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RESEARCH ARTICLE

Youths' Experiences of School Re-Integration Following Psychiatric Hospitalization

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Abstract

Objective: The purpose of this study was to report youths' experiences of school re-integration post-discharge from psychiatric hospital. No reports of school reintegration from the patient perspective could be located; hence, a second objective was to explore school-related and clinical factors associated with youth who reported an unfavourable school re-integration experiences. **Methods:** Patients were recruited while in hospital for acute psychiatric care. They provided informed consent to be contacted post discharge regarding their perceptions of their school reintegration experience. About ten weeks after discharge youth were surveyed via telephone (n=40) or online (n=22) surveys. **Results:** Of the 121 youth who agreed to be contacted after discharge, 62 youth completed the post-discharge survey. Almost half (n=29) of the youth reported that they had considerable difficulty with school reintegration. Youth reported managing social situations, academic pressures and emotions as substantial problems. Youth who reported a negative transition experience had significantly worse scores on self-reported Total and emotion subscale of the Strength and Difficulties Questionnaire, and concern about the impact of emotions on school re-entry, and significantly less psychiatrist-reported improvement than youth who reported a neutral or positive transition experience. There were no differences between the two groups on school-related variables. Youth with prior admission reported greater difficulties with peers and significantly worse clinical factors than youth without prior admissions. **Conclusions:** High emotional difficulty scores and concern about the impact of emotions on reintegration prior to discharge distinguished youths with negative school reintegration experiences. These patients may benefit from greater assistance with managing their emotional problems, and coping and social skills training before and during school reintegration.

Key Words: *school reintegration, post-discharge, psychiatric hospitalization*

Résumé

Objectif: Le but de cette étude était de faire état d'expériences de réinsertion scolaire d'adolescents après avoir obtenu leur congé de l'hôpital psychiatrique. Aucun rapport sur la réinsertion scolaire du point de vue du patient n'a pu être trouvé, ainsi, un deuxième objectif était d'explorer les facteurs liés à l'école et cliniques associés aux adolescents qui déclaraient des expériences défavorables de réinsertion scolaire. **Méthodes:** Les patients ont été recrutés alors qu'ils étaient à l'hôpital pour des soins psychiatriques actifs. Ils ont donné leur consentement éclairé pour qu'on puisse les contacter après leur congé au sujet de leurs perceptions de leur expérience de réinsertion scolaire. Environ 10 semaines après leur congé, les adolescents ont été interrogés par des sondages au téléphone (n = 40) ou en ligne (n = 22). **Résultats:** Sur les 121 adolescents qui ont accepté d'être contactés après leur congé, 62 ont rempli le sondage post-congé. Près de la moitié (n = 29) des adolescents ont déclaré avoir éprouvé des difficultés considérables avec la réinsertion scolaire. Les

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adolescents ont considéré que gérer les situations sociales, les pressions scolaires et les émotions était des problèmes substantiels. Les adolescents qui déclaraient une expérience de transition négative avaient des scores significativement pires au total auto-déclaré et à la sous-échelle des émotions du questionnaire des forces et des difficultés, s'inquiétaient de l'effet des émotions sur le retour à l'école, et avaient significativement moins d'amélioration attestée par le psychiatre que les adolescents qui déclaraient une expérience de transition neutre ou positive. Il n'y avait pas de différences entre les deux groupes en ce qui concerne les variables liées à l'école. Les adolescents ayant été hospitalisés auparavant déclaraient de plus grandes difficultés avec les camarades et des facteurs cliniques significativement pires que les adolescents n'ayant jamais été hospitalisés. **Conclusions:** Des scores élevés de difficultés émotionnelles et des préoccupations quant à l'effet des émotions sur la réintégration avant le congé distinguaient les adolescents ayant eu des expériences négatives de réinsertion scolaire. Ces patients peuvent bénéficier d'une aide accrue pour gérer leurs problèmes émotionnels, et d'une formation aux aptitudes d'adaptation et sociales avant et pendant la réinsertion scolaire.

Mots clés: *réinsertion scolaire, post-congé, hospitalisation psychiatrique*

Mental health disorders are the leading health problems of Canadian children (Waddell, McEwan, Shepherd, Offord, & Hua, 2005). Most psychiatric disorders begin in childhood (Kessler et al., 2005) and often persist into adulthood (Angold & Costello, 1995) with significant costs to society (Cohen, 1998). One of the major concerns for youth with psychiatric illness is the potential for poor health outcomes including mortality and social outcomes including academic difficulties and low educational attainment that can lead to low employment, low income, homelessness and social exclusion (Edward-Galabuzi, 2009; Marmot & Wilkinson, 2006; Raphael, 2009). These impacts may be worse for people who develop psychiatric illness in childhood or early adolescence because of the disruption to cognitive, psychological and social development (Rutter & Sroufe, 2000) and the disruption to school attendance and educational outcomes. Mental health disorders are associated with significant economic, emotional (personal well-being) and educational burden including stigma, reduced participation in activities and psychosocial impairment for youth and their caregivers (Angold et al., 1998; Busch & Barry, 2007).

It is commonly reported that at least 20% of children and adolescents experience a mental health problem, though it is estimated that about 14% have clinically impaired symptoms; that is, these children and adolescents (henceforth termed youth) experience significant distress and impairment at school, at home and in the community (Angold & Costello, 1995; Offord, Boyle, Fleming, Monroe-Blum, & Rae Grant, 1989; Waddell et al., 2005). Furthermore, in Canada, the rate of child and adolescent hospitalization for mental health disorder is growing, and far exceeds the rate of hospitalization for any other disorder; rates of child and adolescent inpatient psychiatric hospitalizations increased by 37% while rates declined for other conditions in this age group (Canadian Institute for Health Information, 2015). Analyses of recent trends in Ontario, Canada of youth indicate that between 2006 and 2011, there were significant increases in visits to mental-health emergency departments by 32.5% and increases in psychiatric hospitalizations by 53.7% (Gandhi et al., 2016). Most (90%) have been reported as crisis admissions with suicide risk as the most prevalent problem precipitating admission (Greenham & Persi, 2014) and the primary diagnostic reasons for admission were reported as mood and anxiety disorders (Gandhi et al., 2016; Greenham & Persi, 2014). In Ontario, the number of admissions to child and adolescent inpatient psychiatry decreases in the summer months and December (Greenham & Persi, 2014) which coincide with natural breaks from school. Thus, a considerable and growing number of youth are admitted for psychiatric crisis stabilization and treatment and seemingly at times when youth are engaged in academic activities.

Children and adolescents are admitted to in-patient psychiatric care for crisis intervention and stabilization for a number of mental health disorders. While in hospital, youth can participate in educational activities; however, they are absent from their regular schools. Youth who have been absent from school due to psychiatric hospitalization have the added burden of school reintegration following discharge from hospital. Caregiver and clinician perspectives of the challenges these youth face upon school reintegration include academic, social and emotional challenges (Clemens, Welfare, & Williams, 2010; 2011; Simon & Savina, 2007; Savina, Simon & Lester, 2014; Weiss et al., 2015). However, no report has been located in which youth directly described their experience of transitioning back to school after psychiatric hospitalization. Moreover, youth with mental illness have been shown to have academic difficulties and problems with school engagement often due to the psychological difficulties they have (Cueller, 2015; McLeod, Uemura, & Rohrman, 2012). Youth may try to avoid facing these difficulties altogether by avoiding school (Knollmann, Knoll, Reissner, Metzelaars, & Hebebrand, 2010). Additionally, hospital readmission rates have been reported to range from 30% to 60% within time frames varying from about one to ten years indicating a large proportion of youth hospitalized for psychiatric illness experience school reintegration more than once (Arnold et al., 2003; Blader, 2004; James et al., 2010). High readmission rates suggest a need for greater attention to the continuity of care. Moreover, these youths can be contacted to provide information about

their past experiences with the transition. Some research with youth hospitalized for psychiatric illness (e.g., Knollman et al., 2010; Preyde, Parekh, Warne, & Heintzman, 2017) suggests that understanding and addressing school-related difficulties may improve youths' school experiences and academic achievement, and reduce recidivism. Knowledge of youths' experiences of school reintegration may inform discharge planning and transition services.

The purpose of this study was to explore the youths' perceptions of school reintegration following psychiatric hospitalization, and to explore clinical features (i.e., self-reported mental health problems and psychiatrist reported acuity, length of stay (LOS), and improvement) and school variables (i.e., school engagement, academic difficulty and school refusal) associated with negative school re-entry experiences. Practice experience also suggested that youth with prior admissions may have different school reintegration experiences than youth without prior admissions; thus, differences in school re-entry experiences were explored between these two groups. Though this study is exploratory in nature with no specific hypotheses, it was anticipated that youth with negative school re-entry experiences would report greater emotional problems and school-related difficulties, and would have higher acuity, LOS and less improvement than youth with positive school re-entry experiences. An initial survey was conducted with 161 youth while hospitalized for psychiatric care to explore their concerns when anticipating discharge from hospital (see Preyde et al., 2017). The present report was based on actual experiences post-discharge gathered with a post discharge survey about the recent school reintegration experience completed post-discharge. Institutional clearance was provided by the Research Ethics Boards of Grand River Hospital and the University of Guelph.

Methods

Setting

The setting was the Child and Adolescent In-patient Psychiatry (CAIP) unit which provides services to the local communities and surrounding regions. CAIP provides stabilization, treatment, and comprehensive psychiatry assessment and care through multidisciplinary team involving Psychiatrists, Mental health Nurses, Social workers, Child Youth workers, a School teacher, and a music therapist. The comprehensive assessment includes assessments of the intensity and risk factors for self-harm or suicide attempts, medication use and dose adjustments, laboratory findings and imaging studies, and the psychological-, social- and family-related stressors. In addition to stabilization, the team may also attend to improving communication between patients and families; mental health education to patient and family members; safety and crisis planning for after discharge; communication with school and other community agencies to improve support for patients and family members; and post discharge follow up and treatment planning. While in the hospital youth engage directly with treatment team clinicians as well as in group settings; and also are provided with materials for self-learning on common mental health issues and for developing coping skills. The team also addresses issues around life style choices, nutrition, exercise and sleep, drug abuse or addiction issues. One important aspect of acute hospitalization is to assess for need to engage in long term hospitalization in other appropriate institutes in the community, and help families with referral processes and to facilitate transfers of patients.

Since this is a regional unit, transition services are different for different regions. For the city in which the hospital is located, Transition Support Services (TSS) are available. TSS is a multidisciplinary team treatment approach that includes Child and adolescent psychiatrists, mental health nurses, social workers, a child youth worker and a occupational therapist. TSS offers up to 3 months of post in-patient comprehensive mental health and behavioral support to patients and families. The program offers continuation of treatment after in-patient care; short term individual therapy and family support work; medication management; ongoing engagement with community agencies including schools; as well as help with long term outpatient treatment planning and referral process. Prior to discharge patients are referred to TSS and often a member of the outpatient team visits the unit to meet the patient, thus the first appointment is a meeting with an outpatient team member and the inpatient psychiatrist prior to discharge. While hospitalized patients develop a set of goals for both inpatient and outpatient care, and they take that goal sheet to the outpatient team after discharge which includes the psychiatrist who cared for the youth during his/her hospital stay. At the first TSS visit the youth and clinician use the set of goals to help set the focus of the outpatient treatment plan. These youths can also access support available from Community Care Access Centres (CCAC) either as an alternative to the TSS program or after discharge from the TSS program.

For some other regions the main transitional support is provided by CCAC often with mental health nurse liaison. Mental Health and Addictions Nurses in Schools program was developed to serve students who could benefit from short-term support from a community mental health and addiction nurse. Nurses can provide a range of assistance including aid for students who have recently presented to hospital, and students with psychotropic medication issues. In another main neighbouring city, post discharge CAIP patients are mostly scheduled for psychiatric follow-up one to three weeks post discharge in the community hospital, and then other individualized community services that are organized on CAIP are gradually introduced. For a neighbouring county, most patients are referred back to community mental health care provided by the Canadian Mental Health Association, and are generally assigned to a case manager/

crisis worker who follows up with them usually within two weeks and then takes CAIP recommendations and further works on developing a service plan.

Participants

In the original survey, youth 14 years and older, and parents of youth 13 years and younger were informed by hospital personnel that a study was in progress, and requested consent to release their contact information to research assistants (RA) to learn more about the study. For those who consented to be contacted by the RA, the RA fully described the study and obtained informed consent. For youth 14 and older, the RA then administered the survey. For youth younger than 14, the RA obtained informed consent from the caregiver and then obtained informed consent from the youth, and then administered the survey. Surveys were completed in a quiet space in the in-patient unit. Youth were also asked if they would like to participate in follow up surveys after discharge (FUS), and if so, their contact information was collected.

Contact was made by either telephone or email, depending on the contact information the youth provided. Some youth preferred to respond to questions by phone with the RA (n=40); others preferred to complete on the survey online using Qualtrics (n=22). Informed consent was obtained.

Measures

For both the phone and online survey, the survey instrument contained open- ended questions about their experiences of returning to school. Youth were asked: "Think back to your first day (or first few days) of going back to school after CAIP, how did that go for you? Did you experience any challenges or problems?" "How did you manage challenges?" "Did anything go particularly well with going back to school?" The survey ended with the question "Is there anything else you think it is important for researchers to know about your experiences?"

Measures obtained while the youth were hospitalized included standardized self-report measures of mental health problems, school engagement, school avoidance and academic difficulty, and four items where youth were asked to rate their concerns about studies, friends, other students and emotions for transitioning to school upon discharge on a scale of 1 (no concern) to 5 (very concerned). Mental health problems were measured with the Strengths and Difficulties self-report scale (SDQ; Goodman, 1997; Goodman, Renfrew, & Mullick, 2000) which has been shown to be valid and reliable (Goodman, 2001; Goodman, Ford, Simmons, Gatward, & Meltzer, 2000; Goodman & Goodman, 2009; Goodman, Meltzer, & Bailey, 1998; Lundh, Wangby-Lundh, & Bjarehed, 2008). The SDQ has five subscales: emotional problems, hyperactivity, conduct problems, peer problems and prosocial behaviours. The total score is the sum of the first four subscales (not including prosocial behaviours). It is one of the most widely used instruments in youth mental health research (Vostanis, 2006).

School engagement was measured with the School Engagement Scale (Fredericks, Blumenfeld, Friedel, & Paris, 2005) which contains 15 items on a 5-point scale (with a higher score indicating greater engagement). It has shown good internal consistency and predictive validity and strong face validity (Fredericks et al., 2005). A sample question is: "I am interested in the work at school." Academic difficulties and school avoidance were measured with modified subscales of the Child report version of The MacArthur Health and Behaviour Questionnaire (HBQ-C: Armstrong, Goldstein, & the MacArthur Working Group on Outcome Assessment, 2003) which was modified to allow for a 5-point response option in order to be consistent with the school engagement measure. A sample item for the academic difficulties measure is "It's hard for me to learn new things." A sample item for the school avoidance is "Sometimes I pretend I am sick so I can stay home from school." The HBQ-C has demonstrated strong psychometric properties (Ablow et al, 1999; Essex et al., 2006; Lemery-Chalfant et al., 2007; Shirtcliff & Essex, 2008), and has been used with children and adolescents with mental health disorders.

In addition to the youth self-reported SDQ, clinical features were obtained from the most responsible psychiatrist (MRP) who provided clinical information based on the Global Clinical Impression scale (Guy, 1976). Scores for acuity can range from 1 (normal) to 7 (most extremely ill). Scores on improvement can range from 1 to 7 with 1 representing very much improved, 4 representing no change and 7 indicating that the youth is very much worse.

Data Analysis

Phone interviews were recorded and transcribed verbatim. Youths' responses to the online survey were already in typed form. Thematic content analysis (Braun & Clark, 2006; Green & Thorogood, 2013) was used to categorize the qualitative data. Common responses were coded to develop themes. Negative case analysis was made explicit with the inclusion of polar questions (e.g., what was challenging; what went well). Two trained research assistants analyzed the data independently, with agreement on all but one case, and consensus was readily reached with discussion. Coders first read each transcript to get a general or overall sense of the information then used coding to organize the information by common experiences. To compare pre-discharge characteristics of youth who reported a neutral or positive transition experience to youth who reported a negative experience, youths' responses were categorized as having either a neutral-positive or negative experience based on their responses to the question "Think back to the first day or few days of going back to school after leaving

CAIP, how did that go for you?" The 'neutral-positive' grouping included responses that contained both positive and negative experiences such as "I was nervous but it went good" and "Good and bad" and "Scary but I had a lot of support" and "The first day was really good. My teachers were really supportive. A few days after that I got really stressed out with how much I was behind." The neutral-positive group also included the idea that school reintegration was fine but alterations had been made such as "It was a bit nerve wracking, uhm, but I felt… better that, uhn, it was less pressuring now that I didn't have to do credits… and that we re-evaluated the way I would do school". Examples of responses that were coded as a negative experience include "It was too stressful so I didn't go back to school", ""Bad. Terrible. Stressful. Horrid. I felt like they put me on a ship that they wanted to sink", "Horrid, it was tough, everyone was asking where I had been…" and "I was really overwhelmed … they like just kind of dumped my work on me." Two youth did not provide response to this question thus they were not included in this analysis. Subsequently, t-tests were used to explore statistically significant differences on pre-discharge measures between youth who reported neutral-positive versus negative experiences, and between youth with prior versus no prior CAIP admissions. It should be noted that the assumption of independence was not maintained with exploring the total SDQ and emotional subscale with two separate t-tests, thus the Bonferroni correction can be used to interpret the results; the significant α level is 0.025. We also explored whether the youths with previous CAIP admissions differed from those with no prior admission experience on their reported transition experiences with Chi-square.

Table 1. Youth characteristics, n = 62

Age, mean (SD)	15.63 (1.780)
Gender, no. (%)	n = 59
Female	42 (86)
Male	17 (27)
Grade, no. (%)	n=58
8	2 (3.2)
9	9 (14.5)
10	19 (30.6)
11	15 (24.2)
12	13 (21)
Number of school days missed, mean (SD)	n = 45 6.8 (6.96)
Returned to school, no. (%)	n = 160
Yes	58 (94)
No	4 (6)
Primary diagnosis, n (%)	n = 60
MMD (included 1 youth with BPD)	36 (60)
Anxiety disorder	14(23)
Adjustment disorder	9(15)
ADHD	6(10)
Parent-child relationship disorder	4(7)
Substance use disorder	4(7)
PTSD	2(3)
ODD	2(3)

Results

Of the original 161 patients who participated in the pre-discharge survey, 121 patients consented to participate in follow up surveys post-discharge; however, in ten cases the contact information was not valid and 47 did not respond to messages that were left. The RA tried an average of 5.5 times to contact youth before discontinuing attempts. Thus, we were only able to contact 64 youth and 62 youth actually participated; that is, two youth declined interviews after they were contacted by telephone. Their mean age was 15.56 years and 68% reported being female (See characteristics in Table 1). The most common primary diagnosis was mood disorder (n=32; 52%) followed by anxiety disorder (n=14; 23%).

In total, 60 youth responded to the question: Think back to the first few days of going back to school after CAIP, what was it like to go back to school? How did that go for you? Of these 31 (51.7%) reported neutral-positive experiences and 29 (48.3%) reported negative experiences. A greater proportion of youth who reported negative experiences were female (n=25 vs 3 in neutral-positive group; chi squared = 8.9, p = 0.04). Viewing pre-discharge data, the emotional problems subscale (p=0.02) and the total scores (p=0.04) on the SDQ were lower for youth reporting negative school reintegration experiences (see Table 2) than for those reporting neutral-positive experiences. There was also a statistical difference in psychiatrist reported improvement prior to discharge with youth with neutral/positive experiences considered much improved and youth with negative integration experiences as minimally improved (p=0.02). Though not statistically significant, hyperactivity (p=0.08) and length of stay (p=0.09) may be important to explore in future research. It should be noted that there were no statistically significant differences between youth who reported a neutral-positive transition and youth who reported a negative transition on self-reported academic difficulty, school engagement, school avoidance or concern for studies.

Some youth did not return to school or did not fully return. Of the 62 youth, four youth reported that the transition was too overwhelming and they did not go back to school, one had attempted but was uncertain about returning. Four youth reportedly returned with a reduced or altered work load or setting. For example, two youth stated that they went back

Table 2. Characteristics of youth with neutral-positive versus negative school reintegration experiences

Characteristic	Neutral-Positive n = 31	Negative n = 29	T-Test	Significance
SDQ Total, mean (SD)	19.8(5.7)	22.7(4.9)	2.08	0.04*
Emotional problem	6.8(2.6)	8.1(1.7)	2.31	0.02*
Hyperactivity	6.3(2.2)	7.3(1.9)	1.77	0.08
Conduct disorder	2.6(1.9)	3.1(2.2)	0.94	0.35
Peer problems	4.1(1.8)	4.3(2.3)	0.34	0.74
Prosocial behaviour	8.2(1.8)	8.7(4.4)	0.6	0.55
Concern emotions	3.8(1.4)	4.5(0.9)	2.27	0.03*
Concern friends	2.7(1.3)	3.1(1.5)	0.91	0.37
Concern other students	3.2(1.4)	3.6(1.5)	1.05	0.3
Concern studies	3.5(1.3)	3.2(1.2)	1.08	0.28
Academic difficulty	3.2(0.7)	3.1(0.8)	0.17	0.87
School engagement	2.6(0.7)	2.5(0.5)	0.58	0.56
School avoidance	3.4(0.9)	3.6(0.8)	0.96	0.34
Acuity	3.51(1.0)	3.90(0.8)	1.61	0.11
Improvement	1.97(1.2)	2.62(0.9)	2.37	0.02*
LOS	6.53(2.9)	8.10(3.0)	1.75	0.09

*p < 0.05

but "spent a lot of time in my guidance office" and "I didn't really go to class. I sat in a side room and moved around the school until I could leave." One youth reported a gradual return to full classes. Another youth stated: "I only go to half days now. School is very hard for me now."

Three main themes surrounding school reintegration emerged from the youths' qualitative responses in response to the questions on experience and challenges: youth reported difficulties with social situations, academic progress and mental health symptoms. In total, 16 youth expressly reported social difficulties, ten expressly reported academic difficulties including difficulties with catching up and ten youth expressed difficulty with emotions. Many youth reported ongoing difficulty with managing clinical symptoms and their connection to either social or academic difficulties.

Social situations: Many youth expressed heightened concern about social encounters upon reintegration. Many difficulties concerned not know how to respond to questions, worry about what others thought of them, attempts to keep the hospitalization and their personal health information a secret, loss of friendships or supports, and bullying. The most numerous social difficulties concerned not knowing how to handle social situations. For example, one youth reported: "Embarrassing. [I] did not know what to say to people who would ask me and I did not know how to handle this situation". Some of the difficulties with social difficulties included sentiments about their outlook such as "I had difficulties maintaining interpersonal relationships at school and also keeping up with schoolwork. I did not have the will to attend school."

Many youth reported the impact on friends. Example comments include: "Lost friends...", "…my friends…dropped me so that didn't leave me with a lot of support" and "Yes, I lost a lot of friends." Some youth also reported negative responses from classmates. For example, one youth offered: "one of my friends told the school that I was in the hospital so people started calling me names and being afraid of me". Other youth reported feeling bullied. Such comments include: "I saw people that I didn't necessarily want to see. And people where asking me where I was a lot. Uhm, I experienced more bullying." and "Name calling, questions, rumours, people hurting me physically." This youth's comment includes the notion of perceived stigma: "It was hard trying to explain to people where I had been, many of them knew I was a self-harmer and were quick to make assumptions. I actually only returned for my grade and graduation.

It was horrible. I was bullied and came back to CAIP an hour later."

While some youth found it beneficial to inform their teachers and friends and to gain support from them, other youth went to great lengths to conceal their mental health problems. For example, one youth stated "Kids asked me a lot of times where I was and I had to lie" and another youth explained "It was scary because no one knew what/where I went and everyone was asking me… I told people I went on vacation".

Academic: Several youth reported considerable difficulty with their academic studies. Example comments from youth include: "I was very behind on projects and scraped a 75% (a pity pass), not a good experience", "Yes. Failed geography because of absence." and "I had difficulties catching up and felt my teachers didn't help. I was expected to do everything I was supposed to do before, everything I missed and everything new we were doing." Some youth also reported difficulty with academic learning or the setting that predated their hospitalization. For example, one youth offered: "The academic portion is what I'm worried about because being in a classroom setting is something that makes me overwhelmed." Another youth offered: "… the biggest problem was me stressing out over the tests on the subject that we learned uhmm even with all the help I got, I was still having trouble remembering it all… I fell behind …learning stuff is hard to catch up on if you're not smart enough, right?".

It should also be noted that some youth managed their coursework, sought and obtained extra assistance from teachers, and were able to undertake the extra work needed to catch up. For example, one youth stated: "I had to work… like double time… because I was out of school for a while...I brought a lot of my work home and did it".

Mental Health Symptoms: The on-going difficulty of managing psychiatric symptoms while at school or while trying to complete academic tasks was a considerable challenge for many youth. Example comments include: "Yes, trouble focussing and staying at school.", "I had difficulties with anxiety, focus, mood, temper, and trouble keeping up with work.", "Stressful getting back.", "I was really nervous and anxious." and "My main problem was dealing with my anxiety." One youth reported "I was really grumpy all the time. Snappy. Just mostly snappy…Umm, I kinda had a lot of like back and forth positive-negative thoughts, mental conflict. Umm, it was focus, but I tend to have focus problems anyway…"

Some youth spoke about the impact of symptoms socially, for example: "It was challenging to be emotionally stable. It was hard to be with friends at school. My mom kept me home from school for a few days after I was discharged because I was not ready to go back." In some cases, some aspect of the school seems to have preceded difficulty with symptoms. For example, youth commented: "I had a couple of anxiety attacks from dealing with the flood of people and noises and all that." and "…missed class time caused extreme stress."

Many youth also expressed problems in motivation or despair or disconnect. Youth reported: "I was failing all the classes so there was no point.", "There was a sense of ummm emotional disconnect from my peers and my friends." and "It was pretty horrible. I didn't talk to anyone. I felt like school was pointless and that I didn't belong there. There's just no redeeming qualities that I can think of. I have no direction, no motivation, no passion, no friends, only loneliness, sadness, hopelessness, distraught, dissatisfaction and my own thoughts."

In the follow-up survey, 38 of the 62 youth (61%) responded to the question: Did anything go particularly well with going back to school? Twelve youth reported that assistance from school personnel including teachers, guidance counsellors, social workers and child & youth workers helped with their school reintegration. Eleven youth mentioned support from 'friends' (one stated classmates and one stated 'people') as facilitating the transition. Six youth reported factors outside the school system such as improvements in home life or family relationships (e.g., "Relationship with my mom got a bit better" and "I was able to cut some toxic people out of my life with help from CAIP and my school") and two youth reported improved mental health symptoms that eased the transition back to school (e.g., "I wasn't as moody"). For example, one youth reported: "After leaving CAIP my mind was calmer and less stressed than before. Because of CAIP my self-harm and suicidal thoughts seemed to have gone away for two months. It was difficult at first but when I learnt to control my stress, I was alright." Two youth reported that the 'routine' or 'rhythm' of school facilitated the transition.

Of the 62 youth 43 reported that this school re-entry was their first. There was no statistically significant difference between those with or without prior admissions to CAIP and whether or not they experienced a positive or negative school reintegration (χ^2= 2.39, p = 0.122). Viewing pre-discharge data, statistically significant differences were evident with youth with prior CAIP admissions (n=19) reporting greater concerns for school re-entry for friends (p=0.001) and other students (p=0.03) and greater peer problems (p=0.04) but not concern for studies than youth without a prior admission. In addition, the MRP reported longer length of stay (p=0.03), greater acuity (p=0.04) and less improvement (p=0.04) for youth with prior admissions compared to youth for whom this admission was their first admission (See Table 3).

Youth were asked if they received any special resources at school and 36 (58%) replied to the question. Only one youth expressly reported receiving assistance from a 'transition worker' and four youth reported assistance from a

Table 3. Characteristics of youth with and without prior admissions

Characteristic	Prior Admit n=19	No Prior n=43	T-test	significance
SDQ Total, mean (SD)	22.6(5.5)	20.4(5.4)	1.48	0.15
Emotional problem	7.9(2.1)	7.3(2.3)	1.01	0.32
Hyperactivity	6.9(2.3)	6.6(2.1)	0.48	0.64
Conduct disorder	3.2(2.0)	2.7(2.1)	0.92	0.36
Peer problems	4.9(1.8)	3.8(2.0)	2.13	0.04
Prosocial behaviour	8.2(1.8)	8.4(3.7)	0.28	0.78
Concern emotions	4.2(1.2)	4.0(1.3)	0.48	0.63
Concern friends	3.7(1.3)	2.5(1.2)	3.55	0.001*
Concern other students	3.9(1.4)	3.0 (1.4)	2.18	0.03*
Concern studies	3.1(1.2)	3.5(1.2)	1.21	0.23
Academic difficulty	3.1(0.6)	3.2(0.8)	0.05	0.99
School engagement	2.4(0.7)	2.5(0.6)	0.72	0.48
School avoidance	3.7(0.8)	3.4(0.9)	1.01	0.32
Acuity	4.00(0.7)	3.6(1.0)	1.78	0.04*
Improvement	2.74(1.1)	2.12(1.1)	2.08	0.04*
LOS	8.74(4.1)	6.64(3.0)	2.24	0.03*

*p < 0.05

nurse from the Community Care Access Centre (CCAC). Other sources of support include social work and counselling. Seventeen youth of the 53 who replied to this question (32%) reported receiving accommodations including use of a resource room and student success rooms.

Discussion

This report addresses two interconnected topics; what are the school reintegration experiences of youth hospitalized for psychiatric care, and are school-related factors and / or clinical features associated with a negative school re-integration experience. School-related and clinical factors were compared between youth with and without prior admission. Three main themes were identified in youth reported experiences of school re-integration following psychiatric hospitalization: difficulties with social situations, academic achievement and mental health symptoms. A significant proportion of youth reported considerable difficulty with social interactions during school reintegration. Many of these difficulties stemmed from the youths' anxieties or worries about what others thought of them, how to explain their absences, and when people did learn of their psychiatric condition and hospitalization some youth reported negative social consequences including bullying and losing friendships. While most reports about school personnel were positive, a few youth reported negative experiences with teachers including being worried what teachers thought of them. These findings also suggest that many youth who were admitted to psychiatric hospital experience significant social interactional challenges that may place them at-risk for social isolation and exclusion.

The qualitative responses suggest that stigma is a considerable issue with which youth with psychiatric illness must manage upon school re-entry, and raises questions about the best way to help youth navigate this situation. Three main strategies commonly used to help reduce stigma are protest, education and contact; however, none have been shown to reduce stigma toward specific individuals (like the youth in this study) though stigma in general may be affected (Penn & Couture, 2002). While attempts at normalizing or reducing stigma through exposure in the school setting may be well-meaning, not one youth reported finding it helpful or even desired. How to best address stigma, discrimination and bullying against youth who receive psychiatric treatment in the school setting is an important topic for future research.

Upon school reintegration, many youth reported considerable academic difficulties. Many youth felt overwhelmed with the prospect of completing missed work and the impact on their grades or number of credits. Many youth reported that the challenges in trying to catch up exacerbated their mental health symptoms. These findings suggest that many

youth who were admitted to psychiatric hospital experience significant academic challenges that may place them at-risk for low educational attainment and the subsequent consequences with respect to reduced employment options, low income and reduced self-sufficiency. The uniqueness of each youth's experiences with their mental health symptoms and academic challenges suggest individualized supports may be needed. Additionally, the uniqueness of each youth's approach to schoolwork in general, independent of their mental health difficulties at the time, may influence their approach to completing missed work. The other issue which may contribute is that many youth do not really want to be discharged from CAIP and think they should stay longer, which may influence their perception of the school reintegration experience.

A third theme concerned attempts to manage on-going clinical symptoms, or the interactions between mental health symptoms and academic difficulties or social encounters. Many youth reported feeling anxious, overwhelmed, nervous and scared in general, and in relation to social situations or missed school work. A small number of youth reported that their mental health symptoms prevented their return to school at all or seriously affected their ability to fully engage in academic activities or navigate the school environment. Some youth also reported challenges related to a lack of motivation, feelings of despair or disengagement from others. The only self-reported variables pre-discharge that differentiated those who transitioned well from poorly were the emotional difficulties subscale and the total psychological difficulties scale as measured by the SDQ, and concerns for emotions when contemplating a return to school. Psychiatrists also reported less clinical improvement pre-discharge in youth who transitioned poorly compared to those whose transition was neutral or positive. These findings suggest that some youth at-risk for negative school reintegration experience may be identifiable pre-discharge which can guide treatment and discharge plans.

It should be noted that some school reintegration experiences of youth with psychiatric illness may be similar to children with complex medical illnesses. In particular, children with medical illness may also experience academic, cognitive and socio-emotional difficulties across various medical diagnoses and stages of recovery, and that children can experience challenges when trying to manage the symptoms of their illnesses (Botcheva, Hill, Kane, Grites, & Huffman, 2004). Differences in school reintegration experiences may be present for conditions that are visible (e.g., burns) versus invisible (some psychiatric illnesses) and for conditions that may be associated with stigma (e.g., psychiatric illness) versus those with less stigma (e.g., cancer).

Implications for practice and research

The youth who reported negative transition experiences also reported greater emotional problems and concern for their emotions, and were rated as having significantly less improvement during treatment as reported by their psychiatrist than their counterparts. It should be noted that there were no statistically significant differences between youth with negative versus neutral/positive re-entry experiences on school-related factors (i.e., school engagement, avoidance and academic difficulty). Thus, youth who are at risk for transition difficulties might be identifiable before discharge. These at-risk youths might benefit from additional and personalized clinical supports with a particular focus on coping skills and management of their emotions prior to and after discharge.

Despite attention to transition services, many youth still report considerable challenges when returning to school post-discharge. Some youth reported that their challenges prevented them from returning to school, or returning to the same school environment. Conversely some youth reported a seamless transition to school. These results suggest the need to identify youth at risk for adverse outcomes following psychiatric hospitalization including negative social experiences during school re-entry, negative impacts on educational achievements and difficulty managing on-going clinical symptoms. Moreover, no standardized measure of school reintegration post-psychiatric hospitalization could be located; hence these findings may prove useful for future scale development.

Youth with prior admissions to CAIP reported significantly greater concerns about friends and other students when thinking about reintegration than youth with no prior admission (and perhaps no reintegration experience following psychiatric hospitalization). Youth with prior admissions were also rated by the MRP as having greater acuity, less improvement and longer length of stays. Further research is needed to advance understanding of readmissions and targeted intervention for these patients.

Limitations

To our knowledge this report is the first to document child and adolescent patients' perspectives of their actual school re-integration experiences following psychiatric hospitalization; however, it should be interpreted with a view to its limitations. This study was conducted with one hospital serving mid-sized cities and rural areas within geographical regions with patients attending schools in seven different school boards, private schools, alternative schools (Section 23), homeschooling and one college, and some were not in school at all. Since the youth had different post-discharge service environments, these findings may not have accurately captured these differences or be reflective of youths'

experiences in other areas such as large cities or remote areas. The study sample size is considered more than adequate for qualitative inquiry (Creswell, 2007) but not for multivariate analyses (Long, 1997). Additionally, whether these experiences are representative of all youths' school transition experiences following hospitalization for psychiatric care requires further exploration. The influence of investigator bias is possible; though several efforts to minimize bias were utilized including two independent raters, significant agreement between raters, peer debriefing (provided by MP) and the use of a semi-structured interview protocol. In addition, this study only reflects the views of the patients which may not provide as full a description of school integration if hospital- and school-based professionals' perspectives were added to the findings. In addition, self-reported measures of academic and mental health problems, and school engagement and avoidance were gathered while the youth was hospitalized for psychiatric care, which may have affected their responses. Lastly, two different methods of data collection were used: post-discharge surveys were completed by telephone (n =40) with a trained interviewer or by an online platform (n= 22) depending on the youths' preference, though there were no statistical baseline differences between those who completed the telephone versus online surveys. Most of the time, responses were brief phrases and simple sentences. The responses elicited by telephone were fuller descriptions than the online option that required youth to type their responses and the opportunity for clarifying the question or answer was possible with the phone interview. Taken together, telephone surveys post-discharge may have yielded fuller descriptions and were most costly than the online format.

Conclusion

These youths' school reintegration experiences provide critical insight into a pivotal transition and developmental period. Despite recent efforts to provide transition support, many youth still report considerable difficulties with school re-entry including not returning to school, not knowing how to handle social situations, not performing well academically, difficulties with interpersonal relationships, difficulty managing psychiatric symptoms, and stigma and bullying. However, several youth also reported being empowered with coping skills learned through programs, successfully completing academic requirements and the support of good professional and social networks. Youth who reported negative school reintegration experiences reported higher severity of emotional problems and had less improvement while hospitalized compared to youth who reported neutral or good reintegration experiences. Thus, identifying which youth are at risk for poor outcomes following psychiatric hospitalization and providing greater access to mental health resources post-discharge may enhance school experiences and outcomes.

Acknowledgements / Conflicts of Interest

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