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**Children's Reentry To School After Psychiatric Hospitalization: A Qualitative Study**

Madeline Digiovanni

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CHILDREN’S REENTRY TO SCHOOL AFTER PSYCHIATRIC HOSPITALIZATION: A QUALITATIVE STUDY

A Thesis Submitted to the Yale University School of Medicine in Partial Fulfillment of the Requirements for the Degree of Doctor of Medicine

By

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2024
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Abstract

School reentry after inpatient psychiatric hospitalization requires careful coordination between multiple stakeholders to ensure stability across transitions, given the documented potential for negative academic and socioemotional impacts in the post-discharge period. Existing studies of lived experiences of school reentry after psychiatric hospitalization are limited, and no study examines the perspectives of multiple stakeholders from the child’s home, school, and psychiatric experiences simultaneously. This study aims to characterize the dynamics between children and adults in the transition process, to better inform future school-hospital-family partnerships. We conducted a qualitative study based on semi-structured interviews, and utilizing purposive recruitment to assess a spectrum of educational experiences. For each child interviewed, we recruited adults from home, school, and the hospital. Individual interviews occurred via video teleconferencing, with concurrent data analysis toward a grounded theory born of thematic analysis. Across 16 interviews, we analyzed perspectives from 17 related participants (three quartets and one quintet): four children, four parents, five school staff, and four hospital staff. Student profiles include first-time vs multiple admissions and the presence or absence of adequate special education services. We identified four key themes in service of an overarching grounded theory: 1) Centering the socioemotional role of school; 2) Clarifying what constitutes good communication; 3) Reconciling multiple sources of authority; and 4) Navigating limitations with creativity. Together, these themes converge into the theoretical concepts of stereovision and patchworking. Stereovision represents the synthesis of multiple
stakeholder perspectives or “lines of sight,” which cross to create a densely interactional system. When represented schematically, the crossed perspectives appear similar to threads in a fabric, a fitting metaphor for the safety net woven by teams to support a child in transition. *Patchworking* represents the creative problem-solving and makeshift pathways utilized by participants, the cobbling together of case-by-case solutions to develop an adequate support plan in the face of multiple limitations or barriers. In conclusion, by incorporating the above four thematic findings into a novel grounded theory, we argue that when navigating school reentry after psychiatric hospitalization, children and adults must use stereovision and patchworking to create a strong, flexible support fabric. These reflections increase representation of child and adult stakeholder voices in the literature and inform future school-hospital-family partnerships for school reentry after psychiatric hospitalization.
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Above all, this thesis represents the lived experiences and generous reflection of 17 participants: Thank you for your time, energy, candor, and wisdom.

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**Introduction**

When youth mental health problems are severe enough to warrant inpatient hospitalization, educational attainment suffers\(^1\,^2\). Studies of adolescents across countries demonstrate that inpatient psychiatric admission during the teenage years is associated with lower likelihood of graduating from secondary school or pursuing post-secondary schooling compared to peers without psychiatric hospitalization\(^1\,^2\). Unfortunately, the negative impact of psychiatric needs on education is neither uncommon nor limited to adolescents alone. In the United States, nearly 10% of all hospitalizations in patients between 3 and 20 years of age are for primary mental health diagnoses\(^3\), and an estimated 12-30% of all school-aged children experience mental health needs significant enough to interfere with educational progress, according to a meta-analysis of socioemotional factors affecting academic outcomes\(^4\).

A particularly challenging aspect of the interaction between children’s mental health and educational progress is reentering the school environment after hospital discharge, which poses challenges for youths and their adult supporters alike\(^5\). Unfortunately, the literature base exploring how to improve these transition experiences is relatively nascent, with most foundational papers appearing only in the past two decades (e.g., Simon and Savina 2005 onward) and limited evidence-based recommendations for school reentry programs\(^6\,^7\).

**School-Mental Health Interactions**

Evaluating the school reentry process after psychiatric hospitalization is part of a broader recognition of the significant interaction between the educational and children’s
mental health systems. Schools serve as major providers or entry points for mental health services in pediatric populations\textsuperscript{8–10}; by some estimates, more than half of youth receiving mental health services first do so through the education sector\textsuperscript{10}. Schools also provide opportunities for general mental health promotion, with ongoing research into evidence-based mental health programming that takes place during the school day\textsuperscript{11–13}.

Students with higher mental health needs experience unique school-specific challenges. For example, students with emotional/behavioral disabilities (EBD) demonstrate lower academic achievement over time, not only relative to peers without disabilities, but also relative to peers with non-EBD disabilities\textsuperscript{14}. In the above study, EBD is defined as disorders associated with an “inability to learn that could not be explained by intellectual, sensory, or health factors,” such as children displaying “emotional/behavioral impairments such as an inability to build or maintain satisfactory interpersonal relationships, depression, or tendency to develop physical symptoms or fears”\textsuperscript{14}. Similar negative educational impacts are found in studies of individuals with psychiatric diagnoses that are not explicitly classified as EBD\textsuperscript{15}.

Academic difficulties for students with mental health needs partially stem from disrupted school attendance, which negatively impacts academic achievement\textsuperscript{16}. For example, specific to students with EBD, existing research illustrates attendance problems and academic deficits in multiple domains at the elementary and secondary school levels, both for such children in self-contained settings\textsuperscript{17} and generally\textsuperscript{18,19}. One contributor to school absences for students with EBD is inpatient psychiatric hospitalization, which removes a child from their typical school environment for multiple days at minimum and may or may not return the child to the original setting. Absences due to mental health
treatment demonstrate negative impact in both prolonged absences, such as in residential programs, as well as shorter absences, such as in acute inpatient psychiatric hospitalization\textsuperscript{20,21}.

**Focusing on the Reentry Experience**

The school reentry transition is a particularly suitable point at which to provide targeted support not only because of the importance of protecting educational achievement, but also because of the significant psychiatric vulnerability of the post-discharge period. After a psychiatric hospitalization, students struggle to readjust\textsuperscript{22}. Even with the majority of children receiving aftercare mental health services, the readmission rate at the six-month mark is nearly one third\textsuperscript{23}, with the risk of readmission highest within the first 90 days\textsuperscript{24}. Moreover, psychiatric admission lengths have become increasingly shorter, with average length of stay decreasing to less than a week\textsuperscript{25}. Shorter admissions do not necessarily indicate faster readiness for discharge, as school reentry readiness is not always part of discharge criteria, and students’ mental health may suffer despite no longer meeting acuity criteria for inpatient hospitalization\textsuperscript{26,27}.

Consequently, given that hospitalization itself and the post-discharge period are fraught with opportunities for negative impacts to both academic and psychological well-being, ensuring adequate support during the school reentry transition is paramount in promoting a child’s success after an acute mental health event. Existing literature exploring this process stems mainly from investigations of non-psychiatric hospitalizations, such as for students with brain injury, chronic illness, and cancer\textsuperscript{28–30}. Such studies emphasize staff collaboration, illness education, and incorporation of
school-based professionals in managing transitions, such as guidance counselors and school psychologists\textsuperscript{31-35}.

Regarding mental health, recent research has attempted to clarify the school reentry recommendations specific to psychiatric hospitalization. Conducting investigations specific to mental health concerns is critical because psychiatric hospitalization engenders unique challenges compared to hospitalization for physical illness. As described above, mental illness is associated with unique intersections between academics and well-being, with differing outcomes between youth with psychiatric and non-psychiatric disabilities. Adapting to life after treatment also poses challenges: Children must transfer treatment gains from the hospital environment to the home, school, and community, all while meeting newly-adjusted academic and socioemotional demands\textsuperscript{36}. Moreover, mental illness carries significant stigma, which creates a barrier to seeking support for mental health in school settings\textsuperscript{37,38}. Adapting literature and recommendations based on hospitalizations for physical illness is therefore insufficient to support the school reentry transition for psychiatric hospitalization.

**Review of Existing Literature**

Existing explorations of mental health-related school reentry experiences are few in number, particularly for qualitative approaches, though researchers have begun broadening the participant base to include stakeholder commentary in addition to children’s perspectives. Several papers explore the qualitative reflections of students, focusing mainly on adolescents, with mean participant age in the teenage years\textsuperscript{39-46}. Additional qualitative studies have separately explored the perspectives of caregivers\textsuperscript{47,48},
mentally healthcare providers\textsuperscript{49,50}, special educators\textsuperscript{51}, and school psychologists\textsuperscript{52,53}, reflecting the involvement of multiple kinds of adult stakeholders in a child’s school reentry experience.

\textit{Qualitative Perspectives}

Within these studies, students describe what works and does not work regarding school reentry, often touching on educational, social, and team-based dynamics. In multiple studies, students note that challenges are made more difficult by continuation of the same mental health symptoms that contributed to the preceding crisis, at times with the addition of new stressors\textsuperscript{40,44,45}, a finding corroborated in studies of the mental health providers assisting students with school reentry\textsuperscript{50}. These ongoing difficulties contribute to the vulnerability of the post-discharge period and makes the school reentry process a particularly important one to assess carefully.

Within school-related thematic findings, students frequently highlight stressors. Common themes include feeling panicked about catching up on missed work, feeling academically behind, and feeling disconnected from learning and teachers\textsuperscript{39,40,42,44–46}. These reflections are also corroborated in studies of caregiver and mental health provider reports\textsuperscript{47,50}. Students describe school staff as ill-equipped to navigate conversations about psychiatric hospitalization\textsuperscript{39}. Regarding special education, some students express ambivalence about whether their pre-hospital supports were efficacious or not, leaving room for improvements in the implementation of special education accommodations\textsuperscript{39}. Frequently mentioned accommodations include schedule changes, excused work, and dedicated catch-up periods\textsuperscript{39,40,42,46}.
Within the social-related thematic findings, feelings of connectedness tend to be slightly more positive, though still accompanied by significant worry. Several studies note impaired social connection with peers before and after hospitalization; another study describes improved connectedness due to enhanced social support; and yet another illustrates varying experiences. Across the board, students report intense concern about what peers will say about their absence and how to tackle sensitive conversations about their hospitalization. Adult providers similarly note students’ preoccupation with how to handle peer conversations.

Within the team-related thematic findings, students and adult stakeholders comment on which dynamics are helpful rather than frustrating. For students, reentry stakeholders at school are predominantly guidance counselors and social workers, which are both viewed as positive supports. Guidance from these adults contributes to a better sense of personal growth and development. Students also describe the comfort in having a plan, a finding also noted by school-based psychologists, though some students wish for a more active role in determining next steps rather than defaulting to parents as decision-makers. Unfortunately, planning also figures as a stressor in multiple reports: More often than not, schools have no standardized teams or processes to support either the students or the adult stakeholders through the transitions.

Another commonly-mentioned team dynamic across thematic studies is the importance of communication and collaboration, both from students’ perspectives, as well as mental health providers in and out of schools, special educators, and caregivers. Collaboration between schools and hospitals tends to take place prior to discharge, and parents report mixed satisfaction with this process, wishing for schools
to be proactive and for their voices to be heard more consistently throughout the process\textsuperscript{47,54}, as well as for school-hospital communication to be smoother\textsuperscript{48}.

**Assessment of Existing Programs**

To address the concerns noted above and capitalize on the positive aspects of student and stakeholder experiences, various school reentry programs attempt to meet competing demands. Tougas et al. conducted a review of existing programs, finding 13 unique reports describing eight programs, with core components consisting of multidisciplinary teams, multicomponent interventions, an established reintegration plan, gradual transitions, frequent contact for extended support\textsuperscript{7}. Despite a general consensus on most helpful core components, few papers contribute to an evidence base for future implementation: The authors found primary research articles for only three of the eight programs, and only two programs specifically target reentry into school. First, the School Transition Program (STP) centers family support and school coordination, featuring a family connector, a school-based transition specialist, and frequent connection, communication, and reflection for students facilitated by adults\textsuperscript{47,55}. Second, Bridging Resilient Youth in Transition (BRYT) incorporates a dedicated transition classroom space within the school, extra adult support including clinical guidance, flexibility within a structured plan, and support and resources for both the child and the family\textsuperscript{56}. Unfortunately, Tougas et al. determined that the quality of evidence supporting either intervention was of insufficient rigor, and further well-designed studies are needed to determine quality standards for reentry programs\textsuperscript{7}. 
Savina, Simon, and Lester conducted the first synthesis of preliminary school reentry literature, achieving a major milestone by outlining the application of Bronfenbrenner’s 1979 bioecological theory to school reentry after psychiatric hospitalization. Briefly, bioecological theory frames individuals within environments in terms of the ontosystem (the developing youths themselves), their microsystems (the developing person and their patterns within a given setting, such as home or school), mesosystems (the interrelations between microsystems, such as playing with friends at school and at home), exosystems (settings adjacent to but not including the participant, such as a local school board), and macrosystems (overarching organization of a culture, such as differing school systems across countries).

Tougas et al. later extended this initial theoretical framing by conducting a systematic review of 14 qualitative, quantitative, or mixed-methods studies investigating the school reentry process after psychiatric hospitalization. Recurrent thematic findings were organized into problems and needs within the various bioecological levels: For example, on the macrosystem level, a commonly reported problem across studies was stigma against mental illness, with the corresponding needs identified as acknowledgement and legitimacy. The review encompassed the three microsystems of school, family, and hospital, with the corresponding mesosystem dyads of family-hospital, school-hospital, and family-school. Across these bioecological levels, many of the identified problems incorporated elements of disenfranchisement, limited resources, and insufficient training or knowledge; the needs therefore reflected improved empowerment and involvement across stakeholders, additional resources, and
competency development. Within the “conceptual saturation” achieved by their systematic review, Tougas et al stress the importance of “communication, coordination, and collaboration” and also call for further investigation of the topic, due to the wide variety of quality and specificity of the articles included in the review.

**Statement of Purpose**

The studies above provide valuable, in-depth reports about attitudes and experiences for each type of stakeholder, as well as recommendations for improvement in the school-hospital transition. They do not, however, represent the interplay between children and adult stakeholders, as each of the above studies surveys only one type of character per investigation. Tougas et al.’s systematic review situates findings within theory, but remains a second-hand accounting of studies from disparate timepoints, populations, and reentry events. To our knowledge, there is therefore currently no work exploring school reintegration after psychiatric hospitalization from the perspectives of the child and adult stakeholders simultaneously, assessing the same reentry experience from multiple lenses, with a theoretical underpinning. To accomplish this, we conducted an in-depth analysis of perspectives from children, parents, school staff, and hospital staff regarding the same hospitalization and reentry events.

The design of this thesis study answers calls to action from both Savina, Simon, and Lester’s landmark overview and Tougas et al.’s systematic review. Savina, Simon, and Lester note the challenges of studying a phenomenon that is high acuity but relatively low incidence with potential for “diffusion of responsibility” across multiple stakeholders, recommending that future studies of school reentry should “either access
large numbers of children in the hospital setting or provide in-depth investigation into the entire transition for a small number of children.” This thesis does the latter. Tougas et al. note that the studies included in their review reflect long latency between the school reentry experience and the timepoint of assessment, focus on adolescents, and reflect highly variable quality of analysis and reporting. This design of this thesis study addresses those concerns, in addition to the “inclusion of different stakeholders’ point of view” advocated for as one of the “promising avenues to take into consideration.” Consequently, the purpose of this study is to supplement and strengthen existing literature by directly responding to several areas of improvement requested in prior research.

**Methods**

**Student Contributions**

As thesis author, I: conceptualized the project, conducted the initial literature search, applied for and received funding from the Office of Student Research, wrote the protocol and accompanying documents for IRB approval, received necessary permissions for use of electronic medical records for research, coordinated with faculty sponsor and additional contributors for recruitment, consented participants, conducted all interviews, transcribed by hand and coded all transcripts, trained two student coders in assisting with data analysis, led coding meetings, presented work at a research collaborative and incorporated feedback, presented preliminary findings at relevant professional conferences, and wrote the thesis manuscript. The faculty sponsor (AM) and another contributor (MG) were primarily responsible for participant identification and initial
recruitment, as well as manuscript review. Two student coders (ECS and AA) coded all transcripts and participated in all coding meetings. An additional contributor (LB) contributed qualitative methodological support, in conjunction with the QUA-Lab, a qualitative and mixed-methods lab for research in child and adolescent psychiatry.

**Ethics Statement**

This study adhered to the ethical guidelines of the Yale Institutional Review Board, in accordance with the human subjects research requirements outlined below. Participants were advised of potential risks to participant comfort (i.e., feeling emotional distress from discussing sensitive or upsetting experiences regarding their hospitalization or mental health) and confidentiality (i.e., possibility of breach of data privacy). To protect participant comfort, participants were informed that participation was optional and could be terminated at any time without negative consequence to the participant, and that all interview questions were optional. The interview guide was flexibly adapted in each interview to participant comfort or desire to elaborate on certain topics. To protect participant confidentiality, all recruitment and audio files were stored on a university-approved, HIPAA-compliant Box file storage platform, along with de-identified transcripts; video files were deleted and not utilized for analysis. To further protect confidentiality, I manually transcribed and de-identified all audio files. Only de-identified transcripts were shared with other members of the research team.
**Human Subjects Research**

This study received approval from the Yale Institutional Review Board (2000033621). Written informed consent was waived for this study, although the thesis author did collect written consent from parents to contact additional members of the child’s care team, i.e., hospital staff and school staff. Verbal informed consent was attained for all adult participants. Given the inclusion of minors in this study, the study protocol received approval for expedited review, and verbal informed assent was attained for child participants. All participants received a written information sheet regarding the study. The IRB additionally granted a waiver of HIPAA authorization for access to and use of protected health information (PHI) as described in the study protocol for recruitment, as well as a waiver of HIPAA authorization for verbal authorization for use of PHI for the entire study.

**Setting**

This study took place at the Children’s Psychiatric Inpatient Service (CPIS) at Yale-New Haven Hospital (YNHH), which possesses unique clinical features that make it an ideal setting for this study. Namely, the CPIS is the only facility in the state to contain a state-accredited special education classroom. The classroom is situated between the locked clinical unit and the clinician offices, creating a middle ground within the CPIS spaces for clinical and administrative functions. School staff includes a school principal, a school teacher, and a classroom aide. Children on CPIS attend an hour of class each day, divided into a younger and older group according to the unit roster at the time. Children are accompanied to and from the classroom space and locked unit by staff.
members. Participation in school hours adapts to each child’s needs on a given day and may intersect with clinical care, reflecting flexibility between the unit and classroom. The curriculum provides approximate grade-level work to each group, using materials that emphasize engagement rather than specific academic achievement goals. A child’s participation in the unit school is funded by the hospital for 10 school days (i.e., two academic weeks), after which point a child’s original school district becomes responsible for paying tuition for the out-of-district placement.

**Participant Recruitment**

Participant eligibility for this study included: 1) admission to the CPIS; 2) Ages 6-14 years old; 3) enrollment in local public school; and 4) return to the same school environment after discharge. We purposively sampled for a range of admission types and school supports: children with first-time admission versus repeat admissions, and children with varying levels of special education services at school prior to the current admission. For each child participant, we aimed to recruit at least one parent or adult guardian, one school official familiar with the child’s educational trajectory, and one hospital clinician familiar with the child’s admission trajectory, resulting in *stakeholder quartets*. Recruitment procedures aligned with qualitative methodology: Grounded theory emphasizes theoretical sampling, i.e., adjusting the data collection process to pursue developing hypotheses and choosing subjects deliberately for their potential to contribute to or challenge your developing theory\(^58\).

During the course of a child’s admission on the inpatient unit, two authors (AM and MG) purposively sampled for children and families who fit the eligibility criteria and
invited them to participate in the study after discharge. The consent process emphasized that participation in the study had no bearing on clinical care during or after the current admission, and participation of one stakeholder was not contingent upon participation of any others within the recruitment quartet. Eligible candidates provided verbal consent for participation via phone with one author (MD), with parents providing either a verbal referral to a specific staff members or written consent via email for unit staff to determine a suitable candidate. Parents additionally provided written consent for their child to participate and for the study team to contact school and hospital officials. All participants consented to digital recording of the interview session.

**Procedure**

At a time of each participant’s choosing, MD conducted individual semi-structured interviews using the university-approved, HIPAA-compliant Zoom videoconferencing platform. A list of guiding interview questions developed by the study authors is provided in **Appendix 1**. Audio files were maintained for transcription; video files were deleted. All files were maintained in a university-approved, HIPAA-compliant Box file storage platform. Each participant received a $15 Amazon gift card in appreciation of their participation.

**Qualitative analysis**

MD transcribed digital audio files manually prior to analysis, and three authors (MD, ECS, AA) participated in data analysis aided by NVivo (2020 Release) software. Each author independently identified salient themes from the transcripts using a line-by-
line, inductive coding approach, with multiple coding meetings interspersed throughout data collection to help inform subsequent interviews. Through a series of coding meetings, three authors created the final coding framework, triangulated and verified by all three coders. The coding team additionally received support through two consults to the QUALab, a qualitative and mixed methods collaborative for child and adolescent psychiatry research, particularly in developing the grounded theory. Memos from coding meetings allowed the team to reach theoretical sufficiency prior to cessation of the interview period, reflecting a blend of theoretical saturation and inductive thematic saturation consistent with the methodology and framework described below. Participants did not preview transcripts or the final framework during analysis. Multiple quotes supported each code in the final framework, and study design and manuscript preparation followed best practice guidelines for qualitative research.

The final framework reflects a thematic analysis methodology, with data interpretation and framing informed by grounded theory. Despite existing literature demonstrating application of the bioecological framework to school reentry after psychiatric hospitalization, coding took particular care to identify themes independently through thematic analysis. Thematic analysis is a qualitative approach involving the active construction of overarching patterns and meaning across a dataset that encourages coders to “reframe, reinterpret, and/or connect elements of the data,” allowing for authentic, inductive analysis of the transcript material rather than relying on existing theoretical framework. Accordingly, in this thesis’s analysis, hypotheses were generated and tested as they were identified during the iterative data collection and analysis process.
Grounded theory is a flexible approach that aims to gather rich data in service of developing conceptual categories toward a new theoretical framework firmly rooted in the data itself rather than pre-existing theories. With its focus on “open-ended research questions that focus on processes, patterns and meaning within context and that require the crucial examination of subjectivity of experience,” grounded theory is well-suited for this study because it allows for construction of a bird's-eye view of the dynamics creating the school-hospital transition process through input from multiple stakeholders. In alignment with our inductive approach to thematic analysis, a grounded theory project does not begin with a specific hypothesis in mind, in order not to bias the data collection and interpretation in any particular direction, allowing the theory to form from “the ground up” as an interpretation of the events described in the interviews.

**Reflexivity**

All authors possess varying degrees of experience in mental health training, qualitative research, and educational roles, necessitating careful reflexivity throughout study development, data collection, and analysis. Reflexivity is particularly important for the three study coders: MD is a biracial female medical student with several years’ experience in qualitative methods, a career interest in child and adolescent psychiatry, and prior employment as a high school special education teacher; the latter detail was openly shared with participants when relevant. ECS is an Asian-American female medical student with introductory experience in qualitative methods, a career interest in emergency psychiatry, and prior employment experience with elementary school reading comprehension support. AA is a Black female medical student with an interest in child
and adolescent psychiatry, an academic background in organizational behavior, and personal experience with the topic through family members’ school reentry after psychiatric hospitalization. Triangulation and open conversation between all three interviewers helped to minimize bias or preconceived assumptions based prior experience.

Results

Four recruited groups participated in this study (three quartets and one quintet), for a total of four children, four parents, five school staff members, and four hospital staff members. Participant characteristics are shown in Table 1. Participant attrition occurred with only one family during the recruitment phase, due to ineligibility per inclusion criteria (did not return to original school placement after rehospitalization during the study period), leading to a total of 19 consenting participants with 17 completed and analyzed interviews. Final participants (n = 17) completed individual semi-structured interviews, with the exception of two school staff members who interviewed jointly to discuss the same case. The number of interviews is consistent with existing evidence examining sample size necessary to reach theoretical sufficiency. Interviews lasted approximately one hour each (n = 16, mean = 49 minutes, range = 31 to 70 minutes), with no repeat sessions, and all participants provided verbal consent for digital recording of the session. Length of time between discharge and interview averaged three weeks for child and parent participants and ranged from 2-14 weeks across all participants. All children attended and returned to their original public-school settings.
Table 1: Participant characteristics

**Quartet: Group 1**

C1  
- 13yo, transgender male  
- No special education services prior to admission  
- First admission (suicidal ideation)

P1  Mother

S1  Guidance counselor, female

H1  Unit school staff, female

**Quintet: Group 2**

C2  
- 12yo, cisgender female  
- 504 prior to admission, subsequent IEP evaluation  
- First admission (suicidal ideation, self-harm)

P2  Mother

S2a  Social worker, female

S2b  Guidance counselor, female

H2  Social worker, female

**Quartet: Group 3**

C3  
- 10yo, cisgender male  
- 504 escalated to IEP prior to admission  
- Repeat admission (behavior outburst, self-harm urges)

P3  Mother

S3  School psychologist, female

H3  Unit school staff, female
**Quartet: Group 4**

C4  
- 14yo, cisgender male  
- 504 prior to admission  
- Repeat admission (suicidal ideation)

P4  Mother

S4  Social worker, male

H4  Nursing staff, female

*C* = child, *P* = parent, *S* = school staff member, *H* = hospital staff member; *IEP* = *individualized educational program*, *i.e. a document outlining the special education services a child is legally required to receive in accordance with their individual needs*

**Theme 1: Centering the socioemotional role of school**

Rather than perceiving school as predominantly academic, child and adult stakeholders highlight developmental functioning, emphasizing school as a place for adults to help children develop into young adults. Disruption of a child’s schooling due to psychiatric hospitalization revealed reconceptualization of school’s responsibilities, emphasizing socioemotional development as primary rather than academic growth. **Table 2** includes representative quotes.

**Subtheme 1.1: Deprioritizing academics in the home school environment**

For participants, although school played a significant role in children’s mental health support and hospitalization experiences, academics were neither the primary
concern nor the primary target before or after hospitalization. Multiple participants commented that students “never had any kind of academic struggles” [P2], attributing challenges before, during, and after hospitalization “not to any learning stuff, but more the psychiatric component” [H3]. Schoolwork was not usually a concern except as a marker for overall functioning, with academic changes preceding the precipitating event for hospitalization: “Normally, it comes very easily to her – [she’s an] honors student, [but] she was failing four classes” [P1]. Post-hospitalization, academics did contribute to stress, with students fretting about catching up with missed assignments or feeling behind on lessons: “School-wise, I’ve been having, like, a hard time getting into, like, all this new schoolwork that I have to do” [C2].

Nonetheless, worries about catching up did not place academics as a priority after discharge from the hospital, even in the school environment. Instead, participants described academic work as a secondary task compared to well-being, which became the most important endpoint: “The academic’s easy. Make up work, have a schedule, you know, exempt it, whatever… you know, make it up slowly” [H1]. In schools, this focus manifested as increased accommodations to address socioemotional challenges despite resulting in a relatively less strenuous academic workload. For students without special education plans, teams initiated the evaluation process: “They started the PPT [planning and placement team] process, so now they’re testing her for like, everything-everything” [P2]. For students with existing IEPs or 504s, teams updated the plans to reflect more comprehensive supports in school: “We were concerned that the 504 plan was not sufficient enough to cover his level of need, so… we moved to evaluate him for special education” [S3]. Accommodations included extended time for assignments or schedule
changes to ease the stress of the school day, and some students required modifications, such as excusing entire assignments or completing the remainder of the term virtually within the same school community.

The relatively secondary status of academics also manifested in the types of support staff involved in the student’s transitions. Per all stakeholder types, classroom content teachers did not play a prominent role in the student’s hospitalization trajectory: “The teachers – they just stay in their classrooms, so they’re like… we’re not experiencing that side of him” [P4]. Content teachers appeared in school re-entry meetings and provided intermittent input on students’ functioning for special education meetings, particularly in team-based school systems, but the majority of a student’s contact with adults in the educational system went through guidance counselors, school psychologists, or social workers: “You just hope and cross your fingers that the social worker at the school will communicate that information to the teacher, to set that better plan up ahead” [H3]. Content teachers usually communicated with the families indirectly, such as through guidance counselors, and students reported that their content teachers were not particularly familiar with or involved in their mental health needs beyond what was stated in an IEP, although not all accommodations were followed: “Now that I think about it, [extended time] actually was a part of my plan… But… I never noticed it, because they would grade my stuff on the regular due date” [C4].

Students overall expressed relief about the academic leeway. In fact, many students appreciated not having to discuss their hospitalization with content teachers, since they identified the most significant adults in their school environment as the support teams rather than teachers: “I don’t really wanna talk about it with them, I guess…” [C1].
Students appreciated not having to worry about academics as they dealt with transitioning out of the hospital, but at times, the devaluation of academics became frustrating as students became more adapted to their post-hospitalization changes: “Like I get why they want to do it, but it’s difficult making – getting [to the counselor] three times a day… and also doing the thing where they try to figure out if I’m eligible for any of the, like, ways to help in education… So that takes about one period out of my day as well” [C2].

Subtheme 1.2 – Finding relief in the inpatient unit school setting

Relief about academic leeway elicited reflections on relative preferences for unit school versus normal school: “It’s a lot less academically driven, and a lot more therapeutically driven. I think that’s what [child] really preferred” [H3]. Students particularly appreciated the workload contrast with their typical schools, noting preference for the softer academic engagement, shorter time demand, and consistency: “The work is just easy and… not the work that we would be doing in regular school. Also, it’s only for one hour, and one classroom” [C4]. Simultaneously, students were clear that they did not want only easy work, but rather a better match between the intellectual challenge and the workload intensity: “A perfect school would… be like how my school is now, but just less stressful, less workload. Because at [unit school], you don’t really learn that much… it’s really easy” [C4]. Adult participants acknowledged the challenge of reducing academic stress while maintaining sufficient academic rigor in the unit school: “We do have a curriculum; we do want to meet academic needs… [but] the top-down is that social-emotional focus” [H1]. Consequently, both child and adult
participants valued decreasing academic challenges and centering socioemotional considerations, just with varying degrees of intensity.

Commentary on the benefits of unit school highlighted participants’ valuation of therapeutic supports in schools to support children with mental health needs, with the overall consensus that typical school structures would benefit from a more socioemotional approach, particularly from the perspective of hospital staff: “The emotional well-being of the children and of the teachers has to be paramount for things to move smoothly, for children to learn [and] be able to focus” [H1]. Unfortunately, typical school was not considered as deeply mental health-minded as unit school: “There’s a little bit of disconnect with the public-school setting… and not as much of a disconnect at [the unit school]” [H3]. Unit school offered a unique middle perspective between academic growth and therapeutic support, and participants hoped for a similar balance in their school systems at home: “How can we build in some flexibilities? And then how can we put in some social-emotional interventions? Even not having to go to the cafeteria can be a life-game-changer for a kiddo in middle school” [H1]. Symbolically, on the inpatient floor, the unit school physically occupied middle ground between the unit, the departmental offices, and the hospital exit.

*Subtheme 1.3 – Emphasizing adult guidance in regular school*

Comparison between public school and the specialized inpatient unit school raised questions about how or whether public schools can realistically offer similar therapeutic benefits. Participants expressed doubt that typical school settings could replicate such a therapeutic environment, noting that the unit school is an artificial environment that does
not recreate the real-world stressors present in students’ daily lives: “It’s a… little bubble of a womb where we just take care of everyone and meet you where you are… [But] the world, the school environment, the home environment, the community… [it’s] very, very different” [H1]. Consequently, even socioemotional adjustments listed in students’ return support plans were limited by the practicalities of public education, necessitating emphasis on skills development while in the hospital: “How can we teach you some skills that are going to help you when you go back to public school? This is good practice ground for you… to make it easier, better for you, when you leave here” [H1].

To develop the necessary skills in either inpatient or outpatient settings, participants commented on the importance of maintaining adult guidance to provide a regulating, processing function for children: “We always joke that if we could have every child here on the inpatient unit on a one-to-one, we would have a length of stay of like 72 hours” [H4]. Both child and adult participants framed adult guidance as critical for self-regulation and learning coping skills: “When those feelings emerge, what are more adaptive strategies that we can use?” [S2a]. Adult participants particularly valued their role in reframing challenges, enhancing communication skills, and providing validation and emotional warmth. School reentry plans frequently involved a higher degree of adult contact or supervision, such as daily guidance counselor check-ins: “I have to check in with guidance every day after—before and after school” [C1]. Thus, even though therapeutic modifications to school demands may not have been feasible for each team to replicate the unit school benefits, therapeutic accommodations remained accessible via adult action and presence in school.
The benefit of adults’ regulating function for children was particularly relevant for social situations, a frequent stressor for students in this study. Both child and adult participants expressed sensitivity to the social dynamics of school reentry, particularly the stigma of mental illness and how to discuss unexplained absences to their peers: “They were – [mumbling, whispering]… Well, I heard from so-and-so that he was like at the hospital… Who did you hear it from? And they’re like, a little birdy! I’m like, WHO’S THE LITTLE BIRDY?” [C3]. Students felt anxious about returning to their peers at school; consequently, teams frequently included reentry conversation planning during the discharge process, alongside other social supports to ease stressors from peers: “Let’s rehearse and let’s practice something… because that social transition is really, really hard for kids coming from the inpatient unit” [H1]. In this way, adults maintained their regulating function to support students through a fragile transition. At the same time as finding adult guidance soothing, however, students voiced the limitations of adult involvement, being acutely aware of the spotlighting effect of school aides or support modifications and not wanting to be even more visibly different from their peers: “You have to be with the para to do everything, you don’t really know anything… and no one’s with you, you’re all by yourself, you’re not popular, you have no power” [C3].

All students in this study did return to their original school placement, with no student moving to a therapeutic school placement. Perhaps as a reflection of this fact, no participants viewed therapeutic school as entirely necessary to achieve the level of therapeutic support that could be accomplished by the adult guidance described above: “I don’t think that children with specialized needs or children who have mental health diagnoses need to be shipped out… I think that there needs to be more training and more
focus on that social-emotional piece” [H1]. Both kids and adults believed that stabilization after a mental health crisis requires healthy doses of time and practice (“It’ll take time for us to get, you know… stable” [C1]), and that progress is not linear but can be accomplished with support in the original school placement, further emphasizing the significant role that adjustments to adult supervision and guidance can play in school reentry and student well-being.

Table 2:
Representative Quotes for Theme 1:
Centering the socioemotional role of school

<table>
<thead>
<tr>
<th>Subtheme</th>
<th>Quote</th>
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<tbody>
<tr>
<td>1.1 - Deprioritizing academics in the home school environment</td>
<td>“A lot of kids are anxious about missing school. You know, decreasing the workload or the makeup work, and making the transition as smooth as possible and less anxious as possible from a parent’s and a child’s [view]… not having the child walk into a boatload of work that they need to do.” [H3]</td>
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</table>
| 1.2 – Finding relief in the inpatient unit school model | “A lot of these private schools… they’re putting these building blocks that create healthy environments, so there won’t be a need for all these accommodations… And I just feel like that’s preparing for real life. It’s not, like, militant. You’re going outside during the day, you’re going to sports, you’re getting a study hall, it’s just all these very healthy things are being built
into the schedule. And we don’t see that in the public schools at all.” [P4]

1.3 – Emphasizing adult guidance in regular school

“Most of the time what I find particularly helpful is validation, allowing them just to feel that way and know that they can feel that way, but also trying to think more forward-thinking in terms of what’s going to get you out of here, what do we need to work on to get you to that next step… So focusing on their plan in terms of what’s going to help them move forward, but also providing a lot of validation and just support for how they’re feeling in the moment.” [H2]

Theme 2: Clarifying what constitutes good communication

Participants easily recommended good communication as invaluable in the process of collaborating with teams for school reentry, but further conversation revealed the specifics of what constitutes effective communication between stakeholders. Overall, participants describe good communication as requiring consistent, well-known sources of information, with frequent, up-to-date contact and access to as much or as little information as one wants, in order to feel well-informed without being overwhelmed. Table 3 includes representative quotes.
Subtheme 2.1 – Finding comfort in consistency and predictability

Participants frequently spoke about the importance of communication given that transitions between environments could be complex, fast-paced, and confusing, adding additional strains on an already-stressful situation. Parents perceived the hospitalization process as fast and sometimes abrupt:

“It was so quick. It was like, you know, do you consent to her-- and [partner] signed the paperwork, and then boom, she was gone. It was, like, that fast. And the staff in the unit were like, okay bye! And then we kind of just stood there, sort of dumbfounded, and I was like, I don’t… you know, what happens now?” [P2]

Similarly, students felt bewildered by the variable pace of transitions: “When you’re there, at first you’re like, I wanna leave, I wanna leave… and they’re like okay, we’re discharging you! And you’re like, huh?!” [C3]. Consequently, several students appreciated having a brief respite period of a day or few after discharge before resuming school.

Amidst the hectic and confusing transitions, communication between stakeholders was reported to be highly variable and sometimes muddied, leading to further frustration. The flow of communication between individuals was broadly inconsistent, creating gaps where various stakeholders felt left out of the loop:

“[Sometimes] I just don’t get a call. I just don’t. Even with DCF, sometimes we get a letter saying they’ve accepted the case, and then other times we don’t… but then we’ll get a letter from the case worker… Other times we don’t know a family’s involved with DCF… so a lot of times we get things after the fact” [S1].
Many providers stated that they appreciate direct contact with parents, but simultaneously acknowledged the unfair burden of casting parents as middlemen between professionals and wondered about ways to balance clear lines of contact without overwhelming families: “Parents felt like they were the middlemen, and they had so much going on, so I didn’t feel like that was their responsibility to kind of go between and ask” [S3]. Between professionals, hospital staff mostly liaised with whichever social workers, guidance counselors, or school psychologists had the most contact with the student. Children often noted that their communication with adults went through other adults rather than speaking directly with multiple adults within their transition team.

For all stakeholder types, consistency and predictability characterized the most desirable communication systems: Child and adult participants all wanted to know what to expect. This finding was consistent across the patient sample, regardless of first-time or multiple hospitalizations: “I’m trusting you with my child… this is new for us… I want to know these things” [P4]. Participants wanted meetings to address practical expectations in addition to providing reassurance, and stated that everyone does better when knowing what to expect next: “It’s really a disservice to them, that that communication does not happen” [S4]. To provide this clarity, participants appreciated collaborations that demystified aspects of the system that were unfamiliar to them: explaining how special education works, outlining the side effects of a new psychiatric medication, reiterating safety plan details, and role-playing conversations with peers about one’s absence.

Part of the desire for predictability meant knowing whom to contact when feeling stuck or uninformed. Participants spoke frequently about the importance of knowing
one’s point person, acknowledging that there is a lot to learn on all sides and therefore hoping for a quick consult to fill in gaps: “It would be ideal if they have like a personal hotline to call the doctors, be like hey, they did this, is that okay? Just having resources to answer those questions” [H3]. Liaisons with roles in multiple worlds therefore played a particularly important role. In this study, the unit school benefitted from a school principal with strong partnerships with local school staff, and these relationships went a long way in providing open channels of communication and education about the interface between the psychiatric system and the education system: “She understands the value of any information that she is getting from the school, to relay it to the [medical] team” [H3].

Subtheme 2.2 – Aligning on the same page

In addition to clear channels of information flow with consistent and predictable next steps, participants frequently mentioned having team members know the same information. Good communication meant frequent, timely updates, with everyone on the same page: “We got to a place where they were all in contact with each other… and everybody was all kind of talking to each other” [P2]. Child and adult participants alike did not want to feel left out or missing information, and adults preferred frequent information about the child’s progress in order to stay flexible with planning: “I always think kids benefit from as much collaboration as possible between the providers, just so that everyone’s on the same page, no one’s kind of left unknown with what’s going on with this child” [H2].
At the same time, not every family felt ready to hear such a tremendous volume of new information about their child’s situation, and not every provider had the bandwidth for constant contact: “Being mindful of everybody’s time… I don’t think there needs to be over-communication” [S3]. Participants therefore grappled with how to balance having as much information as one wants without it becoming overwhelming: “My initial conversations with parents and also the student is how much do they want me to share?” [S4]. For these participants, asynchronous technology provided a creative solution: A shared Google document allowed school professionals and family members to add non-urgent updates that could impact each stakeholder’s interactions with the child, and team members could peruse the document at their leisure. Another parent suggested utilizing bullet points with hyperlinks for school bulletins or other lengthy missives, so that all parents could read an overview and select which topics to read in more depth. Strategies for customizable engagement therefore appropriately balanced the competing needs for information and moderation.

Although participants in this study appreciated open flow of communication, school and hospital professionals noted that other families have struggled with concerns about confidentiality, driven by stigma and mistrust. From the providers’ side, declined release of information forms from families hampered inter-institutional collaboration: “When it doesn’t work well is typically when a parent doesn’t want our team to talk to school, when there isn’t consent obtained... and they don’t fully understand how impactful it can be in a school setting” [S4]. At school, stigma and lack of comfort managing mental illness also negatively affected the transition back to school: “The school gets pretty worried about kids coming back… Will it ‘contaminate’ the school
environment? Will they say too much? Are they going to be safe? Do we need to give them a 1:1? Can they go to the bathroom? Can they go to art class?” \[H1\].

Students and adults also described feelings of mistrust and shame. Students disliked feeling accusations from adults on their transition teams, sensing blame or mixed messages when adults struggled to discuss sensitive topics: “One time… I thought that they gave me more medication than I needed… [and the staff] basically said that I was making up scenarios in my head…. It made me feel like I was crazy” \[C4\]. Students also struggled with a sense of judgment and stigma from peers, noting that sometimes peers have hypothesized about their absence and discussed information that the student wished to keep private, often preferring to remain vague about their experience: “A lot of my friends actually asked where I went, and I told them I went to the hospital. Just the hospital, not the mental hospital” \[C1\]. Between adults, reluctance to feel liable for blame from other stakeholders created further barriers in the clarity of communication: “They don’t want to put your hopes up and they also don’t want to tell you something that’s like really frightening. So everybody’s, like, hedging all the time” \[P2\].

Table 3:

Representative Quotes for Theme 2:

**Clarifying what constitutes good communication**

<table>
<thead>
<tr>
<th>Subtheme</th>
<th>Quote</th>
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| 2.1 - Finding    | “It was like while he was there, we were getting everything set up for when he gets out, it’s all lined up, he knows what to expect, which is another big thing that helped us…. I think that a
*consistency and predictability*

lot of kids that are having psychiatric issues, they need that… they NEED to know…. As soon as you get out, starting on Monday, this is what your schedule’s going to look like. That helped ease a lot of things…. It was a good transition because of all those things.” [P3]

2.2 – *Aligning on the same page*

“It would prevent some things falling through the cracks. Like if I had a point person at [local organization] … I could call their direct extension, you know? Or I’d have their email and [ask] if you’re not able to take [child] could you explain why, or is it better to go through me, is it better to go directly to the hospital…? And they would already know their point person at the hospital, if that makes sense.” [S1]

**Theme 3: Reconciling multiple sources of authority**

Although all participants possess expertise through lived experience or professional training, the acuity of hospitalization necessitated help from other individuals with different skills or resources. Stakeholders diverged on who should be “in charge,” both wanting to uphold one’s own authority and to be taken care of by other experts. **Table 4** includes representative quotes.
Subtheme 3.1 - Confronting the limitations of psychiatry

Because participants were identified through contact with the psychiatric inpatient system, conversation included discussion about the role of psychiatry, doctors, and inpatient hospitalization, revealing varied perceptions. Participants tended to view hospital staff as high-level authorities that step in once other resources have been exhausted, as an escalation or last resort: “You’ve been admitted, this is quote-unquote like the worst that it can get” \([H3]\). Hospitals and psychiatric staff were perceived to have more influence and power for follow-up services, providing a sense of reassurance and relief at finally having arrived at a possible solution: “Because you know, a group of doctors – they can recommend this – how can you say no?” \([P1]\). Participants also relied on psychiatric professionals for education, ruing a lack of knowledge of how to navigate mental health concerns in children: “I’m not used to having kids on my caseload who are hospitalized and then reentering, so it was helpful for me to understand that” \([S3]\). Desire for better insight also extended into special education nuances, with parents valuing the medical perspective on how special education plans like IEPs and 504s encompass mental health needs in addition to more familiar diagnoses like learning disabilities.

At the same time as viewing medical staff as high-level, well-equipped experts, families and school professionals also rued the health system’s limitations, expressing frustration that psychiatric professionals could do so much and yet still not enough. Participants viewed hospitalization as a temporary touchpoint that offered some supports but remained a flawed piece of the puzzle rather than a solution: “I could see how being here in inpatient unit can be a lot more stabilizing and we’re like, great, we stabilized the
kid, and then they leave and we’re like what the heck! How are they in the emergency room five days from now?” [H4].

In particular, despite being grateful for the hospital’s perceived power to make things happen, participants were frustrated that professionals could not make stronger, clearer connections to outpatient supports: “It was sort of a crisis, because he left [the inpatient unit] with no care at all. And I couldn’t find any care. [Hospital social worker] kept with me [but] she couldn’t find any care either” [P3]. Difficulty finding follow-up care even engendered a sense of abandonment: “We were super frustrated that [hospital] would not see him in the catchment area... It felt a little bit like [they were] sending him out there to dry” [P3]. Moreover, even the hospital’s capacity for mental health education was uncertain: Kids and adults diverged on whether children actually acquire coping skills through hospital programming or whether the unit is more of a holding tank or an actively triggering environment. Consequently, although commentary revealed a desire for psychiatric help to represent the ultimate level of support, lived experiences demonstrated that even the most acute level of care suffered from gaps that needed filling.

Subtheme 3.2 - Balancing expertise and inexperience

Despite considering psychiatric care a high-level support, participants did not perceive a clear hierarchy of decision-making or information across stakeholder types, with all participants advocating for their own authority. Simultaneously, due to the complexity and severity of the situation, stakeholders also acknowledged being out of their depth and reliant on expertise from others or nervous about overstepping
professional purviews: “At that point, our role ends, because… it’s not like I’m like, hey… what I have to say is more important than your conversation with the doctor – so it gets a little dicey” [S2a]. Consequently, across participant quartets, it was not clear who was running the show, so to speak. Although hospital staff operated at the most acute level of care, participants noted that hospitals have only a limited window into the child’s experience and suffer from lack of daily insight. By contrast, schools see the child daily and therefore have a deeper understanding of the child’s functioning and wish their viewpoints to be solicited more frequently (“Generally my sense is a lot of the providers don’t coordinate with schools as much as they probably could or should” [H2]) – but simultaneously feel ill-equipped to answer psychiatric questions. Parents argued that they pose the ultimate authority on their child’s experience (“We may not have a MD or PhD or whatever, but we’re with them all the time” [P1]) – but simultaneously feel out of their depth and at the mercy of school and health professionals to navigate such a vulnerable period. Finally, the kids themselves appreciate when they are given control, though still relying heavily on the adult caretakers around them for safety and guidance:

“Interviewer: What do you think school could do to help you just feel like you can be you?
“Interviewee: Trust me and let me get out.” [C3]

A particular tension between children and adult stakeholders concerned the balance of safety and comfort. Adult participants frequently emphasized safety measures, positioning temporary discomfort as necessary to maintain safety as the paramount concern: “It’s not supposed to be long term, it’s supposed to get you stabilized, and it’s really hard to go there – but that’s what it’s for” [P4]. Kids, however, highlighted their subjective experiences of fear, loneliness, and discomfort: Even though the hospital is meant to “make sure that when they send them out that they’ll be safe, and to put them on
the right medication… I feel like they could make it a less miserable experience” [C4].

Within expressions of discomfort, child participants seemed to be advocating for adults to honor their perspective more seriously, although adults did report trying to uplift the child’s agency throughout the transition processes.

With no clear chain of command emerging between stakeholders given the balance of agency and insufficiency for all participants, all agreed that navigating complex transitions of hospitalization and school reentry requires a multifaceted team: “One person has to be able to oversee or organize, but… for that point person [to not be] so inundated… because if something happened to me, if I have all this information, nobody else is aware, now that’s a disservice to others [and to the] student” [S1].

Participants frequently mentioned many team members, expanding beyond the four stakeholder types in this study to include community crisis responders like 211 services, extended family, and outpatient providers. Participants also reiterated the importance of not being siloed, identifying this as one of the predominant ingredients for successful collaboration: “We have good leaders that don’t want fragmentation” [H1].

Table 4:

Representative Quotes for Theme 3:

Reconciling multiple sources of authority

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<thead>
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<th>Subtheme</th>
<th>Quote</th>
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| 3.1 – Confronting the limitations of psychiatry | “Basically, once I told the social worker that our psychiatrist recommended that we come here, it’s automatically like, all right, we’re going to take him in. Because… it’s not always
guaranteed that the kid’s going to get taken in. So because we have all those teams of people, where it’s like – the social worker told me he needs to go to the hospital, the psychiatrist told me that he recommends that he goes in to get stabilized on a new medication… everything moved kind of smoothly for me.”

[P4]

3.2 – Balancing expertise with inexperience

“In the past, any time we’ve taken the ambulance ride with the student… I was involved kind of saying, why are we here… but mom did show up at the same time and was told, you know, the protocol is only one adult, so I wasn’t going to take the spot of the parent at that point! … I felt like I couldn’t say-- what? I want to be with the student for a little while and talk to the staff, mom, please wait outside?” [S2b]

Theme 4: Navigating limitations with creativity

Even as participants took an expansive view of how to handle hospital transitions and school reentry, calling for reductions in silos and significant teamwork, all stakeholder types acknowledged multiple levels of limitations. Participants reflected thoughtfully on how to balance increased needs and limited bandwidth, wanting more but seeing cracks in an overburdened system. Table 5 includes representative quotes.
Subtheme 4.1 – Acknowledging insufficiencies

When dreaming about possible improvements for school reentry after psychiatric hospitalization, common aspirations focused on the concept of “more.” Parents and providers wanted more outpatient resources available, either independently of the inpatient system or as an extension of it, because finding clinical services after discharge (and sometimes before) posed a significant challenge: “Having programs available to everybody regardless of insurance, income… Just having accessible services to everybody, at all levels of care, not just outpatient” [H2]. School staff noted that staffing ratios and the complexity of classroom differentiation make educational needs more difficult to meet, wishing for resources to ease those challenges: “I automatically think having a smaller classroom, but of course that would be just… unrealistic to say” [H3]. Students were acutely aware of their peers’ needs, independently volunteering that one of their wishes for the future was for other struggling children to have the resources they had: “Just to make sure that everybody can access tools to help feel better… whether they’re coming out of the hospital, going in, have been out of the hospital for a long time, have never been in the hospital, don’t have that many struggles with it, but still want to talk, you know?” [C2]. Time arose as a particularly desired resource: time to check in more frequently with kids, time off of work for families to attend meetings, and time to collaborate with others, further underlining the tension between sufficient collaboration without overwhelming teams’ bandwidth.

Often in the same breath as the requests for more, participants reiterated their acknowledge of limitations in resources or bandwidth. Aspirations and appreciation were frequently accompanied by caveats about reality: “I feel like they’re doing everything
they can to keep her safe, but there’s only so much you can do – a whole school full of kids, you know?” [P2]. In particular, participants noted that not all families are able to support their children the way that others might hope they could. Barriers included difficulty accessing technology, difficulty accepting children’s gender identities, involvement with protective services, or parents’ own trauma. Overall, acknowledging the myriad barriers and limitations to more comprehensive care for children reentering school after psychiatric hospitalization served to underline the complexity of the situation and the need for high-quality collaboration.

Subtheme 4.2 – Forgoing standardization in favor of flexibility

To address barriers and limitations, participants spoke of flexibility, creativity, and workarounds to traditional policies. Adult participants noted that rigidity in policies or legal requirements makes good planning difficult: “Insurance is definitely a barrier. A lot of insurances won’t allow the same service, or even two services, depending on the insurance, in the same day” [H2]. Participants also felt that the educational and healthcare systems are not built for successful hand-offs between levels of care, leading to feeling in limbo or like one’s hands are tied: “The hospital should really be the ones making sure that that follow-up counseling is actually taking place, because now I’m just in limbo” [P1]. As a remedy, individualization and case-by-case planning became paramount: “Everyone has their different policies and procedures, but it’s not a one-size-fits-all for every student” [S1].

In most positively-regarded cases, adults created workaround to existing policies to get children the necessary supports, and flexibility reigned supreme in the fragile post-
discharge environment. Participants emphasized the importance of “out-of-the-box thinking” given the rigidity of systems’ requirements for funding [H1]. Some teams adjusted transportation schedules to allow students access to specific after-school supports; others added additional therapeutic support beyond the clinician’s usual hours with the child; others customized attendance requirements for an existing outpatient program, forgoing the cookie-cutter programming to maximize the elements most impactful for that child.

Subtheme 4.3 - Supporting the whole team

To navigate barriers and maintain hope and creativity, adult participants reflected on the importance of having adequate support for themselves. Although the entire process was necessarily child-centric, having caregiver peer support was essential, as adult participants faced multiple psychological stressors themselves: “It just hit me like a bomb. It’s just like one thing after another, and I was like beside myself” [P2]. For parents in particular, not having support was “probably been among the hardest parts of this for me” [P3]. Given the complexity of transitions, parents and professionals could easily feel overwhelmed, especially those with repeat experiences or managing multiple caseloads at once: “You just have to somehow find a balance, because in this profession, it’s giving, giving, giving, you know? So you have to replenish, in a sense” [S1].

Having supportive adults to lean on made it easier to maintain wellness and operate as a cohesive team. School staff noted the importance of team debriefs and “time to process and to come down” after school crises, because “in the moment, you don’t recognize – or maybe you do recognize – but your cortisol goes up when someone’s in
danger!” [S2a]. Participants also noted the importance of structuring teams in ways that support provider well-being: “I work my tail off to make sure people get time off or switch shifts – because I full-heartedly believe that children will be more successful if the staff are at their best” [H4]. Consequently, although education and healthcare are both student- and patient-focused, respectively, attending to the needs of the adult stakeholders is critical to ensure the health of the entire ecosystem around the child.

Table 5:
Representative Quotes for Theme 4:
Navigating limitations with creativity

<table>
<thead>
<tr>
<th>Subtheme</th>
<th>Quote</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1 – Acknowledging insufficiencies</td>
<td>“I think it’s difficult for all parties involved. The hospitals right now are very busy, schools are very busy, parents are also swamped, and it’s a very stressful process to go through for them…” [S3]</td>
</tr>
</tbody>
</table>
| 4.2 – Forgoing standardization in favor of flexibility | “She had tried their intensive outpatient program (IOP) previously and found it not helpful, and so when we were sitting with her, I asked, what about that program did you not find helpful? And she was able to talk about how the first hour, where other children were talking about things that maybe weren’t relevant to what she was going through… weren’t helpful. So I had a conversation with [community program] and
we were able to come up with a plan where she would go to the IOP three days a week and miss the first hour, so she would start an hour late, go three days a week, and then in addition, keep her outpatient once a week.” [H2]

4.3 – Supporting the whole team

“We have a great team, [and] it’s always great to just bend their ear and get their thoughts on things… A great example is… I felt horrible in not being able to support the parents more, and just to make sure that I was doing everything possible that I can, I reached out to the school psychologist and we just had a conversation, you know, what else could be done? So certainly, utilizing my coworkers has been excellent.” [S4]

Grounded theory

The concept of ecosystem reflects the interactional nature of the transitions through psychiatric hospitalization and school reentry, reliant on multiple team members with unique functions and skillsets working in tandem. Participants stressed interdependency as key, noting the importance of eliminating silos, having open lines of communication, and honoring each stakeholder’s vantage point simultaneously. At the same time, participants outlined multiple breakdowns in system processes or resources, emphasizing the successes of flexibility and creativity in coordinating supports for each child. Consequently, we hypothesize that successful school reentry after psychiatric hospitalization can be characterized as a system of stereovision and patchworking. Table
Figure 1 includes representative quotes. Figure 1 depicts a schematic representation of the theory.

Figure 1: Schematic Representation of Stereovision and Patchworking. Crossed lines of perspective constitute stereovision, weaving together to form a support network for the school reentry environment. Where missing resources create gaps in the woven fabric, patchworking helps supplement the support system.

Stereovision

Stereovision refers to the integration of multiple perspectives of the same object, moving from a two-dimensional view to a three-dimensional view, in order to capture a more accurate or comprehensive understanding of the subject. The concept, also referred to as binocular stereopsis, originates from the physiology of vision, with each eye
constructing a perception of a subject from slightly different vantage points. The brain then integrates the two images into a singular representation with depth perception, not achievable with monocular vision alone. For school reentry, we prefer the term stereovision over binocular stereopsis in order to expand the concept beyond two views: In this conception, stereovision broadens to encompass each agent within the transition team ecosystem – child, parent, school staff, hospital staff – and also agents not included in this study, such as outpatient providers, classroom teachers, extended family, and so on. We consider each agent as possessing one or more “lines of sight” that cross perspectives with each other agent, representing the densely interactional system described by participants in this study. When represented schematically, the crossed perspectives appear similar to threads in a fabric, a fitting metaphor for the safety net woven by teams to support a child in transition.

Stereovision encompasses this study’s first three thematic findings. First, because participants 1) center the socioemotional role of school, schools and mental health systems must synthesize their individual “lines of sight” on the child toward a more cohesive view of the interactions between education and mental health, creating a more multi-dimensional vision of the child in both contexts. Second, because participants 2) clarify good communication as being on the same page with titratable individual engagement, the reentry process therefore needs to achieve cohesion of multiple perspectives not just within one individual, but across multiple team members, in order to identify successes and gaps in transitions of care. Third, because participants find themselves having to 3) reconcile multiple sources of authority simultaneously, teams therefore must acknowledge that despite the consistent desire for another “grown-up” to
manage difficult transitions, there is no primary vantage point or leader, further reinforcing the need to synthesize coexisting perspectives, i.e., stereovision. One successful example is building teams that include inter-institutional liaisons, staff members who bridge the educational and mental health worlds in order to align reentry solutions to the child’s socioemotional and academic needs.

*Patchworking*

As is known all too well by participants in this study, even the most densely-connected safety nets suffer from gaps due to limited resources such as time, staffing, and bandwidth; i.e., realistically, there is no perfect stereovision. Consequently, even with team members doing their best to create a sufficient reentry plan, participants reflected on ways they wish the system could improve and noted incidents of creative problem solving that they utilized to craft makeshift support plans, as in Theme 4: *Navigating limitations with creativity.* These workarounds are captured in the second component of our grounded theory, *patchworking*: a process of bricolage or patchworking, cobbling together case-by-case solutions that skirt around traditional procedures or processes. Though patchworking results in case-by-case solutions, it reflects less a sense of customized, bespoke reentry plans and more a sense of scrappy, make-do survival. Patchworking became essential for participants in this study and seemed to be the most effective strategy to help teams navigate the myriad limitations in an overburdened child mental health ecosystem. Interestingly, patchworking lies in tension with another thematic finding from participants, namely the desire for predictability and consistency,
representing a dialectic in participants’ attitudes within the school reentry process after psychiatric hospitalization.

In conclusion, by incorporating the above four thematic findings, we argue that when navigating school reentry after psychiatric hospitalization, kids and adults must use stereovision and patchworking create a strong, flexible support fabric - contradicting expectations of hierarchical authority or standardized procedures seen in prior literature or commonly found in medical or educational systems.

Table 6: Representative Quotes for the Grounded Theory

<table>
<thead>
<tr>
<th>Concept</th>
<th>Quote</th>
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</thead>
<tbody>
<tr>
<td>Stereovision</td>
<td>“I think the value of different perspectives, of medical, nursing, and academic is really important for us to then bring all together. Not that doctors don’t like to talk to school professionals, it’s just that doctors have a doctor perspective, nursing has a nursing perspective, and school has a school perspective. Maybe I should put it like that.” [H4]</td>
</tr>
<tr>
<td></td>
<td>“As educators, we’re valued on the unit and that we have a place and we’re not siloed. I think for me, that would be the most important thing, that – we are not at all siloed. That you know, we’re – that we’re really part of the clinical team and go to clinical team, and you know, are a part of things, just you know, not this separate entity.” [H1]</td>
</tr>
</tbody>
</table>
Patchworking: “Everything… doesn’t have to fit a certain sort of… descriptor or model, although I do know they work within frameworks, and that it is within their framework, but…. Each kid also feels like they’re treated as an individual human being that has their own concerns, their own challenges.” [P3]

“It’s not one size fits all. It’s different for each child. Like, they didn’t know if their needs are different, so you want to meet their needs – you don’t want to do something unnecessarily just to do it, you know?” [S1]

Discussion

By conducting in-depth analysis of multiple stakeholder quartets to explore school reentry after psychiatric hospitalization, we developed a grounded theory that not only supports and strengthens prior theoretical perspectives, but also offers novel theoretical contributions through the concepts of stereovision and patchworking. Together, the main thematic findings and overarching grounded theory offer potential recommendations for future practice.

Situating findings within existing theory

First, this study supports prior thematic findings across multiple stakeholder types. The themes in this study parallel findings synthesized from the prior literature in
Savina, Simon, and Lester’s first theoretical overview, discussing the perceptions and needs of children, parents, school staff, and hospital staff; our study differed in that it did not assess for peer perceptions. Our findings also corroborate the updated review by Tougas et al., which strengthened Savina, Simon, and Lester’s original theory through rigorous systematic review and organized thematic findings into the various bioecological levels (e.g. youth ontosystem, family or school microsystems, macrosystems). Particular synergy between this study and that of Tougas et al. arises in consideration of mesosystems (family-hospital, family-school, and school-hospital communication or collaboration) and exosystems (policy rigidity and other systemic barriers).

Second, this study does not merely replicate but rather strengthens the foundation established by Savina, Simon, and Lester and Tougas et al., because it is the first to qualitatively assess the stakeholders from multiple bioecological microsystems in a single primary study. In other words, our findings verify that prior theoretical proposals can be borne out in real-world samples, rather than piecing together disparate populations and contexts from individual studies. In fact, this project directly answers the call from Savina, Simon, and Lester one decade ago, suggesting that future research “provide in-depth investigation into the entire transition for a small number of children.” A real-world sample is particularly valuable in evaluating not just thematic commonalities within a stakeholder group, but also tensions or synergies between different stakeholder types. For example, in our study, we identified differences in children being more preoccupied with discomfort whereas adults prioritized safety; children and adults disagreeing about whether hospitalization teaches coping skills; and similarities in adult roles across the transition team to act as regulators or processors for the children in transition.
Moreover, the unique setting of this study offers insight into previously unmet needs described in other work, further strengthening the application of the proposed theoretical framework. Our sample was recruited from a pediatric inpatient psychiatric unit that houses a state-accredited school on site, with a school principal that liaises between the unit and the local schools, facilitating interdisciplinary collaboration in a way not accessible in every setting. Contrast between thematic findings of this study and prior investigations makes this access evident: In Tougas et al.’s review, participants asked for quicker (or any) contact between the schools and hospitals, formation of actual reentry plans, facilitation of release of information, and more informed cross-perspectives between education and mental health. By contrast, in our sample, participants frequently remarked on how much they appreciated the school principal liaison role, identifying sharing of information and co-planning as a positive experience rather than an area for improvement. Our setting also encompasses younger children, whereas most of the existing literature surveys adolescents.

Third, this study offers novel theoretical contributions using grounded theory. For example, stereovision expands and enriches the prior findings about collaboration across systems. Savina, Simon, and Lester utilized the term “cross-system collaboration” to describe a similar set of concepts as stereovision: joint responsibility, different perspectives, and multiple sources of expertise. Simultaneously, however, they noted the challenge of “diffusion of responsibility” among team members due to the large number of individuals involved in the reintegration process and called for further investigation into how stakeholders in each setting can interact with each other effectively. Stereovision addresses the potential diffusion of responsibility by illustrating increased
density rather than diffusion of connections. Similarly, Tougas et al. noted that stakeholders in each microsystem (e.g., home, school) wanted others to give them more credence but also share responsibilities more evenly within mesosystems (e.g., family-school, school-hospital); stereovision honors each stakeholder’s perspective equally and moves beyond framing collaboration in terms of dyadic mesosystem pairs, but rather a more cohesive and comprehensive view of the ecosystem as a whole. Rather than a concentric organization of systems as found in Tougas et al.’s representation of Bronfenbrenner’s bioecological theory, stereovision provides a network schematic to understand how multiple mesosystems interact simultaneously and share resources and responsibility during the entire hospitalization-to-reintegration timeline, aligning with our participants responses about what type of communication and collaboration worked best.

Similarly, patchworking helps fill in gaps when mesosystem interactions are insufficient to meet child, family, or professional needs or when exosystem strains affect stakeholders’ ability to collaborate. For example, Tougas et al. noted that key exosystem barriers include rigidity of administrative regulations at school, insurance policies that complicate appropriate placements, and confidentiality laws that impede information sharing. By defining patchworking as a strategy to navigate system insufficiencies, our grounded theory supplements prior descriptive studies of barriers and provides a mindset for future steps when previously-described adaptations to barriers do not work in a given situation. Moreover, patchworking addresses the tension between differing conclusions from Savina, Simon, and Lester and Tougas et al. Whereas the former recommended the ideal of “a statewide standard school reintegration protocol [that] could be developed and used in both hospitals and schools,” the latter noted that “high levels of complexity and
variety… probably cannot be met appropriately by general approaches like standardized individual, familial, or group interventions.” Patchworking acknowledges the reliance on existing structures or standards for reintegration while also honoring the complexity of case-by-case needs and providing a mindset for holding both in balance.

Moving beyond theoretical perspectives of school reentry, the network schematic of stereovision and patchworking also aligns with other theoretical approaches to social dynamics and health. Berkman et al. theorize that four pathways predominate when assessing how social networks and social integration impact interpersonal behavior and health⁶⁸. These four pathways create an “overarching model which integrates multilevel phenomena,” similar to the approach taken by stereovision and patchworking: “(1) provision of social support; (2) social influence; (3) on social engagement and attachment; and (4) access to resources and material goods”⁶⁸. First, social support encompasses emotional support, which aligns with the thematic findings from this study indicating that children and adults alike want to feel like someone is in their corner. Being connected to others in a network, visualized within stereovision, can help stakeholders feel supported. Second, Berkman et al. describe how social influence reflects mutual shared norms, recognized and effected bidirectionally, which mirrors the findings in this study that school and health systems appreciate connectedness so as to better understand the values of the other. Good communication involves cross-pollination, in other words, and the stereovision network model makes concrete the paths of cross-pollination. Third, social engagement may capture what participants refer to as “collaboration,” i.e. interacting with other actors in the “network context which provides the theatre in which role performance takes place”⁶⁸. Finally, the fourth pathway of
access to resources directly reflects Theme 4 and the necessity of patchworking: Ideally, emphasizing a network approach can provide better access to care. In this study, participants did benefit from more integrated care due to the presence of a unit school principal as a mediator between school and health systems, which resulted in perceptions of better reentry support compared to family’s and staff’s experiences with hospitals without such a role. Aligning the findings of this study with other theoretical approaches to social dynamics and health beyond the school reentry literature can help contextualize the findings moving forward and hopefully provide avenues for future study or policy efforts.

**Mobilizing theory towards practical recommendations**

*Integrating education and mental health*

Beyond theoretical contributions, we hope this study can also advance practical recommendations for navigating school reentry after psychiatric hospitalization. Strategies to work towards stereovision can be organized by each of the first three thematic findings. To address Theme 1: Centering the socioemotional role of schools, schools and mental health providers can work towards stereovision by synthesizing their individual “lines of sight” into better integration of education and mental health. This can be accomplished through incorporating more therapeutic approaches into public education, which directly echoes requests across our participant sample. Efforts to identify and implement mental health interventions in school are ongoing but highly dependent on context. The University of Maryland Center for School Mental Health outlines a triangular model for school-based prevention, with the bottom tier targeting the


majority of students through school environment and relationship enhancement to target the entire learning community, the second tier targeting all students using universal prevention strategies like interventions for problem-solving and prosocial skills, and higher tiers using selective and indicated prevention to target smaller groups of at-risk students. Other models include mental health consultations and coaching for school staff, as a way to bring mental health expertise into educational spaces more frequently rather than tasking in-school professionals with additional mental health responsibilities.

A school-based mental health promotion strategy that mirrors commentary from our participant sample is to target teacher- and school-connectedness, which aligns with participant feedback that feeling cared for and knowing who to turn to were important supports for children and adults alike. Prior studies demonstrate that a sense of teacher support – feeling that teachers are fair and care about students – is protective against suicide attempts and other high-risk health behaviors. Connectedness is also protective against suicide in the post-hospitalization period: Additional research in adolescents seen in the emergency department demonstrates protective effect of school and social connectedness against suicide attempt in the three months following hospitalization for multiple adolescent subgroups.

In accordance with the multi-stakeholder tenet of stereovision, increasing the connection between school and mental health need not rely only on educators or mental health professionals. In a review of empirically-supported school-based mental health interventions, the majority of the interventions that were found reliably improve both academics and mental health involve both parents and educators. Parent-child
connectedness is already known to protect against suicidal ideation in adolescents, both for two-parent and mother-only households, and perceived parental involvement in children’s academic progress is associated with fewer mental health difficulties and suicidal thoughts or behaviors in middle school and high school students alike. Increasing parental involvement in children’s school lives can not only provide protection against adverse mental health risks, but also increase stakeholder interconnectedness and uplift parental insight for school and mental health providers, which was desired by parents both in our sample and prior literature.

These strategies may help also address participant’s questions about balancing therapeutic support with academic rigor, an especially important consideration given that falling behind academically was a major common theme in prior literature. Increasing the integration of mental health and education through school connectedness and parental involvement need not sacrifice academic challenge the way that other accommodations or therapeutic leniency in the unit school were perceived to do so, based on commentary from participants in this sample regarding the in-hospital unit school. Overall, finding better cohesion between education and mental health systems will facilitate denser interconnectedness between components of a child’s support system, i.e., stereovision, to better navigate the challenges of school reintegration and support well-being regardless.

*Leveraging inter-institutional liaisons*

To address Theme 2: Clarifying what constitutes good communication and Theme 3: Reconciling multiple sources of authority, stakeholders need strategies and systems for collaboration that allow for clearer lines of communication in a non-hierarchical or non-
rigid way. In this study, the most impactful component of collaboration was the presence of an in-hospital school principal. Such inter-institutional liaisons go a long way in breaking down professional silos and crossing perspectives between educational and mental health systems, both a key wish from participants and a main tenet of stereovision. This role also addresses Theme 1 by allowing for continuity of education during psychiatric hospitalization, which helps address the stressor of falling behind academically after hospitalization, as a survey of students with EBD in day treatment or residential programs found that maintaining educational continuity while hospitalized is important to ease the transition back into the original school setting\textsuperscript{78}.

Research on hospital-based teachers or schools is limited, but what does exist demonstrates significant variability across the relatively small number of programs studied\textsuperscript{79}. Additionally, not every health system staffs an educational professional that can liaise between the hospital and local schools, as existing research explores predominantly hospital-based teachers rather than principals or other educational administrators, and these teachers may not be supervised by personnel with a school-hospital liaison role\textsuperscript{79}. School staff from our sample corroborated the fact that other hospitals do not have a similar role to this study’s school principal, and in those instances, inter-institutional communication is significantly more impaired. Studies of well-established hospital-based school programs or school liaison programs for students with chronic or other non-psychiatric illness demonstrate positive effect on collaboration with special education supports and cross-disciplinary stakeholders in the community\textsuperscript{80}, as well as greater parental satisfaction, understanding, and support regarding their child’s academic progress\textsuperscript{81}. 
Finally, the concept of inter-institutional liaisons aligns with existing evidence for good collaboration. In a systematic review of interagency collaboration for children’s health, facilitating factors included good communication, similar training and understanding between agencies, mutual valuing across agencies, a named link person, and support from senior management. In this study, the unit principal as school liaison fulfilled all of the above facilitating factors. The above findings also echo participants’ commentary that being able to identify a point person is a helpful feature of inter-institutional collaboration. A final facilitating factor from the above systematic review was having protocols for interagency collaboration, which remains an area for improvement based on participant responses in this study.

Based on prior literature and current findings, the model of inter-institutional collaboration that participants report as most beneficial would be classified as “integrated working,” where “services are synthesized… [and] professionals operate as a team, with the expectation that roles will be blurred or expanded.” Because of the expansion of roles, engaging in integrated working with inter-institutional liaisons may also help ease concerns about confidentiality, which arose as a barrier both in the current and prior studies, because the liaison is a trusted member of both networks.

The integrated working model also features a “key person, or link worker, [who] coordinates services for families and liaises with other professionals and agencies on their behalf.” In this study, participants emphasized the importance of having such a point person, and often pointed to the unit school principal as a key link between schools, the hospital, and the parents. Notably, this point person can exist across institutions to supplement the transition team members at each institution (e.g., guidance counselors at...
the school, parents, hospital social workers), helping guard against fragmentation of communication or responsibility. Having the point person for integrated working existing across institutions, as seen in this study’s unit principal, reflects a shift from an inter-organizational to an intra-organizational process, which aligns with the concept of stereovision. This is additionally beneficial because remaining siloed into independent institutions (e.g., school, family, hospital) maintains an inter-organizational framework, and “inter-organizational collaborations are often marked by conflicts and instability as a result of the lack of formal authority,” which mirrors frustrations of participants in this study. Consequently, expanding a similar liaison role as demonstrated by this study’s unit principal to other pediatric psychiatric hospital units could facilitate better integration and transitions of care.

Increasing resources and evidence-based programming

Addressing recommendations for Theme 4, Navigating limitations with creativity, requires acknowledgement of the conundrum that the concept of patchworking poses for how to provide recommendations for future practice. Patchworking exists in tension with the finding that stakeholders prefer consistency and predictability. In fact, additional studies have reported that “a lack of specific protocol or policy is a barrier to a student’s transition” and major frustrations include when “the protocol is loose, nonexistent, or not followed, and administrators are not pushing to hammer out better procedures.” Although clear policies and protocols and flexibility can certainly coexist, participants in this sample did characterize policies and protocols more as a rigid barrier than a desired support, naming the flexibility and out-of-the-box thinking as more helpful in navigating
post-discharge demands. Future recommendations could therefore potentially frame policies and protocols as rough guidelines while allowing greater permissions for adaptation on a case-by-case basis, allowing the coexistence of structure and flexibility.

Moreover, although this study found that maintaining flexibility is critical when navigating transitions or creating follow-up plans, patchworking is essentially adapting to a suboptimal environment, leaving continued need to improve the baseline supports available to families and professional teams. Avoiding the need for patchworking in the first place requires improving the knowledge, resources, and support for mental health and school collaborations, one of the major thematic takeaways from this study (Theme 4.1).

To address Theme 4: Navigating limitations with creativity, future work must increase the resources available for families and professionals. One step could be increasing the inter-institutional liaisons described above, including through hospital-based school programs or school liaison programs similar to the one lauded in this study as a key facilitator of school reintegration for children and adult stakeholders alike. Another step could be continuing the ongoing efforts to increase the pediatric psychiatric workforce: In recent decades, multiple recruitment and training initiatives have attempted to address the national workforce shortage of child and adolescent psychiatrists, including from a clinical research standpoint. These recommendations would address participant frustrations about lack of connection to accessible mental health resources after hospital discharge. Another step is increasing research into transition programs specific for school reintegration after psychiatric hospitalization, one of the requests from Tougas et al.’s overview of existing programs, which demonstrated no clear evidence-
based best practices for how to build an effective school reentry program, given the limited quantity and quality of assessments of existing programs. Developing high-quality evidence-based programs will require support from and collaboration between participants, practitioners, researchers, and policymakers alike.

Limitations and next steps

To ensure a sufficiently informative sample, this study’s purposive recruitment carefully considered the breadth of experiences across school reintegration. Participants were selected with attention to balancing first versus multiple admissions, existence or extent of special education support prior to hospitalization, varied contexts for the hospitalization incident, varied gender identities, and diverse roles within the hospital and school samples. Our study additionally characterizes the concerns of younger children, i.e., middle school-aged, whereas the majority of prior qualitative studies of school reintegration after psychiatric hospitalization survey adolescents.

Nonetheless, our participant sample still exhibits room for improvement. Notably, all parent participants in this study were mothers, despite study participation being open to any adult caregiver. This echoes prior findings that fathers are underrepresented in research on and clinical interventions for children’s mental health. Future qualitative investigations of supporting school reintegration after psychiatric hospitalization could therefore explore differences in parent engagement in children’s educational or mental health trajectories to examine potential facilitators or barriers in the reintegration process. Similarly, nearly all school and hospital staff who elected to participate in this study were
female, raising opportunities to explore the potential role or significance of provider
gender on the school reintegration experiences of professionals.

Moreover, although this study expanded prior knowledge by incorporating
children, parents, school staff, and hospital staff in the same study, not all stakeholder
types are represented in the participant quartets. Interestingly, no participant volunteered
the name of a classroom teacher to serve as the school staff representative for their
quartet, instead opting for guidance counselors, social workers, or school psychologists.
Consequently, this study does not represent the perspectives of classroom educators,
despite educators playing a major role in the school connectedness and academic
achievement of each child. This echoes participants’ perceptions that educators were not
as central to their experience as the other support staff, with children even expressing
relief at not having to discuss their hospitalization experience with their classroom
teachers. Future research should explore this tension, especially in light of the findings
that teacher- and school-connectedness have been shown to be protective for mental
health. This study also does not include outpatient providers due to the focus on the
hospital-school transition. Nonetheless, future work should include both classroom
educators and outpatient providers in order to obtain an even more comprehensive
understanding of how stakeholders can support the school reentry process across the
spectrum of supporters.

Future investigations would also benefit from incorporation of quantitative
assessment of school reintegration outcomes, such as persistent or worsening mental
health symptom burden, readmission rates, and academic achievement, especially across
a longer time course. Given the negative associations between mental health difficulties,
insufficiently-supported school reentry, and academic performance, engaging in stereovision and patchworking to improve the transition experience should be associated with distinct improvements in well-being and academic achievement over time.

**Conclusion**

School reentry after psychiatric hospitalization requires complex interaction of multiple stakeholders, and existing research on how to improve transitions is limited. By incorporating the above four thematic findings into a novel grounded theory, we argue that when navigating school reentry after psychiatric hospitalization, kids and adults must use stereovision and patchworking create a strong, flexible support fabric. These reflections increase representation of child and adult stakeholder voice in the literature and inform future school-hospital-family partnerships for school reentry after psychiatric hospitalization.

**Dissemination**

The findings of this thesis were presented at two professionally-relevant conferences: the 2023 annual meetings of the American Academy of Child and Adolescent Psychiatry and the National Center for School Mental Health.
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Appendix 1: Interview Guide

In the semi-structured interviews in our study, we aim to answer the following general questions:

1) What attributions and explanations do the children provide about the school-to-hospital transition and their academic experiences in the home school and unit school? How might attitudes toward school manifest and contribute to the process?

2) What attributions and explanations do each of the three stakeholders provide (parent/guardian, teacher, unit staff) about the school-to-hospital transition, and what specific themes arise for each type of stakeholder?

3) What alignment or divergence is there between each of the four players’ perceptions and narratives, and how might this play out in the transition process? What does this mean for the transition back to school to avoid a repeat hospitalization?

To target these questions, the interviews will be flexible according to what elements of their perspective participants hope to discuss, but in general the following sensitizing questions will guide discussion, listed below. Not all questions may be asked depending on participant comfort or where the participant guides the conversation, and all participants can elect not to answer any question for any reason with no penalty.

Sensitizing Questions

<table>
<thead>
<tr>
<th>Child</th>
<th>Tell us a little bit about what school looks like for you. What feelings or thoughts do you have about school?</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Tell us about what happened when you went to the hospital.</td>
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<tr>
<td></td>
<td>- What was happening before that?</td>
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<tr>
<td></td>
<td>- What happened during the journey of going to the hospital?</td>
</tr>
<tr>
<td></td>
<td>- What happened when you left the hospital and went back to school?</td>
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<td></td>
<td>How did you feel during this whole process?</td>
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<tr>
<td></td>
<td>What adults were important, if any, in this journey? What about other kids?</td>
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<td></td>
<td>If you could wave a magic wand and make this experience different for other kids, what would you change or keep the same? Why?</td>
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<thead>
<tr>
<th>Parent/guardian</th>
<th>Tell us a little bit about your child’s school setting. What thoughts or feelings do you have about your child’s school? What thoughts or feelings do you think your child has about school?</th>
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<tbody>
<tr>
<td></td>
<td>Tell us about what happened when your child went to the hospital.</td>
</tr>
<tr>
<td>Role</td>
<td>Questions and Discussions</td>
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</table>
| School staff    | - What was happening before that?  
- What happened during the hospitalization process?  
- What happened when your child was discharged back to their school setting?  

How did you feel during this whole process?  
What supports, if any, were important for you in this journey?  
What works or doesn’t work about the transition for you or your child from school to hospital and back? |
|                 | Tell us a little bit about your student’s school experience.  
What thoughts or feelings do you have about this student regarding their health and/or education?  
What thoughts or feelings do you think this student has about school?  

Tell about what happened when this student went to the hospital.  
- What communication did you receive or engage in about this process?  
- What happened when this student was absent from your classroom?  
- What happened when this student returned to your classroom?  

How did you feel during this whole process?  
What supports, if any, were important for you in this journey?  
What works or doesn’t work about the transition for students from school to hospital and back? |
| Unit staff      | Tell us a little bit about this child’s experiences in the unit school.  
What thoughts or feelings do you have about this student regarding their health and/or education?  
What thoughts or feelings do you think this student has about school or being in the hospital?  

Tell us about what happened when this child arrived to the unit school.  
What about anything that happened when the child was discharged?  

What communication took place between you and other adults in the child’s life?  
How did you feel during this whole process?  
What works or doesn’t work about the transition for students from school to hospital and back? |