, the participant who reported lower scores in these areas yielded a lower total score for the level as a whole. However, the mean scores for ORG, IND, and GLO were not significantly impacted when this participant was removed from the frequencies analysis.

Since the assumption of no outliers was met when analyzing all survey responses across GSE and SCKSS scores through box plot analyses, the researcher checked normality among the GSE and SCKSS scores using the Shapiro-Wilk Normality Test. When choosing a preliminary normality test, the researcher chose to go with the Shapiro-Wilk test since it is more appropriate for sample sizes under 50 participants (Shapiro & Wilk, 1972). Table 4 and Table 5 represent the normality test output for GSE and SCKSS scores respectively. GSE scores for each condition group (TG, WCG) across all three time points (GSE1, GSE2, GSE3) were normally distributed, as assessed by the Shapiro-Wilk test (TG, $p = 0.953, 0.142, 0.259$; WCG, $p = 0.668, 0.806, 0.700$ respectively). SCKSS total scores for each condition group (TG, WCG) across all three time points (SCKSS1, SCKSS2, SCKSS3) were normally distributed, as assessed by the Shapiro-Wilk test (TG, $p = 0.666, 0.446, 0.991$; WCG, $p = 0.385, 0.336, 0.160$ respectively). Lastly, the researcher checked the sphericity assumption for GSE and SCKSS scores to ensure a repeated measures ANOVA analyses would be appropriate for examining GSE and SCKSS scores at the three time points. Mauchly's test indicated that the assumption of sphericity had

been met for GSE scores, $\chi^2(2) = 4.29$, $p = 0.117$. Additionally, Mauchly's test indicated that the assumption of sphericity had been met for SCKSS scores, $\chi^2(2) = 2.92$, $p = 0.233$.

Table 4. Normality Test for GSE

		Kolmogorov-Smirnov[a]			Shapiro-Wilk		
	Group	Statistic	df	Sig.	Statistic	df	Sig.
GSE1	TG	.149	14	.200*	.977	14	.953
	WCG	.180	13	.200*	.955	13	.668
GSE2	TG	.201	14	.131	.907	14	.142
	WCG	.120	13	.200*	.963	13	.806
GSE3	TG	.166	14	.200*	.925	14	.259
	WCG	.150	13	.200*	.957	13	.700

*. This is a lower bound of the true significance.
a. Lilliefors Significance Correction

Table 5. Normality Test for SCKSS

		Kolmogorov-Smirnov[a]			Shapiro-Wilk		
	Group	Statistic	df	Sig.	Statistic	df	Sig.
SCKSS1	TG	.130	14	.200*	.957	14	.666
	WCG	.139	13	.200*	.934	13	.385
SCKSS2	TG	.193	14	.166	.942	14	.446
	WCG	.118	13	.200*	.929	13	.336
SCKSS3	TG	.097	14	.200*	.984	14	.991
	WCG	.157	13	.200*	.906	13	.160

*. This is a lower bound of the true significance.
a. Lilliefors Significance Correction

Data Analyses

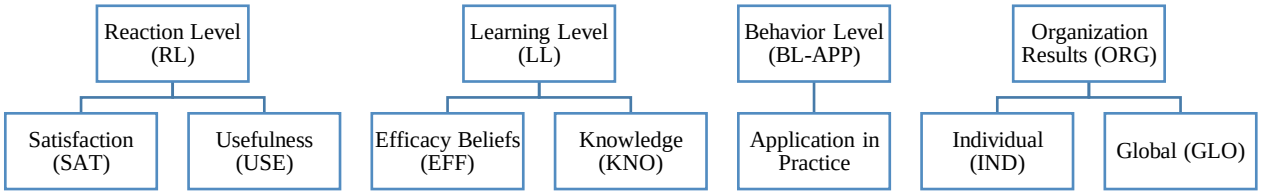
Research Question 1 (R1)

How effective is the Learning to Be STRATEGIC training for school counselors in the various areas of training evaluation (i.e., reaction, learning, behavior, and results)?

All 27 participants (TG and WCG) completed the Qualtrics survey with the 12-item Q4TE measure with four levels: reaction (RL), learning (LL), behavior (BL-APP; also known as application in practice), and organization results (ORG). Three out of the four levels in the measure have additional sublevels measuring satisfaction (SAT), usefulness (USE), efficacy

beliefs (EFF), knowledge (KNO), individual results (IND), and global results (GLO). See Figure 6 for the corresponding levels to subscales.

Figure 6. Q4TE Levels and Sublevels



The Q4TE has a Likert scale ranging from 0-100 percent which the researcher adapted to 0-10 for participants to respond. Descriptive statistics of the Q4TE scores across the four levels and sublevels are displayed in Table 6. Both the TG and WCG rated the training highly according to the total Q4TE averages of 103.36 (TG) and 118 (WCG) out of a possible 140. As reflected in Table 6, descriptive statistics indicate that the WCG had the highest overall scores in each level and sublevel. Differences between the groups' perceptions of the training on the RL, LL, and BL-APP levels varied slightly. The ORG level and corresponding sublevels varied the most between the two groups indicating that the TG agreed significantly less with these items (M = 23.50) than the WCG (M = 31.46). This suggests TG participants had neutral agreeance and WCG participants had high agreeance for items ranking the training's impact on their self and larger school/district. Altogether, the RL had the highest average scores when compared to the other levels (TG, M = 33.79; WCG, M = 35.31), representing that participants had high agreeance with the items rating the satisfaction and usefulness of the training. Following close behind, the LL also had high mean scores when compared to the other levels (TG, M = 31.79; WCG, M = 34.92) indicating participants had high agreeance for the items ranking the participant's self-efficacy beliefs and retained knowledge of the training. Lastly, both the TG (M

= 14.71) and WCG (M = 16.62) had similar mean scores for the BL-APP level indicating high agreeance for items ranking the training's ability to be applied in their work settings.

Table 6. Q4TE Descriptive Statistics

n = 27	Sublevel	Group	Mean	Total Possible Score	%	SD	Range
Q4TE		TG	103.36	140	73.82%	19.65	64.00
Total		WCG	118.00	140	84.29%	12.34	38.00
		Total	110.41	140	78.86%	17.86	65.00
RL		TG	33.79	40	84.48%	4.19	12.00
		WCG	35.31	40	88.28%	3.88	11.00
		Total	34.52	40	86.30%	4.04	13.00
	SAT	TG	16.79	20	83.95%	2.29	7.00
		WCG	17.08	20	85.40%	1.97	6.00
		Total	16.93	20	84.65%	2.11	7.00
	USE	TG	17.00	20	85.00%	2.54	8.00
		WCG	18.23	20	91.15%	2.20	6.00
		Total	17.59	20	87.95%	2.42	8.00
LL		TG	31.79	40	79.48%	5.44	15.00
		WCG	34.92	40	87.30%	2.33	7.00
		Total	33.30	40	83.25%	4.45	15.00
	EFF	TG	15.50	20	77.50%	3.30	10.00
		WCG	17.62	20	88.10%	1.56	5.00
		Total	16.52	20	82.60%	2.78	10.00
	KNO	TG	16.29	20	81.45%	2.55	8.00
		WCG	17.31	20	86.55%	1.32	4.00
		Total	16.78	20	83.90%	2.08	8.00
BL-APP		TG	14.71	20	73.55%	3.95	11.00
		WCG	16.62	20	83.10%	1.98	6.00
		Total	15.63	20	78.15%	3.25	11.00
ORG		TG	23.50	40	58.75%	9.97	30.00
		WCG	31.46	40	78.65%	5.75	22.00
		Total	27.33	40	68.33%	9.03	30.00
	IND	TG	12.14	20	60.70%	4.97	16.00
		WCG	15.23	20	76.15%	3.77	14.00
		Total	13.63	20	68.15%	4.63	17.00
	GLO	TG	11.36	20	56.80%	5.29	15.00
		WCG	16.23	20	81.15%	2.39	9.00
		Total	13.70	20	68.50%	4.77	17.00

Note. Each item has a maximum score of 10 in each sublevel. For sublevels out of 20 possible points, a mean score in the range of 10 indicates that participants tended to neither agree nor disagree with the items in that sublevel. A mean score range of 16 in sublevels indicates that participants tended to agree with the scale-based items, while a mean score of 20 indicates a strong agreeance. For levels out of 40 possible points, these mean scores would be 20, 32, and 40 respectively.

Research Question 2 (R2)

Is there a difference on school counselors' self-reported scores of general self-efficacy after the implementation of the Learning to Be STRATEGIC training?

Hypothesis: *School counselors' self-reported scores of general self-efficacy will increase after the implementation of the Learning to Be STRATEGIC training.*

To test the hypothesis for R2, a repeated measures ANOVA analysis was conducted with GSE scores across the three time points. The first time point (GSE1) included the TG's pre-test scores immediately prior to the training and the average scores of the first two pre-tests for the WCG prior to the delayed training. The second time point (GSE2) included post-test scores two weeks following the completion of the training, and the third time point (GSE3) included post-test scores three weeks following the completion of the training. The researcher used the scores across the three time points (GSE1, GSE2, GSE3) as the within factor and the treatment condition (i.e., treatment group and waitlist control group) as the between factor. See Table 7 for mean, standard deviation, and number for each time point. Mean scores for GSE increased by a total of 2.44 points from GSE1 to GSE3. From GSE1 to GSE2 mean scores increased 1.37 points upon receiving the training intervention, and 1.07 from GSE2 to GSE3 the weeks following the training. Results of the repeated measures analysis there was a significant difference in GSE scores across the three time points $F(2,50) = 17.31$, $p < 0.001$, $\eta_p^2 = 0.41$. The interaction between time point and group was not found significant $F(2,50) = 2.84$, $p = 0.068$, $\eta_p^2 = 0.10$ with inadequate statistical power (observed power = 0.53). Thus, the hypothesis was supported since the findings indicate significance differences across the three time points for GSE scores with no differences found between the group conditions.

Table 7. GSE Descriptive Statistics Across Time Points

Time Point	Group	Mean	Std. Deviation	N
GSE1	TG	32.50	3.06	14
	WCG	31.46	2.83	13
	Total	32.00	2.94	27
GSE2	TG	33.00	4.02	14
	WCG	33.78	3.09	13
	Total	33.37	3.55	27
GSE3	TG	34.14	4.50	14
	WCG	34.77	2.65	13
	Total	34.44	3.67	27

A post-hoc pairwise comparisons analysis was conducted to identify where significant differences occurred across each time point. Post-hoc pairwise comparisons with a Bonferroni adjustment indicated there were significant differences between GSE1 and GSE2 ($p = 0.004$) and GSE1 and GSE3 ($p < 0.001$). Additionally, the post-hoc analysis reported significant differences between GSE2 and GSE3 ($p = 0.021$) further supporting the hypothesis that GSE scores will increase after the implementation of the training.

Research Question 3 (R3)

Is there a difference on school counselors' skills and knowledge around multi-tiered systems of support (MTSS) after the implementation of the Learning to Be STRATEGIC training?

Hypothesis: *School counselors' skills and knowledge around multi-tiered systems of support (MTSS) will increase after the implementation of the Learning to Be STRATEGIC training.*

To test the hypothesis for R3, a repeated measures ANOVA analysis was conducted with SCKSS scores across the three time points. The first time point (SCKSS1) included the TG's pre-test scores immediately prior to the training and the average scores of the first two pre-tests for the WCG prior to the delayed training. The second time point (SCKSS2) included post-test scores two weeks following the completion of the training, and the third time point (SCKSS3) included post-test scores three weeks following the completion of the training. The researcher

used the scores across the three time points as the within factor and the treatment condition (i.e., treatment group and waitlist control group) as the between factor. See Table 8 for mean, standard deviation, and number for each time point. SCKSS mean scores increased from 6.13 points from SCKSS1 to SCKSS2 and 4.48 points from SCKSS2 to SCKSS3. Overall, SCKSS mean scores increased by 10.61 from SCKSS1 to SCKSS3. Results of the repeated measures analysis indicated there was a significant differences in SCKSS scores across the three time points $F(2,50) = 33.50$, $p < 0.001$, $\eta_p^2 = 0.57$. The interaction between time point and group was not found significant $F(2,50) = 0.33$, $p = 0.720$, $\eta_p^2 = 0.01$ with inadequate statistical power (observed power = 0.10). Thus, the hypothesis was supported since the findings indicate significance differences across the three time points for SCKSS scores with no differences found between the group conditions.

Table 8. SCKSS Descriptive Statistics Across Time Points

Time Point	Group	Mean	Std. Deviation	N
SCKSS1	TG	121.64	18.03	14
	WCG	119.96	17.63	13
	Total	120.83	17.51	27
SCKSS2	TG	127.57	14.74	14
	WCG	126.31	16.79	13
	Total	126.96	15.47	27
SCKSS3	TG	131.29	15.81	14
	WCG	131.62	12.71	13
	Total	131.44	14.13	27

A post-hoc pairwise comparisons analysis was conducted to identify where significant differences occurred across each time point. Post-hoc pairwise comparisons with a Bonferroni adjustment indicated there were significant differences between SCKSS1 and SCKSS2 ($p < 0.001$) and SCKSS1 and SCKSS3 ($p < 0.001$). Additionally, the post-hoc analysis reported

significant differences between SCKSS2 and SCKSS3 ($p < 0.001$) further supporting the hypothesis that SCKSS scores will increase after the implementation of the training.

The SCKSS measure contains four factors aligning with the RTI tier levels measuring school counselors' knowledge and skills of MTSS: (1) individualized supports and practices (ti), (2) schoolwide supports and practices (sw), (3) targeted supports and practices (is), and (4) collaborative supports and practices (cs; Olsen et al., 2020). See Table 9 for the descriptive statistics of each SCKSS factor across the three time points.

Table 9. SCKSS Factors - Descriptive Statistics

	Group	Mean	Std. Deviation	Total Possible Score	N
ti1	TG	24.00	2.91	30	14
	WCG	24.65	3.37	30	13
	Total	24.31	3.10	30	27
ti2	TG	24.93	2.89	30	14
	WCG	25.79	3.21	30	13
	Total	25.04	2.99	30	27
ti3	TG	25.79	2.83	30	14
	WCG	26.15	2.30	30	13
	Total	25.96	2.55	30	27
sw1	TG	37.57	6.56	50	14
	WCG	34.00	7.39	50	13
	Total	35.85	7.07	50	27
sw2	TG	38.93	6.63	50	14
	WCG	35.85	7.35	50	13
	Total	37.44	7.02	50	27
sw3	TG	40.36	6.20	50	14
	WCG	36.77	6.27	50	13
	Total	38.63	6.38	50	27
is1	TG	49.79	8.59	70	14
	WCG	50.85	7.96	70	13
	Total	50.30	8.15	70	27
is2	TG	52.86	6.38	70	14
	WCG	54.23	7.90	70	13
	Total	53.52	7.05	70	27
is3	TG	53.86	6.79	70	14
	WCG	57.15	5.67	70	13

	Total	55.44	6.38	70	27
cs1	TG	10.29	2.13	15	14
	WCG	10.77	1.86	15	13
	Total	10.52	1.98	15	27
cs2	TG	10.86	1.35	15	14
	WCG	11.08	1.80	15	13
	Total	10.96	1.56	15	27
cs3	TG	11.29	1.77	15	14
	WCG	11.54	1.45	15	13
	Total	11.41	1.60	15	27

Each item has a maximum score of 5 in each factor and factors have various total possible scores resulting in a total SCKSS maximum score of 165. Participants used a Likert scale ranging from 1 to 5 where a score of 1 represents none or little, 3 represents moderate, and 5 represents mastery perceived knowledge and skills of MTSS. Therefore, when comparing the average scores across each factor to the total possible score, participants reported the strongest perceived MTSS knowledge and skills in the targeted supports factor focused on Tier 2 items (e.g., I know a range of community services to assist students with emotional/behavioral problems). Regarding the schoolwide supports (sw) factor, participants reported moderate to strong perceived MTSS knowledge and skills focused on Tier 1 items (e.g., I know our school's policies and programs regarding the prevention of behavior problems). Participants reported moderate to strong perceived MTSS knowledge and skills in the individualized supports (is) factor focused on Tier 3 items (e.g., selecting and using materials that respond to cultural, gender or developmental differences). Moderate to strong perceived MTSS knowledge and skills scores were reported in the collaborative supports (cs) factor with items focused on cooperation and consultation (e.g., collaborating with the school's student assistant team to implement student's behavior intervention plans).

The researcher ran a repeated measures ANOVA to observe differences within and between the factors to determine what factors attributed to the overall significance of the SCKSS scores. A repeated measures ANOVA was conducted with the targeted supports (ti) factor scores from the SCKSS across the three time points (ti1, ti2, ti3). Mean scores for the targeted supports (ti) factor increased by 1.65 from ti1 to ti3, with an increase of 0.73 from ti1 to ti2 and 0.92 from ti2 to ti3, after implementation of the training. Mauchly's test indicated that the assumption of sphericity had been violated for targeted supports, $\chi^2(2) = 7.70$, $p = 0.021$, and therefore degrees of freedom were corrected using Huynh-Feldt estimates of sphericity ($\varepsilon = 0.861$). Results of the repeated measures analysis indicated there was a significant difference in targeted supports (ti) factor scores across the three time points, $F(1.723,43.071) = 9.87$, $p < 0.001$, $\eta_p^2 = 0.28$. The interaction between time point and group was not found significant $F(1.723,43.071) = 0.17$, $p = 0.810$, $\eta_p^2 < 0.01$ with inadequate statistical power (observed power = 0.07). The researcher observed the between-subjects effects and found no significant differences between the TG and WCG groups for targeted supports (ti) factor scores, $F(1,25) = 0.16$, $p = 0.695$, $\eta_p^2 < 0.01$. Post-hoc pairwise comparisons with a Bonferroni adjustment indicated there were significant differences between ti1 and ti3 ($p = 0.003$), and ti2 and ti3 ($p = 0.004$), but did not find significant differences between ti1 and ti2 ($p = 0.249$). These findings indicate there were significant differences of the targeted supports (ti) factor scores from ti1 to ti3 and ti2 to ti3 time points, but there were not significant differences for scores from ti1 to ti2 and between groups across the time points or average targeted supports (ti) factor scores.

A repeated measures ANOVA was conducted with the schoolwide supports (sw) factor scores from the SCKSS across the three time points (sw1, sw2, sw3). Mean scores for the schoolwide supports factor increased by 2.78 from sw1 to sw3, with an increase of 1.59 from

sw1 to sw2 and 1.19 from sw2 to sw3, after implementation of the training. Results of the repeated measures analysis indicated there was a significant difference in schoolwide supports (sw) factor scores across the three time points, $F(2,50) = 13.77$, $p < 0.001$, $\eta_p^2 = 0.36$. The interaction between time point and group was not found significant $F(2,50) = 0.15$, $p = 0.864$, $\eta_p^2 < 0.01$ with inadequate statistical power (observed power = 0.07). The researcher observed the between-subjects effects and found no significant differences between the TG and WCG groups for schoolwide supports (sw) factor scores, $F(1,25) = 1.83$, $p = 0.188$, $\eta_p^2 = 0.07$. Post-hoc pairwise comparisons with a Bonferroni adjustment indicated there were significant differences between sw1 and sw2 ($p = 0.023$), sw1 and sw3 ($p < 0.001$), and sw2 and sw3 ($p = 0.049$). These findings indicate there were significant differences of the schoolwide support factor scores across the three time points, but there were not significant differences between groups across the time points or average schoolwide supports (sw) factor scores.

A repeated measures ANOVA was conducted with the individualized supports (is) factor scores from the SCKSS across the three time points (is1, is2, is3). Mean scores for the individualized supports (is) factor increased by 5.14 from is1 to is3, with an increase of 3.22 from is1 to is2 and 1.92 from is2 to is3, after implementation of the training. Results of the repeated measures analysis indicated there was a significant difference of individualized supports (is) factor scores across the three time points $F(2,48) = 31.18$, $p < 0.001$, $\eta_p^2 = 0.57$. The interaction between time point and group was not found significant $F(2,48) = 1.51$, $p = 0.231$, $\eta_p^2 = 0.06$ with inadequate statistical power (observed power = 0.31). Results of the between-subjects effects indicated no significant differences between the two groups, $F(1,24) = 1.24$, $p = 0.277$, $\eta_p^2 = 0.05$. Post-hoc pairwise comparisons with a Bonferroni adjustment indicated there were significant differences between is1 and is2 ($p < 0.001$), is1 and is3 ($p < 0.001$), and is2 and

is3 (p = 0.005). These findings indicate there were significant differences of the individualized supports (is) factor scores across the three time points, but there were not significant differences between groups across the time points or average individualized supports (is) factor scores.

A repeated measures ANOVA was conducted with the collaborative supports (cs) factor scores from the SCKSS across the three time points (cs1, cs2, cs3). Mean scores for the collaborative supports (cs) factor increased by 0.89 from cs1 to cs3, with an increase of 0.44 from cs1 to cs2 and 0.45 from cs2 to cs3, after implementation of the training. Mauchly's test indicated that the assumption of sphericity had been violated for collaborative supports, $\chi^2(2)$ = 10.12, p = 0.006, and therefore degrees of freedom were corrected using Greenhouse-Geisser estimates of sphericity (ε = 0.744). Results of the repeated measures analysis indicate a significant effect of collaborative support (cs) scores across the three time points, $F(1.49,37.20)$ = 9.63, p = 0.001, η_p^2 = 0.28. The interaction between time point and group was not found significant $F(1.49,37.20)$ = 0.15, p = 0.711, η_p^2 = 0.38 with inadequate statistical power (observed power = 0.08). Results of the between-subjects effects indicated no significant differences between the two groups, $F(1,25)$ = 2.05, p = 0.618, η_p^2 = 0.01. Post-hoc pairwise comparisons with a Bonferroni adjustment indicated there were significant differences between cs1 and cs3 (p = 0.004), and cs2 and cs3 (p = 0.010). The post-hoc pairwise comparisons test also indicated no significant differences between cs1 and cs2 (p = 0.135). These findings indicate there were significant differences of the collaborative supports (cs) factor scores from cs1 to cs3 and cs2 to cs3 time points, but there were not significant differences for scores from cs1 to cs2 and between groups across the time points or average collaborative supports (cs) factor scores.

Research Question 4 (R4)

What is school counselors' feedback on the implementation of the Learning to Be STRATEGIC training?

To obtain feedback on the implementation of the Learning to Be STRATEGIC training, the researcher included two scaling questions and five total open-ended questions at the end of the training time point and at time point three (TP3) (i.e., one-week post-training). These questions can be found in Figure 2 mentioned in Chapter III. As this is the first investigation of the effectiveness of the Learning to Be STRATEGIC training, the researcher aimed to explore the ease or difficulty of understanding aspects of the training, participant perceptions of aspects that will benefit or not benefit their work as school counselors, and what additional questions participants still had about the training or the student reentry process following psychiatric hospitalization. The researcher sought to answer the ease or difficulty of understanding aspects of the training by using two slider scale questions from 0-10 (0 = strongly disagree, 5 = neutral, 10 = strongly agree). As seen in Table 10, the total mean score for SSQ1 was 9.11 (TG, M = 9.36; WCG, M = 8.85) indicating high agreeance that many aspects of the training were easy to understand. Additionally, the total mean score for SSQ2 was 0.89 (TG, M = 0.79; WCG, M = 1.00) indicating low agreeance that many aspects of the training were difficult to understand or confusing.

Table 10. Scaling Questions - Descriptive Statistics

Sliding Scale Questions		Mean	SD	Range
Many aspects of the training were easy to understand. (SSQ1)	TG	9.36	0.745	2.00
	WCG	8.85	0.899	2.00
	Total	9.11	0.847	2.00
Many aspects of the training were difficult to understand or confusing. (SSQ2)	TG	0.79	0.699	2.00
	WCG	1.00	0.707	2.00
	Total	0.89	0.698	2.00

To analyze the open-ended questions, the researcher used Braun and Clarke's (2006) six-step process for thematic analysis (TA) thematic analysis. For the first phase, the researcher familiarized herself with the data through organizing all responses in one document by question and engaged in repeated reading and writing down notes or ideas stemming from the data. Once the researcher felt familiar with the data, phase two of TA was initiated. Phase two consisted of the researcher manually generating data-driven, initial codes of the responses and highlighting commonalities between the responses for each open-ended question. Once codes had been generated for all responses in each question, the researcher transition into phase three which encompasses searching for themes (Braun & Clarke, 2006).

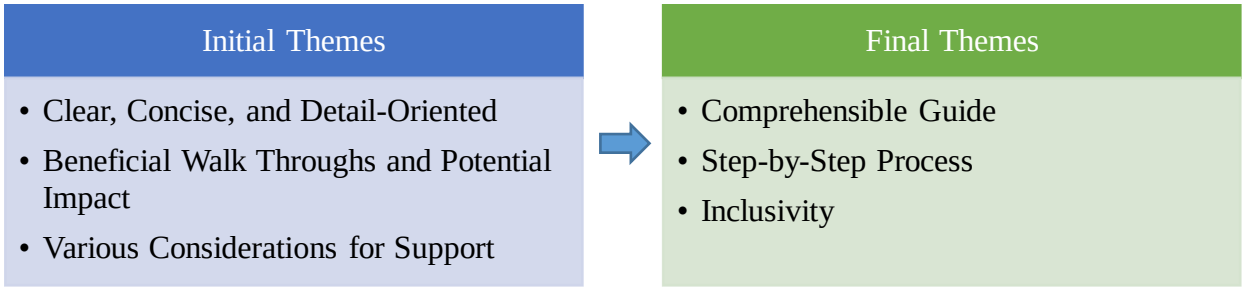
The researcher highlighted common codes to help produce initial themes found within the dataset for each question. Initial themes found among the code sets for Q12 (i.e., aspects of the training participants believed beneficial to their work) included *Clear, Concise, and Detail-Oriented*, *Beneficial Walk Throughs and Potential Impacts*, and *Various Considerations for Support*. Regarding aspects of the training participants felt were not beneficial to their work, initial themes found among the code sets for Q13 included *Confidentiality Concerns*, *Referral Concerns, Training Time Constraints*, and *Impact of Change*. Q14 and Q4 were similar questions asked at different time points encompassing what participants still wanted to know about the Learning to Be STRATEGIC training and student reentry process following psychiatric hospitalization. Therefore, the researcher felt they produced similar initial and final themes. Initial themes for Q14 included *Correspondence and Confidentiality Concerns*, and *Process Requirements of Various Settings*. Initial themes for Q4 included Caregiver, School, and District Considerations, Confidentiality Concerns, Referral Concerns, and Age-Appropriate Interventions. Lastly, initial themes for Q3 (i.e., ways the training has impacted participant's

work) included *Greater Confidence in the Process and Role as School Counselor*, *Formal Reentry Records*, *Detailed Outlines of Action Plans*, *Addressing Student Needs and Assistance*, and *Increased Training Recall*.

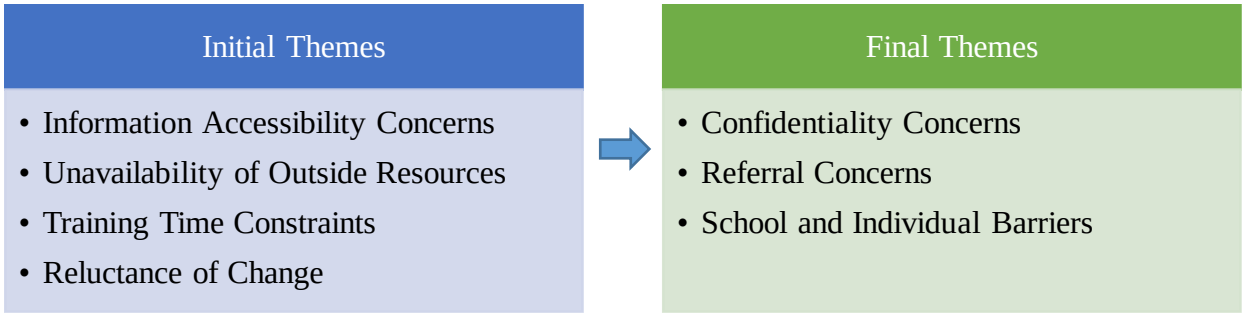
Upon completion of the initial themes, the researcher moved on to phase four which requires the researcher to review and refine initial themes for internal and external homogeneity (Braun & Clarke, 2006). The researcher reviewed initial themes for each question and felt the current themes formed a coherent pattern and description of the code sets but would need to be refined to collectively demonstrate the overall responses. To address the essence of responses to each question, the researcher redefined and named final themes for each question. Final themes for perceived beneficial aspects of the training (Q12) included *Comprehensible Guide*, *Step-by-Step Process*, and *Inclusivity*. Regarding training aspects perceived not beneficial (Q13), final themes included *Legal and Ethical Considerations*, and *School and Individual Considerations*. Final themes for questions participants still had about the training and student reentry process following psychiatric hospitalization included *Student's Right to Privacy*, and *District, School, and Hospital Technicalities*. Regarding ways the training has impacted the participant's work as school counselors, final themes included *Improved Self-Efficacy and Competence*, *Evidence of Documentation*, *Coordination of Services*, *Promoting Student Welfare*, and *Knowledge Retention*. Lastly, areas participants would still like to know about the student reentry process following psychiatric hospitalization (Q4; similar question as Q14, asked a second time) included *Legal and Ethical Considerations*, *School and Individual Considerations*, and *Developmental Considerations*. See Figure 7 for initial and final thematic concept maps. All code sets, initial themes, and final themes per open-ended question can be found in Appendix P.

Figure 7. Thematic Analysis Concept Maps of Open-Ended Questions

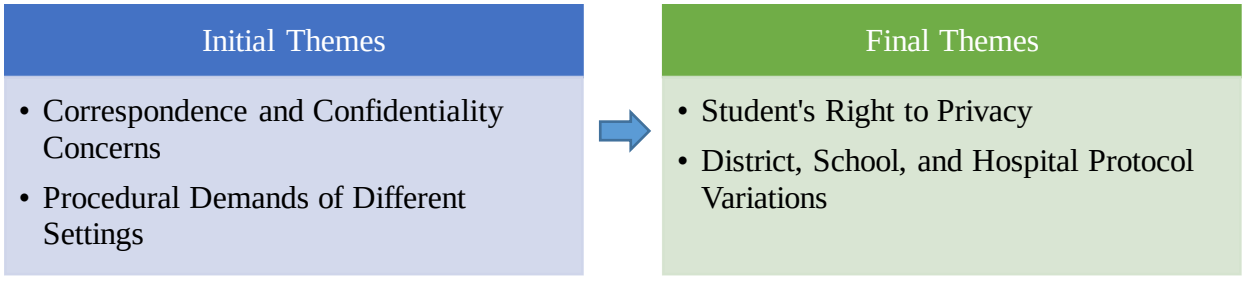
Training Time Point (TTP) – Q12. What aspects of the training do you believe benefit your work as a school counselor?



TTP – Q13. What aspects of the training do you believe are not beneficial to your work as a school counselor?



TTP – Q14. What questions do you still have about the Learning to Be STRATEGIC Training and the student reentry process following psychiatric hospitalization?



Time Point Three (TP3) – Q3. In what ways has the training impacted your work as a school counselor?

Initial Themes	Final Themes
• Greater Confidence in the Process and Role as a School Counselor • Formal Reentry Records • Detailed Outlines of Action Plans • Addressing Student Needs and Assistance • Increased Training Recall	• Improved Self-Efficacy and Competence • Evidence of Documentation • Coordination of Services • Promoting Student Welfare • Knowledge Retention

TP3 – Q4. What do you still want to know about the student reentry process following psychiatric hospitalization?

Initial Themes	Final Themes
• Caregiver, School, and District Considerations • Confidentiality Concerns • Referral Concerns • Age Specific Interventions	• Legal and Ethical Considerations • School and Individual Considerations • Developmental Considerations

To establish trustworthiness within TA, the researcher followed Williams and Morrow's (2009) recommendation to bracket biases early on when jotting down the initial ideas during the familiarization phase, balancing subjectivity through re-reading and reviewing the data responses code sets, initial themes, and final themes to differentiate between participant meaning and researcher interpretation. Additionally, the researcher established trustworthiness in conducting thematic analysis through Nowell et al.'s (2017) recommendation of reflexivity through continuous editing and development of initial code sets to participant responses, and triangulation throughout the six steps of TA. Triangulation included referring to the researcher's

original research questions, reviewing the responses and scores from the Q4TE, GSE, and SCKSS to compare to the final themes found using TA.

Research Question 5 (R5)

Is there a difference between the waitlist control group and treatment group self-efficacy, knowledge and skills of (MTSS), and training evaluation scores?

Two separate repeated measures ANOVAs were conducted to analyze GSE and SCKSS scores across the three time points with a focus on between-subject interactions (i.e., treatment group and waitlist control groups). Results from the between-subjects effects of a repeated measures ANOVA conducted with GSE scores found no significant differences between the TG and WCG groups, $F(1,25) = 0.01$, $p = 0.924$, $\eta_p^2 < 0.01$. Results from the between-subjects effects of a repeated measures ANOVA conducted with SCKSS scores found no significant differences between the TG and WCG groups, $F(1,25) = 0.02$, $p = 0.886$, $\eta_p^2 < 0.01$. These findings indicate there was not a significant difference between the TG and WCG across average GSE and SCKSS scores.

An independent t-test was performed to evaluate whether there was a difference between Q4TE scores of the TG and WCG. The t-test was two-tailed as a hypothesis was not given for an assumption of the direction, making a one-tail test unnecessary. Levene's test was found not significant ($p = 0.057$) for Q4TE total scores, therefore, variances in the two groups were assumed equal. The t-test indicated a significance difference between mean Q4TE scores on treatment condition ($t(25) = 2.30$, $p = 0.03$) with a large effect size (Cohen's $d = 0.885$). Since significance was found between the TG and WCG for total Q4TE scores, the researcher performed multiple one-way ANOVAs simultaneously to identify significant differences between the mean Q4TE level scores (RL, LL, BL-APP, and ORG) and sublevels (SAT, USE,

EFF, KNO, IND, and GLO) for the TG and WCG. The researcher opted for multiple one-way ANOVAs instead of multiple t-tests to also observe effect sizes and understand disparities between means in each factor based on treatment condition. Regarding the mean Q4TE level scores (RL, LL, BL-APP, and ORG), Levene's test was found not significant for RL ($p = 0.894$), therefore, variances in the two groups were assumed equal across this level. Levene's test was found significant for LL ($p < 0.001$), BL-APP ($p = 0.002$), and ORG ($p < 0.001$), therefore, variances in the two groups were not assumed equal across these levels.

Results from the one-way ANOVAs indicated no significant differences between the TG and WCG for RL ($F(1,25) = 0.954$, $p = 0.338$, $\eta_p^2 = 0.04$), LL ($F(1,25) = 3.69$, $p = 0.066$, $\eta_p^2 = 0.13$), and BL-APP ($F(1,25) = 2.44$, $p = 0.131$, $\eta_p^2 = 0.09$). Results from the one-way ANOVA indicated significant differences between the TG and WCG for ORG ($F(1,25) = 6.32$, $p = 0.019$, $\eta_p^2 = 0.20$). Out of the sublevels for this level (IND and GLO), results from the one-way ANOVAs indicated no significant differences for IND ($F(1,25) = 3.27$, $p = 0.083$, $\eta_p^2 = 0.12$) and significant differences for GLO ($F(1,25) = 9.28$, $p = 0.005$, $\eta_p^2 = 0.27$) between the TG and WCG. These findings indicate that there were significant differences of the GLO sublevel score and overall ORG level score between the TG and WCG. While GLO had adequate observed power (0.833) and large partial effect size (0.27), these results may be attributed to the outlier described in the preliminary analysis section.

CHAPTER V: DISCUSSION

With an increase in child and adolescent psychiatric hospitalization (Clemens et al., 2011; Hall & DuBois, 2020; Leeb et al., 2020) and reliance on outpatient services post-discharge (Blader, 2011; Preyde et al., 2021; White et al., 2017), Chapter I outlined the significance for a guide to the student reentry process for school personnel (Iverson, 2018; Marraccini et al., 2021; Tisdale, 2014). Chapter II outlined the current trends in the student reentry process and presented further evidence on the impact of the role of schools in psychiatric referrals (Marraccini et al., 2021; Preyde et al., 2021; Savina et al., 2014; Tougas et al., 2022; White et al., 2017), community considerations (Blackstock et al., 2018; O'Malley et al., 2018;), and cultural considerations of students reentering school (Marrast et al., 2016; Mellin & Weist, 2011; Peterson et al., 2017; Turcotte et al., 2017). The review of the literature further supported the creation of a training built upon two theoretical frameworks, recommendations outlined within the student reentry literature, specific pedagogical approaches, and ability to be implemented within all schools.

Chapter III detailed an experimental design to test the effectiveness of the Learning to Be STRATEGIC training developed to provide an eight-step process to the student reentry following psychiatric hospitalization. Constructs identified in Chapter III examining the effectiveness of the training included general self-efficacy (Schwarzer & Jerusalem, 1995), knowledge and skills around MTSS (Olsen et al., 2020), Kirkpatrick's four areas of training evaluation (Grohmann & Kauffeld, 2013), and open-ended feedback on implementation and impact of the training. Chapter IV presented the findings from the measures and open-ended feedback on the effectiveness of the training across various constructs. Chapter V provides a

comprehensive summary of the findings, implications for school stakeholders, study limitations, and proposes directions for future research.

Summary of the Findings

Training Effectiveness

One fundamental aspect of the study involved examining the participants' responses to the effectiveness of the Learning to Be STRATEGIC training through the Q4TE short form measure. The development of the Q4TE measure was informed by Kirkpatrick's four areas of training evaluation and their corresponding sub levels (see Figure 6). As indicated in the results section, both groups rated the training highly according to the average total Q4TE scores of 103.36 for the TG and 118 for the WCG out of a possible 140. These findings indicate favorable agreeance of the training's effectiveness across the four levels of reaction, learning, behavior, and organization results.

Participants reported the strongest scores in the reaction level, indicating an 86.30% consensus on the satisfaction and usefulness of the training when compared to the other levels. Items from these sublevels included, "I enjoyed the training very much" and "The training is very beneficial to my work." The second level with the strongest scores for agreeance (83.25%) of the items included the learning level, suggesting the training was helpful in increasing self-efficacy beliefs and knowledge gained from the training. Items from this level included, "As a result of the training, I feel better able to meet the demands of my job than I did before the training" and "After the training, I know substantially more about the training contents than before." The behavior level ranked third for highest scores, with total average scores in 78.15% of agreeance with items, indicating participants felt the training was sufficiently applicable in their work as school counselors. Items from this level included, "In my everyday work, I often

use the knowledge I gained in the training" and "I successfully manage to apply the training contents in my everyday work." The organization results level had the lowest reported scores with total average scores in 68.33% agreeance with the items, suggesting participants had moderate agreeance for items on individual and global (i.e., workplace) results. Items from this level included, "Since the training, I have been more content with my work" and "Overall, it seems to me that the organizational climate has improved due to the training." It is important to note that these scores were recorded at one week following implementation of the training. Therefore, these results are not consistent with the creators' objectives of using the behavior level and organizational level to demonstrate the long-term impact of the training (Grohmann & Kauffeld, 2013). Future research may benefit by including items from these levels over extended durations following the implementation of the training to allow participants to effectively apply the training in their professional settings.

Upon the researcher's observation of higher scores among the waitlist control group compared to the treatment group across average total and level scores of the Q4TE (see Table 6), an independent t-test confirmed a significant difference between the mean total scores on treatment condition (i.e., TG and WCG). To further identify which levels of the Q4TE measure had significant differences based on treatment condition, the researcher conducted one-way ANOVAs including all levels and sublevel scores (if applicable). No significant differences between groups were found with average scores across the reaction, learning, and behavior levels. However, significance was found between the treatment and waitlist control groups for the organization results level, specifically the global results sublevel, suggesting participants in the waitlist control group found higher agreeance for impact of the training within their work

environments than participants in the treatment group. These results may be due to an outlier found within the waitlist control group for the organization level scores.

It is also worth considering the practical significance, or effect size, to further explain the impact and direction of the results through observation of partial eta squared (η_p^2) and Cohen's *d*. For partial eta squared, effect size can be interpreted as small (η_p^2 = 0.01), medium (η_p^2 = 0.06) or large (η_p^2 = 0.14; Balkin & Lenz, 2021). For Cohen's *d*, effect size can be interpreted as small (*d* = 0.2), medium (*d* = 0.5), and large (*d* ≥ 0.8; Warne, 2021). Results from the independent t-test had a large effect size (*d* = 0.885) suggesting a strong magnitude of differences between the mean total Q4TE scores based on treatment condition. Furthermore, results from the one-way ANOVAs ranged within medium to large effect sizes ($0.04 < \eta_p^2 < 0.27$), suggesting moderate to strong practical applications for each level of the Q4TE. Results from the sliding scale questions (see Table 10) provided in the same survey further support the Q4TE's findings. A total mean score of 9.11 for SSQ1 and 0.89 for SSQ2 suggested participants highly agreed aspects of the training were easy to understand and participants were not left confused. Since this training is one of the first of its kind, further research should continue to explore the effectiveness of student reentry programs with school personnel using measures like the Q4TE to demonstrate training effectiveness and feedback around professional development.

General Self-Efficacy

Scores from the GSE indicated strong self-efficacy for participants in both the treatment group (TG) and the waitlist control group (WCG) across all three time points, resulting in significant interactions found between each time point. Self-efficacy scores increased by a total of 1.37 points from the first time point (GSE1) to the second time point (GSE2), and 1.07 total points from the second time point (GSE2) to the third time point (GSE3). The significant

findings with a moderate effect size (η_p^2 = 0.41) between the three time points, are consistent with the researcher's hypothesis that participants' GSE scores would increase following the implementation of the Learning to Be STRATEGIC training. Furthermore, the lack of significance observed between the time points and group type, and no significant differences between the groups reinforces this hypothesis. Waitlist control groups are often used in research to account for the potential impact of the passage of time on the effectiveness of an intervention (Elliott & Brown, 2002). Therefore, these findings indicate that the timing of when participants received the training did not play a significant role on GSE scores across the three time points and both treatment conditions were similarly effective on self-efficacy.

The self-efficacy findings align with previous literature on school counselors' desire to have more training due to a lack of confidence around this phenomenon, and the crucial role of professional development (Iverson, 2018; Tisdale, 2014). More importantly, the researcher could suggest that in accordance with previous literature on professional development in the school counseling field, these findings may support the idea that school counselors report higher self-efficacy levels for trainings and psychoeducation designated for their roles (Luke & Goodrich, 2017; Merlin-Knoblich et al., 2024). Researchers discovered schools that overlooked trainings or resources supporting students with mental health needs experienced diminished outcomes during the reentry process (Marraccini & Pittleman, 2022; Midura et al., 2023). Programs dedicated to addressing and assisting the student reentry process reported outcomes of improved student attendance, increased help-seeking behaviors, and higher graduation rates. These programs also simultaneously reduced self-harm, mood and emotion dysregulation, impaired school functioning, and risk of rehospitalization (Weiss et al., 2015; White et al., 2017). Therefore, further programs and training directed towards school mental health personnel should be

developed to address the unique needs and systemic challenges of students reentering following psychiatric hospitalization.

Knowledge and Skills of MTSS

Since MTSS naturally emerged as a framework from the Learning to Be STRATEGIC model addressing tier interventions within the reentry process, the researcher investigated participants knowledge and skills of MTSS both before and after the implementation of the training. Furthermore, culturally responsive interventions within MTSS have been shown to increase students' engagement within their school environments and encourage school staff to adopt antiracist practices (Edirmanasinghe et al., 2022; Goodman-Scott et al., 2020). To further support one of the training's aim to be a culturally sensitive intervention for students reentering schools, the researcher hypothesized that participants' MTSS knowledge and skills would increase following the implementation of the Learning to Be STRATEGIC training.

Results from the repeated measures ANOVA found significant differences in total SCKSS scores across the three time points. These results aligned with the 10.61-point increase in mean SCKSS scores from time point one (pre-test prior to the training) to time point three (three weeks post-training) outlined in the descriptive statistics. Furthermore, there was no significant differences found between the mean total SCKSS scores on treatment condition indicating the timing participants completed the training did not have an effect on total SCKSS scores. Therefore, both the treatment group and waitlist control group were similarly effective on MTSS knowledge and skills. These results are consistent with the researcher's hypothesis that participants' SCKSS scores would increase following the implementation of the Learning to Be STRATEGIC training.

To identify the significant interactions of the SCKSS's four factors, the researcher conducted separate repeated measures ANOVAs. The individualized supports (is) factor had the strongest significance with the largest effect size, indicating scores from this factor increased substantially and resulted in a strong practical application from the training's outcomes. This finding aligns with previous researchers' recommendations of emphasizing Tier 3 interventions (e.g., individual counseling, check-in/check-out, and individual reentry plans) and centering on the student's voice during the reentry process (Hall & DuBois, 2020; Iverson, 2018; Marraccini et al., 2021). The schoolwide supports (sw) factor had the second strongest significance and effect size also indicating a large shift in scores across each time point and strong practical application from the training's outcomes. This further aligns with research supporting the need for Tier 1 interventions during the reentry process to increase staff competency, positive school culture, and a sense of belonging among students while simultaneously reducing mental health stigma (Loeper, 2021; Marraccini & Pittleman, 2022; Vanderburg et al., 2023). While targeted supports (ti) and collaborative supports (cs) had less of an effect size than individualized and schoolwide supports, both factors still showed significant differences in scores among the three time points and large effect sizes indicating these factors also played a key role in the training's impact on MTSS knowledge and skills. Findings on the targeted and collaborative supports indicate additional research on Tier 2 interventions and school counselors' cooperative consultation efforts during this process may be warranted.

Qualitative Data Interpretation

To gain deeper insights into the Learning to Be STRATEGIC training's strengths and areas for improvement, the researcher incorporated open-ended questions into the training evaluation time point (i.e., one-week post-training completion). The researcher conducted

thematic analysis for participant responses to each question, ensuring each question contained a maximum of six final themes for each question, and a 30:70 ratio of data excerpts and analytic commentary in line with recommendations from Clark et al. (2015). As a result, the themes identified within the qualitative data provided rich explanations of the training's implementation and further expanded on the outcomes of the scores from the GSE and SCKSS. Participants were asked open-ended questions at the time of the training and one-week post completion of the training on the training's components, implementation, and application to their school settings.

Final themes identified on aspects of the training participants believe will benefit their work as a school counselor included the training's comprehensible guide, step-by-step process, and inclusivity. Specifically, participants reported appreciation of the training's clear guidelines, the case example demonstration, and considerations tailored to multiple stakeholders. Two participants wrote,

> I think that the most beneficial piece will be [that] this is such a systematic process, making sure that we are considering all aspects of reentry. It's a clear roadmap for what is needed for that individual child's reentry to be positive.
>
> The reentry meeting template is super helpful. In my district, we have a really clear and thorough process to adhere to when students are exhibiting self-injury behaviors or suicidal ideation. The reentry process and its follow-up procedures are not as clear. This explicitly states why it is important and how to meet the students' and families' needs.

These findings correspond with research on the student reentry process school recommendations of consistency and organization following discharge due to the disruption and youth's mixed experiences of the psychiatric hospitalization process (Moses, 2011; Plemmons et al., 2018; Salamone-Violi et al., 2015). Furthermore, implementing a structured process with

formal reentry meetings that prioritized the student's voice has exhibited increased perceptions of a successful reentry and smoother transition by students (Iverson, 2018).

When asked about aspects of the training school counselors felt were not beneficial in their work, prevalent themes encompassed concerns around confidentiality, the referral process, and challenges at the school and individual levels. Confidentiality concerns entailed determining the appropriate level of details and navigating potential subpoenas of the documented reentry plans. Concerns around referrals specifically addressed worries about community resources unavailability or reaching capacity, and the reliance on outpatient services. Specific school and individual barriers identified by participants included understaffing, time constraints, and change not being welcomed in the district/community. Two examples of participant responses included,

> Keeping information documented in such a detailed manner can be difficult given the possibility of being subpoenaed etc.
>
> My concern is not having enough resources for specific things, having private insurance and families not being able to find counselors close by or willing to take new patients. I am sure everyone struggles with that.

Researchers have also highlighted these barriers within the reentry process, expanding on attitudes and reactions from individuals in the school setting as well as the limited inter-disciplinary or inter-agency collaboration (Savina et al., 2014). These concerns emphasize the heightened expectations and reliance on outpatient services, specifically school services due to their accessibility, and the importance of resource mapping to ensure referral lists are up to date and aligned with the school's/district's mission for student mental health (James et al., 2022; van Vulpen et al., 2018). Further research should explore the influence of ethical and legal dilemmas

on the student reentry process to further inform case scenarios that can be demonstrated within the reentry trainings and provide comprehensive solutions to address these situations.

At the time of the training, participants reported the student's right to privacy and protocol variations across districts, schools, and hospitals as common themes they still had questions about the training and student reentry process. Specifically, participants want to know more on how to handle correspondence with unauthorized staff while maintaining confidentiality and ways to adapt the training based on the current procedures in place at the hospital and school. Two participants asked,

> What are your suggestions for storing this information and who has access to it in the future?
>
> Would you do a brief write up to give to teachers that do not give details but also enough for teachers to be aware? Would you use this after inpatient residential treatment?

Another participant provided insight into their school districts 504/IEP process in correspondence with student reentry,

> None but I did want to point out the IEP and 504 accommodations would not need to be decided at a reentry meeting. A referral could be made, however, accommodations are determined by the 504 or IEP committee during that conference. We do Notice of Conference forms, Parents Rights, etc. for those meetings.

Navigating the student's privacy and limiting the dissemination of information to only those who have been authorized has emerged as a significant dilemma emphasized within the reentry literature (Hoffman, 2021; Savina et al., 2014). Upon returning to school, students often perceive a loss of privacy and autonomy as their families/caregivers navigate discrepancies in professional opinions, sometimes resulting in power differentials, when interacting with the

various settings (Tougas et al., 2022). Future research can continue to explore the reentry process through the perspectives of the students and their families to further understand relevant challenges in communication with respect to confidentiality.

Participants were asked again of any remaining questions they still have around the student reentry process one week after completing the training. Themes from these responses aligned with those previously mentioned and aspects deemed unbeneficial, consisting of considerations around legal and ethical dilemmas, school and individual factors, and student developmental levels. Specifically, participants reported questions around the different considerations across multiple stakeholders (i.e., caregivers, schools, and districts), confidentiality, referring to outside resources, and how to apply the training to different age groups. Three participants wrote,

> What are some ways staff can support students when caregivers don't want to take the [school's] advice, recommendations, or services? I know in some [state's] legislation is also making this more difficult.
>
> More case examples similar to the one provided in the training video to help provide different ways to handle different reentry scenarios.
>
> Could this vary by age or grade level (i.e., what resources would be used, topics for guidance lessons, larger schoolwide trainings, etc.)?

While numerous researchers have explored the various perspectives of the student reentry process following psychiatric hospitalization among stakeholders (Clemens et al., 2010; Marraccini et al., 2022; Marraccini & Pittleman, 2022; Preyde et al., 2021; Tisdale, 2014; Vanderburg et al., 2023), few have explored differences in the reentry process based on

developmental levels and age-specific themes across school levels (Iverson, 2018; White et al., 2017).

One week after completing the training, participants were asked in what ways the training has impacted their work as a school counselor. Themes for this question included improved self-efficacy and competence, evidence of documentation, coordination of services, promotion of student welfare, and knowledge retention of the training. Specifically, participants noted that the training increased their comfortability and competence of their role within the student reentry process, formal reentry protocols, detailed action steps, ability to address student needs, and training recall through the STRATEGIC acronym. Three participants mentioned,

> I feel comforted knowing that there are models helping integrate students back into school after a psychiatric hospitalization. Honestly, most information given is for helping refer students to receive psychiatric help, so this is helpful to see what happens after they return.
>
> I appreciated the acronym to help people remember the recommended steps. Additionally, I found that the reentry guide is easy to follow and believe any staff member could follow it without confusion.
>
> I feel more prepared to handle this situation as it comes up and inform other staff members of the school of ways, we can navigate the transition to better fit the student's needs.

Responses regarding training recall align with the researcher's aim of incorporating specific pedagogical approaches such as Schunk's (2016) model on Information Processing Theory (IPT) to enhance participants' working memory of the training's components. To demonstrate chunking and ways participants retained information from the training, the

researcher used live feedback questions prompted in the case example demonstration, deconstructed by each letter in the STRATEGIC acronym, as a quality assurance check. All participants successfully passed the quality assurance check and linked prior MTSS knowledge from the school counseling field with new information on Levels of Care within the clinical mental health field, enhancing their understanding of the transition from psychiatric hospitalization. Furthermore, the researcher utilized a few of Ambrose et al.'s (2010) seven principles of the Science of Learning, including incorporating prior knowledge using Response to Intervention (RTI), organization of knowledge through using an acronym to detail the eight outlined steps, having participants practice through the case scenario, and obtaining feedback to enhance learning. Integrating the case example demonstration introduced a level of Experiential Learning (Kolb, 1984), encouraging participants to take ownership of their education. This approach facilitated additional considerations within the live feedback questions and identified areas where participants sought further knowledge regarding the training and student reentry process.

Participant responses on the impact of the training encompass previous findings on the positive impact of programs or interventions designed to promote student wellbeing and inclusivity within the reentry process, as well as school staff's desire to have professional development around this phenomenon (Loeper, 2021; Midura et al., 2023; Weiss et al., 2015; White et al., 2017). Furthermore, responses from this question corroborate the significant findings of the GSE scores, indicating the increase in self-efficacy scores may be based on participant's reports of feeling better prepared and comfortable in handling this process as it arises. Lastly, participants feedback regarding the organization and structure of the training and reentry plan document strengthened the training's content validity. The feedback confirmed that

the training coincides with consistent research findings on essential components within the student reentry process following psychiatric hospitalization such as holding formal reentry meetings, providing psychoeducation, and reviewing accommodations (Hall & DuBois, 2020; James et al., 2022; Marraccini et al., 2021; Savina et al., 2014; Tougas et al., 2022; van Vulpen et al., 2018).

Limitations

While the researcher attempted to ensure consistency and continuous attention to the study's procedures, this study is not without limitations. Due to the convenience and snowball sampling used, the training was provided to a small sample of school counselors across the United States working in a public, K-12 schools with professional school licensure. As a result, the exclusion of school counselors working in private school settings and school counselors-in-training reduced generalizability of the study's results to the larger school counseling population. Further research is needed to explore the impact of the Learning to Be STRATEGIC training with a more diverse sample of school mental health support personnel, including a variety of schools, communities (i.e., rural, metropolitan, and suburban), and professional level (i.e., licensed professionals and professionals-in-training).

Another limitation to this study related to the time commitment and participant attrition rates. Although online training programs increases accessibility and delivery of services, researchers have identified attrition as a potential issue for such programs due to the potential for technical difficulties and challenges in maintaining participant motivation (Sitzmann et al., 2010). As shown in Table 1, participants were susceptible to attrition due to the time commitment of engaging in a training and taking multiple surveys spanning over three to four weeks. These findings indicated that many participants took the initial pre-test but did not engage

or complete the training. Open-ended feedback providing insight into the attrition rates included the time constraint of completing a one-hour training during the busy school week. Additional considerations around the attrition rates include limitations regarding threats to external validity such as situational/contextual factors (i.e., time of day or year). The researcher obtained IRB approval to begin the study prior to winter break, resulting in significant participant recruitment occurring after the start of the New Year. Furthermore, due to the time commitment of the study (i.e., three weeks for the TG and four weeks for the WCG), many participants engaged in the study during scheduled school breaks, leading to delays in data collection and inconsistency between time points.

Limitations regarding threats to internal validity were also considered within this study. Since the researcher collected data across varies time points, participant history could not be guaranteed. Therefore, confounding variables for this study included school breaks, participation in professional development, and school counselor training. At the training evaluation time point conducted one week after training completion, participants were asked to report any professional development they received since completing the training. Only a single participant responded indicating they had received professional development, specifically focused on course curriculum updates. Additionally, threats to internal validity may have included unanticipated events that occurred during the completion of the measures (e.g., fire drills or crisis management) since participants had the flexibility to complete the surveys at their convenience.

Other considerations included limitations to instruments and measures used for the study. First, it is important to consider the restrictions within Qualtrics survey software, including a lack of consistency of survey formatting based on the device used (i.e., mobile versus computers). This limitation is particularly noteworthy given the training survey's computer layout better

enhances user experience, specifically with the facilitation of the live feedback questions, as the mobile option is not as user-friendly. Additionally, the study included a heavy reliance on self-report measures (i.e., GSE, SCKSS, and Q4TE) which could have increased the risk of social desirability bias. Therefore, Bauhoff (2014) outlines that the observed changes in the training's evaluation using the self-report measures could be due to the true effect of the training, the influence of self-report bias, or a combination of both factors. Aside from the potential bias resulting from self-reporting scores, it is important to note the intended population for which the measures were initially designed. Among the three measures, the only one designed to be implemented specifically with school counselors is the SCKSS, aimed at gathering school counselor's perceptions on their knowledge and skills around the MTSS framework, commonly used in their setting (Olsen et al., 2020). Although the GSE and Q4TE have been extensively used across various fields and populations, it is important to acknowledge their initial development derived mainly from German samples. Additionally, the Q4TE's foundation is built upon Kirkpatrick's four levels of training evaluation which has specifically been tested across larger organization sectors (i.e., government, military, corporate, consulting, and humanitarian; Grohmann & Kauffeld, 2013; Kirkpatrick, 1998).

While the researcher adhered to recommendations from previous studies on establishing trustworthiness when using thematic analysis such as bracketing biases, balancing subjectivity, reflexivity, and triangulation, it is important to acknowledge the lack of a second researcher to engage peer debriefing (Braun & Clarke, 2006; Clark et al., 2015; Nowell et al., 2017; Williams & Morrow, 2009). Additionally, since the researcher aimed to keep anonymity of participants' responses and the open-ended feedback survey was not structured as an interview or focus group, there was no involvement with participants for member checking of the qualitative data.

Therefore, additional qualitative research is warranted to evaluate participants' open-ended feedback on the Learning to Be STRATEGIC training, ensuring fit between the participants' responses and researcher's representation, while also uncovering unanticipated themes of the training.

Implications

The primary exploration of the Learning to Be STRATEGIC model and training with school counselors suggested many implications for future research on the student reentry process following psychiatric hospitalization. Researchers have consistently emphasized the need for structured reentry programs that are feasible across diverse school environments, particularly as the rates of child and adolescent psychiatric hospitalization continues to increase (Clemens et al., 2011; Hall & DuBois, 2020; Leeb et al., 2020; Midura et al., 2023). Furthermore, families and students consistently rely on school settings to provide accessible mental health services as communities navigate barriers such as local agencies at capacity, a lack of inter-disciplinary communication, and shorter hospital stays (Blader, 2011; Marraccini et al., 2019; Preyde et al., 2021; Savina et al., 2014). As a result of these challenges, school stakeholders have frequently requested targeted professional development opportunities to enhance their understanding and proficiency in managing this process as it unfolds (Carlson & Kees, 2013; Hoffman, 2021; Loeper, 2021).

Researchers have frequently relied on Ecological Systems Theory (EST) to serve as the framework for their recommendations on the student reentry process. However, researchers using this framework have additionally highlighted the lack of cultural considerations and examination of proximal processes within this phenomenon (Hoffman, 2022; Marraccini et al., 2022; Marraccini & Pittleman, 2022). To address these concerns, the researcher intentionally

expanded on EST to incorporate frameworks that extend beyond the systemic levels to address specific needs of the individual and attention towards cultural considerations, proximal processes, person characteristics, context, and time (PPCT; Bronfenbrenner & Morris, 2006; Merçon-Vargas et al., 2020; Navarro et al., 2022; Spencer, 2006). The findings from this study add to the literature in support of examining the student reentry process "beyond the rings" and interventions created with the intention of being student-first-focused (Iverson, 2018; Loeper, 2021; Marraccini & Pittleman, 2022; Preyde et al., 2021). Therefore, it is recommended that any future research on professional development or interventions aimed at assisting the student reentry process following psychiatric hospitalization continue to critically consider theoretical frameworks and conceptual models that can increase the equity and inclusivity for all students.

Future Research

This study illuminated promising results for the Learning to Be STRATEGIC program effectiveness at helping school counselors navigate the student reentry process. For example, participants in both groups demonstrated statistically significant increase in self-efficacy and their MTSS knowledge and skills following the completion of the training. Additionally, the open-ended feedback survey highlighted unanticipated areas for further exploration on participants' lingering questions of the training and student reentry process. Some of these areas included balancing confidentiality through detailed documentation and its limitations (e.g., subpoenas), navigating advocacy efforts for change in areas where this is unwelcomed, and exploring alternative methods of implementing structured reentry guides based on school considerations (e.g., understaffing and differing mental health beliefs).

While the current research design proved useful at gathering quantitative and qualitative data of the training's effectiveness, the limitations and areas for further research highlight

important considerations for future modifications. A goal for future implementation of the training would be to observe differences in participants' scores through conducting the training in-person rather than virtually. An in-person version of the training would also allow the facilitator to gain "true" live feedback around lingering questions and the case scenario demonstration from participants. Although certain areas of the study's findings demonstrated large effect sizes and met observed power through significance, another objective of the Learning to Be STRATEGIC research would be to secure a larger sample size. By obtaining a larger sample size through different training modalities or presentation opportunities, the increase in participants could be effective in providing consistent, large effect sizes and power of the analysis.

While the findings of the study portrayed lower scores for organization results (ORG) after the implementation of the training, the researcher recognizes this area of the Q4TE measures long-term outcomes, indicating a longitudinal study may be warranted. To get a greater sense of the training's effectiveness, the researcher would ideally want future research to observe the implementation of the Learning to Be STRATEGIC model and reentry plan document within a school district across an academic year. Ideas for longitudinal studies include researcher's recommendations to obtain data from all stakeholders (i.e., staff, families/caregivers, students, and medical personnel) to examine the reentry process holistically, and further validate a comprehensible guide that can be used in a variety of environments (Marraccini & Pittleman, 2022; Midura et al., 2023; Tougas et al., 2022).

For Counselor Educators

Those within higher education institutions should continue to keep up with the longstanding and current challenges in the counseling field, including the inequities and systemic

barriers that hinder access to mental health services for children and adolescents (Savilahti et al., 2023). Specifically, this includes further examining the trends in schools and mental health settings for students with marginalized identities, and appropriate solutions to address these disparities (Marraccini et al., 2019; Mellin & Weist, 2011). Examples of these factors include reluctance to seek mental health services due to stigma, historical mistrust of the health care system, accessibility to specialists and insurance, increased use of disciplinary referrals, and compound stressors (Marrast et al., 2016; Mellin & Weist, 2011; Peterson et al., 2017; Turcotte et al., 2017).

Culturally sensitive approaches include encouraging school counselors-in-training to consider their own cultural assumptions, biases, and preconceived judgements of students and families. By doing this, school counselors-in-training can consider values impacting their work with students and various factors contributing to help seeking behaviors, prioritize the voices of stakeholders, and attend to levels of privilege, power, and oppression within their therapeutic relationships (Edirmanasinghe et al., 2022; Marraccini et al., 2022). Within graduate counseling programs, the Council for Accreditation of Counseling and Related Educational Programs (CACREP) identifies several standards on social and cultural identities and experiences students must meet to fulfill expectations on knowledge of multicultural concepts, cultural humility, and intersectionality. Examples of these standards include the student's understanding of, "the effects of various socio-cultural influences, including public policies, social movements, and cultural values, on mental and physical health and wellness," "disproportional effects of poverty, income disparities, and health disparities toward people with marginalized identities," and "strategies for identifying and eliminating barriers, prejudices, and processes of intentional and unintentional oppression and discrimination" (CACREP, 2024, p. 13). Therefore, counselor educators play a

large role as gatekeepers ensuring school counseling students within CACREP-accredited programs continue to meet these expectations, and should be modeling approaches such as broaching, decolonialized curriculum pedagogy, and social justice advocacy (Goodman et al., 2015; Ieva et al., 2021; Mayes & Byrd, 2022).

For School Counselors

This study emphasizes the importance of school counselors' ability to appropriately implement elements of MTSS, as most of the recommendations outlined in the student reentry research derive from RTI interventions. Additionally, MTSS provides a framework where school counselors on collaborative, staff teams can identify appropriate interventions to match the students current developmental, emotional, and behavioral needs (Goodman-Scott et al., 2023). Consistent with researchers' recommendations, the study's findings support the notion that school personnel should continue to advocate for targeted trainings and professional development. Tailoring trainings to staff's specialties and areas of concern enhances their confidence and ability to implement larger, schoolwide frameworks effectively (Luke & Goodrich, 2017; Merlin-Knoblich et al., 2024).

Carlson and Kees (2013) found that school counselors expressed a need to incorporate additional school-based therapists, or mental health therapists, within schools to promote collaboration, consultation, and support among staff. Researchers' findings on advocacy needs for school counselors and staff within the student reentry process suggests more investigation on ways to improve school counselors' self-efficacy, training, and realistic responsibilities applicable to this process. Furthermore, the community considerations identified within the literature connect the idea of bridging the gap between clinical mental health and school counseling through an increase in interdisciplinary communication and identifying local agencies

with congruent mental health mission and vision statements (James et al., 2022; Tougas et al., 2022). School counselors can continue to increase accessibility of services and promote positive messages of mental health through the formation of partnerships with community agencies/resources through resource mapping (James et al., 2022). By establishing a community network of accessible and verified referrals, school counselors can continue to build upon tier level interventions, collaborate with healthcare professionals through consultations, and play an active role within the student reentry process (Goodman-Scott et al., 2023; Iverson, 2017; Tisdale, 2014).

Conclusion

The purpose of this study was to examine the initial effectiveness of the Learning to Be STRATEGIC training with school counselors through an experimental design, incorporating open-ended questions to obtain a mixture of feedback. Findings indicated the Learning to Be STRATEGIC training is an effective tool in preparing school counselors for the student reentry process following psychiatric hospitalization, increasing self-efficacy, and school counselors' knowledge and skills on MTSS. Moreover, participants' qualitative feedback reported positive themes on the ways the training's impact on their work, beneficial aspects of the training, and areas for potential improvement. The overall results from this study are a first step in providing school support personnel accessible interventions to better support their students struggling with mental health challenges and promote overall wellbeing.

REFERENCES

Agency for Healthcare Research and Quality (AHRQ). (2022). *2022 National healthcare quality and disparities report.* AHRQ Pub.

Ambrose, S. A., Bridges, M. W., DiPietro, M., Lovett, M. C., & Norman, M. K. (2010). How learning works: Seven research-based principles for smart teaching. Jossey-Bass.

American Academy of Pediatrics (AAP). (2021). Consensus statement on the core tenets of chronic condition management in schools. https://downloads.aap.org/AAP/PDF/Consensus%20Statement%20-%20Core%20Tenets%20of%20CCMS%20%202021-08%20.pdf

American School Counseling Association (ASCA). (n.d.). School reentry: The school counselor's role. *School Counseling Standards in Practice*, 1-10.

American School Counseling Association. (2022). *ASCA ethical standards for school counselors*. https://www.schoolcounselor.org/getmedia/44f30280-ffe8-4b41-9ad8-f15909c3d164/EthicalStandards.pdf

American School Counselor Association. (2022). *The role of the school counselor*. https://www.schoolcounselor.org/getmedia/ee8b2e1b-d021-4575-982c-c84402cb2cd2/Role-Statement.pdf

Anderson, N. J., Neuwirth, S. J., Lenardson, J. D., & Hartley, D. (2013). Patterns of care for rural and urban children with mental health problems. *Rural Health Research & Policy Centers*, *49*, 115.

Arslan, G., Allen, K. A., & Waters, L. (2023). Strength-based parenting and academic motivation in adolescents returning to school after COVID-19 school closure: Exploring

the effect of school belonging and strength use. *Psychological Reports*, *126*(6), 2940-2962.

Balkin, R. S., & Lenz, A. S. (2021). Contemporary issues in reporting statistical, practical, and clinical significance in counseling research. *Journal of Counseling & Development*, *99*(2), 227–237. https://doi.org/10.1002/jcad.12370

Bauhoff, S. (2014). Self-report bias in estimating cross-sectional and treatment effects. In Encyclopedia of Quality of Life and Well-Being Research (pp. 5798–5800). Springer Netherlands. https://doi.org/10.1007/978-94-007-0753-5_4046

Blackstock, J., Chae, K., McDonald, A., & Mauk, G. (2018). Achieving access to mental health care for school-aged children in rural communities. *The Rural Educator*, *39*(1), 12-25. https://doi.org/10.35608/ruraled.v39i1.212

Benner, A. D., Wang, Y., Shen, Y., Boyle, A. E., Polk, R., & Cheng, Y.-P. (2018). Racial/ethnic discrimination and well-being during adolescence: A meta-analytic review. *American Psychologist*, *73*(7), 855–883. https://doi.org/10.1037/amp0000204

Blader, J. C. (2011). Acute inpatient care for psychiatric disorders in the United States, 1996 through 2007. *Archives of General Psychiatry*, *68*, 1276–1283. https://doi.org/10.1001/archgenpsychiatry.2011.8

Blizzard, A. M., Weiss, C. L., Wideman, R., & Stephan, S. H. (2016). Caregiver perspectives during the post inpatient hospital transition: A mixed methods approach. *Child & Youth Care Forum*, *45*(5). 759–780. https://doi.org/10.1007/s10566-016-9358-x

Blum, R. W., & Libbey, H. P. (2004). School connectedness (executive summary). *The Journal of School Health*, *74*(7), 231–232. https://doi.org/10.1111/j.1746-1561.2004.tb08278.x

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative research in psychology*, *3*(2), 77-101.

Brenner, D. (2016). Rural education and the every student succeeds act. *The Rural Educator, 37*(2). https://doi.org/10.35608/ruraled.v37i2.271

Bronfenbrenner, U. (1979). *The ecology of human development: Experiments by nature and design*. Harvard University Press.

Bronfenbrenner, U., & Morris, P. A. (2006). The bioecological model of human development. In W. Damon, R. M. Lerner, D. Kuhn, R. S. Siegler (Eds.), *Handbook of child psychology* (pp. 793-828). John Wiley & Sons.

Brown, G. K., & Jager-Hyman, S. (2014). Evidence-based psychotherapies for suicide prevention: Future directions. *American Journal of Preventive Medicine, 47*(3), S186–S194. https://doi.org/10.1016/j.amepre.2014.06.008

Burns, S., Doering, K., Koller, D., & Stratton, C. (2021). School reintegration following hospitalization for children with medical complexity and chronic disease diagnoses: a scoping review protocol. *BMJ Open, 11*(10). https://doi.org/10.1136/bmjopen-2021-052493

Canter, K. S., & Roberts, M. C. (2012). A systematic and quantitative review of interventions to facilitate school reentry for children with chronic health conditions. *Journal of Pediatric Psychology*, *37*(10), 1065–75. https://doi.org/10.1093/jpepsy/jss071

Carlson, L. A., & Kees, N. L. (2013). Mental health services in public schools: A preliminary study of school counselor perceptions. *Professional School Counseling*, *16*(4), 211-221.

Cassity-Caywood, W. (2019). Contemporary mental health care in rural areas: Challenges and strategies. *Contemporary Rural Social Work Journal*, *11*(1), 13.

Cave, L., Cooper, M. N., Zubrick, S. R., & Shepherd, C. C. (2020). Racial discrimination and child and adolescent health in longitudinal studies: A systematic review. *Social Science & Medicine*, 250(2020), 112864. https://doi.org/10.1016/j.socscimed.2020.112864

Chen, A., Dinyarian, C., Inglis, F., Chiasson, C., & Cleverley, K. (2020). Discharge interventions from inpatient child and adolescent mental health care: a scoping review. *European Child & Adolescent Psychiatry*, *31*(6), 857–878. https://doi.org/10.1007/s00787-020-01634-0

Chen, R., Bao, Y., & Li, Z. (2021). From being trapped to breaking through: manifestations of cabin fever in young people in response to COVID-19 and suggestions for adaptation. *China Journal of Social Work*, *14*(2), 133-152.

Childs, E. M., Boyas, J. F., & Blackburn, J. R. (2022). Off the beaten path: a scoping review of how 'rural' is defined by the U.S. government for rural health promotion. *Health Promotion Perspectives*, *12*(1), 10–21. https://doi.org/10.34172/hpp.2022.02

Clarke, V., Braun, V., & Hayfield, N. (2015). Thematic analysis. In J. A. Smith (Eds), *Qualitative psychology: A practical guide to research methods* (pp. 222-248). SAGE Publications Ltd.

Clemens, E. V., Welfare, L. E., & Williams, A. M. (2011). Elements of successful school reentry after psychiatric hospitalization. *Preventing School Failure: Alternative Education for Children and Youth*, *55*(4), 202-213.

Council for Accreditation of Counseling and Related Educational Programs (CACREP). (2024). *2024 CACREP standards*. https://www.cacrep.org/wp-content/uploads/2023/06/2024-Standards-Combined-Version-6.27.23.pdf

Crepeau-Hobson, F. (2013). An exploratory study of suicide risk assessment practices in the school setting. *Psychology in the Schools*, *50*(8), 810-822.

Creswell, J. W., Plano Clark, V. L., & Plano Clark, V. L. (2011). *Designing and conducting mixed methods research* (2nd ed.). SAGE Publications.

Crockett, L.J., Carlo, G., & Temmen, C. (2016). Ethnic and racial minority youth in the rural United States: An overview. In Crockett, L., Carlo, G. (Eds), *Rural Ethnic Minority Youth and Families in the United States: Theory, Research and Application* (pp.1-12). Springer.

Curfman, A. L., Hackell, J. M., Herendeen, N. E., Alexander, J. J., Marcin, J. P., Moskowitz, W. B., Bodnar, C. E. F., Simon, H. K., McSwain, S. D., & Section on Telehealth Care, Committee on Practice and Ambulatory Medicine, Committee on Pediatric Workforce. (2021). Telehealth: Improving access to and quality of pediatric health care. *Pediatrics*, *148*(3). https://doi.org/10.1542/peds.2021-053129

Cyr, M. E., Etchin, A. G., Guthrie, B. J., & Benneyan, J. C. (2019). Access to specialty healthcare in urban versus rural us populations: a systematic literature review. *BMC Health Services Research*, *19*(1), 1-17. https://doi.org/10.1186/s12913-019-4815-5

Domlyn, A. M., Collier, T., Chehoski, B. E., Haines, C., Patterson, B., Stevens, R., Niles, M. L., & Weist, M. D. (2024). Early COVID-19 school policies' impact on families and youth engagement in virtual learning and telemental health. *Children & Schools*, *46*(2). https://doi.org/10.1093/cs/cdae006

Edirmanasinghe, N., Goodman-Scott, E., Smith-Durkin, S., & Tarver, S. Z. (2022). Supporting all students: multitiered systems of support from an antiracist and critical race theory lens. *Professional School Counseling*, *26*(1). https://doi.org/10.1177/2156759X221109154

Eiraldi, R., McCurdy, B. L., Khanna, M. S., Goldstein, J., Comly, R., Francisco, J., Rutherford, L. E., Wilson, T., Henson, K., Farmer, T., & Jawad, A. F. (2022). Development and evaluation of a remote training strategy for the implementation of mental health evidence-based practices in rural schools: Pilot study protocol. *Pilot and Feasibility Studies*, *8*(1). https://doi.org/10.1186/s40814-022-01082-4

Elliott, S. A., & Brown, J. S. L. (2002). What are we doing to waiting list controls?. *Behaviour research and therapy*, *40*(9), 1047-1052.

Faul, F., Erdfelder, E., Lang, A.-G., & Buchner, A. (2007). G*Power 3: A flexible statistical power analysis program for the social, behavioral, and biomedical sciences. *Behavior Research Methods, 39*, 175-191.

Ferro, F., Tozzi, A. E., Erba, I., Dall'Oglio, I., Campana, A., Cecchetti, C., Geremia, C., Rega, M. L., Tontini, G., Tiozzo, E., & Gawronski, O. (2021). Impact of telemedicine on health outcomes in children with medical complexity: An integrative review. *European Journal of Pediatrics*, *180*(8), 2389–2400. https://doi.org/10.1007/s00431-021-04164-2

Fox, K., Burgess, A., Massey, J., Shaler, G., Pearson, K., MacKenzie, J., Merchant, K., Zhu, X., & Ward, M. (n.d.). Implementation of telehealth services in rural schools: A qualitative assessment. *The Journal of School Health*, *92*(1), 71–78. https://doi.org/10.1111/josh.13104

Goodman, R. D., Williams, J. M., Chung, R. C. Y., Talleyrand, R. M., Douglass, A. M., McMahon, H. G., & Bemak, F. (2015). Decolonizing traditional pedagogies and practices in counseling and psychology education: A move towards social justice and action. *Decolonizing "multicultural" counseling through social justice,* 147-164.

Goodman-Scott, E., Betters-Bubon, J., Donohue, P., & Olsen, J. A. (Eds.). (2023). *The school counselor's guide to multi-tiered systems of support (Second)*. Routledge.

Goodman-Scott, E., Betters-Bubon, J., & Olsen, J. (2020). *Making MTSS work.* American School Counselor Association.

Grohmann, A., & Kauffeld, S. (2013). Evaluating training programs: development and correlates of the questionnaire for professional training evaluation. *International Journal of Training & Development*, *17*(2), 135–155. https://doi.org/10.1111/ijtd.12005

Guo, S., Kataoka, S. H., Bear, L., & Lau, A. S. (2014). Differences in school-based referrals for mental health care: understanding racial/ethnic disparities between asian american and latino youth. *School Mental Health: A Multidisciplinary Research and Practice Journal*, *6*(1), 27–39. https://doi.org/10.1007/s12310-013-9108-2

Hall, S., & DuBois, M. (2020). Facilitating student reentry following psychiatric hospitalization. *National Association of School Psychologists. Communique*, *49*(3), 26–28.

Hamlet, H. S., Gergar, P. G., & Schaefer, B. A. (2011). Students living with chronic illness: the school counselor's role. *Professional School Counseling*, *14*(3), 202–210.

Hay, G. H., Nabors, M. L., Sullivan, A., & Zygmund, A. (2015). Students with pediatric cancer: A prescription for school success. *Physical Disabilities: Education and Related Services*, *34*(2), 1–13. https://doi-org.libproxy.uncg.edu/10.14434/pders.v34i2.19643

Health Resources and Services Administration (HRSA). (2022). *Defining rural population*. https://www.hrsa.gov/rural-health/about-us/what-is-rural

Helms, A. S., Schmiegelow, K., Brok, J., Johansen, C., Thorsteinsson, T., Simovska, V., & Larsen, H. B. (2016). Facilitation of school reentry and peer acceptance of children

with cancer: A review and meta-analysis of intervention studies. *European Journal of Cancer Care, 25*, 170–179. https://doi-org.libproxy.uncg.edu/10.1111/ecc.12230

Hoffman, E. (2021). *Teacher and support staffs' knowledge on how to support children's psychological needs after hospitalization* (dissertation). Eastern Washington University.

Hoffman, J. A., & Miller, E. A. (2020). Addressing the consequences of school closure due to COVID-19 on children's physical and mental well-being. *World medical & health policy*, *12*(3), 300-310.

Ieva, K. P., Beasley, J., & Steen, S. (2021). Equipping school counselors for antiracist healing centered groups: A critical examination of preparation, connected curricula, professional practice and oversight. *Teaching and Supervision in Counseling*, *3*(2), 7.

Iverson, P. J. (2018). Adolescents' experiences returning to school after a mental health hospitalization [ProQuest Information & Learning]. In Dissertation Abstracts International Section A: Humanities and Social Sciences (Vol. 78, Issue 10–A(E)).

James, S., Reinking, A. & Swanke, J. (2022). The impact of trauma on rural communities. *In Children and Trauma: Critical Perspectives for Meeting the Needs of Diverse Educational Communities.* Stylus Publishing, LLC.

Kaffenberger, C. J. (2006). School reentry for students with a chronic illness: A role for professional school counselors. *Professional School Counseling*, 223-230.

Kirkpatrick, D. L. (1998). The four levels of evaluation. *Evaluating corporate training: Models and issues*, 95-112.

Knoche, L. L., & Witte, A. L. (2016). Strengths-based educational interventions in rural settings: Promoting child development through home-school partnerships. In L. J. Crockett & G.

Carlo (Eds.), *Rural ethnic minority youth and families in the United States: theory, research, and applications* (pp. 227-246). Springer.

Kolb, D. A. (1984). *Experiential learning: Experiences as a source of learning and development*. Englewood Cliffs, NJ: Prentice-Hall.

Kreber, C. (2001). Learning Experientially through Case Studies? A Conceptual Analysis. *Teaching in Higher Education*, *6*(2), 217–228.

Kruczek, T. (2022). A bioecological model for school-based trauma-informed practice. In B. Kramer, J. McKenzie (Eds.), *Children and trauma: Critical perspectives for meeting the needs of diverse educational communities*. Myers Education Press.

Larson, L. M., & Daniels, J. A. (1998). Review of the counseling self-efficacy literature. *The Counseling Psychologist, 26*(2), 179–218. https://doi.org/10.1177/0011000098262001

Larson, E., Patterson, D., Garberson, L., & Andrilla, C.H.A. (2016). Supply and distribution of the behavioral health workforce in rural America. Data Brief #160. Seattle, WA: WWAMA Rural Health Research Center, University of Washington.

Lau, N., Colt, S. F., Waldbaum, S., O'Daffer, A., Fladeboe, K., Yi-Frazier, J. P., McCauley, E., & Rosenberg, A. R. (2021). Telemental health for youth with chronic illnesses: Systematic review. *JMIR Mental Health*, *8*(8), e30098. https://doi.org/10.2196/30098

Leeb, R. T., Bitsko, R. H., Radhakrishnan, L., Martinez, P., Njai, R., Holland, K. M. (2020). Mental health–Related emergency department visits among children aged <18 years during the COVID-19 pandemic — United States, January 1–October 17, 2020. *Morbidity and Mortality Weekly Report*, *69*(45), 1675–1680. http://dx.doi.org/10.15585/mmwr.mm6945a3external icon

Lix, L. M., & Keselman, H. J. (2018). Analysis of variance: repeated-measures designs. In G. R. Hancock, L. M. Stapleton, R. O. Mueller (Eds), *The reviewer's guide to quantitative methods in the social sciences* (pp. 15-28). Routledge.

Loeper, T. (2021). *A bioecological approach to supporting adolescent re-entry to school following psychiatric hospitalization* (Order No. 28770248). Available from ProQuest Central; ProQuest Dissertations & Theses Global. (2587001694). https://login.libproxy.uncg.edu/login?url=https://www.proquest.com/dissertations-theses/bioecological-approach-supporting-adolescent-re/docview/2587001694/se-2

Long, J. C., Delamater, P. L., & Holmes, G. M. (2021). Which definition of rurality should I use?: The relative performance of 8 federal rural definitions in identifying rural-urban disparities. *Medical Care, 59*(Suppl 5), 413–419. https://doi.org/10.1097/MLR.0000000000001612

Luke, M., & Goodrich, K. M. (2017). Assessing an LGBTQ responsive training intervention for school counselor trainees. *Journal of Child and Adolescent Counseling*, *3*(2), 103–119. https://doi.org/10.1080/23727810.2017.1313629

Luszczynska, A., Gutiérrez-Doña, B., & Schwarzer, R. (2005). General self-efficacy in various domains of human functioning: Evidence from five countries. *International Journal of Psychology*, *40*(2), 80–89. https://doi.org/10.1080/00207590444000041

Marraccini, M. E., Lee, S., & Chin, A. J. (2019). School reintegration post-psychiatric hospitalization: Protocols and procedures across the nation. *School Mental Health: A Multidisciplinary Research and Practice Journal, 11*(3), 615-628. http://dx.doi.org/10.1007/s12310-019-09310-8

Marraccini, M. E., Pittleman, C., Toole, E. N., & Griffard, M. R. (2021). School supports for reintegration following a suicide-related crisis: A mixed methods study informing hospital recommendations for schools during discharge. *Psychiatric Quarterly*, *93*(1), 347–383. https://doi.org/10.1007/s11126-021-09942-7

Marraccini, M. E., & Pittleman, C. (2022). Returning to school following hospitalization for suicide-related behaviors: Recognizing student voices for improving practice. *School Psychology Review*, *51*(3), 370–385. https://doi-org.libproxy.uncg.edu/10.1080/2372966X.2020.1862628

Marraccini, M. E., Resnikoff, A. W., Brick, L. A., Brier, Z. M. F., & Nugent, N. R. (2022). Adolescent perceptions of school before and after psychiatric hospitalization: Predicting suicidal ideation. *School Psychology 37*(2), 119–132. https://doi.org/10.1037/spq0000487

Marrast, L., Himmelstein, D. U., & Woolhandler, S. (2016). Racial and ethnic disparities in mental health care for children and young adults: a national study. *International Journal of Health Services: Planning, Administration, Evaluation*, *46*(4), 810–24. https://doi.org/10.1177/0020731416662736

Matson, J. L., & Cervantes, P. E. (2014). Assessing aggression in persons with autism spectrum disorders: An overview. *Research in Developmental Disabilities*, *35*(12), 3269–3275. https://doi.org/10.1016/j.ridd.2014.08.004

Mayes, R. D., & Byrd, J. A. (2022). An antiracist framework for evidence-informed school counseling practice. *Professional School Counseling*, *26*(1a). https://doi.org/10.1177/2156759X221086740

McBride, S., & Preyde, M. (2020). Loneliness and social isolation in a sample of youth hospitalized for psychiatric illness. *Child & Adolescent Social Work Journal, 39,* 157-166. https://doi-org.libproxy.uncg.edu/10.1007/s10560-020-00723-y

Mellin, E. A., & Weist, M. D. (2011). Exploring school mental health collaboration in an urban community: a social capital perspective. *School Mental Health: A Multidisciplinary Research and Practice Journal*, *3*(2), 81–92. https://doi.org/10.1007/s12310-011-9049-6

Merçon-Vargas, E. A., Lima, R. F. F., Rosa, E. M., & Tudge, J. (2020). Processing proximal processes: What bronfenbrenner meant, what he didn't mean, and what he should have meant. *Journal of Family Theory & Review*, *12*(3), 321–334. https://doi-org.libproxy.uncg.edu/10.1111/jftr.12373

Merlin-Knoblich, C., Dack, H., & Elizondo, J. A. (2024). A pre-experimental pilot study of school counselors completing an 8-month professional development program to improve self-efficacy. *Counseling Outcome Research and Evaluation*, *15*(1), 21-36. https://doi.org/10.1080/21501378.2023.2243320

Midura, S., Fodstad, J. C., White, B., Turner, A. J., & Menner, S. (2023). Supportive transition planning for adolescents transitioning from psychiatric hospitalization to school: A systematic literature review and framework of practices. *Continuity in Education*, *4*(1), 23–40. https://doi.org/10.5334/cie.61

Moses, T. (2011). Adolescents' perspectives about brief psychiatric hospitalization: What is helpful and what is not? *Psychiatric Quarterly*, *82*(2), 121–137. https://doi.org/10.1007/s11126-010-9151-1

Mullen, P. R., Uwamahoro, O., Blount, A. J., & Lambie, G. W. (2015). Development of counseling students' self-efficacy during preparation and training. *The Professional Counselor*, *5*(1), 175–184. https://doi.org/10.15241/prm.5.1.175

Myers, C. R. (2019). Using telehealth to remediate rural mental health and healthcare disparities. *Issues in Mental Health Nursing*, *40*(3), 233–239. https://doi.org/10.1080/01612840.2018.1499157

Nash, K. A., Zima, B. T., Rothenberg, C., Hoffmann, J., Moreno, C., Rosenthal, M. S., & Venkatesh, A. (2021). Prolonged emergency department length of stay for US pediatric mental health visits (2005–2015). *Pediatrics*, *147*(5).

National Alliance on Mental Illness (NAMI). (2018). *Navigating a mental health crisis: A NAMI resource guide for those experiencing a mental health emergency*. https://www.nami.org/Support-Education/Publications-Reports/Guides/Navigating-a-Mental-Health-Crisis/Navigating-A-Mental-Health-Crisis

National Center for Education Statistics (NCES). (2022). *NCES locale classifications and Criteria*. https://nces.ed.gov/programs/edge/docs/LOCALE_CLASSIFICATIONS.pdf

Navarro, J. L., Stephens, C., Rodrigues, B. C., Walker, I. A., Cook, O., O'Toole, L., Hayes, N., & Tudge, J. R. H. (2022). Bored of the rings: Methodological and analytic approaches to operationalizing bronfenbrenner's ppct model in research practice. *Journal of Family Theory & Review*, *14*(2), 233–253. https://doi-org.libproxy.uncg.edu/10.1111/jftr.12459

Nowell, L. S., Norris, J. M., White, D. E., & Moules, N. J. (2017). Thematic analysis: Striving to meet the trustworthiness criteria. *International Journal of Qualitative Methods*, *16*(1). https://doi.org/10.1177/1609406917733847

NY Dept. of Health and Mental Hygiene. (2016). *Epi data brief: Adult psychiatric hospitalizations in New York city*. https://www1.nyc.gov/assets/doh/downloads/pdf/epi/databrief71.pdf

Office of the Surgeon General. (2021). *Protecting youth mental health: the US surgeon general's advisory*. U.S. Department of Health and Human Services. https://www.hhs.gov/sites/default/files/surgeon-general-youth-mental-health-advisory.pdf

Olsen, J. A., Blum, C., & Cheney, D. (2016). *School counselor knowledge and skills survey for multi-tiered systems of support*. Unpublished survey, Department of Counseling, University of North Carolina at Charlotte.

Olsen, J., Foxx, S. P., & Flowers, C. (2020). A confirmatory factor analysis of the school counselor knowledge and skills survey for multi-tiered systems of support. *Professional Counselor*, *10*(3), 376–392.

O'Malley, M., Wendt, S. J., & Pate, C. (2018). A view from the top: superintendents' perceptions of mental health supports in rural school districts. *Educational Administration Quarterly*, *54*(5), 781–821. https://doi.org/10.1177/0013161X18785871

Pajares, F. (2006). Self-efficacy during childhood and adolescence. *Self-efficacy beliefs of adolescents*, *5*, 339-367.

Peterson, L. S., Villarreal, V., & Castro, M. J. (2017). Models and Frameworks for Culturally Responsive Adaptations of Interventions. *Contemporary School Psychology*, *21*(3), 181-190. https://doi.org/10.1007/s40688-016-0115-9

Plemmons, G., Hall, M., Doupnik, S., Gay, J., Brown, C., Browning, W., Casey, R., Freundlich, K., Johnson, D. P., Lind, C., Rehm, K., Thomas, S., & Williams, D. (2018). Hospitalization for suicide ideation or attempt: 2008-2015. *Pediatrics*, *141*(6), 1–1.

Preyde, M., Parekh, S., Markov, A., Carpenter, H., & Heintzman, J. (2021). School re-entry of adolescent patients discharged from psychiatric hospital: One step in continuous quality improvement. *Adolescent Psychiatry, 11*(4), 260–275. https://doi-org.libproxy.uncg.edu/10.2174/2210676611666211105121616

Preyde, M., Parekh, S., Warne, A., & Heintzman, J. (2017). School reintegration and perceived needs: The perspectives of child and adolescent patients during psychiatric hospitalization. *Child and Adolescent Social Work Journal*, *34*, 517–526. https://doi.org/10.1007/s10560-017-0490-8

Rager, R. Y. (2015). Hospital to school transitions for children: A multiple case study of family experiences (Doctoral dissertation). Available from PsycINFO. (Order No. AAI3613903).

Ramos, G., Ponting, C., Bocanegra, E., Chodzen, G., Delgadillo, D., Rapp, A., Escovar, E., & Chavira, D. (2022). Discrimination and internalizing symptoms in rural latinx adolescents: The protective role of family resilience. *Journal of Clinical Child and Adolescent Psychology*, *51*(6), 997–1010. https://doi.org/10.1080/15374416.2021.1923018

Razai, M. S., Oakeshott, P., Kankam, H., Galea, S., & Stokes-Lampard, H. (2020). Mitigating the psychological effects of social isolation during the covid-19 pandemic. *Bmj*, *369*.

Rosa, E. M., & Tudge, J. (2013). Urie bronfenbrenner's theory of human development: Its evolution from ecology to bioecology. *Journal of Family Theory & Review*, *5*(4), 243–258. https://doi-org.libproxy.uncg.edu/10.1111/jftr.12022

Salamone-Violi, G. M., Chur-Hansen, A., & Winefield, H. R. (2015). "I don't want to be here but I feel safe": Referral and admission to a child and adolescent psychiatric inpatient

unit: The young person's perspective. *International Journal of Mental Health Nursing, 24*(6), 569–576. https://doi.org/10.1111/inm.12163

Salerno, J. P. (2016). Effectiveness of universal school-based mental health awareness programs among youth in the United States: a systematic review. *Journal of school health*, *86*(12), 922-931.

Savilahti, E. M., Haravuori, H., Rytilä-Manninen, M., Lindberg, N., & Marttunen, M. (2023). Comparison of adolescent referred involuntarily or voluntarily to psychiatric hospitalization. *Nordic journal of psychiatry*, *77*(4), 403-410.

Savina, E., Simon, J., & Lester, M. (2014). School reintegration following psychiatric hospitalization: An ecological perspective. *Child & Youth Care Forum, 43*(6), 729-746. https://doi-org.libproxy.uncg.edu/10.1007/s10566-014-9263-0

Schilling, E. J., & Getch, Y. Q. (2018). School reentry services for students with chronic health conditions: An examination of regional practices. *Psychology in the Schools, 55*(9), 1027–1040. https://doi-org.libproxy.uncg.edu/10.1002/pits.22154

Schunk, D. H. (2016). *Learning theories: An educational perspective* (7th ed.). Boston, MA: Pearson.

Schwarzer, R., & Jerusalem, M. (1995). Generalized Self-Efficacy scale. In J. Weinman, S. Wright, & M. Johnston, *Measures in health psychology: A user's portfolio*. Causal and control beliefs (pp. 35-37). Windsor, England: NFER-NELSON.

Seehusen, C. (2021). School counselors' role in working with students living with chronic illness. In Rausch, M., & Gallo, L. L. (Eds.), *Strengthening school counselor advocacy and practice for important populations and difficult topics.* IGI Global. DOI: 10.4018/978-1-7998-7319-8.ch020

Shapiro, S. S., & Wilk, M. B. (1972). An analysis of variance test for the exponential distribution (complete samples). *Technometrics*, *14*(2), 355–370. https://doi.org/10.2307/1267427

Shaw, S. R., Clyde, M. A. J., Sarrasin, M. (2014). Homebound instruction for students with chronic illness: Reducing risk outside of the box. *Health Psychology Report, 2*(1), 1-9. https://doi.org/10.5114/hpr.2014.42786

Sink, C. A. (2016). Incorporating a multi-tiered system of supports into school counselor preparation. *The Professional Counselor*, *6*(3), 203–219. https://doi.org/10.15241/cs.6.3.203

Sitzmann, T., Ely, K., Bell, B. S., & Bauer, K. N. (2010). The effects of technical difficulties on learning and attrition during online training. *Journal of Experimental Psychology: Applied*, *16*(3), 281.

Soto, E. C., Frederickson, A. M., Trivedi, H., Le, A., Eugene, M. C., Shekher, M., et al. (2009). Frequency and correlates of inappropriate pediatric psychiatric emergency room visits. *The Journal of Clinical Psychiatry, 70*(8), 1164–1177.

Spencer, M. B. (2006). Phenomenology and ecological systems theory: development of diverse groups. In W. Damon, R. M. Lerner, D. Kuhn, R. S. Siegler (Eds.), *Handbook of child psychology* (pp. 829-893). John Wiley & Sons.

Tisdale, J. M. (2014). Psychiatric hospitalization to school transitions: Examining professional perceptions of effectiveness and fidelity (Order No. 3627483). Available from ProQuest Dissertations & Theses Global: Health & Medicine; ProQuest Dissertations & Theses Global: Social Sciences. (1559348863).

Tolou-Shams, M., Folk, J., Stuart, B., Mangurian, C., & Fortuna, L. (2022). Rapid creation of child telemental health services during COVID-19 to promote continued care for underserved children and families. *Psychological services*, *19*(S2), 39.

Tossone, K., Jefferis, E., Bhatta, M. P., Bilge-Johnson, S., & Seifert, P. (2014). Risk factors for rehospitalization and inpatient care among pediatric psychiatric intake response center patients. *Child and Adolescent Psychiatry and Mental Health, 8*(1), 27, 1-10. https://doi.org/10.1186/1753-2000-8-27

Tougas, A. M., Rassy, J., Frenette-Bergeron, É., & Marcil, K. (2019). "Lost in transition": A systematic mixed studies review of problems and needs associated with school reintegration after psychiatric hospitalization. *School Mental Health: A Multidisciplinary Research and Practice Journal, 11*(4), 629–649. https://doi-org.libproxy.uncg.edu/10.1007/s12310-019-09323-3

Tougas, A. M., Houle, A. A., Leduc, K., Frenette-Bergeron, É., & Marcil, K. (2023). Framework for successful school reintegration after psychiatric hospitalization: a systematic synthesis of expert recommendations. *Psychology in the Schools, 60*(3), 793–813. https://doi.org/10.1002/pits.22791

Tougas, A. M., Houle, A. A., Leduc, K., Frenette-Bergeron, É., & Marcil, K. (2022). School reintegration following psychiatric hospitalization: A review of available transition programs. *Journal of the Canadian Academy of Child & Adolescent Psychiatry*, *31*(2).

Turcotte, P., Shea, L. L., & Mandell, D. (2017). School discipline, hospitalization, and police contact overlap among individuals with autism spectrum disorder. *Journal of Autism and Developmental Disorders*, *48*(3), 883–891. https://doi.org/10.1007/s10803-017-3359-y

U.S. Census Bureau. (2022). *2020 Urban areas FAQs*. United States Census Bureau. https://www.census.gov/programs-surveys/geography/guidance/geo-areas/urban-rural.html

U.S. Dept. of Education. (2018). *Sec. 300.8 child with a disability*. IDEA: Individuals with Disabilities Education Act. https://sites.ed.gov/idea/regs/b/a/300.8

U. S. Dept. of Education. (2021). *Education in a pandemic: The disparate impacts of COVID-19 on America's students*. https://www2.ed.gov/about/offices/list/ocr/docs/20210608-impacts-of-covid19.pdf

van Vulpen, K. S., Habegar, A., & Simmons, T. (2018). Rural school-based mental health services: parent perceptions of needs and barriers. *Children & Schools, 40*(2), 104–111. https://doi.org/10.1093/cs/cdy002

Vanclooster, S., Benoot, C., Bilsen, J., Peremans, L., & Jansen, A. (2018). Stakeholders' perspectives on communication and collaboration following school reintegration of a seriously ill child: A literature review. *Child & Youth Care Forum, 47*(4), 583–612.

Vanderburg, J. L., Tow, A. C., Marraccini, M. E., Pittleman, C., & Cruz, C. M. (2023). Caregiver experiences of adolescent school reentry after adolescent hospitalization due to suicidal thoughts and behaviors: recommendations to improve reentry practices. *Journal of School Health, 93*(3), 206–218. https://doi.org/10.1111/josh.13291

Vincent, C., Swain-Bradway, J., Tobin, T., & May, S. (2011). Disciplinary referrals for culturally and linguistically diverse students with and without disabilities: Patterns resulting from school-wide positive behavior support. *Exceptionality, 19*(3), 175–190.

Warne, R. T. (2021). *Statistics for the social sciences: A general linear model approach* (Second edition). Cambridge University Press.

Weiss, C. L., Blizzard, A. M., Vaughan, C., Sydnor-Diggs, T., Edwards, S., & Stephan, S. H. (2015). Supporting the transition from inpatient hospitalization to school. *Child and Adolescent Psychiatric Clinics of North America*, *24*(2), 371–383. https://doi.org/10.1016/j.chc.2014.11.009

Whaibeh, E., Mahmoud, H., & Naal, H. (2020). Telemental health in the context of a pandemic: The COVID-19 experience. *Current Treatment Options in Psychiatry*, *7*(2), 198–202. https://doi.org/10.1007/s40501-020-00210-2

White, H., LaFleur, J., Houle, K., Hyry, D. P., & Blake, S. M. (2017). Evaluation of a school-based transition program designed to facilitate school reentry following a mental health crisis or psychiatric hospitalization. *Psychology in the Schools*, *54*(8), 868–882. https://doi.org/10.1002/pits.22036

Wikel, K. C., & Markelz, A. M. (2023). School reentry plans for students with chronic illness: A literature review. *Research, Advocacy, and Practice for Complex and Chronic Conditions*, *41*(1), 22-44. DOI: 10.14434/rapcc.v41i1.31767

Williams, E. N., & Morrow, S. L. (2009). Achieving trustworthiness in qualitative research: A pan-paradigmatic perspective. *Psychotherapy Research Methods*, *19*(4-5), 576-582. https://doi-org.libproxy.uncg.edu/10.1080/10503300802702113

APPENDIX A: REENTRY PLAN DOCUMENT ©

Learning to Be **STRATEGIC** Reentry Plan –
A Reentry Plan for Students Following Psychiatric Hospitalization

Student Name: _____ DOB: _____
Grade Level: _____ Date of Return: _____ Date of Plan: _____
Caregiver Name: _____ Number: _____
The following plan is intended to assist school mental health personnel in facilitating a successful reentry plan for students following psychiatric hospitalization. Plans should be determined on a case-by-case basis and address the student's priorities/needs for reentry.

S – Sharing Information and Communication		
Obtained a Release of Information (ROI)?	Yes ____ No ____	Comments:
Discharge Paperwork?	Yes ____ No ____	Comments:
Medical Treatment Plan?	Yes ____ No ____	Comments:
Does the student want information shared with school members?	Yes ____ No ____	Name of Individuals & Information to Share:

T – Team (Interdisciplinary Members)		
Name of Reentry Coordinator: _____ Occupation: _____		
Name of Member	**Occupation**	**Comments**
Ex. Bob Smith	School Counselor	Designated reentry coordinator

R – Remote Friendly Services and Resource Mapping		
Did the Reentry Coordinator provide the student and their family a resource list?	Yes ____ No ____ Date Completed:	Comments:

Would the student and their family like to receive remote friendly resources?	Yes ____ No ____	Comments:

A – Accommodations and School Services		
Received academic work outside of school during their absence?	Yes ____ No ____	Comments:
Does student qualify for accommodations or special education services at school?	IEP ____ 504 ____ N/A ____	Comments:
Does the student need school services for *academics*?	Yes ____ No ____	Comments: (if yes, please specify)
Does the student need school services for *social/emotional needs*?	Yes ____ No ____	Comments: (if yes, please specify)
Will the student need medication management at school?	Yes ____ No ____	Comments: (if yes, please specify)

T – Training and Psychoeducation		
Does the student or their family want psychoeducation on mental health?	Yes ____ No ____	Comments: (if yes, please specify)
Does the student's teacher(s) want training or psychoeducation on mental health concerns?	Yes ____ No ____	Comments: (if yes, please specify)

E – Easy and G – Gradual Transitions		
Will student require homebound instruction or distance-education services?	Yes ____ No ____	Comments: (if yes, please specify)
What is the agreed upon date for the student to return in-person?	Date:	Comments:
Plan with student on schedule and attendance changes.	Date Completed:	Comments: (please specify)

I – Individualized Reentry Plan		
Discuss the student's risk factors, warning signs (e.g., triggers, stressors), and challenges.	Date Completed:	Comments: (please specify)
Discuss the student's protective factors and supports.	Date Completed:	Comments: (please specify)

Does the student have identified coping mechanisms?	Yes ____ No ____	Comments: (if yes, please specify)
Discuss what goals the student would like to make for the reentry process.	Date Completed:	1. 2. 3.
Have the student identify safe spaces in the school where they can go when they need emotion regulation.	Date Completed:	Comments: (please specify)
Complete a safety plan with the student.	Date Completed:	Comments: (please specify)

C – Check-Ins		
Discuss how the student would like to engage in check-ins.	Date Completed:	Comments:
Have the student identify a trusted school staff member they would like to do check-ins with.	Date Completed:	Comments: (please specify)
Discuss with the interdisciplinary team when everyone would like to meet again to assess the student's progress.	Date Completed:	Comments: (please specify)

Additional Comments/Notes:

Student Signature _____ Date _____

Caregiver Signature _____ Date _____

Reentry Coordinator Signature _____ Date _____

APPENDIX B: DEMOGRAPHIC QUESTIONNAIRE

Directions: Please fill out the survey to the best of your ability. You may choose to quit the study at any point in time. Participants will have the chance to receive an additional entry into the incentive raffle for each survey they complete.

Please create an **identifiable code** for your survey responses starting with the **first letter of your last name** and **the last three digits of your phone number** (i.e., Smith and 012-345-6789 = S789).

Please write down this code to use it in future survey responses.

Please list the state where your school is located.

What level of school do you work in?

- ○ Elementary
- ○ Middle
- ○ High

How many years of experience do you have in the school counseling field?

What is your current level of engagement in school settings?

- ○ Full-Time Employment
- ○ Part-Time Employment
- ○ Other

Please choose the option that best categorizes your school district.

- ○ Rural
- ○ Suburban
- ○ Metropolitan/Urban
- ○ Unsure

To the best of your knowledge, how many students were referred to psychiatric care from your school during the 2022-2023 academic year?

- ○ 0-5
- ○ 6-10
- ○ 11-15
- ○ 15+
- ○ Unsure

Please choose the option that best describes your school district's policies or procedures around the student reentry process following psychiatric hospitalization.

- ○ Formal (written and documented) protocols
- ○ Informal (not written) protocols
- ○ None

If you chose formal or informal protocols in the question above, please briefly describe the policies and procedures for the student reentry process following psychiatric hospitalization.

→

APPENDIX C: GSE

General Self-Efficacy Scale (GSE)

The GSE is a self-reported measure with 10 self-efficacy items. Please answer to the best of your ability.

	Not True At All	Hardly True	Moderately True	Exactly True
I can always manage to solve difficult problems if I try hard enough.	○	○	○	○
If someone opposes me, I can find the means and ways to get what I want.	○	○	○	○
It is easy for me to stick to my aims and accomplish my goals.	○	○	○	○
I am confident that I could deal efficiently with unexpected events.	○	○	○	○
Thanks to my resourcefulness, I know how to handle unforeseen situations.	○	○	○	○
I can solve most problems if I invest the necessary effort.	○	○	○	○
I can remain calm when facing difficulties because I can rely on my coping abilities.	○	○	○	○
When I am confronted with a problem, I can usually find several solutions.	○	○	○	○
If I am in trouble, I can usually think of a solution.	○	○	○	○
I can usually handle whatever comes my way.	○	○	○	○

← →

APPENDIX D: SCKSS

School Counselor Knowledge and Skills Survey for MTSS (SCKSS)

Instructions:
Rate your knowledge, skill level, or awareness of the following items on the following pages. If you are not knowledgeable on a particular set of items or item, it does not reflect poorly on you as a school counselor. The rating scale ranges from one to five across the following anchors:

1=none or little 2=somewhat 3=moderate 4=strong 5=mastery

You should consider your current practical experience in each of your ratings. Please review the provided definitions to assist you in your rating of your knowledge and skill level. Once your understanding of the rating scale and the continuum of knowledge and skills for MTSS is comprehensive, you may proceed by completing the survey based on the definitions.

←

→

1 = None or little
I am not aware of the knowledge, policy, or skill, or I am slightly aware (e.g., heard of it) but have never practiced it or applied it.

2 = Somewhat
I am aware of the of the knowledge, policy, or skill, and I was exposed to this content in some professional development/university course work, and have had some limited applied practice of this knowledge, policy, or skill.

3 = Moderate
I have demonstrated my understanding of the knowledge, policy, or skill through professional development/university course work, and I have used or applied the knowledge policy or skill in an applied setting.

4 = Strong
I have demonstrated my understanding of the knowledge, policy, or skill through professional development/university course work, I have applied it in practice, and I have been evaluated as successful with this knowledge, policy, or skill.

5 = Mastery
I have demonstrated my understanding of the knowledge, policy, or skill through professional development/university course work, I have repeatedly demonstrated successful implementation of the knowledge, skill, or policy as evidenced and validated multiple evaluations.

Rate the following regarding your knowledge on the item:

	1 = None or little	2 = Somewhat	3 = Moderate	4 = Strong	5 = Mastery
I know our school's policies and programs regarding the prevention of behavior problems.	○	○	○	○	○
I understand the role and function of our school-wide behavior team.	○	○	○	○	○
I know our annual goals and objectives for the school-wide behavior program.	○	○	○	○	○
I know our school's system for screening with students with behavior problems.	○	○	○	○	○

	1 = None or little	2 = Somewhat	3 = Moderate	4 = Strong	5 = Mastery
I know how to access and use our school's pre-referral teacher assistance team.	○	○	○	○	○
I know how to provide access and implement our school's counseling programs.	○	○	○	○	○
I know the influence of cultural/ethnic variables on student's school behavior.	○	○	○	○	○
I know the programs our school uses to help students with their social and emotional development (school-wide expectations, conflict resolution, etc.).	○	○	○	○	○
I know a range of community services to assist students with emotional/behavioral problems.	○	○	○	○	○
I know our school's discipline process – the criteria for referring students to the office, the methods used to address the problem behavior, and how and when students are returned to the classroom.	○	○	○	○	○
I know what functional behavioral assessments are and how they are used to develop behavior intervention plans for students.	○	○	○	○	○
I know how our school-wide behavior team collects and uses data to evaluate our school-wide behavior program.	○	○	○	○	○

	1 = None or little	2 = Somewhat	3 = Moderate	4 = Strong	5 = Mastery
I know how to provide accommodations and modifications for students with emotional and behavioral disabilities (EBD) to support their successful participation in the general education setting.	○	○	○	○	○
I know our school's crisis intervention plan for emergency situations.	○	○	○	○	○
Approaches for helping students to solve social/interpersonal problems.	○	○	○	○	○
Methods for teaching the school-wide behavioral expectations/social skills.	○	○	○	○	○
Methods for encouraging and reinforcing the use of expectations/social skills.	○	○	○	○	○
Strategies for improving family-school partnerships.	○	○	○	○	○
Collaborating with the school's student assistance team to implement student's behavior intervention plans.	○	○	○	○	○
Collaborating with the school's IEP team to implement student's individualized education programs.	○	○	○	○	○
Evaluating the effectiveness of student's intervention plans and programs.	○	○	○	○	○
Modifying curriculum to meet individual performance levels.	○	○	○	○	○

	1 = None or little	2 = Somewhat	3 = Moderate	4 = Strong	5 = Mastery
Selecting and using materials that respond to cultural, gender or developmental differences.	○	○	○	○	○
Establishing and maintaining a positive and consistent classroom environment.	○	○	○	○	○
Identifying the function of student's behavior problems.	○	○	○	○	○
Using data in my decision-making process for student's behavioral programs.	○	○	○	○	○
Using prompts and cues to remind student's of behavioral expectations.	○	○	○	○	○
Using self-monitoring approaches to help students demonstrate behavioral expectations.	○	○	○	○	○
Communicating regularly with parents/guardians about student's behavioral progress.	○	○	○	○	○
Using alternative settings or methods to resolve student's social/emotional problems (problem-solving, think time, or buddy room, etc. not a timeout room).	○	○	○	○	○
Methods for diffusing or deescalating student's social/emotional problems.	○	○	○	○	○
Methods for enhancing interpersonal relationships of students (e.g., circle of friends, buddy system, peer mentors).	○	○	○	○	○

	1 = None or little	2 = Somewhat	3 = Moderate	4 = Strong	5 = Mastery
Linking family members to needed services and resources in the school.	○	○	○	○	○

←

→

APPENDIX E: Q4TE – SHORT FORM

Directions: Please fill out the survey to the best of your ability. You may choose to quit the study at any point in time. Participants will have the chance to receive an additional entry into the incentive raffle for each survey they complete.

Questionnaire for Professional Training Evaluation (Q4TE)

The Q4TE (short form) was built to measure short- and long-term training outcomes. Please refer to the Learning to Be STRATEGIC training you received on the student reentry process following psychiatric hospitalization when answering the following questions.

	0 = Completely Disagree	1	2	3	4	5	6	7	8	9	10 = Completely Agree
I will keep the training in good memory.	○	○	○	○	○	○	○	○	○	○	○
I enjoyed the training very much.	○	○	○	○	○	○	○	○	○	○	○
The training is very beneficial to my work.	○	○	○	○	○	○	○	○	○	○	○
Participation in this kind of training is very useful for my job.	○	○	○	○	○	○	○	○	○	○	○
When I am confronted with a problem at work, after the training I have many more ideas than before on how to deal with it.	○	○	○	○	○	○	○	○	○	○	○
As a result of the training, I feel better able to meet the demands of my job than I did before the training.	○	○	○	○	○	○	○	○	○	○	○
After the training, I know substantially more about the training contents than before.	○	○	○	○	○	○	○	○	○	○	○
I learned a lot of new things in the training.	○	○	○	○	○	○	○	○	○	○	○
In my everyday work, I often use the knowledge I gained in the training.	○	○	○	○	○	○	○	○	○	○	○
I succesfully manage to apply the training contents in my everyday work.	○	○	○	○	○	○	○	○	○	○	○
Since the training I have been more content with my work.	○	○	○	○	○	○	○	○	○	○	○

	0 = Completely Disagree	1	2	3	4	5	6	7	8	9	10 = Completely Agree
My job performance has improved through the application of the training contents.	○	○	○	○	○	○	○	○	○	○	○
Overall, it seems to me that the application of the training contents has facilitated the work flow in my company.	○	○	○	○	○	○	○	○	○	○	○
Overall, it seems to me that the organizational climate has improved due to the training.	○	○	○	○	○	○	○	○	○	○	○

→

Powered by Qualtrics

APPENDIX F: LEARNING TO BE STRATEGIC TRAINING SECTION – QUALTRICS

Please watch the following training video on the Learning to Be STRATEGIC Model - a guide on the student reentry following psychiatric hospitalization, and answer the following questions below when prompted. Once you have finished the video, please move onto the final question of the survey.

If you have trouble with the video above, to access the Learning to Be STRATEGIC Training click the following link:
https://youtu.be/Y6Ui_GFv4vc?si=TYIwT0ZLymqgDAvJ

To access the Learning to Be STRATEGIC Reentry Document, please click the file below.
Learning to Be STRATEGIC Reentry Plan © Document

To access the Learning to Be STRATEGIC References, please click the file below.
Learning to Be STRATEGIC Training © Video References

Based on the information above, what information about Manuel can you fill in on the “Sharing Information” stage of the Learning to Be STRATEGIC model?

Based on the information above, who do you include on Manuel’s reentry team and why?

Based on the information above, what would you put in the “Remote-Friendly Services and Resource Mapping” section of the STRATEGIC model?

Based on the information above, what information and accommodations can be included in the reentry plan?

Based on the information above, what training/psychoeducation can you provide these stakeholders?

Based on the information above, what would you propose as the agreed upon date and services?

Based on the information above, what can we fill in on the reentry plan document about Manuel's supports and challenges?

Based on the information above, what SMART goals can you propose to the team based on Manuel’s reports?

Based on the information above, what check-in suggestions would you offer to Manuel and the team?

Considering the context of Manuel’s reentry and his goals for the reentry process, when would you like to meet with Manuel and the team to reassess how he is doing?

What additional information, if any, would you like to include in the Additional Comments/Notes section?

What aspects of the training do you believe benefit your work as a school counselor?

What aspects of the training do you believe are not beneficial to your work as a school counselor?

What questions do you still have about the Learning to Be STRATEGIC Training and the student reentry process following psychiatric hospitalization?

APPENDIX G: TRAINING EVALUATION SCALING AND OPEN-ENDED QUESTIONS

Open-Ended Training Evaluation Questions

Many aspects of the training were easy to understand.

0 1 2 3 4 5 6 7 8 9 10

Click to write Choice 1

Many aspects of the training were difficult to understand or confusing.

0 1 2 3 4 5 6 7 8 9 10

Click to write Choice 1

In what ways has the training impacted your work as a school counselor?

What do you still want to know about the student reentry process following psychiatric hospitalization?

Have you received any additional trainings or professional development since the completion of the training? If yes, please list them below.

○ Yes

○ No

Email Response

The following survey is solely to collect your email information for follow up surveys on the training. All email information will remain confidential and is recorded separately from pre- and post-test responses to keep anonymity. The first 30 participants to complete the entire study (surveys and training) will receive a $15 Amazon gift card.

Please enter your email address

Powered by Qualtrics

APPENDIX I: CASE STUDY EXAMPLE

Manuel Sanchez, a sixth-grade student, is returning back to school from psychiatric hospitalization. He identifies as an 11-year-old, Mexican American, cisgender boy who lives with an extended family. He was referred for hospitalization after the school completed a suicide assessment and he was determined to be high risk. His identified caregiver is his mother, Maria Sanchez. You, the school counselor, have been identified as the reentry coordinator to support Manuel since he left a week ago. The current date is 10/31/23 and Manuel's discharge is scheduled for tomorrow.

S - Manuel's caregivers have agreed to sign an ROI and the hospital released his treatment and safety plans. These plans suggest Manuel identify people who support him at school so he can check-in frequently, managing his new medication, and seek services at school. Manuel has requested that only his homeroom teacher, Ms. Smith, and best friend, Alex, know where he has been. He would like to tell his other teachers and friends that he was sick.

Based on the information above, what information about Manuel can you fill in on the "Sharing Information" stage of the Learning to Be STRATEGIC model?

T – Manuel currently lives with his parents, two siblings, and a grandmother. Manuel's family has become close with the school social worker after she helped them find resources last year. Additionally, the hospital has disclosed Manuel will need to take his new medication throughout the day, which includes at school. Manuel has agreed to take his medication at school and asks if there is someone at the school who can help him find ways to help him concentrate in class.

Based on the information above, who do you include on Manuel's reentry team and why?

R – Manuel's family received a referral for therapists in the area from the hospital, but they want to know if there any additional agencies, especially those that support Mexican American culture, that might be useful in supporting Manuel. His family mentions that Manuel's grandfather died about three months ago and Manuel will no longer talk about him. They also mention that they are having transportation issues lately and want to look into virtual resources that could be helpful for Manuel.

Based on the information above, what would you put in the "Remote-Friendly Services and Resource Mapping" section of the STRATEGIC model?

A – Manuel received schoolwork while he was hospitalized but according to the hospital and his family was only able to complete a portion of his work. Manuel does not have a current IEP or 504 plan. However, Manuel received an anxiety diagnosis at the hospital and the staff have worked with the family to make a 504-plan request. Manuel and his family discuss that he feels stressed from trying to catch up on schoolwork and meet his assignment deadlines. Additionally, Manuel identified that his anxiety increases when he has to take tests or exams.

Based on the information above, what information and accommodations can be included in the reentry plan?

T – Manuel's family received some information about treating anxiety from the hospital but want to know if you have any more mental health information on anxiety in children and adolescents. Additionally, Ms. Smith has asked you if there's any materials or suggestions you have for helping teachers navigate their student's anxiety in the classroom.

Based on the information above, what training/psychoeducation can you provide these stakeholders?

EG – Based on the medical paperwork, Manuel's doctors recommend that he takes a few days before coming back to school. Manuel appears hesitant to come back and wants to stay out of school longer. Manuel's family would like for him to come back as soon as possible but are open to the idea of him being home for a few days. Manuel and his family do not express any concerns around his schedule.

Based on the information above, what would you propose as the agreed upon date and services?

I – You and the family find a day and time to meet for the individualized reentry planning process after Manuel is discharged. Manuel discusses that his challenges are catching up on work, struggling to make friends, and other students making fun of his culture. Additionally, he says he is extremely anxious before tests and at the beginning of the school day. When asked about supports, Manuel reports that he can always talk to Alex, and his family is supportive of his mental health. Manuel reports that when he feels anxious, it helps for him to do breathing techniques and go to the counselor's office to talk. He tells the team that he wants to feel less anxious at school, work on making more friends, and talking to someone when he feels lonely.

Based on the information above, what can we fill in on the reentry plan document?

Based on the information above, what SMART goals can you propose to the team based on Manuel's reports?

C – Manuel reports that he is the most anxious in the morning when getting to school. He often worries he is not prepared for the school day and worries about what other students say about him. Recently students have been making jokes about Manuel's Mexican American culture, but Manuel will not identify the students out of fear of what will happen. Manuel reports that Ms. Smith will often talk with him in the morning to make him feel better and identifies her as a trusted adult at school. Regarding check-ins, Manuel states that he is unsure of what would be helpful for him when he comes back to school and is open to suggestions from you and the team.

Based on the information above, what check-in suggestions would you offer to Manuel and the team?

Considering the context of Manuel's reentry and his goals for the reentry process, when would you like to meet with Manuel and the team to reassess how he is doing?

What additional information, if any, would you like to include in the Additional Comments/Notes section?

APPENDIX J: CASE STUDY QUESTIONS AND ANSWERS

Question	**Quality Assurance Check (Possible) Answers**
1. Based on the information above, what information about Manuel can you fill in on the "Sharing Information" stage of the Learning to Be STRATEGIC model?	1. Obtained an ROI, received medical/hospital discharge paperwork, identified Ms. Smith (homeroom teacher) and Alex (best friend) to know where he was.
2. Based on the information above, who do you include on Manuel's reentry team and why?	2. Social worker, school nurse, school counselor, special education teacher or instructional coach, and family. Additional staff can be included here.
3. Based on the information above, what would you put in the "Remote-Friendly Services and Resource Mapping" section of the STRATEGIC model?	3. Agencies supporting Mexican Americans, grief referrals/resources, and transportation resources.
4. Based on the information above, what information and accommodations can be included in the reentry plan?	4. Extended deadlines, possible time extension, medication management, pass to see counselor, possible space to calm down, and CICO. Additional options can be included here.
5. Based on the information above, what training/psychoeducation can you provide these stakeholders?	5. Managing anxiety in children and adolescents. Additional options may be put here.
6. Based on the information above, what would you propose as the agreed upon date and services?	6. Answers can vary here – a few days, a week, or a specific date (e.g., 11/3/23, 11/6/23)
7. Based on the information above, what can we fill in on the reentry plan document about Manuel's supports and challenges?	7. Supports – Alex, family, breathing techniques, and school counselor; challenges – anxiety, peers teasing him, and struggling to make friends. Additional answers can go here.
8. Based on the information above, what SMART goals can you propose to the team based on Manuel's reports?	8. Answers can vary here but should include goals that address coping mechanisms (anxiety related), working on social connections, and academic needs.
9. Based on the information above, what check-in suggestions would you offer to Manuel and the team?	9. Answers can vary here but should include: CICO, and a trusted adult (Ms. Smith)
10. Considering the context of Manuel's reentry and his goals for the reentry process, when would you like to meet with Manuel and the team to reassess how he is doing?	10. Answers can vary but should include frequent check-ins within the first three months of being back.
11. What additional information, if any, would you like to include in the Additional Comments/Notes section? (Optional)	11. Answers can vary and might include exploring more about potential bullying, exploring grief, and cultural considerations.

APPENDIX K: IRB INFORMED CONSENT

UNIVERSITY OF NORTH CAROLINA AT GREENSBORO

CONSENT FOR PARTICIPATION IN RESEARCH

Protocol Title: Learning to Be STRATEGIC: A Training Evaluation on the Student Reentry Process Following Psychiatric Hospitalization

Principal Investigator:
Alex S. Cammarano
288 Curry Building, PO Box 26170
Greensboro, NC 27402
(757) 771-6259

Faculty Advisor:
Dr. Carrie A. Wachter Morris
288 Curry Building, PO Box 26170
Greensboro, NC 27402
(336) 365-6895

Key Information

You are being asked to volunteer for research. *Below is some key information to keep in mind when thinking about why you may or may not want to be in the research. Additional details will follow.*

Introduction

The purpose of this form is to provide you information that may affect your decision as to whether to participate in this research study. The person performing the research will answer any of your questions. Read the information below and ask any questions you might have before deciding whether to take part. If you decide to be involved in this study, this form will be used to record your consent. You must be at least 18 years of age to participate.

Purpose of the Study

You have been asked to participate in a research study about the Learning to Be STRATEGIC Training ©, a guide to assist school staff supporting students reentering school following psychiatric hospitalization. The purpose of this study is to evaluate the effectiveness of a training for professional school counselors on the student reentry process following psychiatric hospitalization through examination of self-efficacy, skills and knowledge on multi-tiered systems of support (MTSS), and professional training evaluation measures. This study hopes to answer the following questions:

- Research Question 1: How effective is the Learning to Be STRATEGIC training for school counselors on the various areas of training evaluation (i.e., reaction, learning, behavior, and results)?
- Research Question 2: Is there a difference on school counselors' self-reported scores of general self-efficacy after the implementation of the Learning to Be STRATEGIC training?

- Research Question 3: Is there a difference on school counselors' skills and knowledge around multi-tiered systems of support (MTSS) after the implementation of the Learning to Be STRATEGIC training?
- Research Question 4: What is school counselors' feedback on the implementation of the Learning to Be STRATEGIC training?
- Research Question 5: Is there a difference between the waitlist control group's and treatment group's self-efficacy, knowledge and skills of multi-tiered systems of support (MTSS), and training evaluation scores?

Why am I being asked to take part in this research study?

You are being asked to take part in this study because you are a professional school counselor who provides school mental health support to students and you meet the following criteria:

- Be at least 18 years of age
- Hold credentials/licensure as a professional school counselor in your corresponding state
- Be currently employed in a K-12 public school setting
- Work and live in the United States

Your participation in this study is completely voluntary. You may refuse to participate or stop your participation in this research study at any time without penalty or loss of benefits.

How many people will take part in this study and how long will it take?

This study will take four to five weeks depending on your randomly assigned treatment group and will include approximately 100 study participants at the University of North Carolina at Greensboro.

What will you be asked to do?

If you agree to participate in this study, you will be asked to complete the Learning to Be STRATEGIC training and an anonymous series of questionnaires about your self-efficacy, skills and knowledge around multi-tiered systems of support (MTSS), and evaluation of the provided training. Those randomly assigned to the treatment group will take five surveys across a four-week time span, while those randomly assigned to the waitlist control group will take five surveys across a five-week time span. Each survey should take you about 10-15 minutes to complete, and the Learning to Be STRATEGIC training should take about one hour. Participants will complete the surveys prior to the training and at one week, two weeks, and four weeks upon completion of the training. The surveys and training will be completed in Qualtrics, a survey software that allows you to participate from your mobile phone or computer. Qualtrics will randomize participants to either a four-week treatment group or five-week waitlist control group. All participants will receive the Learning to Be STRATEGIC training and the researcher will not know the assignment of participants to either group throughout the entire study.

What are the risks involved in this study?

The risks involved with participation in this study are low and may include stress from answering sensitive questions about the training. The training covers a range of symptoms and behaviors a student might experience during the reentry process and may bring up uncomfortable emotions. You may choose to skip survey questions evaluating the training if you do not feel

comfortable answering them. However, your answers will not be identifiable to anyone, including the researchers.

Some of the content in the Learning to Be STRATEGIC training discusses students who engage in suicide-related behaviors. Should you need additional assistance, please reach out to the mental health resources provided:

- Dial 988 – National Suicide and Crisis Lifeline
- Text "HOME" to 741741 to reach a crisis counselor via the Crisis Text Line
- Visit www.psychologytoday.com to find a mental health care provider in your area

If you have questions, want more information or have suggestions, please contact Alex S. Cammarano at ansmith10@uncg.edu or Dr. Carrie A. Wachter Morris at cawmorris@uncg.edu or (336) 365-6895.

If you have any concerns about your rights, how you are being treated, concerns or complaints about this project or benefits or risks associated with being in this study please contact the Office of Research Integrity at UNCG toll-free at (855)-251-2351.

The researchers will tell you about any important new information that is learned during this study, which might affect your condition or your willingness to continue participation in this study.

What are the possible benefits of this study?

This study may add to the knowledge base on how school counselors can effectively work with students as they reenter school following psychiatric hospitalization. Additionally, this study will assist in evaluating the Learning to Be STRATEGIC model for its effectiveness in the field. Participants who choose to partake in the study will be provided a reentry planning guide that can be used in their work with students and families, and greater clarity on the student reentry process following psychiatric hospitalization.

Do you have to participate?

No, your participation is voluntary. You may decide not to participate at all or, if you start the study, you may withdraw at any time. Withdrawal or refusing to participate will not affect your relationship with the University of North Carolina at Greensboro in any way.

You may choose not to answer a question or question(s) for any reason.

If you would like to participate, please choose an option under the signature section, print your name, and sign the informed consent. Participants have the opportunity to download a copy of this form at the below the signature section.

Will participating in the study cost you anything?

No. There are no direct costs for taking part in this research study.

If you were harmed while participating in the study, who would pay for the necessary medical

care?
In the event that you suffer a research-related injury, your medical expenses will be your responsibility or that of your third-party payer, although you are not precluded from seeking to collect compensation for injury related to malpractice, fault, or blame on the part of those involved in the research.

Will there be any travel or other study-associated costs (for example, child care) and will researchers provide any money to cover those costs?
No. There are no travel or other study-associated costs for taking part in this research study.

Will I be paid for taking part in this research?
The first 30 participants who complete the study entirely (surveys and training) will receive a $15 Amazon gift card. However, if you do not complete the entire survey, you will not have the opportunity to receive a gift card.

How will my information be protected?
Your responses to this research study are completely anonymous. No IP addresses or names will be collected during this study, and email responses for follow-up survey distribution will be collected in a separate survey from the questionnaires in the study. We will make every effort to protect the confidentiality of study records that identify you, but we cannot guarantee total confidentiality. Your information will be viewed by the research team and other people within the University of North Carolina at Greensboro who help administer and oversee research. People outside of the University of North Carolina at Greensboro may also need to see or receive your information for this study. Examples include government agencies (such as the Food and Drug Administration), safety monitors, other sites in the study and organizations that sponsor or help conduct the study. If information from this study is published or presented at scientific meetings, your name and other identifiable information will not be used. If you use a public computer to complete the study, privacy of others walking past the computer cannot be guaranteed. Absolute confidentiality of data provided through the Internet cannot be guaranteed due to the limited protections of Internet access. Please be sure to close your browser when finished so no one will be able to see what you have been doing. Your responses will be stored electronically on a password-protected computer. All data will be de-identified to ensure participant information remains confidential. All information in this study is strictly confidential unless disclosure is required by law.

Additional Information and Details

Could my information be used for future research without asking for my permission?
Yes. If all identifiers (name, date of birth, etc.) are removed, it is possible that the data collected for this study may be used for future research studies or distributed to another investigator for future research studies without your consent.

What will happen if you decide to withdraw from the study?
If you decide to leave the study, contact the researchers so they know. The researchers may ask you the reason but you are not required to provide it.

After you leave the study, no new information will be collected from you. Information that has already been collected can be withdrawn from the database if you choose or will remain in the study database and be used to determine the results of the study.

Whom to contact with questions about the study?
Prior to, during or after your participation you can contact the researcher, Alex Cammarano at (757) 771-6259 or Faculty Advisor, Dr. Carrie A. Wachter Morris at (336) 365-6895 or send an email to ansmith10@uncg.edu for any questions or concerns or if you feel that you have been harmed or injured as a result of being in the research.

Whom to contact with questions concerning your rights as a research participant?
Prior to, during or after your participation you can contact the Office of Research Integrity at UNCG at 855-251-2351 or ori@uncg.edu to:

- Discuss problems, concerns, and questions, including questions about your rights as a person in a research study
- Obtain information
- Offer input.

The Office of Research Integrity at UNCG is not affiliated with any specific research study. You can contact anonymously if you wish.

If you want to volunteer to be in this research, please sign here

---

Signature

You have been informed about this study's purpose, procedures, possible benefits and risks, and you have an opportunity to receive a copy of this form. You have been given the opportunity to ask questions before you sign, and you have been told that you can ask other questions at any time. You voluntarily agree to participate in this study. You agree to allow the researchers to use and share your information as described in this form. By signing this form, you are not waiving any of your legal rights.

Please choose one of the following options:

- Yes, I am at least 18 years old. I have read and understood the content of this consent document, I meet the requirements to participate, and I wish to participate.

- No, I do not wish to participate in this research study or do not meet the requirements to participate.

APPENDIX L: PERMISSION TO USE MEASURES

Freie Universität Berlin

Fachbereich Erziehungs-
wissenschaft und Psychologie
- Gesundheitspsychologie -

Professor Dr. Ralf Schwarzer
Habelschwerdter Allee 45
14195 Berlin, Germany

Fax +49 30 838 55634
health@zedat.fu-berlin.de
www.fu-berlin.de/gesund

Freie Universität Berlin, Gesundheitspsychologie (PF 10),
Habelschwerdter Allee 45, 14195 Berlin, Germany

Permission granted

to use the General Self-Efficacy Scale for non-commercial reseach and development purposes. The scale may be shortened and/or modified to meet the particular requirements of the research context.

http://userpage.fu-berlin.de/~health/selfscal.htm

You may print an unlimited number of copies on paper for distribution to research participants. Or the scale may be used in online survey research if the user group is limited to certified users who enter the website with a password.

There is no permission to publish the scale in the Internet, or to print it in publications (except 1 sample item).

The source needs to be cited, the URL mentioned above as well as the book publication:

Schwarzer, R., & Jerusalem, M. **(1995)**. Generalized Self-Efficacy scale. In J. Weinman, S. Wright, & M. Johnston, *Measures in health psychology: A user's portfolio. Causal and control beliefs* (pp.35-37). Windsor, UK: NFER-NELSON.

Professor Dr. Ralf Schwarzer
www.ralfschwarzer.de

Technische Universität Braunschweig | Institut für Psychologie | Lehrstuhl für Arbeits-, Organisations- und Sozialpsychologie
Spielmannstr. 19 | 38106 Braunschweig | Germany

Prof. Dr. **Simone Kauffeld**
Tel. +49 (0) 531 391-2547
Fax +49 (0) 531 391-8173
s.kauffeld@tu-bs.de

Cooperation-agreement for the usage of the Questionnaire for Professional Training Evaluation (Q4TE)

I hereby confirm to only use the Q4TE (Grohmann & Kauffeld, 2013) for research purposes. Furthermore, I notice that the Q4TE is treated as confidential and is not shared with third parties. If I use the questionnaire for research purposes, I will use it without any changes in content and will add a copyright to the survey as well as an information that I use it with permissions of the authors. Furthermore, I will make the anonymized raw data, with further information on the sample, available to Ms. Prof. Dr. Simone Kauffeld for the further development of the norm sample. I will do this in a timely manner possible and without charging any fees. The data will only be published in an anonymized format.

Alex S. Cammarano 09/21/23

Place, date, signature
University of North Carolina at Greensboro

Contact data

Name: Alexandria Cammarano

Address: 228 Curry Building PO Box 26170
Greensboro, NC 27402-6170

E-Mail: ansmith10@uncg.edu

*After consultation with their committee, the researcher received approval from the creators of the Q4TE to use the measure without the condition to provide raw data in line with university and IRB guidelines.

From: Jacob Olsen <jacob.olsen@csulb.edu>
Sent: Monday, September 11, 2023 8:11 PM
To: Alex Smith <ANSMITH10@uncg.edu>
Subject: Re: Permission to Use the SCKSS

Hi Alex!

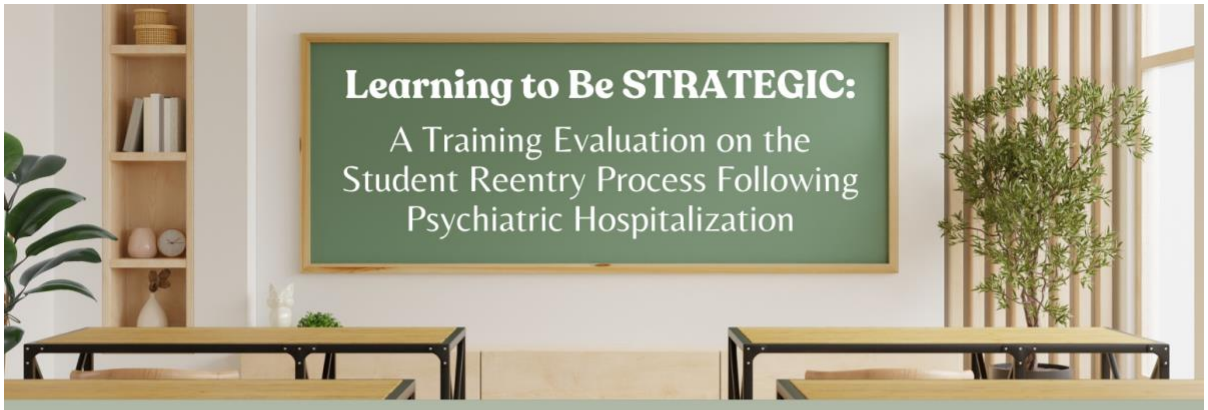
Congratulations on your dissertation work to this point…I know it's a lot! Very exciting topic!

You have my permission to use the SCKSS, please just cite accordingly as I know you would 😊. Please see attached and let me know if you have any other questions etc.

Jake

Jake Olsen, Ph.D.
He, Him, His
Associate Professor
School Counseling Program I ASEC Dept.
College of Education
California State University Long Beach
1250 Bellflower Blvd.
Long Beach, CA 90840

APPENDIX M: DISSERTATION RECRUITMENT FLYER



CALL FOR RESEARCH PARTICIPANTS

ABOUT THE STUDY

The purpose of this study is to examine the effectiveness of the Learning to Be STRATEGIC Training with school counselors. The training outlines an eight-step guide to help school staff support students returning from psychiatric hospitalization.

RESEARCHERS

Alex S. Cammarano, MS, NCC
Principal Investigator
ansmith10@uncg.edu

Dr. Carrie Wachter Morris
Faculty Advisor
cawmorris@uncg.edu

INCENTIVE: THE FIRST 30 PARTICIPANTS TO COMPLETE THE ENTIRE STUDY WILL RECEIVE A $15 AMAZON GIFT CARD

PARTICIPATION

Participants will be asked to complete five 10-15 minute surveys and a 1-hour training.

ELIGIBILITY

- Be at least 18 years old
- Hold credentials/licensure as a professional school counselor in your state
- Employed in a K-12 public school
- Work and live in the United States

KNOW SOMEONE?

Do you know someone who would be eligible and interested in this study? Share this flyer!

TO PARTICIPATE:

Scan the QR code or go to https://go.uncg.edu/strategic to review the informed consent and access the first survey.

UNC GREENSBORO
Department *of* Counseling *and* Educational Development

Version 1/18/24

APPENDIX N: FORMAL AND INFORMAL PROTOCOL RESPONSES

Formal	Completion of questionnaire and reporting to downtown offices
	We have a form that has guiding questions and possible appropriate stakeholders who may attend the re-entry meeting.
	Paperwork needs to be received from facility stating it is okay for student to return, re-entry meeting with parent, student, and social worker, counselor and social worker create safety plan for student and monitor student
	There are sample re-entry forms that are meant to aid in determining if safety measures/plans are needed in school. Expectation is to have a re-entry meeting but there is no follow up or tracking/reporting to superiors so little accountability of policy
	Our counseling department have written a in the safety plan that a meeting should be held when the student returns before going to class, however this does not typically happen right away.
	Coordinate with hospital and meet with student when they return.
	Student and parents come to a re-entry meeting prior to the student returning to the classroom. The meeting includes the student, parents, school counselor, social worker, assistant principal, and school psychologist. Parents are asked to bring documentation of the hospitalization (for attendance) and any safety plans that were put in place. We adapt the safety plan for the school setting. With parents' consent, teachers are informed with what information parents are comfortable sharing.
	Must meet with outside mental health care and be cleared to return to school.
	Students require a doctor's note to return to school, the school holds a re-entry meeting with the school counselor, admin, and teachers, and there is a standardized safety plan worksheet (may be filled out by medical professional or during reentry meeting)
	Students are required to have a letter stating they can return to our school and provide a copy of their treatment plan. They are required to receive follow-up counseling and medication in order to remain in our residential school environment.
	Our school social worker or school psychologist has a document they use for students that return. Some questions include triggers, coping mechanisms, and people on campus student identifies as a safe space
	Reentry requires a child to see a mental health professional and documentation stating the student is able to return.
	Support team meeting with their counselor, principal and parent
	Return safety plan written
	Meet with me as school counselor, principal, school psychologist, family members and student.

	Formal paperwork for referrals to services
	Student must have a signed copy of the state emergency notification form and must meet with the school counselor to establish a student safety plan.
	When a student is sent to be evaluated and then they come back to school, we complete a safety plan with the student and check in with them once a week since they are now a tier 3 student
	You have to come in with a referral letter from the hospital that made the recommendation and agree to confirm to the reentry plan of the school.
	The student has to be cleared to come back based on the emergency/hospital assessment. A safety plan is created, and we follow whatever recommendations are suggested by the hospital staff and family.
	Parent brings in discharge paperwork from hospital. Mental health counselor or school counselor checks in daily for a few weeks upon return.
	Parents and Staff must have a reentry meeting which places supports in place for student. They may have more access to school counselor, breaks throughout the day, and checked in with the nurse if they are on medication.
	We have a medical leave of absence policy that I developed outlining the procedure for a student to go on leave and the return to school process - including indicators of readiness to return, etc.
	We have documentation of safety plan, depending on reason behind placement the student may be placed at our alternative school as a controlled environment due to have 2100+ students, meeting with teachers to assure adequate care.
	Student is re-activated in our system once we have received the discharge notice. Counselor meets with the student and parent/guardian to form a re-entry plan and help try to ensure a positive re-entry process for the student.
	A reentry plan must be created with weekly check ins being part of that plan
	Students must have a release letter to renter school, the assessment team meets to have student a plan in place. Contact districts and send appropriate documentation
	Support Plan is created with student with family input with school appropriate coping skills and warning signs. This is shared with all teachers, admin and appropriate staff.
Informal	At my old school, we had a re-entry meeting with the student and parent about triggers and how we can help them adjust back into school. At my new school this year, I have implemented that but there is no set protocol or documentation for re-entry.
	Our district policies are more informal. Staff members are told to hold a meeting when the student gets back and whoever is in charge identifies who should be a part of the meeting. Any kind of services or accommodations usually depend on the situation, but the most popular seems to be CICO.

	The hospital notifies the school sometimes. If the school is notified, it is not always in time to schedule a meeting with the guardian and the student. However, if I do know, I request a re-entry meeting with the guardian and student to address any needs and review the discharge documents together. We then address any follow-up needs or establish communication with the therapist providing continued care, or I offer School Based Mental Health if no continued care is in place. There is no formal procedure to back up my request to address student needs upon the child's re-entry.
	The student returns to school. If the hospital sends documentation of any diagnosis or recommendations, the school meets with parents to discuss transition and implementation.
	I ask teachers to work with the student as we make their transition back to school as smooth as possible.
	Honestly it would depend upon me. I would make it happen. There really aren't any.
	Before being hired at my school, there wasn't a system in place for when students returned to school after a hospitalization. By the second month of school, I had already referred two students for evaluation and they stayed at a placement. Both the FRYSC and I quickly realized that there wasn't a system in place for when students returned. So, we worked with our family caretaker to identify when students returned to our setting and what support they had. We began to meet with students for weekly check-ins once they returned. Some had only 3 check ins, some continued their check-ins for several months. After Christmas, our district hired a Mental Health Coordinator who began to create new systems for our district. Although we know this is an area of concern, no formal system has been put in place.
	Action Plan created during Suicide Assessment
	We are supposed to hold a meeting with the treatment center, family, and educational staff/IEP team to determine a safety plan
	It depends on the school counselor. I typically, talk with the parents; obtain a discharge summary and look for any recommendations; I take a look at the safety plan, if there is one; inform the teachers about what needs to happen; and meet with the student the morning of their day back.
	Meeting with counselor and administrator; inform teachers of plan; regular check-ins with counselor
	Communicate with hospital as possible. Before reentry, we review the safety plan created by student while hospitalized. Meet with student upon morning of return. Follow up as decided or periodically to check on student.
	I request that the parent and student attend a re-entry meeting with myself, our district mental health coordinator, and one of the principals. The goal is to spend time reviewing any needed safety plans, discuss medication changes and what to look out for, talk about how to handle questions from students about the absence, and check in regarding follow-up services.
	Usually email from contact person at the hospital

	Note stating they were cleared to return. Re-entry meeting with parent and admin. Meet with student for safety planning.
	I recently completed a protocol for our schools in our district to use including information from the doctors and having a meeting with parents and student to help transition them back to school in a way that will support and encourage their continued growth.
	Check ins with student
	We hold a team meeting
	A lot of times students who have returned to school have not contacted the school nor have they come back with paperwork from the hospital. I have done re-entry meetings in the past at other schools and have tried to implement that at my current school.
	This is my first year to this particular district however from what I have learned there is not really a procedure to follow
	If we have notice of return of students and their absences was for a period of more than 2 weeks, we have a meeting with student and parent. We then discuss safety plans and get any releases signed.
	We loosely follow the protocols for reentry after home instruction or hospitalization for any other reason. We also evaluate the case to see if there are any special considerations. For example, a student might need to ease back into the classroom and attend for 1/2 days initially while building up to full days. They may also be exempted from certain long-term assignments or tests so that they can start fresh with a new topic/unit. Any grades obtained during the hospitalization are added into the average by the classroom teacher.
	Ask family for discharge summary and recommendations from facility for reentry. If applicable, and we find out before discharge, we ask facility to send grades, summary, recommendations, etc. we meet with student the day they return, evaluate, send email to teachers regarding any accommodations or advice, tell student we are available for them to visit as needed.

APPENDIX O: THEMATIC ANALYSIS – CODES, INITIAL THEMES, AND FINAL THEMES PER RESPONSE

Training Time Point		
Q12. What aspects of the training do you believe benefit your work as a school counselor?		
Codes per response	Initial Themes	Final Themes
Clear process and documentation Detailed questions on form Helpful case example Specific protocol and form Beneficial form Demonstration of the process All helpful Organized process with lots of considerations Clear roadmap to a positive reentry Organized steps Structured plan Staying on track for different student cases Beneficial for those at many schools Detailed documentation Lots of considerations in the reentry guide Addresses beyond safety assessment Specific and proactive for reentry Importance placed on the student and family's needs Organized, formal plan and documentation Increases mental wellbeing Detailed process Alleviates negative crisis interactions	Clear, Concise, and Detail-oriented Beneficial Walk Throughs and Potential Impacts Various Considerations for Support	Comprehensible Guide Step-by-Step Process Inclusivity
Q13. What aspects of the training do you believe are not beneficial to your work as a school counselor?		
Codes per response	Initial Themes	Final Themes
Detailed plans resulting in less confidentiality Navigating subpoenas Reliance on outpatient services Outside resources are at capacity Understaffed schools Hospitals at capacity	Information Accessibility Concerns Unavailability of Outside Resources Training Time Constraints	Confidentiality Concerns Referral Concerns School and Individual Barriers

Inaccessible communication with medical personnel Lack of notice for return Time constraints Time constraints Change unwelcomed	Reluctance of Change	
Q14 What questions do you still have about the Learning to Be STRATEGIC Training and the student reentry process following psychiatric hospitalization?		
Codes per response	Initial Themes	Final Themes
Informing unauthorized staff involved Consistency across all hospitalizations Complex accommodations process Follow-up on outside care Steps for no ROI Effectiveness of training Implementation in different schools Storing and access to records Different school/district specifications and processes	Correspondence and Confidentiality Concerns Procedural Demands of Different Settings	Student's Right to Privacy District, School, and Hospital Protocol Variations
Time Point 3 (One-Week Post Training)		
Q3. In what ways has the training impacted your work as a school counselor?		
Codes per response	Initial Themes	Final Themes
Increased feelings of comfortability and competence Structure of steps Variety of considerations based on students' needs Confirmed the school counselor's role and self-efficacy Clear method with documentation Beneficial to the students Clearer depiction of roles Reminder of considerations Addresses deficiencies Crisis management Organization in the chaos Documentation or record keeping Prepared responses Increased organization Expanding skill sets Increased organization Better perception of required skills Student-focused Increased feelings of comfortability	Greater Confidence in the Process and Role as School Counselor Formal Reentry Records Detailed Outlines of Action Plans Addressing Student Needs and Assistance Increased Training Recall	Improved Self-Efficacy and Competence Evidence of Documentation Coordination of Services Promoting Student Welfare Knowledge Retention

Addresses different school counseling Uses intervention levels Supporting student's wellbeing Increased feelings of self-efficacy and competency Prepared measures Plan of action Better planning Increased organization Contributing more to schools Supporting student wellbeing Increased feeling of comfortability Solidifying the school counselor's role Memorable acronym Step by step process Memorable training components and steps Memorable acronym Formal documentation Supporting student wellbeing Increased feeling of comfortability and preparedness		
Q4. What do you still want to know about the student reentry process following psychiatric hospitalization?		
Codes per response	Initial Themes	Final Themes
Creating caregiver buy-in Challenging state legislation District level buy-in Sharing information with unauthorized Staff involved Repairing rifts of negative reentry experiences Understaffed schools Correspondence with outside professionals Maintaining confidentiality with detailed records Navigating rehospitalization District level buy-in Desire for more case scenarios School and district level buy-in Varying mental health beliefs Caregiver buy-in Consistency across all hospitalizations	Caregiver, School, and District Considerations Confidentiality Concerns Referral Concerns Age Specific Interventions	Legal and Ethical Considerations School and Individual Considerations Developmental Considerations

Age differences Age or level differences Time constraints Splitting time between schools Consistency across all hospitalizations Caregiver buy-in, school buy-in, district level buy-in		