A Quick Guide

to the

Partnership for Successful Transitions

between schools, communities, and inpatient behavioral health programs

A TST BOCES Initiative

2022 Revision

Introduction to the Partnership for Successful Transitions (PST)

You are likely reading this guide because you are helping to transition a young person between a school and an inpatient mental health program. Whether you are a parent, youth, educator, hospital provider or community provider, the PST is a model that can increase the likelihood of a successful transition back to the school and community. Hopefully, this brief guide will help you understand how the partnership works and your role in the process.

What is the Partnership for Successful Transitions?

When a young person is experiencing a mental health crisis it can be challenging for everyone to communicate effectively. The PST is a model that focuses on building trusting relationships, shared understanding and interlocking best practices. First developed about ten years ago by a group of over one hundred educators, human service agency professionals, hospital providers and youth and parents, the PST was designed to increase the quality of transitions between schools and hospitals. The following **Statement of Shared Understanding** guides the work of the PST:

Who Makes Up the PST?

Anyone who is involved in supporting children and youth as they move into and out of inpatient care for mental health within TST BOCES region are invited to be part of the PST. Every school has a liaison to the PST and our regional hospitals are aware of the model and how we work together.

How does the PST Work?

The PST comes to life when a **PST Team** is formed to uphold the values of the partnership for each child or youth as they experience a hospital admission and transition back to their school community. The purpose of a PST Team is to encourage open communication, collaboration, and common understanding between all team members.

Who is on a PST Team?

PST Teams are made up of the child or youth and parents/caretakers, a representative from the hospital where the child is receiving care, school liaisons, school nurses, primary care providers, mental health providers and representatives from any human service agencies that will support the child or youth through the transition.

The PST Team Map

A PST Map can be created when a team is comes together to offer a visual image of the student's support network. The map includes all of the people that are currently supporting or working with the child or youth. The PST Team Map visually reminds everyone on the team that "we're in this together" and that the success of the youth and family remain the center of everyone's attention. A copy of a PST Team Map is included in this guide.

Who initiates a PST Team?

A PST Team can be started by any person who is part of the child's present support network and/or will be involved in their care during or after the admission. The team is convened by contacting all of the people who are currently supporting the child, sharing information about the PST Model and inviting them to be part of the team. The team works together throughout the admission and supports the transition back to the school and community.

What are the Guides to Best Practice?

Three interlocking checklists guide the transition process. There is one for schools; one for hospitals; and one for families. Copies of these guides are found in the following pages.

In Summary

We hope that this brief introduction to the Partnership for Successful Transitions can support you as you work together to support the youth in our region. Copies of this guide can be found both on the Tstboces.org and the CollaborativeSolutionsNetwork.org websites.

Partnership for Successful Transitions

Return to School Meeting Template

1. Students Name: Date:
2. Partnership for Successful Transitions Team Members present:
3. Student's current strengths:
4. Student's current supports and services (include counseling, medications, other community supports):
5. Current Family supports:
6. Any new community supports needed for student or family?:
7. Review of Safety Plan:
8. Plan for first day back (include schedule, check-ins with supportive adults, how to handle questions about absence, etc..)
9. Plan for missing work/absence from class:
10. Ongoing plan for support during the day/week (who, how often, how to access)
11. Family support and communication plan:

Partnership for Successful Transitions Team Map

Other resources or supports (pets, sports, creative arts, other programs):

Partnership for Successful Transitions

Best Practice Guidelines for Schools

When the school becomes aware that a student is being admitted to a facility

- ☐ Parent/guardian is oriented to the PST Team model via verbal and written information
- ☐ Members of PST Team are identified (School liaison, a school administrator, school nurse, parents, community providers, primary care physician, hospital, etc.)
- ☐ Two-way releases of information are obtained from parent/guardian for all PST team members as soon as possible
- ☐ PST Team Map is developed with youth and family input and shared with team members
- ☐ School liaison informs caretaker /parent about family support resources in the region (NAMI, Families Together of NYS, Tompkins County Mental Health, SPOA, etc.)
- ☐ With parent permission, School PST Liaison contacts the hospital within one day of knowledge of admission and assures that releases are signed
- ☐ Academic records/IEP/relevant school information and school assignments are sent to the hospital within one school day of knowledge of the admission
- ☐ PST liaison and hospital representative agree to frequent communication during admission

Return to School/Community from short-term hospital admission

- ☐ Encourage the youth and family to consult with their county's SPOA Coordinator
- ☐ Meets with youth and parents to explore a plan for transition back to school using the Return to School Meeting Template

- ☐ Reaches out to hospital to discuss discharge plan and requests specific recommendations about strengths and challenges during admission and specific recommendations for the transition back to school
- ☐ Attends discharge planning meeting if possible
- ☐ Encourages the use of the PST Back to School Meeting Template
- ☐ Reviews discharge plan, safety plan and recommendations
- ☐ Develops specific plans for return to school with youth and family
- ☐ PST Team adds any new service providers or supports on the team
- ☐ Two-way releases obtained for new PST team members

Partnership for Successful Transitions

Guidelines for Parents and Caregivers

This simple checklist was developed by parents who have been in your shoes. You are not alone! Both you and your child need and deserve support during and after your experiences with an inpatient mental health program. We hope this checklist guides you to the people and resources who provide the kinds of support you would find helpful.

When your child is admitted to an inpatient mental health program

- ☐ Alert a trusted adult at your child's school. You will be connected to your school's Partnership for Successful Transitions Liaison, who will help to support you and your child.
- ☐ Sign releases of information for your child's pediatrician and other providers, and for your child's school and the inpatient program.
- ☐ Work with your PST Liaison to decide who should be on your child's PST Team. Typically, this will be you, your child, your PST liaison, and other people who are providing support to your child. Your child's PST Team will uphold shared values that support confidentiality and collaborative, family-driven care.

While your child is hospitalized

- ☐ Seek support and guidance for yourself from trusted friends or relatives, or a peer parent partner (National Alliance on Mental Illness, 607-273-2462, or the Mental Health Association of Tompkins County, 607-273-9250).

- ☐ If you don’t have a therapist for yourself, consider finding one to get some mental health support for yourself.
- ☐ If your child has a therapist, tell them your child has been hospitalized and ask how they want to be involved.
- ☐ If your child doesn’t have a therapist, tell the inpatient program what kind of mental health care you prefer for your child. They will arrange for your child to be seen within 5 days of when your child is discharged.
- ☐ Consider talking with your county’s SPOA (Single Point of Access) Coordinator to get suggestions about which community resources may be helpful to you or your child.
- ☐ If medication is part of your child’s treatment, ask the inpatient program how to manage ongoing prescriptions.
- ☐ To prepare for your child’s return to school, encourage your child to share any concerns they have about school. If they offer, it can be helpful to know if they’re worried about falling behind, being around certain people, or concerned about what to say about why they’ve been absent.

As you plan for your child’s discharge from the inpatient program ——————

- ☐ Seek support and guidance for yourself from trusted friends or relatives, or a peer parent partner (National Alliance on Mental Illness, 607-273-2462, or the Mental Health Association of Tompkins County, 607-273-9250).
- ☐ If you don’t have a therapist for yourself, consider finding one to get some mental health support for yourself.
- ☐ If your child has a therapist, tell them your child has been hospitalized and ask how they want to be involved.
- ☐ If your child doesn’t have a therapist, tell the inpatient program what kind of mental health care you prefer for your child. They will arrange for your child to be seen within 5 days of when your child is discharged.
- ☐ Consider talking with your county’s SPOA (Single Point of Access) Coordinator to get suggestions about which community resources may be helpful to you or your child.
- ☐ If medication is part of your child’s treatment, ask the inpatient program how to manage ongoing prescriptions.
- ☐ To prepare for your child’s return to school, encourage your child to share any concerns they have about school. If they offer, it can be helpful to know if they’re worried about falling behind, being around certain people, or concerned about what to say about why they’ve been absent.

Who’s Who ——————————————————————————

- ☐ **PST (Partnership for Successful Transitions) Liaison** – The person at your child’s school who will coordinate school-related matters and provide other kinds of support during your child’s admission and while they transition back to school.

- ☐ **Hospital social worker** – Your primary point of contact at the inpatient program. They will contact you with updates, request information, and share your concerns and questions with your child's treatment team.
- ☐ **Hospital psychiatrist** – The doctor who leads your child's treatment team. They will assess your child's mental health, make a treatment plan, and possibly prescribe medication.
- ☐ **Hospital treatment team** – The social worker, hospital psychiatrist, inpatient teacher, recreational therapist, and others who work together to assess your child's mental health, make plans to help address the concerns, and monitor progress.
- ☐ **Outpatient therapist** – Your child's therapist if they already have one, or the mental health care provider who will be scheduled to see your child after they leave the inpatient program.
- ☐ **SPOA (Single Point of Access) Coordinator** - The person who can help you find the mental health services and resources that you or your child would find helpful.
- ☐ The TST regional SPOA coordinators are:

  Tompkins County: Sally Manning (607) 592-0992
  Seneca County: Bob Ritter: (315) 539-1752
  Tioga County: Wendy Arnold (607) 689-8161

Partnership for Successful Transitions

Best Practice Guidelines for Hospitals

When a student is being admitted to Inpatient Care

- ☐ Partnership for Successful Transitions (PST) Guidelines are reviewed
- ☐ Members of PST Team are identified using the PST Team Map, including the PST School Liaison
- ☐ Two-way releases of information obtained from parent/guardian for school and community providers
- ☐ Contact is made with all team members to assure continuity of care
- ☐ Hospital liaison assures that parent has adequate support or a peer support person (NAMI, Tompkins County Mental Health, Families Together of NYS)
- ☐ Parent/Guardian/Youth are given a family friendly document that outlines what to expect during admission and discharge
- ☐ Hospital contacts school PST Team liaison within one business day of admission
- ☐ Academic records/IEP/relevant school info requested within one day of admission

Discharge from hospital admission

- ☐ New referrals/providers added to the PST Team if indicated
- ☐ Youth and family are encouraged to consult with their county's SPOA Coordinator
- ☐ School and other members of the PST Team are contacted to share anticipated discharge and to begin to discuss transition plan

☐ PST Team members, including a school representative, are invited to attend the discharge planning meeting with parent/guardian permission. The meeting is guided by the PST Return to School Meeting Template.

- ☐ Information is shared with the PST Team about strengths and challenges observed during admission and specific recommendations for discharge (both academic and social emotional)
- ☐ A follow up appointment with community mental health provider is set up for within 5 days of discharge
- ☐ Check to see if the parents/caregivers have the support they need for themselves
- ☐ PST Team explores ways to ease the transition back to the home, school and community (school schedule changes, peer support, scripts for what to tell school staff and peers, referrals to new community resources, etc.)

☐ A copy of basic discharge plan, safety plan and contact information is given to the parent/guardian and the school liaison on the day of discharge with parent permission

☐