



RESEARCH ARTICLE

School Reintegration Following Psychiatric Hospitalization: A Review of Available Transition Programs

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Abstract

Objectives: This study aimed to 1) identify transition programs for school reintegration after youth psychiatric hospitalization, and 2) assess these programs using criteria established by Blueprints for Healthy Youth Development. **Method:** Principles outlined by the Evidence for Policy and Practice Information and Coordinating Centre were used to systematically search 15 electronic databases up to October 2021 for both published and unpublished reports of transition programs. Reports meeting inclusion criteria were examined through three steps: 1) coding of available information, 2) synthesis of programs and 3) assessment of intervention specificity. **Results:** Thirteen reports met the inclusion criteria and identified eight transition programs. Program theories were rarely explicit about the causal mechanisms and outcomes of their interventions. Nevertheless, areas of consensus emerge as to core components of these programs including: 1) the involvement of a multidisciplinary team, 2) the implementation of a multicomponent intervention, 3) the development of a reintegration plan, 4) the need for gradual transitions, and 5) extended support through frequent contact. **Conclusion:** School reintegration programs following psychiatric hospitalization are still rare. They can be hard to implement due to the challenges they impose for inter-professional and intersectoral collaborations. Despite this, four of the eight programs are in a good position for an evaluation of their promising standing. Nevertheless, well-designed controlled trials and cohort studies are needed.

Key Words: *youth mental health, psychiatric hospitalization, transition practices, school reintegration programs*

Résumé

Objectifs: Cette étude visait à 1) identifier des programmes de transition ayant pour but de favoriser la réintégration scolaire des jeunes à la suite d'une hospitalisation psychiatrique et 2) évaluer ces programmes sur la base de critères établis par les experts du Blueprints for Healthy Youth Development. **Méthode:** Les principes énoncés par le Evidence for Policy and Practice Information and Coordinating Centre (EPPI-Centre) ont été suivis pour conduire une requête systématique dans 15 banques de données informatisées, en date du mois d'octobre 2021, à la recherche de documents publiés et non publiés portant sur des programmes de transition. Les documents qui rencontraient les critères d'inclusion ont fait l'objet d'un examen en trois étapes : 1) codification de l'information disponible, 2) synthèse des programmes

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et 3) évaluation des programmes au regard du critère de spécificité de l'intervention. **Résultats:** Treize documents ont rencontré les critères d'inclusion et ont permis d'identifier huit programmes de transition. Les théories de ces programmes sont rarement explicites au sujet de leurs mécanismes causaux et des changements anticipés des interventions qu'ils préconisent. Néanmoins, un consensus se dégage au sujet des composantes clés de ces programmes : 1) l'implication d'une équipe multidisciplinaire, 2) l'implantation d'une intervention multimodale, 3) le développement d'un plan de réintégration, 4) l'importance d'effectuer les transitions de manière progressive, et 5) l'offre de soutien prolongé au moyen de contacts fréquents. **Conclusion:** À ce jour, les programmes de réintégration scolaire à la suite d'une hospitalisation psychiatrique se font rares. Ils peuvent être difficiles à implanter en raison des défis qu'ils posent sur le plan de la collaboration interprofessionnelle et intersectorielle. Malgré cela, quatre des huit programmes identifiés sont en bonne position pour une évaluation de leur caractère prometteur. À cet effet, le recours à des devis de recherche rigoureux, comme des protocoles expérimentaux et des études de cohorte, s'avère nécessaire.

Mots clés: *santé mentale des jeunes, hospitalisation psychiatrique, pratiques de transition, programmes de réintégration scolaire*

Children and adolescents admitted to an inpatient psychiatric care unit show severe and complex mental health problems such as suicide attempts, anxiety, depression and eating disorders. The care and services they receive aim to ensure stabilization, assessment and intensive treatment to foster their recovery (i.e., the personal process by which youth can live a satisfying, hopeful, and contributing life within limitations caused by illness [1]). Despite the care and services received, many youth struggle to return or evolve to a satisfactory state of functioning. In the United States and Canada, it is estimated that close to one third are rehospitalized in the year following discharge (2-6). Moreover, in addition to high social costs (7-8), youth hospitalizations may result in serious academic and social difficulties (e.g., absenteeism, social isolation, stigma, bullying, difficulty managing psychiatric symptoms, low academic performance, motivational problems, dropouts; 9-11). This situation is concerning given the significant increases in psychiatric hospitalizations of children and adolescents (12-14), and the significant decreases in their length of stay (15-16). Within this context, the timing of youth's discharge does not always coincide with their readiness to resume normal functioning at home and in the community (9). Therefore, there is a need for greater attention on the continuity of clinical and psychosocial support after the psychiatric discharge of youth.

Timely and quality services to support school reintegration are a promising avenue in promoting youth recovery and reducing recurrence following psychiatric care (see review 17). Empirical evidence of this link is still in its infancy. For instance, a prospective observational cohort study conducted by James et al. (2010, 4) found that youth who received other support services after discharge (i.e., not considered a mental health specialty), including school counseling, reduced their risk of rehospitalization by 76% over a 30-month period. These findings are in comparison to youth who did not receive any post-discharge services,

after controlling for salient child, family and service use variables. Moreover, youth responses to a survey administered ten weeks after discharge from acute psychiatric care in Preyde et al.'s (2018, 11) qualitative study highlight the importance of supporting school reintegration for their recovery. Implications derived from this study included that 1) youths who reported negative transition experiences also reported greater concern about the impact of emotions on school re-entry, and 2) many youth felt that their mental health symptoms were exacerbated by the challenges in trying to catch up in school (11).

This connection between reintegration and recovery is informed by an association found between school re-entry services and the recovery process of youth who had been hospitalized for physical care. For example, school re-entry services for youth with pediatric cancer are identified as helpful in achieving academic, social and psychological outcomes (see review 18). For youth with acquired brain injury, hospital-to-school reintegration programs are also associated with improved functioning (e. g., improvements in problem solving, lower externalizing and internalizing symptoms, and reduced parent-youth conflict) (see review 19). These associations may indicate the interactive nature of recovery and suggest that a dynamic interplay between person-environmental processes is an integral part of young people's experience (20-24). In this way, there are similarities with the central principles of the Bioecological Theory (25) which views human development and adaptation as the result of complex multidirectional transactions between the individual and their immediate environments. In addition, the strength and complementarity of the relationships between settings (e.g., school, family and health care) may reinforce the positive influence of these connections on youth's development (26).

When addressing mental health problems and the complex systems in which youth develop, a comprehensive

intervention approach is necessary (17, 27). Such an approach can materialize in the form of an intervention program. By definition, a program implies the presence of adequate human, financial and material resources to offer interventions that are specific to the needs of their clients and complementary to what is already provided in the field (28). Explicitly, a program represents “a discrete, organized package of practices [...] that explains what should be delivered, [by whom], to whom, when, where and how” (29, p. 268).

A review of the literature indicated a diverse evidence-base written by a small number of authors who have pioneered policy, practice and program development in the emerging niche area of school reintegration after psychiatric hospitalization. To our knowledge, no systematic effort has yet to rigorously identify and analyze existing programs in the area. Such an approach is necessary to assess their meeting of standards for quality, and progress towards the development of promising programs and best practices.

Objectives

By means of a systematic review, this study aimed to identify transition programs for school reintegration after youth psychiatric hospitalization, and assess the intervention specificity of these programs according to the four criteria recommended by Blueprints for Healthy Youth Development (BHYD, 30): 1) identification of the intended participants, 2) specification of the outcomes of the intervention, 3) discussion of the intervention’s theoretical rationale or logic model, and 4) documentation of the intended intervention structure, content and delivery process.

Method

This study followed internationally established guidelines developed by the Evidence for Policy and Practice Information and Coordinating Centre (EPPI-Centre; 31) that direct the use of formal, explicit and rigorous methods for undertaking literature searches and reviews through a number of common stages: search and selection strategies, report selection, quality and relevance assessment, data extraction, synthesis, and interpretation.

Search Strategy

To identify all existing information on available programs, the search strategy aimed to identify both published (i.e., from scientific or specialized journals) and unpublished reports (i.e., corresponding to *grey literature* that is not controlled by commercial publishers, where publishing is not the primary activity of the producing body [32]). It

was developed through extensive discussions between two reviewers, along with multiple testing and refining of a preliminary scoping review. The following 15 bibliographic databases were systematically searched: PsycINFO, PsycARTICLES, PsycCRITIQUES, PsycExtra, Education Source, Psychology and Behavioral Sciences Collection, SocINDEX and SocINDEX with full text, Social Work Abstracts, ERIC, MEDLINE (full text), Academic Search Complete, Pascal et Francis, CINAHL, Proquest Central, and Proquest Dissertations and Theses. When available, the thesaurus tools of the different databases were used to identify controlled subject terms to designate the population of study (such as “Mental health” or “Mental disorder” or “Psychopathology” AND Adolescent or Child*), the phenomenon to which the sample is exposed (such as “Hospital*” or “Absenteeism”) and the subject of interest (such as “Transitional program” or “Integrated services” or “Intervention” or “Rehabilitation”). At this stage, no restrictions were posed upon publication date, with all possible records up to the date of the last search update (October 2021) being considered. The search strategy for all databases is available from the authors by request.

Selection Strategy

Search results were entered into a bibliographic reference manager (Endnote® X7.3.1, Thomson Reuters, Philadelphia). Duplicates and records produced before 1985 were removed. The timeframe was chosen to best represent the current North American schooling system, which is shaped by laws that triggered an important shift regarding mental health practices in schools by requiring accommodation and support measures for students with integration difficulties (e.g., Rehabilitation Act in the United States, Loi sur l’instruction publique in Québec, Canada). The following inclusion criteria were applied: language (written in English or French), origin (derived from a developed country), target population (children or adolescents with symptom manifestations or presence of a mental health disorder, absence from school due to psychiatric hospitalization), and type of information (transition program prescribing a specific intervention for school reintegration).

Report selection occurred in two phases, each of which assessed potential records against the review’s criteria by a pair of two reviewers. During the first phase, titles and abstracts of the records identified were independently screened on inclusion criteria for eligibility. When a good level of agreement was reached between a pair of reviewers ($k = 0,8$), the remaining records were assessed by only one of them. During the second phase, full texts of all records rated as potentially relevant (i.e., not excluded after the first phase) were obtained and were independently assessed for

eligibility. During both phases, disagreements between the reviewers were discussed until consensus was reached.

Once the selection of reports was completed, supplementary searches were conducted to identify relevant records that were published previously (retrospective searches) and more recently (prospective searches). First, the reference lists of included reports and of two existing reviews (17, 27) were screened to identify additional relevant records that had not come up within the original search. Second, 40 search queries were done through *Google*, each containing a combination of keywords related to the examined concepts (e.g., school reintegration and psychiatric, back to school and mental disorder, school re-entry and mental health crisis). Third, the references of the included reports and of the two existing reviews were searched through *Google Scholar* to identify additional relevant and more recent reports using the function *cited by*. Fourth, the first author of each selected report was contacted by email to obtain additional information about the identified programs.

Quality and Relevance Assessment

To ensure that all reviewed reports were characterized by serious and credible endeavors, two additional criteria were applied during the report selection phase. To be selected, the reports also had to be written by an expert or group of experts, and contain information that facilitates the identification of the process through which the program was developed, implemented or evaluated. An author (or group of authors) was considered an expert if they were a researcher or clinician whose publications or practice is specialized in youth mental health. In cases where the report was a thesis or dissertation, the graduate student was considered an expert because they benefited from the support of an established researcher (PhD) to carry out their work.

Data Extraction

Data on the characteristics of included reports were extracted and entered into a purpose-built table by one reviewer and checked for accuracy by a second reviewer. For each report, the following categories of data were extracted: source (author(s), year of publication, country and setting where the work was carried out), target population (age, symptoms or diagnosis, context of hospitalization), report aims, program name, type of available information (four criteria of intervention specificity [30]).

Data Synthesis

Included reports were imported into NVivo 12 software (QSR International Pty Ltd.) to assist data management and analysis. A three-step analytical strategy was followed, each involving independent consideration, discussions, and consensus between two members of the research team. For each program, available information on intervention specificity was subject to coding (step 1), synthesis (step 2) and assessment (step 3) according to the four criteria recommended by BHYD (30). Table 1 summarizes the definitions used in the current study to operationalize each criterion.

Results

Figure 1 outlines the systematic search process and reasons for exclusions. A total of 13 reports (33-45) were included in this study.

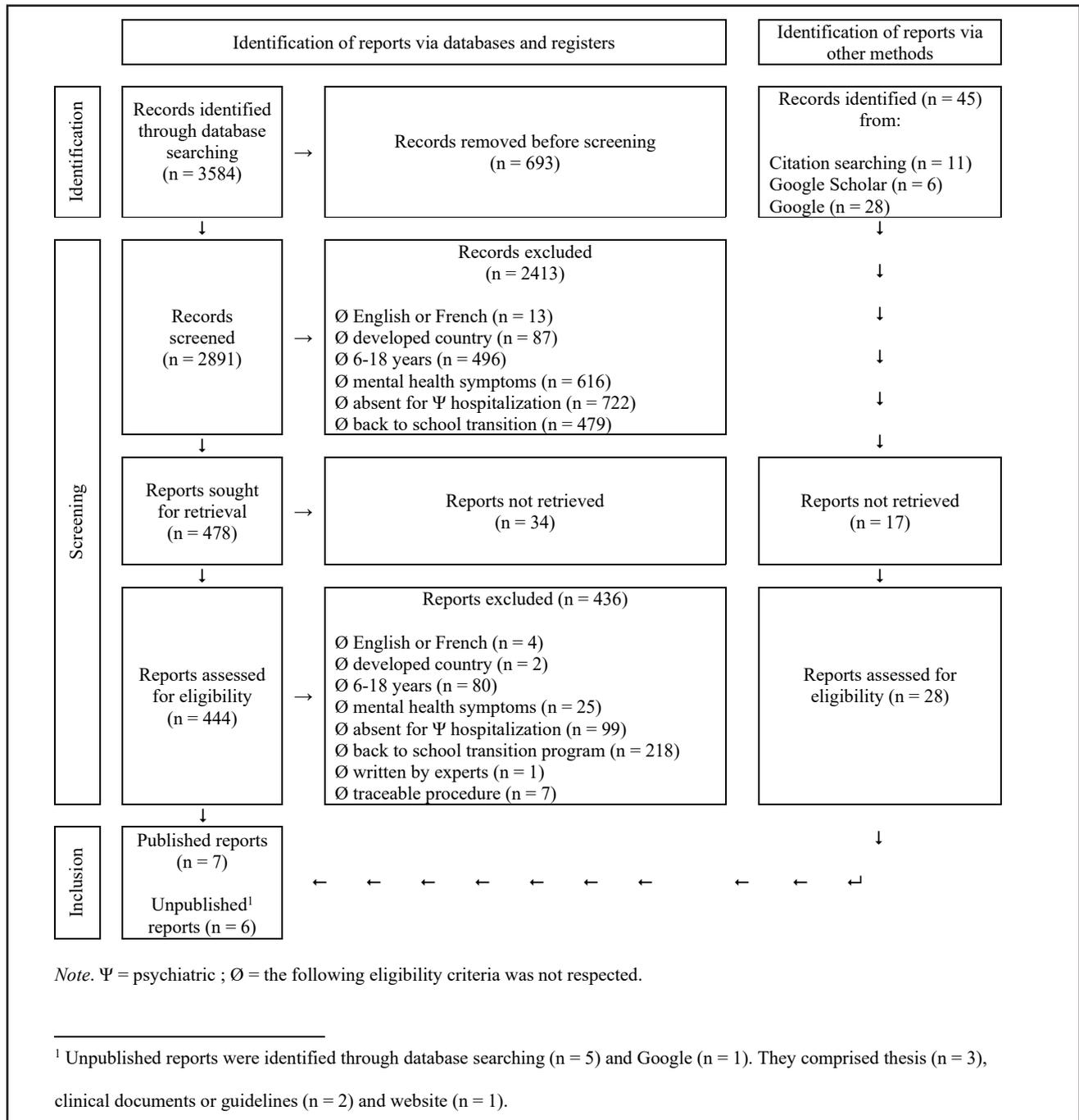
General Characteristics

A summary of each included report following selection and credibility assessment is provided in Table 2. Overall, there are seven published and six unpublished reports. The 13 included reports were produced between 1991 and 2018, including 10 (76.9%) since 2010. Most are from the United-States ($n = 11$, 84.6%), while the others are from Canada ($n = 2$, 16.4%). More than half of the included reports reflect the work led by experts in a university setting ($n = 8$, 61.5%). Conversely, over a third of included reports ($n = 5$, 38.5%) are comprised of work done in clinical settings (mental health center, hospital, department of psychiatry). With regards to the populations targeted, age is specified in eight reports. These reports include adolescents (e.g., middle and high school students, young people aged 11-18; $n = 4$ reports, 30.8%), children (e.g., 4-12 years; 9-11 years; $n = 3$ reports, 23.1%) or children and adolescents (e.g., 6-17 years; $n = 1$ report, 7.7 %). Only 7 of the 13 included reports identify the types of psychiatric problems or symptoms of the population (see Table 2 for details). To specify a context of hospitalization that required an absence from school, 10 reports use one of the following expressions: inpatient psychiatric unit, day care center, inpatient psychiatric stay, partial hospitalization, child psychiatry day hospital and evening hospital program, emergency or psychiatric hospitalization.

Transition Programs for School Reintegration

In total, the current review allowed for the identification of eight transition programs which prescribe specific interventions that aimed to facilitate school reintegration

Figure 1. Flowchart Diagram of the Selection Process



following psychiatric hospitalization of youth (see Table 2). Of the identified programs, most are relatively recent. Five (62.5%) were introduced in scientific or clinical literature after 2011 and two (25%) in 2006 and 2007. The majority are from the United States (6/8, 75%), while two are from Canada (25%). Information concerning six of the eight identified programs were obtained from a single report. For the two remaining programs, the BRYT and the STP,

information was obtained from five reports for the former, and two reports for the latter.

Intervention Specificity

Table 3 presents a synthesis of coded information used to assess each of the eight identified programs according to the four criteria of intervention specificity. This information is aggregated below to provide an overview of their scope, to

Criteria	Definitions
1- Identification of the participants	This criterion assesses the clarity of available information about participants targeted by the intervention: sociodemographic characteristics, inclusion or exclusion criteria and screening process.
2 – Specification of the outcomes	This criterion assesses the clarity of available information about the outcomes of the intervention following participation in the program.
3 - Intervention's theoretical rationale	This criterion assesses the clarity of available information about the theoretical justification of the program. Specifically, this justification should explain the way in which the intervention is expected to achieve the desired change of risk or protection factors targeted by the program.
4 - Documentation of the intended intervention	This criterion assesses the clarity of available information about the structure, content and delivery process planned for the program: "what service, activity or treatment is provided, to whom, by whom, over what period, with what intensity and frequency, and in what setting" (BHYD, 2021, Intervention specificity section, para. 4)

highlight their most salient components as well as emphasize their points of convergence and divergence.

Criterion 1 – Identification of Participants

With regards to participant characteristics and inclusion criteria, two of the eight identified programs are offered specifically to elementary-aged children (Passport to Friendship: 9-11 years old; Transitional Care Program: 4-12 years old), three are for adolescents (BRYT, Bridge Program, Bridges Program: 13-18 years old), and three do not specify an age group (Ending Day Treatment, STP, UCLA's ABC). For more than half the programs (5/8, 62.5%), intervention begins once the youth is discharged from the hospital. Only one program requires a specific duration of absence from school for eligibility (BRYT: 5 or more consecutive days), while two programs emphasize the necessity of a prolonged absence (Bridges Program, Passport to Friendship). The other programs do not specify any inclusion criteria with regards to the length of hospitalization or absence from school. The nature of difficulties leading to the hospitalization of eligible participants is varied. Accordingly, no specific profile seems necessary for admission to these programs. Among the identified programs, only the BRYT specifies that the youth's participation should be voluntary. Finally, all identified programs were designed by experts in urban areas, but available information does not specify whether the location of program participants is an eligibility criterion.

Criterion 2 – Specification of Outcomes

For the majority of reviewed programs, improving or supporting school reintegration is clearly stated as the ultimate outcome of the intervention. The Bridge Program is the only one that differs in this regard. It presents broader outcomes that also aim to foster transition to the community. Intermediary outcomes of the intervention are explicit in the reports describing seven of the eight (87.5%) identified programs. The nature of these outcomes is varied. They concern the youth, their parents, their social environment, as well as the links between the settings in which they evolve. For youth, the programs aim to support or improve daily functioning (BRYT, Transitional Care Program), social and emotional development, positive interactions with others (Bridges Program, BRYT, UCLA's ABC), school attendance, availability to learn, and school achievement (Bridges Program, BRYT). For caregivers, the STP aims to reduce strain and increase empowerment. For social environments, the Passport to Friendship program aims to promote acceptance, empathy and friendship skills for all children in the classroom of the transitioning student. Some programs, such as STP and the Transitional Care Program, also aim to improve the relationship and communication between stakeholders from the hospitalized youth's different settings. Finally, the BRYT program is the only one that considers more macro-systemic outcomes. These include beliefs about stigma and values of inclusivity regarding mental health.

Criterion 3 - Intervention's Theoretical Rationale

Among the eight programs identified, only two (Bridge Program, Bridges Program) include a logic model that highlights the mechanisms of the intervention related to anticipated outcomes (explicit rationale). The Bridge Program's logic model argues that reintegration within the community is fostered by the implementation of a specific sequence of inter-professional activities. These ensure continuity in the support and treatment of participating youth. Conversely, the Bridges Program's logic model recommends successful reintegration through an individual re-entry plan. This plan contains a variety of measures and is adapted to the needs of the youth (e. g., emotional support for student, supportive community, academic support).

Conversely, the interventions' theoretical rationales can be inferred (implicit rationale) for three other programs (BRYT, Passport to Friendship, STP). That is, their rationale is not addressed or presented explicitly (e.g., with a diagram or section of text), but available information in relation to principal components of the program and its implementation offers insight. For two out of three of these programs (BRYT and STP), a general theory is used to guide intervention. The BRYT program is based in the generic model of Multi-Tiered Systems of Support that proposes an adjustment of the intensity and nature of offered interventions (i.e., universal, selective and targeted). In that respect, the BRYT program suggests that school reintegration can be promoted through a flexible approach that is adapted to the needs of students (e.g., academics, social-emotional, mental health). As for the STP, it is based on the Double ABC-X Model of family stress. Their interventions rely on youth and caregiver empowerment, support, and access to resources to foster the families' coping with the stress caused by the transition back-to-school. Finally, for the Passport to Friendship program, emphasis is placed on structured thematic activities with students in the class and psycho-educational activities for school personnel. In this way, the program suggests that knowledge and openness towards mental health are key facilitators for school reintegration.

Finally, available information about the three remaining programs (Transitional Care Program, Ending Day Treatment, UCLA's ABS Partial Hospitalization Program) are insufficient to draw conclusions about anticipated outcomes (absent rationale). However, it is possible that these three programs attempt to promote school reintegration by relying on a combination of interventions for youth, caregivers and school staff.

Criterion 4 - Documentation on the Intended Intervention

Content. With regards to activities offered within the different programs, direct interventions with the youth are prioritized. These direct interventions are varied and correspond to youth's various needs. In relation to information needs, direct interventions take the form of individual or group psycho-education. In relation to competency development, direct interventions involve problem solving, emotional expressions, friendships and advocacy skills. In relation to psychological needs, counseling and emotional support are offered, while academic needs are addressed by make-up work, educational planning and academic support. Lastly, in relation to social integration needs, interventions target peer support and connections to resources.

While the programs emphasize direct intervention with the youth, almost all (7/8, 87.5%) qualify themselves as multicomponent interventions, meaning that they also involve parents and/or school professionals. For parents, the programs often provide activities in the form of support groups, information-sessions to answer their questions, and recommendations for resources. For school staff, their involvement is often requested to offer psycho-education, to plan and coordinate the reintegration plan, to monitor the students' progress, and to maintain communication with the family.

Indirect interventions are also suggested by some programs to foster collaboration between stakeholders. This collaboration primarily takes the form of liaison activities, and close coordination or consultation between school personnel and the community, between the hospital and the community, or between the hospital and the school (BRYT, Bridge Program, STP).

Provider. In most programs (6/8, 75%), the intervention is led by a transition team comprised of at least two professionals from different disciplines (e.g., an educator and a social worker; Transitional Care Program) that are in contact with the treatment team. In the case of the Bridge Program, transition services are led by a clinical liaison nurse. In these contexts, nurses or social workers generally play a role within the community, while educators support class activities.

Duration, Length, and Frequency. The intervention's duration is specified for five out of eight programs (62.5%) and ranges between periods of four weeks ($n = 1$; Passport to Friendship), three months ($n = 3$; Bridge Program, BRYT, STP) and six months ($n = 1$; Transitional Care Program). Three of these programs (BRYT, Passport to Friendship, STP) indicate the intensity with which the intervention is

Table 2. General Characteristics of Included Reports (n = 13) for Each of the Identified Programs (n = 8)

Author (year) – Country Setting, Type of document		Document aims	Population (age, symptoms, context of hospitalization)	Available information on intervention specificity			
				Criterion 1 ¹	Criterion 2 ²	Criterion 3 ³	Criterion 4 ⁴
Bridge for Resilient Youth in Transition (BRYT; n = 5⁵)							
Simone (2017) - USA University Thesis	To explore the experience students have re-entering high school following psychiatric hospitalization, and within programming designed to assist with this transition	Adolescents (15-19 years) hospitalized during the school year (partial or inpatient) for at least 5 days and having participated in the Bridge for Resilient Youth in Transition (BRYT) programming for at least 3 weeks; mood, anxiety, or depressive related symptoms	X	X			X
The Brookline Center for Community Mental Health (2018) - USA Mental health center Website	To describe the Bridge for Resilient Youth in Transition (BRYT) program approach	Adolescents with serious mental health condition and experiencing extended absences from school	X	X	X		X
White (2014) – USA University Column	To describe a novel program called Bridge for Resilient Youth in Transition (BRYT)	Students returning to school after experiencing a major psychiatric episode; depression, anxiety, suicide attempts, suicide thoughts	X				X
White, LaFleur, Houle, Hyry- Dermith, & Blake (2017) – USA University Primary research article	To conduct an evaluation of the clinical and academic characteristics of transition program participants, their participation in program offerings, and to assess students' day-to-day functioning during their participation in the program	Students returning to school after a hospitalization or partial hospitalization for a primary mental health diagnosis and participating in the Bridge for Resilient Youth in Transition (BRYT) program; mood, anxiety, eating, substance abuse, autism spectrum disorder, psychotic disorders	X	X			X
White, Langman, & Henderson (2006) – USA Mental health center Column	To describe a school-based transition program and report the results from its implementation	Adolescents who weather a mental health emergency or psychiatric hospitalization and transition back to school and community	X				X
Bridge Program (n = 1)							
Cameron, Birnie, Dharma-Wardene, Raivio, & Marriott (2007) – Canada Mental health clinic Primary research article	To describe a transitional service called the Bridge Program, designed to help adolescents make a successful transition from the hospital to the community	13-18 years; adolescent inpatient psychiatry unit; mood disorders, psychosis, pervasive developmental disorder, behavioral issues, eating disorders, suicidal ideation, substance misuse, attachment disorder, personality disorders	X	X	X		X
							continued

Table 2. continued				Available information on intervention specificity			
Author (year) – Country Setting, Type of document	Document aims	Population (age, symptoms, context of hospitalization)	Criterion 1 ¹	Criterion 2 ²	Criterion 3 ³	Criterion 4 ⁴	
Bridges Program (n = 1)							
Platt (2011) - USA University Thesis	To explore / describe: 1) the impact of the program in facilitating the re-entry of students, 2) how the program supports successful reintegration, 3) the program's role as a means to assisting students with mental health care concerns	Students enrolled and graduates of a transition program (Bridges) designed for adolescents returning to public high school subsequent to a prolonged absence or psychiatric hospitalization; clinical anxiety and/ or depression as manifested in substance abuse, suicidal ideation, eating disorders and school refusal	X	X	X	X	
Ending Day Treatment (n = 1)							
Parsons & Imhoff (1991) – USA Day care center Book chapter	To describe some of the special projects that have been introduced to the Day Care Center treatment program	Emotionally disturbed children scheduled to leave the Day Care Center treatment program	X			X	
Passport to Friendship (n = 1)							
Paney (2017) – USA University Thesis	To create a workbook to help children who had been out of school for an extended time to successfully transition back into the social environment of the classroom	Children aged 9-11 returning to school after prolonged illness (physical or psychiatric) as well as their classroom peers	X	X		X	
School Transition Program (STP; n = 2)							
Blizzard, Weiss, Wideman, & Stephan (2016) – USA University Primary research article	To examine the psychosocial resources of caregivers of children leaving intensive psychiatric care and participating in a post- inpatient transition program, and to describe their reported needs at home and school	Children and adolescents (6- 17 years) admitted to inpatient psychiatric units at two hospitals; attention deficit/hyperactivity disorder, mood disorder, depressive disorder, and other	X	X		X	
Weiss, Blizzard, Vaughan, Sydnor- Diggs, Edwards, & Stephan (2015) – USA University Primary research article	To describe the development of the School Transition Program (STP)	Youth transitioning back to school and community after an inpatient psychiatric stay	X	X	X	X	

continued

Table 2. continued				Available information on intervention specificity			
Author (year) – Country Setting, Type of document	Document aims	Population (age, symptoms, context of hospitalization)	Criterion 1 ¹	Criterion 2 ²	Criterion 3 ³	Criterion 4 ⁴	
Transitional Care Program (n = 1)							
Bourke, Zerkowitz, Smart, Guzder, Sochaczewski, Short, Langstaff, & Ekhouzer (2014) – Canada Hospital Clinical resource	To offer a pragmatic manual that will be helpful to those working with children and families who, after experiences at the Day Hospital or similar facilities, are re-adjusting to life at their community schools	Children aged 4-12 who have graduated from the Child Psychiatry Day and Evening Hospital Programs of Montreal's Jewish General Hospital (JGH); oppositional-defiant disorder, conduct disorder, aggressive behaviour, suicidality, attention deficit disorder, selective mutism, school refusal and posttraumatic stress disorder	X			X	
UCLA's ABC Partial Hospitalization program (n = 1)							
Singh (2015) – USA University Clinical resource	To highlight the problem and strategies for improvement in relation to transitioning students from Psychiatric Hospitalization to Schools	Students returning from psychiatric hospitalization	X			X	
¹ Criterion 1 = identification of the intended participants ² Criterion 2 = specification of the outcomes of the intervention ³ Criterion 3 = discussion of the intervention's theoretical rationale or logic model ⁴ Criterion 4 = documentation of the intended intervention structure, content and delivery process ⁵ n = number of reports retrieved about the program							

offered. Intensity is most clearly indicated for the STP: one structured weekly phone call with the parents, one monthly meeting with the family and a daily check-in with the student. None of the programs prescribe the length of participation at each contact.

Setting. With regards to the modalities and resources used to implement activities aimed at facilitating school reintegration, two programs (25%) benefit from an intermediate physical space (e. g., supervised home base classroom [BRYT], transition school [Ending Day Treatment]). For the Ending Day Treatment program, the transition classroom is structured like a regular classroom, while, for the BRYT program, the dedicated classroom represents a setting that is both a safe-space and is work-oriented. Conversely, the activities in the other programs take place in locations that

are regularly visited by youth and their families (e.g., home, classroom, space at school or treatment center).

Mode of Delivery. For almost all programs (7/8, 87.5%), the implementation of activities involves multiple occasions to meet and interact, both formal and informal, with the youth (e. g., daily check-in), their family (e. g., monthly meeting), and the practitioners involved (e. g., liaison between hospital and school settings). In addition to face-to-face meetings, frequent contacts by phone or email are generally planned to maintain regular communication and a close rapport between the parents and practitioners. To support the implementation of activities for youths' return to the classroom, five of the eight programs (62.5%) support the development of a transition or follow-up plan, for the most part, by multidisciplinary teams. Finally, gradual transitioning is used as one of the ways to facilitate youths' adaptation to reintegration in half of the programs.

Table 3. Description of Identified Transition Programs for School Reintegration (n=8)

Outcomes		Intervention			
Participants	Rationale [clarity] ¹	Content	Provider	Duration and frequency	Setting and mode of delivery
Bridge for Resilient Youth in Transition (BRYT) - USA (Brookline, MA)					
Adolescents Who have missed significant amounts of school (5 or + consecutive days) due to mental health crisis, psychiatric hospitalization (most frequent reasons: depression, bipolar and anxiety disorders) or serious medical problem Voluntary involvement	Improve reintegration Prevent relapse, academic failure and derailment of socioemotional development Improve participants' day-to-day functioning Improve participants' school attendance and high school graduation rates Reduce stigma and facilitate inclusion [implicit rationale] Multi-Tiered System of Support Model (MTSS) - BRYT MTSS Triangle	<u>Alongside the student:</u> Assessment, Emotional support, Counseling, Case management, Educational planning, Psychoeducation group, Cope with the challenges of returning to day-to-day social and academic demands <u>Alongside caregivers:</u> Parent support group, Resources for families <u>Alongside school staff:</u> Coordination, Tutoring and Coaching	1 program leader/clinician (social worker, counselor or psychologist) 1 academic coordinator: classroom aide or teacher 1 child psychiatrist (supervision)	Post-discharge M = 6-12 weeks Care coordination: M = 21 hrs / student Family support: M = 7 hrs / student	School, home, hospital, community --- Group meetings Dedicated classroom for students (comfortable and work-oriented) Professionals always present in classrooms to allow constant access to a supportive and competent adult for students. Tutoring and coaching supports to help students Gradual reintegration in a regular classroom Structured and flexible transition plan Close coordination with school counseling staff and community providers
Bridge Program - Canada (Calgary, AB)					
Adolescents (13-18 years) Inpatient psychiatry unit who are ready to leave hospital environment (Young Adult Program, YAP) and require some assistance transitioning into their community	Help adolescents make a successful transition from the inpatient psychiatry hospital services to residential treatment services in the community Reduce the average length of stay in YAP Reduce readmissions to the YAP and other inpatient psychiatric units and the number of visits to the emergency department. [explicit rationale] Bridge Program Logic Model (Cameron et al., 2007)	Bridge Program - Canada (Calgary, AB) <u>Phase 1: Pre-transition</u> Identification of eligible adolescents via YAP Visits from the ENP with families <u>Phase 2: Intake to ENP</u> Interactions with the school to determine appropriate classroom placement Development of a treatment plan <u>Phase 3: Treatment</u> Short-term mental health care Therapy Psychoeducation <u>Phase 4: Discharge</u> Follow-up support with community services	Partnership between an adolescent inpatient psychiatry unit (Young Adult Program, YAP) and an adolescent residential treatment center (Exceptional Needs Program, ENP); 1 clinical liaison nurse (CLN) YAP staff ENP staff Families	Post-discharge	Hospital, community --- Transitional services led by CLN Case management facilitation role Involvement in the YAP and ENP Liaison between hospital and community settings Education and support for staff

continued

Table 3. continued

		Intervention			
Participants	Outcomes Rationale [clarity] ¹	Content	Provider	Duration and frequency	Setting and mode of delivery
Bridges Program - USA (Chicago, IL)					
Adolescents Returning to public high school subsequent to a psychiatric hospitalization and/or prolonged absence or treatment settings	Provide transitional services for students reentering public high school that will magnify opportunities for successful reintegration Be in attendance and be emotionally secure and available to learn [explicit rationale] Logic Model (Platt, 2011)	Alongside the student: Adult advocacy, Liaison services, Social and emotional support, Therapy, Peer support, Supportive community, Academic support	2 specialized educators 1 social worker 1 administrator 1 assistant/Bridges faculty monitor (instructional)	N/A ² Daily tutoring Monthly meetings for parents	School ---- Reentry meeting Individual reentry plan Gradual transitioning Individual and group counseling Tutoring Grade and schedule adjustments Workload management Evaluation for readiness Meetings, phone calls and emails for parents
Ending Day Treatment - USA (Denver, CO)					
Children of all ages Emotionally disturbed children scheduled to leave the Day Care Center treatment program in 4 to 5 months Transition Group composed of 6 or 7 children of all ages	Support the transition of students between the Day Care Center and their home school	<u>Alongside the student:</u> Group therapy, Rap Sessions, Problem solving, Empowerment in the face of avoidance behaviors, Psychometric evaluations and observations <u>Alongside caregivers</u> Information <u>Alongside school staff</u> Planning for regular classroom reentry	1 educator (transition schoolteacher) 1 social worker	Process that begins 4 to 5 months pre-discharge and continues for several months Rap Sessions (3/week x 45 min)	Transition School (structured like a regular classroom) ---- Role play Ongoing communication between the Transition Schoolteacher and social worker Liaison with the treatment team Meetings with the parents, teacher, and school administration
Passport to Friendship - USA (Azusa, CA)					
Children aged 9 to 11 years (4th and 5th grade) Returning to school after prolonged illness (physical or psychiatric) as well as their classroom peers	Teach and support specific friendship skills [...] immediately upon reentry to the classroom Educate all children about identifying emotions, acceptance, empathy, and friendship skills [...] [implicit rationale] Workbook procedure, Steps prior to administering manual	<u>Alongside the student</u> Thematic activities (n = 7, 2/week, x 20 min.) aimed towards competency development (labeling emotions, friendship skills, understanding loneliness, empathy, peer acceptance) <u>Alongside school staff</u> Psychoeducation	1 educator Optional help from hospital transition programs and parents School and hospital staff	Post-discharge As soon as the student returns to class Use of workbook 2x/week 20-30 min./ activity	School, classroom setting ---- Inclusion of peers in the reintegration process Workbook for participants Support manual for the educator and teachers Individual and group activities

continued

Table 3. continued

Participants		Intervention				Setting and mode of delivery
Outcomes Rationale [clarity] ¹	Content	Provider	Duration and frequency			
School Transition Program (STP) - USA (Baltimore, MD)						
Children and adolescents Discharged from inpatient psychiatric care	Provide support to children and their caregivers and access to resources during the transition Teach and support specific friendship skills [...] immediately upon reentry to the classroom Educate all children about identifying emotions, acceptance, empathy, and friendship skills [...] [implicit rationale] Workbook procedure, Steps prior to administering manual	Alongside the student: Emotional support, Psychoeducation, Connection to resources, Mood and coping monitoring, Development of communication and advocacy skills and problem-solving barriers Alongside caregivers: Communication and advocacy skills, Education modules (mental health, education, and self-care) Alongside school staff: Psychoeducation and tools, School's crisis protocol	1 legacy family member of a child with EBD (Family Connector) 1 social worker (School Transition Specialist) 1 school practitioner (School Connector)	Post-discharge 3 months Structured weekly phone calls (up to 1 hour) Monthly meeting with families Daily check-ins with the student	School, home --- Consultation with hospital and school staff Transition support plan Family Education Peer-to-peer support Structured phone calls Meeting with families School meetings Check-ins with the student by the school practitioner Feelings faces and a toolbox sheet for students	
Transitional Care Program - Canada (Montreal, QC)						
Children aged 4-12 That were discharged from child psychiatry programs at the Jewish General Hospital	Provide support to families and help children with mental health issues re-enter their community schools successfully by sustaining the patterns and skills they learned while in treatment at the Day Hospital. Improve children's functioning at home and school Improve good relationship between parents and school. [absent rationale] Chronology = sequence of activities and multimodal approach applied to the program	Alongside caregivers: Emotional support, Psychoeducation, Coaching on parenting skills and strategies, Follow-up on child's progress, Liaison to community resources Alongside school staff: Mental health education, Family-school communication, Follow-up on student's progress, Direct observations in school	1 educator 1 social worker from the child psychiatry department	Post-discharge 6 months Min. 1/week phone communication with parents	Hospital Home --- Phone communication with parents Home visits Role play to practice parenting skills Communication log Meetings with parents, school staff and transition team Liaison with child psychiatry personnel Follow-up plan at home and at school	

continued

Table 3. continued

Outcomes		Intervention			
Participants	Rationale [clarity] ¹	Content	Provider	Duration and frequency	Setting and mode of delivery
UCLA's ABC Partial Hospitalization Program - USA (Los Angeles, CA)					
Students returning from psychiatric hospitalization	Facilitating successful transition from hospital to school Improve interactions with others [absent rationale]	<p>Alongside the student: Catching-up with subjects, CBT group, Art therapy, Teachings on healthy and controlled emotional expression, Teachings on positive social interactions with peers and adults</p> <p>Alongside caregivers: Individual and family therapy, Planning of a home support system, Monitoring of the students' progress after the end of the program</p> <p>Alongside school staff: Monitoring of the students' progress after the end of the program</p>	Social workers Occupational therapists Art therapists Child psychiatrists	N/A	Schedule of hospital activities according to the schedule of a regular school day (7:45am to 2:30pm) Objectives to reach to begin the school reentry process Reinforcement system Gradual reentry and adjustment back to school in parallel with hospital support Elaboration and implementation of the school reentry plan with a multidisciplinary team

¹explicit rationale = a theory or logic model that explains the intervention's theoretical rationale; implicit rationale = the intervention's theoretical rationale can be inferred from available information about the program; absent rationale = available information is insufficient to infer the intervention's theoretical rationale

² Information not available

Discussion

This study reveals that the literature on school reintegration programs following psychiatric hospitalization remains scarce. The eight programs identified were generally the result of local initiatives and, to date, have only been implemented on small scale levels. On the one hand, the rarity and low rate of dissemination of these programs may be explained by the more recent interest of researchers and practitioners. For instance, two existing systematic reviews on the topic have been published less than eight years ago and are comprised of a small sample of primary studies (17, 27). On the other hand, the rarity of these programs in practice settings may be explained by the challenge of measuring their cost-benefit value. Specifically, it is challenging to highlight program effectiveness given the small number of youths served, and the difficulties associated to evaluating program outcomes in a rigorous manner. Finally, to understand the situation surrounding the small number of programs and their limited implementation, it is important to consider the challenge posed by introducing new stakeholders in practice settings. As reported in previous studies, challenges in communication, collaboration and coordination are at the heart of issues related to school reintegration following psychiatric hospitalization (e. g., 9, 46-48).

The challenges of inter-professional and intersectoral collaboration are widely cited in literature in a variety of areas of practice with youth in difficulty (e.g., medicine, education, youth protection). Notably, this may be explained by the fact that stakeholders often have different frameworks, use different terminology and work towards different mandates within their organizations (49-50). As a result, it may be difficult for them to reach mutual agreement on a problematic situation, to define common intervention goals, and to understand their respective expectations regarding roles and responsibilities (51-53). The limited knowledge of the realities of stakeholders' settings, as well

as a misunderstanding of available resources in those settings, may also lead to confusion and tension (e.g., hospital recommendations not enforceable in the school environment; 48). In some cases, these tensions are associated to stereotyped ideas towards stakeholders, and even conflicts, which hinder collaboration (54-57). Lastly, barriers to collaboration may also be derived from issues of power imbalance such as power struggles, hierarchies within roles, and different statuses between stakeholders (51, 58-60). To overcome these challenges, recommendations include the development of protocols, and agreements or mutual objectives that encourage interdependence between stakeholders and reinforce partnership in the work culture (51, 54, 56, 61-62). This relates to the importance to make a shift to an institutionalized system of interdisciplinary collaboration that provides systemic support such as leadership that establishes infrastructure, allocates time and resources, and incentives (63). While this is difficult to operationalize and evaluate within a program, these initiatives may be promising to foster a sharing of expertise, resources and responsibilities (64) without having to introduce new stakeholders in practice settings.

With regards to intervention specificity, the clarity of available information suggests that four out of the eight programs identified are in a good position to meet this screening standard. At first glance, the Bridge program, the Bridges program, the BRYT and the STP could pursue an evaluation of their promising character according to the three other standards proposed by the BHYD (30): evaluation quality, intervention impact and dissemination readiness. Yet, available evidence reveals that these programs do not reach the standards of evaluation quality. Specifically, they do not comply with the standard that dictates that an intervention must be evaluated by at least one randomized controlled trial or two quasi-experimental evaluations.

Evidence supporting the BRYT and the Bridge programs can be considered of low credibility and trustworthiness due to the use of an observational, non-experimental research design. More specifically, a study by White et al. (44) used a one-group, pre-post-test research design to evaluate the BRYT. They reported that “statistically and clinically significant improvements were seen in program staff members’ ratings of students’ overall functioning, most significantly in relation to moods/emotions, self-harmful behaviors, and school functioning between intake and follow-up, usually 8–12 weeks later” (p. 877). In addition, a comparison of health records databases before and after inception of the Bridge Program was used by Cameron et al. (35). Results from this formative evaluation study suggest “the remarkably low hospital readmission and emergency

department visit rates may be due to the Bridge Program’s facilitation of connections to support services in the community for discharged patients and their families” (p. 28).

Evidence supporting the Bridges program and the STP can be qualified as insufficient/poor, because findings are derived from an observational-descriptive research design. For example, Platt’s (38) thesis reports results from a qualitative case study exploring: “How do stakeholders perceive the impact of the Bridges program in facilitating the re-entry of students into a specific public high school in a northern suburb of Chicago?” (p. 84). They conclude that “[from] the perspective of stakeholders responding in this study, Bridges is successful in its mission to assist transitioning students back to public school” (p. 200).

While it is still too early to discuss promising programs within the area of school reintegration, some findings from the current study can offer suggestions in that direction. Notably, results highlighted five areas of consensus between programs about the core components of their intervention: involvement of a multidisciplinary team, implementation of multi-component interventions, development of a reintegration (or transition) plan, gradual transitioning, and prolonged support through frequent contacts between all stakeholders (medical team, school staff, youth, family). Concerning the involvement of a multidisciplinary team (i.e., including social workers, psychiatrists, nurses, specialized educators, administrators, etc.), its composition can vary from one program to another. Accordingly, gathering stakeholders from school and hospital settings ensures a better relationship between these partners which, in turn, may allow for a better support during youth’s transition. For multi-component interventions, these activities mobilize a diversity of stakeholders at different levels. These include youth themselves, their family, and school staff. In this context, interventions aim to optimize program outcomes for youth. Regarding the reintegration plan, its development and implementation is recommended in many programs to ensure the individualization of interventions according to the needs of youth and their families. Moreover, gradual transitioning involves the implementation of a strategy for both youth and their school setting to progressively adjust to the reality of school re-entry. It may also reduce the likelihood of rehospitalization by reducing feelings of burden and distress. Finally, prolonged support through frequent contacts may allow for the adjustment of interventions in a timely manner, all the while fostering the maintenance of relationships and communication between all stakeholders.

Finally, it is important to note that the BHYD program’s recommended criteria pertain to the clarity of available information. Yet, despite their clarity, available information

was limited and did not permit a thorough understanding of the process of reviewed programs, and of the program models that link their interventions to outcomes. For instance, many programs value collaboration between hospitals, parents, and schools, but few specify how to address this collaboration or what observable outcomes may be identified. Therefore, future studies are necessary to increase knowledge about practices that foster consensus between experts. This would provide opportunities to articulate essential components of the programs, test the theoretical rationales that connect interventions with outcomes (for youth, caregivers, school staff and medical teams) and make it more applicable for practice. In addition to distinguishing between the essential components of programs, it is important to understand in which contexts interventions should be individualized. Accordingly, results from our previous work suggest that precautions should be taken to adequately support the reintegration of students hospitalized following a suicide attempt and limit the possible contagion effect (65). In this way, more research is necessary to highlight what factors might significantly impact the success of school reintegration as a function of the problems experienced by youth. Finally, future studies are also necessary to explore the links between some components of school reintegration and rehospitalization. Considering difficulties associated with program evaluation, it would be relevant to first examine if the implementation of key components makes a difference in the promotion of reintegration and reduction of rehospitalization.

Several limitations of this study should be considered. First, the language of publication, restricted to English or French, therefore potentially relevant documents might have been overlooked. Second, most documents originated from the USA, which implies that programs may be difficult to implement in other countries that do not have the same resources (human, financial, and material) for health and educational services. Third, the heterogeneity of the population targeted within the identified programs (e. g., age, symptoms and context of hospitalization) must be recognized considering it is likely that the intervention offered was adapted accordingly (e.g., content, duration, mode of delivery). This limitation resonates with the necessity to adopt a comprehensive approach with these youths according to the complex nature of the issues they experience and the systems within which they evolve (17, 27). Fourth, it is possible that the descriptions of existing programs are incomplete because some reports were excluded for lack of precision or lack of replies from authors contacted for more information. The latter may also explain the absence of reports identified since 2018.

Conclusion

By means of a rigorous and transparent procedure, this systematic review sought to identify transition programs for school reintegration after youth psychiatric hospitalization, and assess these programs using a well-established framework in the area of promising programs. Findings from 13 reports allowed for the identification of eight programs. Although available information would benefit from some clarification, consensus emerged between programs about the core components of their intervention. Future studies are necessary to increase knowledge about school reintegration practices after psychiatric hospitalization and establish promising programs that meet standards of quality.

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Conflicts of Interest:

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