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School Reintegration and Perceived Needs: The Perspectives of Child and Adolescent Patients During Psychiatric Hospitalization

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Abstract Youth hospitalized with psychiatric illness often experience disruption in their school attendance. Knowledge from the youths' perspective of concerns for returning to school after hospitalization is very limited. Exploring youths' concerns for school reintegration may inform transition practices for youth with psychiatric illness. The purpose for this study was to explore youths' concerns for school reintegration and to report their perceived needs for support before leaving hospital. A questionnaire was developed to capture qualitative perceptions and quantitative self-reports of youths' concerns for school reintegration. Child and adolescent patients accessing in-patient psychiatric care completed surveys containing open-ended questions about their concerns and service needs at discharge, and self-ratings of their concerns for their studies, friends, other students and emotions. One hundred and sixty-one youth (mean age 15.41, SD 1.4; 75% female; 57% with a primary diagnosis of major depression) reported considerable concerns about anticipated social situations at school, academic standing, feeling overwhelmed with school and great difficulty with managing their emotions. Youth identified a need for ongoing supports from mental health professionals and school personnel, social support from friends and family, and educational assistance or modifications. High rates of intense worries reported about school issues and school reintegration suggest this vulnerable population may benefit from increased attention to transition planning. Two important developmental domains, social development and educational outcomes, appear at-risk and this risk highlights the need for a greater emphasis on continuity of care.

Keywords School re-integration · Social isolation · School-related difficulties · Needs assessment · Social development

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Introduction

It has been estimated that approximately 20% of youth experience a mental health disorder with 14% in the clinic range (Angold & Costello, 1995; Waddell, Offord, Shepherd, Hua, & McEwan, 2002). Moreover, recent reports indicated "rapid burgeoning" of visits to mental-health emergency departments and significant increases in psychiatric hospitalizations (Chun, Mace, & Katz, 2016; Gandhi et al., 2016) by American and Canadian youth. Children and adolescents are referred to in-patient psychiatric care for crisis intervention and stabilization for a number of mental health disorders.

Hospitalization can disrupt educational attainment (Breslau, Lane, Sampson, & Kessler, 2008; Shaw & McCabe, 2008) and mental health symptoms can disrupt learning in the classroom (Stewart, Klassen, & Hamza, 2016). Moreover, investigators have shown that in addition to or interwoven into the mental health disorder are academic or school-related challenges that many of these youth also experience. Challenges at school may be related to their mental health, the crisis leading to admission and / or their school re-entry after psychiatric hospitalization. Some of these challenges may include poor academic functioning (Buckle et al., 2005; Reid et al., 2004; Zimet & Farley,

1993), school-associated problem behaviour such as attentional and thought problems, and social problems (Fagel et al., 2014) school avoidance (Knollmann et al., 2010) and bullying (Waseem, Arshad, Leber, Perales, & Jara, 2013). Difficulty transitioning back to the community school upon discharge has been identified as a major concern (Clemens, Welfare, & Williams, 2010, 2011; Simon & Savina, 2007; Savina, Simon, & Lester, 2014; Weiss et al., 2015); however, no report of the youths' perspective of concerns for school re-entry could be located. Therefore, the purpose for this study was to explore youths' concerns for school reintegration while hospitalized for psychiatric care, and to explore youths' reported needs for transitioning back to their regular school upon discharge. This study is consistent with emerging emphasis on youth voice, engagement, empowerment and respect, and a patient-centred approach that may foster user-friendly services.

Transitioning from psychiatric hospital to school has been examined by eliciting the perceptions of the mental health professionals and caregivers. Simon and Savina (2007) and Clemens et al. (2010) found that the mental health professionals reported that youth experience difficulties in academic functioning; interpersonal relationships with peers, parent and school personnel; personal coping skills and readjustment; youths' mental health challenges (e.g., anxiety and disruptive behaviour); and that readiness for discharge may not necessarily indicate readiness for return to school. Caregivers of youth hospitalized for mental health disorder have reported a need for increased knowledge, emotional support and improvement in their child's socio-emotional functioning and access to school supports (Blizzard, Weiss, Widemann, & Stephan, 2016). No reports could be located of youth-reported perceptions of academic and school difficulties related to the youths' mental illness and transition to school post discharge from psychiatric hospitalization. This preliminary research suggests that understanding and addressing school-related difficulties and supporting youth through the transition may reduce recidivism, ease stress and improve youths' quality of life, and ultimately their educational outcomes and employment.

Theoretical Framework

Adolescence is a developmental period characterized by pubertal changes, increased reliance on peers and greater autonomy from parents, as well as increased susceptibility to social contexts (Blackmore & Mills, 2014). For many youth, the pre-adolescent and adolescent period also marks the onset of mental health disorders that hinder social functioning which could be experienced by youth as stressful. Particularly for youth with psychiatric illness, the social environment may be uniquely important for specific developmental risks, such as social isolation and loneliness (Matthews et al., 2016) and protective factors such as school connectedness (Bond et al., 2007). Moreover, hospitalization and school disruption can be significant stressors for youth with psychiatric illness and their caregivers. Lazarus and Folkman (1984) posited in their theory of stress and coping that the youths' appraisal of their situation (in this case, the impending discharge), of their coping abilities and resources will affect how they view the situation, including how stressful they may perceive it to be. These theories allow for the exploration of youths' experiences through intrapersonal, interpersonal and ecological lenses.

Purpose

The purpose for this study was to explore these patients' perspectives about their impending transition from psychiatric hospital to the community school and their needs for support, and to discover the extent to which child and adolescent psychiatric patients report learning difficulties due to their clinical symptoms. This report is part of a larger study on youth experiences of psychiatric hospitalization. Given the exploratory nature of this study, no specific hypotheses were set; the aim was to describe youths' perceptions of their concerns and anticipated needs for school reintegration following discharge.

Methods

Institutional clearance was provided by the Research Ethics Boards of Grand River Hospital and the University of Guelph. From October 2015 to March 2016 all children and adolescents who were consecutively admitted to the child and adolescent in-patient psychiatry (CAIP) unit were invited to participate while they were in hospital. It is routine practice for medical staff to assess patients' mental capacity to engage in or provide consent for treatment. For this study medical staff assessed patients' capacity to provide informed consent, and patients with active psychosis and developmental disability were excluded. Adolescents aged 14 years and older were informed by Nursing staff about the study and asked if they would like to speak with a research assistant (RA) to learn about the study. For adolescents who agreed to speak with an RA, the RA fully described the study and obtained informed consent. For children under 14 years of age, CAIP staff contacted parents/guardians, informed them that a study opportunity was available and asked if they would like to speak with an RA to learn about the study for their children to participate. For

those who agreed, the RA contacted the parent by phone, fully described the study and requested informed consent for the children's participation, and obtained child assent. For those who provided informed consent, the RA administered a semi-structured, paper-and-pencil questionnaire in a private room in the CAIP unit. The most responsible psychiatrist (MRP) provided clinical information based on the Global clinical impression scale (Guy, 1976).

To maintain confidentiality, two tracking systems were used. The nurses maintained one record of all youth and recorded reasons for exclusion and whether consent to refer to an RA was granted. The RA tracked only youth for whom consent to hear more about the study was obtained. The RA then recorded whether informed consent (or child assent) was granted. The surveys were coded, and the code transcribed onto the clinical form so that the surveys and clinical information could later be linked without any identifying information. The RA temporarily knew the name of the youth to indicate to the psychiatrist for which youth the form was to be completed and the psychiatrist destroyed the note that included the name and returned the anonymous clinical forms to the RA.

Setting

The CAIP unit is a general psychiatric child and adolescent unit and a crisis unit: assessment, stabilization and treatment are provided. The mean length of stay is approximately 7 days. Following admission, parents often visit the unit the next day to provide intake information and receive counselling. The unit serves the city of Kitchener, Ontario, Canada and the surrounding regional counties including rural areas, towns and cities.

Measures

A questionnaire was developed to capture descriptive information and qualitative responses about concerns for school re-entry and perceived needs after discharge. Youths were asked to rate their concerns for transitioning to school upon discharge on a scale of 1 (no concern) to 5 (very concerned), and they were asked a general open-ended question about their main school-related concerns after discharge (Do you have concerns about returning to school when you leave CAIP? If so, what are your concerns?). This general question was followed by specific questions about their studies (Do you have any concerns about your studies or grades? If so, please describe them), teachers (Do you have any concerns about teachers? If so, please describe them), and friends or other students (Do you have any concerns about friends at school or other students? If so, please describe them). Youth were also asked about other concerns besides school and if they had ever changed schools because of difficulties.

To describe the sample, the survey included standardized measures of a behavioural and psychological screening questionnaire and clinical diagnoses provided by the psychiatrist. Psychological difficulties were measured with the strengths and difficulties self-report scale (SDQ; Goodman, Ford, Simmons, Gatward, & Meltzer, 2000). It has shown good validity and reliability (Goodman, 2001; Goodman et al., 2000; Goodman & Goodman, 2009; Goodman, Meltzer, & Bailey, 1998; Lundh, Wangby-Lundh, & Bjarehed, 2008) and has five subscales: emotional problems, hyperactivity, conduct problems, peer problems and prosocial behaviours. It is one of the most widely used instruments in youth mental health research (Vostanis, 2006). The total score is the sum of the first four subscales (not including prosocial behaviours). A four-fold classification system (Goodman, 1997) is used to interpret scores as close to average (80% of the population), slightly high (the next 10%), high (5%) and very high (the severest 5% of the population).

Data Analysis and Sample Size

Qualitative and quantitative data were collected simultaneously and were equally important for describing youths' characteristics and perceptions; a partially mixed concurrent equal status design was used for analysis. Patient characteristics were presented with descriptive statistics using SPSS version 23 (SPSS Inc., Chicago, IL, USA). Qualitative responses were transcribed verbatim and analyzed with content analysis and a consensual approach (Braun & Clarke, 2006; Green & Thorogood, 2009; Hill et al., 2005; Hsieh & Shannon, 2005) using NVIVO, (2012). The RA's notes were also compared with the transcribed data to enhance clarity and completeness. The primary author (MP) and two trained research assistants (both completed or nearing completion of undergraduate honor's degree and nearing entrance into master of science program) independently read the full transcripts and then used open coding to categorize the qualitative responses to identify broad categories or themes of youths' anticipated concerns for school reintegration, followed by concerns for specific areas (i.e., grades, teachers, friends and peers) and support needs. Sub-categories or subthemes within each domain were identified. That is, coders identified themes that emerged from the data; no predetermined categories guided analysis. There were eight instances of discrepancies which were readily resolved through discussion. Validation strategies (Creswell, 2007) consisted of comparison of independent coding, peer debriefing conducted by the first author (MP)

and negative case analysis. A sample size of 20 is often considered sufficient in qualitative health research (Green & Thorogood, 2009) to reach saturation.

Results

Not including repeat visits, 239 youth accessed CAIP during the study period, and 223 met inclusion criteria (11 youth were ineligible due to intellectual disability and five had active psychosis that did not subside in time for inclusion in the study). Of those 14 years old and older, 25 youth declined, six were discharged before the research could be completed and six were lost to the nurses' tracking system. Of the 25 youth who were younger than 14 years of age, two parents refused, one child refused and for 22 potential participants the staff were not able to contact parents about the study. The study sample included 161 (RR 72%) youth (Table 1). The mean age was 15.41 (SD 1.4) and ranged from 8 to 18 years. Most (n = 121, 75%) were female.

In general youth reported the most psychological difficulty with their emotions followed by inattention and hyperactivity (Table 1). On the SDQ, the total score, and the emotion and inattention/hyperactivity subscales were very high, the peer problem subscale score was high, and the conduct problem and prosocial scores were in the normal range. Of the 160 youth who completed this question, 151 reported difficulties with emotions, concentration or being able to get along with others. For 113 youth (70%) these difficulties interfered with classroom learning considerably. Many youth also reported that these difficulties interfered with home life, friendships and leisure activities (score range 1–4 with higher score indicating greater difficulty).

The mean length of stay was 7.32 days (SD 4.02). The most common primary diagnoses were major depression (n = 91; 57%), adjustment disorder (n = 22; 14%), ADHD/ADD (n = 22; 14%), parent–child relational problem (n = 17; 11%), social anxiety disorder (n = 14; 9%), polysubstance abuse and dependency (n = 11; 7%) and generalized anxiety disorder (n = 10; 6%). The most common diagnoses the psychiatrists reported as the reason for the current hospitalization were generalized anxiety disorder (n = 29; 18%), major depression (n = 24; 15%), parent–child relational problems (n = 14; 9%), social anxiety (n = 13; 8%), ADHD (n = 11; 7%) and adjustment disorder (n = 10; 6%). It should be noted that for 2 youth, no primary or most responsible diagnosis was provided, for 4 youth a most responsible but no primary was provided, and for 40 youth no most responsible diagnosis was provided by psychiatrists.

In terms of school specific questions, 43 youth reported changing schools due to difficulties; these main difficulties included bullying (n = 19), mental health symptoms (n = 13) and poor or no social relationships (n = 7). Youth were asked to rate concerns for returning to school (Table 2); their greatest concern was with their emotions followed by their studies (range 1–5 with higher scores indicating greater concern).

Most youth (n = 119; 74%) provided qualitative comments about concerns for returning to school while only 2 youth stated that they had no concerns and were ready to go back. In response to the general question five main

Table 1 Youth characteristics, n = 161

Age, mean (SD)	15.41 (1.40)
Gender, no. (%)	
Female	121 (75)
Male	37 (23)
Grade, no. (%)	n = 147
3–6	3 (2)
8	6 (4)
9	25 (17)
10	47 (32)
11	37 (25)
12	29 (20)
Number of school days missed, mean (SD)	*n* = 120 6.15 (6.13)
Returned to school, no. (%)	*n* = 160
Yes	123 (77)
No	37 (23)
Strengths and difficulties questionnaire, mean (SD)	157 ≤ *n* ≤ 161
Prosocial behaviour	8.06 (3.01)
Emotional symptoms	7.51 (2.40)[b]
Inattention-hyperactivity	6.99 (2.68)[b]
Peer problems	4.32 (2.52)[a]
Conduct problems	3.05 (2.10)
Total	21.74 (5.75)[b]
Difficulties[c]	145 ≤ *n* ≤ 151
Length of difficulties, no. (%)	
1–5 months	20 (13.1)
6–12 months	11 (7.2)
Over a year	122 (79.7)
Intensity of distress, mean (SD)[d]	3.13 (0.76)
Intensity of Interference, mean (SD)[d]	
Classroom learning	3.11 (0.86)
Home life	2.77 (0.82)
Friendships	2.66 (0.93)
Leisure activities	2.45 (0.98)
Impacts peers and others	2.71 (0.84)

[a]High score

[b]Very high score

[c]Selected only youth who reported difficulties with emotions, concentration or being able to get along with others

[d]Scores can range from 1 to 4

Table 2 Concerns when anticipating return to school post-discharge

Concerns about returning to school*, mean (SD)	
Emotions	3.91 (1.28)
Studies	3.35 (1.28)
Other students	2.97 (1.47)
Friends	2.76 (1.41)

*Scores can range from 1 to 5

themes were reported by youth: Themes were concerns with social situations, academic concerns, symptoms and school work, the school environment, and managing symptoms. For each theme, the definition, subthemes, and quotes from the patients appear in Table 3. Subsequently, youths' responses to questions about specific concerns about their teachers and peers were coded and are presented below.

Social Situations

The most prominent theme (n = 57) concerned how to manage social situations upon return to school, including how friends and teachers would react and what to tell them. This theme was subdivided by specific social groups: peers, friends, teachers and bullies. Youth (n = 47) were concerned about their peers' reaction. Two youth also reported that while they were at CAIP, another patient was from their same school, and the youth were worried what the other patient would say about them to classmates. Several youth (n = 9) were specifically concerned about their friends and whether their friendships would endure.

Table 3 Coded data with themes, definitions, examples and representative quotes

Theme, definition, subthemes, quotes
Social situation
Concern about how to manage social situations upon return to school, including how friends and teachers would react and what to tell them
Social group: Peers and their reactions
"People asking where I was…"(#158), ".. people find out and think I'm psycho.."(#114),"People judging me" (#86)
Social group: Concern about friends, their reactions, and if the friendship endure
"I'm worried that my friends won't talk to me anymore" (#97)
Subtheme: Concern about teachers and whether teachers will understand and be accommodating
"Teachers not understanding because I am almost in grade 11 and still don't have any credits"(#93), "That everyone will ask me what happened and the teachers won't do anything about it" (#110), "…don't want my teachers to know what happened" # (137)
Social group: Concern about bullies, and whether bullies would continue to victimize the youth
"Being bullied, being told to kill myself from peers, mainly boys." "I'm scared they are going to continue what they have been doing to me" # (59), "Seeing people who wished I would have gone through and actually have committed suicide" # (123)
Academic concerns
Concern about the amount of missed work, being behind in their studies and not feeling confident about being able to catch up
"..how much work I have missed…"(#20), "being too far behind…" (#37), and "I am scared I won't be able to catch up"(#50). "I am already quite behind in school and after returning I will be further behind; this will affect my marks which will affect my university admission" (#67) "Last year I got honour roll and now I'm going to fail my first semester"
Concern exacerbated because youth experienced academic challenges prior to hospitalization
"I wasn't able to manage going to school before which is why I came to CAIP. I find it hard to cope and causes a lot of stress" (#90) and "catching up because I was behind before coming" (#24)
Psychiatric symptoms and school work
Concern that mental health symptoms will affect academic progress
"Returning thoughts of what brought me here in the first place"(#154), "I'm nervous that I will continue to have panic attacks/negative thoughts that affect my learning."(#105), "… the way my mood has been affecting my schooling…"(#49), "Not being able to focus" (#104), "I fear that I will have difficulty concentrating on my work…"(#120)
Concern that academic challenges will affect mental health
"the schoolwork is stressing me out" (#42)
The school environment
Concern about the impact of the school social structure and organization on the youth
"The school system is terrible and will not be beneficial to me re-integrating with society" (#61), "…concerned that things will be the same when I return to school, and school was what brought me here"(#79),"Not being able to handle the environment of people…" (#153), "Don't like the social aspect, afraid it will make my anxiety worse"(#54), "Not being able to fit back in." (#160), "too many people and actually going to class" (#69)
Concern with adjusting to school routine
"feeling overwhelmed by being back to 5 classes a day,,,"(#140)
Managing symptoms
Concern with intensity of emotional symptoms and the ability to manage or control them
"I find it hard to cope and causes a lot of stress."(#90), "I am just always really stressed and anxious." (#108), "I'm nervous to go back. I don't think I'm going back due to the stress it causes" (#1)

Nine youth mentioned concerns about their teachers and their teachers' understanding of the youths' situation, and whether the teacher would assist the youth in the transition. Youth also spoke openly about bullying as one of their main concerns for going back to school. Youth expressed acute worries about social encounters in the school environment upon reintegration.

Academic Concerns

The second most common theme concerned about academic progress (n = 50). Youth reported feeling behind in their studies and needing to catch up. Several youth spoke about aspirations to attend university and that their grades were being affected by their mental health disorder. Moreover, several students reported struggling with the academic component of school prior to admission. In addition to social encounters, these academic struggles were a major concern for youth.

Psychiatric Symptoms and School Work

The third most common theme (n = 30) concerned the relationship between mental health symptoms and school tasks. This theme is subdivided into the influence of symptoms on school work, and the influence of school demands on mental health symptoms. Many youth were concerned that their mental health symptoms would interfere with their learning, or they had not made progress with their mental health. Many youth spoke about difficulty with working when they were experiencing problems with being able to focus or concentrate. Conversely, a few youth were concerned that the stress of academic demands would aggravate their mental health condition. The interplay between emotional symptoms including stress and academic demands were of considerable concern to many youth.

The School Environment

Many youth (n = 21) commented on the organization and environment of the school system and their negative impact on the youth. Their concerns were with the social environment, the organizational climate and the way school is structured. Three youth mentioned concerns with adjusting to the routines of school. Though there may be some overlap with the first theme, *Social situations*, these comments appeared to be directed at a macro-level rather than an interpersonal one.

Managing Symptoms

Several youth (n = 20) reported having feelings of being overwhelmed, stressed and anxious and having difficulty coping without attributing these feelings to anything specific. For some youth it was unclear whether the youth was having difficulty with coping with the social environment, the academic component or any other aspect of school.

Specific Concerns Regarding Teachers and Peers

After responding to the general question about transition concerns, youth were subsequently asked separate questions about their concerns for their studies, teachers, friends or other students. When asked specifically about studies or grades, many youth reported that their grades were dropping; they had difficulty focussing or being motivated. Some students reported having had high grades before that were now suffering. When asked about teachers, 20 youth provided very positive comments such as "…all my teachers are good at their jobs." "I love the teachers." "All of my teachers are pretty understanding of my condition". However, several youth reported concerns about not being understood by teachers, not being liked by their teacher, and difficulty communicating with teachers. Examples include: "I worry that teachers won't like me and grade me differently due to that" "I have trouble talking to teachers" "not understanding the full situation" and "Some teachers are not trained in anxiety attack situations. Some teachers do not care I am in hospital and are being slightly rude to my mother in emails."

A few youth reported a good relationship and good support from friends; however, most youth reported difficulty with friends, not having any or many friends, and bullying. For example, youth reported: "Don't really have friends at school" "I have none" "I feel like I won't have any friends when I go back…" "I just want to make more friends" "Some people are very mean, and I don't have much friends" "I worry that I will be bullied again" "What they will treat me like" "They will spread rumours". Conversely, a few youth stated that they had no concerns about their friends; for example, one youth offered "…friends are understanding and don't ask questions." Other youth reported a network of supportive friends. Example comments include "My friends are like a mental health group, so they will understand…" Asking youth these specific questions about teachers and peers provided a deeper and broader frame through which to attempt to understand the youths' experiences.

Support Needs

One and twenty-three youth listed the type of support they thought that might help them after discharge: 52 (42%) youth thought professional support such as counselling or therapy, coping skills training, social skills training, monitoring progress and emotional support would be beneficial.

For example, youth reported: "Talking to therapists" "counselling" "Any support that would help me learn to cope better" and "I just know a few things that calm me but I can't do most of them". Several youth (n = 33; 27%) thought that being able to talk to friends, family or someone who would listen would help. Several youth (n = 32; 26%) reported that assistance with school work such as a reduced load, extra tutoring, alternate educational programs and "being allowed mental health days" would be beneficial. Only three youth stated that they did not think they had any need for supports; two of these youth stated they already had all the supports they needed, and one youth stated: "Nothing really. I like to do stuff for myself."

Discussion

The youth in this study reported considerable difficulty with emotional, attentional and hyperactivity problems, and they reported considerable concerns for their return to school. They also expressed concerns about prior challenges with peers or friends, teachers and academic difficulties, and they were anticipating difficulties upon re-integration to the school system. The most common concern involved anticipated social interactions at school, and specifically not knowing how to respond to questions or how to explain their absence. Their qualitative comments suggest that many youth were very worried about going back to school and did not feel equipped to respond or manage social encounters while some youth reported concerns about social isolation or loneliness, and bullying. These concerns are consistent with the concerns of youth accessing out-patient psychiatric services who also expressed concerns about relationships including feelings of loneliness and exclusion (Anttila et al., 2015) and with reports of bullying (Roberts, Axas, Nesdole, & Reetti, 2016) by youth accessing pediatric emergency mental health services. Moreover, youth in the present study who accessed in-patient psychiatry were requesting assistance for the development of social skills. Such skills-training may not only improve the actual encounters, but alleviate the worries about future encounters, and improve the quality of youths' social-emotional well-being. Social skills may help the youth manage social situations when reintegrating to school following hospitalization for psychiatric illness.

Social skills may enhance youths' social relationships which are fundamental to human development and well-being and become critical resources in situations perceived as stressful (Lazarus & Folkman, 1984). It is important to note that many of these youth reported feeling socially isolated or lonely during a developmental period (adolescence) which is characterized by increased reliance on peers; that is, these experiences of isolation and loneliness may be heightened given the social tasks for this developmental period. Social isolation refers to the absence of or limited social relationships; loneliness refers to a distressed state resulting from perceptions of insufficient or inadequate social connections. Not all socially isolated youth feel lonely, and some youth may feel lonely even when they may have some social connections. Social connectedness has been shown to affect health (Umberson & Montez, 2015); however, loneliness has been strongly correlated with depression across all age groups (Heinrich & Gullone, 2006) and as such warrants special attention when developing discharge and transition plans.

Youth also reported considerable concerns about their academic progress. Some youth were high achievers and placed a great deal of pressure on themselves to succeed. Some youth were struggling before hospitalization and were afraid of falling even further behind. Finally, many youth reported heightened distress about various aspects of the school environment and the demands of school, and school work exceeding their ability to cope. Several youth also indicated that they did not feel ready to go back to school. These findings suggest youth might benefit from greater attention on transition intervention (for example, see Weiss et al., 2015) and greater academic assistance upon re-entry to foster connectedness.

Educational achievement is fundamental to economic independence and is a social determinant of health (Hertzman & Power, 2006). Hospitalization is often experienced by youth as a disruption in their education. Some youth in the present study were struggling academically prior to hospital admission and in fact indicated that this struggle was the impetus for seeking professional mental health assistance. Others reported the experience of falling grades for the first time since hospitalization. For example, a few youth reported having had high grades, and then experiencing mental health challenges followed by experiencing low grades or even failure for the first time. For this group, attention to self-concept and esteem might be important alongside initiatives to enhance school connectedness.

Many youth in this sample were struggling with three very important domains of life: social relationships, education and managing emotions. These findings are consistent previous research focused on caregivers' perceptions of transition needs (Blizzard et al., 2016) and mental health professionals' perspectives (Clemens et al., 2010). However, this present study revealed youths' perceptions of several barriers to successful school re-integration, successful academic achievement, and healthy social relationships. These barriers included feeling worried and overwhelmed about what others would think of them, their social interactions at school with peers and teachers, and missed school work and academic performance. Other youth noted school behavior problems (e.g., thought problems, social

problems, and bullying) that were interfering with their ability to engage academically and socially at school. A few youth reported not feeling ready to go back to school; some youth did not feel they had changed, and some youth did not go back to their regular school at all due to bullying, intense feelings of stress or on-going mental health disorder.

The large number of youth reporting concern using intense language suggests that school is a major source of stress for these youth and a very important component of the youths' mental health struggles. The social and academic contexts of the school environment, and difficulty managing their emotions and symptoms were reported by youth to be overwhelming. These findings suggest that youth may benefit from greater emphasis on these identified needs during and after their hospitalization. Indeed, youth expressed a 'need' or desire for professional mental health assistance for the post-discharge period as well as simply having someone with whom to speak regularly who cares or who is invested in the youth and will "monitor" the youth. If this person is in the school setting, then interaction may also foster school connectedness.

Implications for Practice and Research

The results of this study suggests that part of the hospital treatment should be devoted to addressing the school-related concerns of child and adolescent patients including the social and academic contexts, and to decrease barriers to successful school reintegration post-psychiatric hospitalization. One avenue is to create bridges between hospitals and schools. Another is to strengthen transition practices of inpatient therapists. In particular, youth may benefit from coaching and skill building for social interactions, assistance with formulating responses to difficult questions about their absence and other issues with which they struggle, and the opportunity to practice responding to these difficult social situations multiple times including incorporating expert feedback. Youth in the present study reported varied experiences suggesting individualized transition plans may be warranted particularly if the plans include members of the youths' social groups. Peer support groups (Buchanan & Bowen, 2008) and family support (Senior, Carr, & Gold, 2016) in schools may foster youth connectedness and coping. It is also recognized that simply adding members to a youths' social group may not alleviate loneliness, which may require increased attention to decreasing the youths' negative social cognitions (Matthews et al., 2016). Such a focus is consistent with the aims for interpersonal therapy.

No effectiveness study on transition intervention from psychiatric hospital to community school could be located; however, some guidance can be gleaned from descriptive publications. Some program elements that may be beneficial for these patients include a designated mentor in the school system who is knowledgeable about the youth's mental health disorder, engaging families, a focus on high-risk patients, and improved discharge planning, co-ordination and continuity of care (Children's Hospital Boston, 2002; OCECYMH, 2012; Singh, 2015; Weiss et al., 2015). It might also be possible for socially isolated youth to be identified and targeted for specific supports (e.g., teacher invitation to group activity with other students to foster engagement with social support).

Future research should be focussed on the creation and testing of interventions to better support youth through the transition from psychiatric hospital to school, and improving mental health preparedness. For example, do youth [and parents] have informational needs? Do they feel able to manage their mental health disorder? Are they equipped with the skills to navigate a difficult social environment? Moreover, the social isolation and loneliness expressed by youth as well as experiences of stigma should be explored in-depth. Future research should also be focussed on the actual transition experiences of youth and stigma.

Limitations and Strengths

While this study makes unique contributions to the research literature, it is important to interpret the findings with a view to its limitations. The overall sample size is adequate; however, there were a number of youth who did not participate. In particular, one procedural requirement hindered participation of children: For children under 14 years of age, staff members were required to contact parents first to obtain consent to give their contact information to the RA who would then obtain informed consents from the parent and the child for study participation. Staff members were unable to approach many parents regarding the research which may have affected the representativeness of the sample. The main strengths of this study are the youth voice and the direct sampling of youth 14 years old and older. The REB approved this procedure because youth were already in a safe place, and medical staff members in psychiatric care are skilled and experienced with determining mental capacity for consent because making this determination is a routine practice. Another issue which could be viewed as a strength or limitation may be that this report reflects data collection at one point in time with a patient population that is still undergoing rapid development; thus, it captures youths' concerns at a critical point in development; however, there may be some fluidity in certain characteristics of the sample. There were also a few missing

data that were anticipated and the target sample size was set to overcome.

Conclusion

To our knowledge, this is the first study conducted to reveal concerns for school re-integration perceived by hospitalized child and adolescent psychiatric patients. These findings expand our knowledge of youths' perspectives of their concerns for transitioning out of hospital; they were anticipating significant challenges. Most of these patients reported experiencing considerable stress when thinking about going back to school, especially as it related to social encounters and explaining their absence, and when thinking about their academic progress and the impact of hospitalization and mental health disorder on academic achievement. The findings suggest the need for increased attention and resources for transition planning, bridging the hospital and school environments, and the provision of on-going mental health and social supports.

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Compliance with Ethical Standards

Conflict of interest Michèle Preyde declares that there is no conflict of interest. The other authors declare that they do not have any conflict of interest.

Ethical Approval All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

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