GETTING BACK TO SCHOOL – UNDERSTANDING ADOLESCENTS’ EXPERIENCE OF REENTRY INTO SCHOOL AFTER PSYCHIATRIC HOSPITALIZATION

A thesis presented

By

Daniel J. Simone

to
The School of Education

In partial fulfillment of the requirements for the degree of
Doctor of Education

In the field of
Education Leadership

College of Professional Studies
Northeastern University
Boston, Massachusetts
October 2017
ABSTRACT

The purpose of this qualitative study was to explore the experience students have reentering high school following psychiatric hospitalization, and within programming designed to assist with this transition. To accomplish this goal, two research questions were formulated to guide this study: What is the experience of re-entering high school, for adolescents, after a psychiatric hospitalization? and How does the transition programming work with students reentering the high school after hospitalization, considering the bridge for resilient youth in transition model milieu program as a Community of Practice? Participants were chosen from suburban high schools that offer the bridge for resilient youth in transition model programming. Data were collected from eight participants through a series of semi-structured, in-depth interviews. Data were analyzed using general inductive analysis, and was coded using multiple strategies, including open and axial coding. Three conclusions derived from the findings of this research. First, reentering high school after psychiatric hospitalization is an experience that produces academic and social stressors for students as they continue to manage symptoms. Second, BRYT reentry programming helps to support academic recovery, and mental health recovery, through relationship development and connectedness at school. Finally, BRYT reentry programs exist as Communities of Practice, where students’ identities and their shared endeavor of reentry after psychiatric hospitalization are improved via meaningful engagement in the milieu.

Keywords: post-hospitalization, reentry, school counselors, adolescent mental health, BRYT transition programming, school-based mental health, Community of Practice
DEDICATION

This thesis is dedicated in loving memory to my mother, Patricia J. Simone. Mom was the person who always believed in me, no matter what I was getting myself into. I hope that the completion of this doctoral journey is a small tribute to her and honors her legacy. Mom’s belief in the power of education and in psychology inspired me. All we were ever talking about was solving the problems in the world. Her love has carried me for my entire life.
ACKNOWLEDGMENTS

The most important acknowledgments and thanks I have are to my wife, Sadie. You have sustained me in this journey from the start. I cherish your belief in me, and your love has changed my life. I would not have and could not have done this without you, and will be forever grateful. Thank you for your patience for my stops and starts, and your willingness to help me push through. You are the smartest person I know, Sadie. And you are the best mom! I am so lucky to share forever with you. Thank you for everything.

Greetings and thanks to my friends and family. To my mother-in-law, Sue Chapman, I loved our chats and am forever in your debt. The countless Grammy hours were awesome and helped make this possible. To Dad, Mary, Tom, and John, I have felt your support and encouragement from the start. Thank you for your love, for always asking how it was going, and for wanting me to succeed. I also have special thanks to give to my children, Evelyn and Gabriel. You know what we say, "Work hard and have fun!" Every day you inspire me to try to be a better person. I hope you always reach for the stars, see the light on the horizon, and achieve your truest dreams. Your mom and I love you.

To my friend and colleague, Dr. Alison Nowicki. When we started this whole thing together we both knew you'd finish first. Ha! What a crazy trip, indeed! I could always rely on your spirited support and encouragement. Your drive and your scholarship inspired me. You helped keep me on track and I can't thank you enough!

Thank you to the Lighthouse Keepers, past and present, who have supported me and inspired me. I am honored to be a part of this community.

To Elizabeth Barragato and Stephen Harrington, the best of the best. Your love and support for me, both before and during this journey, has meant the world to me.
To Dr. Diane Hotten-Sommers, you helped me through when I was most stuck, thank you for your wisdom and encouragement. To Heather Bowlan, thank you for your professionalism, warmth, and support.

To Alannah DiBona, thank you for your keen eye for detail, and your huge heart, I am so thankful for your help. To Lisa Winner, thank you for your unwavering and enthusiastic encouragement.

A heartfelt thanks to my advisor, Dr. Corliss Brown Thompson. Thank you for your invaluable guidance and wisdom. I really appreciated knowing you were always there for me. You supported me throughout and your thoughtful suggestions on my writing made all the difference. Thank you to the other members of my committee, Dr. Kristal Clemons and Dr. Dalia Llera for your support and wisdom. Dr. Clemons you helped guide me in my research. And, Dr. Llera you have continued to help shape and teach me throughout my career; thank you, again, for everything.

Huge thanks to Dr. Paul Hyry-Dermith and to each of the staff members of the BRYT programs who supported and assisted with this research; it has been great working with you. To Dr. Henry White at Brookline Mental Health, your leadership of the BRYT mission is a powerful legacy.

Lastly, to all the young people with whom I had the honor of spending some meaningful time. Thank you for allowing me the privilege of knowing you and the great fortune to have the opportunity to try to make a difference.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABSTRACT</td>
<td>2</td>
</tr>
<tr>
<td>DEDICATION</td>
<td>3</td>
</tr>
<tr>
<td>ACKNOWLEDGMENTS</td>
<td>4</td>
</tr>
<tr>
<td>TABLE OF CONTENTS</td>
<td>6</td>
</tr>
<tr>
<td>LIST OF TABLES</td>
<td>10</td>
</tr>
<tr>
<td>CHAPTERS</td>
<td></td>
</tr>
<tr>
<td>CHAPTER ONE – INTRODUCTION</td>
<td>11</td>
</tr>
<tr>
<td>Topic</td>
<td>11</td>
</tr>
<tr>
<td>Justification for the Research Problem</td>
<td>12</td>
</tr>
<tr>
<td>Deficiencies in the Research</td>
<td>14</td>
</tr>
<tr>
<td>Significance of Research Problem</td>
<td>14</td>
</tr>
<tr>
<td>Positionality Statement</td>
<td>15</td>
</tr>
<tr>
<td>Research Questions</td>
<td>17</td>
</tr>
<tr>
<td>Theoretical Framework</td>
<td>18</td>
</tr>
<tr>
<td>Communities of Practice</td>
<td>18</td>
</tr>
<tr>
<td>CHAPTER TWO – LITERATURE REVIEW</td>
<td>21</td>
</tr>
<tr>
<td>Study Contextualization</td>
<td>21</td>
</tr>
<tr>
<td>Why Mental Health in Schools?</td>
<td>21</td>
</tr>
<tr>
<td>Literature Review</td>
<td>25</td>
</tr>
<tr>
<td>Social Emotional Adolescent Adjustment</td>
<td>25</td>
</tr>
<tr>
<td>Post-Discharge Considerations at School</td>
<td>29</td>
</tr>
<tr>
<td>Relating to Adults</td>
<td>30</td>
</tr>
<tr>
<td>Joining a Milieu</td>
<td>31</td>
</tr>
</tbody>
</table>
Organizational Change........................................................................................................... 94

Conclusion .................................................................................................................................. 95

REFERENCES ................................................................................................................................... 96

APPENDIX A – BRYT CONSORTIUM EMAIL ........................................................................ 105

APPENDIX B – SITE ACCESS LETTER .................................................................................... 106

APPENDIX C – CLINICAL DIRECTOR INITIAL CONTACT AND CONSENT .................... 107

APPENDIX D – GUIDELINES FOR SUBJECT SELECTION .................................................. 109

APPENDIX E – RECRUITMENT LETTER .................................................................................... 110

APPENDIX F – INFORMED CONSENT LETTER ..................................................................... 111

APPENDIX G – PARAGRAPHS TO EXPLAIN STUDY TO A MINOR ................................... 114

APPENDIX H – FIRST INTERVIEW QUESTIONS .................................................................... 115
LIST OF TABLES

Table 1. Race Demographics From Schools Within this Study and Across Massachusetts 51
CHAPTER ONE – INTRODUCTION

Topic

The National Institute of Mental Health (2010) reported that youth were disproportionately affected by mental disorders, with “about 20 percent of U.S. youth during their lifetime are affected by some type of mental disorder to an extent that they have difficulty functioning” (p. 1). With 12% of regional teens reporting having seriously considered suicide, and four percent of current students reporting having attempted suicide (Emerson Hospital, 2010), the need for significant counseling intervention is clear. Concord Carlisle High School, a suburban high school with approximately 1,300 students, offers a college preparatory curriculum, course offerings, and teaching methods that propel students to the world’s most competitive universities year after year. In 2011, 92.1% of graduates planned to attend a 4-year college (Guidance and Counseling Department, Merrymount High School, 2011). Even amid this success, several students (some achieving high grades and some not) are disengaged from learning and the school.

Within a high school, the school’s guidance counselors, social workers, psychologists, special educators, and administrators work together to develop comprehensive student support after hospitalization, substance abuse treatment, or a serious medical event to improve a student’s success at reentry. As a team, they need to work to ensure that psychosocial factors are addressed following discharge (Chung, Edgar-Smith, Palmer, Bartholomew, & Delambo, 2008). In addition, students work with their teachers to try to get back on track following their absences.

The intervention plans that a school puts together for a student after re-entry are critical for students’ health and well-being, as the first 90 days, immediately following a hospitalization, comprises the period when students are most at-risk of being re-hospitalized (Blader, 2004).
Regaining academic and social traction after an extended absence can be difficult for any student, but students with mental and emotional challenges often struggle even more so after being hospitalized (James et al., 2010). Most schools have not taken a coordinated or programmatic approach to supporting students with re-entry. Students are often left to attempt to navigate the process on their own, or with varying and limited support from a guidance counselor. To address this problem, Dr. Henry White, clinical director at Brookline Community Mental Health Center, developed the Bridge for Resilient Youth in Transition (BRYT) program.

The BRYT program model places mental health professionals in the school and tasks them with the specific responsibility of supporting students transitioning back from treatment. The model consists of a minimum of two full time staff members, one clinical and one academic, working in a dedicated classroom within the school. The program has been replicated, initially by six area schools, and has grown to include approximately 40 schools in Massachusetts. Currently, a coordinated effort exists with the intention of developing a manual for schools interested in replicating the model. Additionally, a study is currently being conducted through George Washington University, which is focused primarily on quantitative outcomes and assessing the efficacy of the model (White & Houle, 2016). Therefore, the purpose of this study was to explore students’ experiences of returning to high school after psychiatric hospitalization, with the benefit of the BRYT model programming. With a focus on a qualitative investigation, a better understanding of the student experience in the context of this new programming is presented.

**Justification for the Research Problem**

There were no peer-reviewed studies found regarding targeted programmatic support for this population in a public-school setting. Understanding the needs of the population was
enhanced by Clemens, Welfare, and Williams (2011), who wrote about staff perceptions of the needs of this population. Additionally, Simon and Savina (2005) documented that most support and therapeutic attention to discharge needed to happen prior to discharge, and Savina, Simon, and Lester (2014) identified factors on which to focus support at the time of reentry following psychiatric hospitalization. Among these was the primary importance of youth’s perceptions of their experiences of being hospitalized and the ensuing reentry into school. While these studies offer consider the perceived needs of this population, none of the research focused on the qualitative experience of young people living through this experience.

The gap in data was even wider, given that there was also a paucity of research demonstrating efficacy of interventions in alternative (not in the public school) settings (Flower, McDaniel, & Jolivette, 2011; Kleiner, Porch, & Farris, 2002). Currently, there are only a few public-school programs designed to support the needs of adolescents transitioning back to school from treatment. None of these programs have been written about in a peer-reviewed journal. Developing evidence of the efficacy of programming that addresses student mental health and educational needs, and an understanding of the phenomenon of re-entry after hospitalization from a student’s perspective of the experience is critical (Brownson, Fielding, & Maylahn, 2009; Daniel, Goldston, Harris, Kelley, & Palmes, 2004).

While post hospital experiences have not been sufficiently explored, adolescents report the most meaningful components of their inpatient treatment include peer contact and therapeutic support, which help them acquire the ability to set achievable goals (Grossoehme & Gerbetz, 2004). Peer support and feedback, as well as gaining a sense that there are others going through similar struggles, is rated as the most supportive part of treatment (Moses, 2011). Given the lack
of information about adolescent perspectives on their treatment and outcomes, the value of qualitative research is clear.

Deficiencies in the Research

Because of the newness and specificity of this programming, there was no research found in the literature. For students whose emotional struggle leads to their safety being at risk, inpatient hospitalization may be required. With 11% of adolescent deaths reported as being due to suicide (Minino, 2010), adolescent suicide remains a major concern. Brinkmann-Sull, Overholser, and Silverman (2000) stated that when depression persisted at discharge for students, who faced higher degrees of hopelessness and depression at the point of hospital admission, were left more vulnerable to another suicide attempt. Pairing these data with the growing numbers of students returning from hospitals, the urgency for schools to respond was clear. However, there were no data available from research specifically investigating post hospitalized students’ experiences in their public school setting. Understanding their experiences in schools, where specific programming did exist to support them, could help to inform future programming and research. Findings from this study should be a specific interest to the following audiences: school counselors, administrators, departments of education, and mental health professionals in the community. Better understanding the student experience would help to inform programmatic implementation in support of this high-risk population.

Significance of Research Problem

Researchers have found that the number and duration of necessary inpatient services are decreasing (Butcher, 2012; Daniel et al., 2004; Geller & Biebel, 2006) and the need for inpatient services has increased dramatically among adolescents (Blader, 2011). There is a call to address the psychosocial needs of adolescents being discharged, and to identify a staff member at school
to manage the follow-up support needed for students returning to school (Carpenter-Aeby & Aeby, 2005; Ferdinande & Colligan, 1980). Even with the significant needs of this population, most schools do not have targeted programmatic services for students transitioning back to school from treatment.

The programming under investigation attempts to support students academically, socially, and emotionally by placing students together who have a common experience of returning to school after an extended absence. The intention is to reduce re-hospitalization, decrease absenteeism, improve students’ functioning, and increase students’ connections to school. Considering that adolescents benefit from being known (Eccles, Early, Fraser, Belansky, & McCarthy, 1997), the intervention is designed to engage students and create relational supports.

Research was needed because little was documented about the student experience of reentry. Evaluating school services, though challenging, is important to assessing efficacy, informing good practice, and justifying funding (Gomby & Larson, 1992). Attaining a phenomenological understanding of the adolescent experience during this transition back to school, while examining their experiences within the programmatic support provided by these new school based programs, would further school personnel’s ability to assist these students.

**Positionality Statement**

I experienced seeing teenagers struggle with mental illness when I was a teenager. Twenty-eight years ago, when I was 17 years old, I had a couple of close friends who were at-risk from major mood disorders and substance abuse, which included thoughts and attempts of suicide. Watching them struggle before, during, and after treatment was a significant challenge. I felt empowered and responsible to try to help them, while I felt over my head determining what
to do and what to say. I can vividly remember my visit to a friend who was struggling in the
hospital. At the time, I wondered, “How can things get back to normal?” and “Will they ever be
the same? And can we even be friends?” My experience was a true paradox of emotions that
involved a sense of urgent importance and vulnerable limitation. As I have pursued studies and a
career in psychology and education, I continued to focus on trying to offer help amid the
vulnerabilities and limitations inherent in the counselor role.

As a school adjustment counselor, I have spent years working with students reentering
high school after psychiatric hospitalization. In my experience I have seen the struggle that
students face when returning from the hospital. I have seen students’ symptoms worsen,
particularly when they are not offered programming and need to be re-hospitalized. Further,
confirmed from conversations with school counselors from many different schools, I know that
there is a common and high-level concern among counselors who struggle to determine how best
to support these students. I believe that the purpose of public education is to get everyone across
the river. What I mean by this is that the social trust and task of educators is to ensure that all
students learn, not just the most able. For me, this is more important than the business of
measuring or rewarding those who can achieve more easily or quickly. This belief is informed
and supported by the charge to take responsibility for all students’ access to educational
opportunity, as clearly outlined in the American School Counselor Association’s (ASCA, 2016)
*Ethical Standards for School Counselors*. ASCA’s call to social justice advocacy and leadership
also informed my commitment to this research.

Developing and strengthening student support services for students with disabilities (i.e.,
emotional disabilities) directly links to my commitment to combat mental health stigmatization
and my commitment to fair and equal access for struggling adolescents. The ASCA (2016)
reminds me that as a school counselor I am responsible for “the educational, academic, career, personal and social needs and encouraging the maximum development of every student” (para. 15). My new role as a scholar-practitioner has given me the tools I require to help myself and others meet the multifaceted needs of students through student services.

Using evidence-based approaches is a key part of being a scholar-practitioner (Butin, 2010; Short & Shindell, 2009). With this emphasis in mind, Butin (2010) stated, “It means being cognizant of the complexity around you while nevertheless moving forward in your daily practices” (p. 16). Similarly, through this study, I wanted to understand better the complexity involved in creating reentry plans that are responsive to students’ needs, while understanding student experiences. In my department, I want to use research-based decision-making because it is not just a matter of learning, but it also has direct implications for educators and students – what impacts people’s lives is learned. Grounding student service decisions in the available research, as well as grounding future research decisions on past practice and research, was central to what I hope to achieve with my thesis.

I have been at the center of implementing this transition programming at the high school where I work. With this affiliation, I have participated in the data collection and collaboration within the study through George Washington University. The research I conducted was with students from other area high schools, who have experienced similar programming, but who have not had previous or current contact with me as a counselor.

**Research Questions**

A small number of high schools have developed transition programming to help students reenter the school environment. Understanding the experience of reentry in the context of this programming was the goal of this research. The two guiding research questions were:
1. What is the experience of re-entering high school, for adolescents, after a psychiatric hospitalization?

2. How does the transition programming work with students reentering the high school after hospitalization, considering the BRYT model milieu program as a community of practice?

**Theoretical Framework**

The BRYT programs are designed to support students during this time of transition by providing services and support in a designated classroom within the school. This programming brings students together to provide academic, social, and emotional support during this difficult reentry phase. The program unites students with a common task of returning to school after an extended absence. The intention is to reduce re-hospitalization, decrease absenteeism, improve students’ relationships, and develop students’ connections to school. Part of this investigation included considering students in BRYT programming to be in a community of practice (CoP; Wenger, 1998). Enthoven and de Bruijn (2010) stated, “The crucial element in these development processes in a community of practice is an ongoing interaction between its members” (p. 290). The robust CoP construct, articulated by Wenger (1998), provided the theoretical framework for investigating the phenomenon experienced by high school students reentering school via transition programming. This construct is explained below.

**Communities of Practice**

The skills learned from being a caring community member are essential to acquire and are key to learning. Regarding a CoP, Wenger (1998) espoused, it was

A living context that can give newcomers access to competence and also invite a personal experience of engagement by which to incorporate that competence into an identity of participation … communities of practice are a privileged locus for the *acquisition* of knowledge. (p. 214)
He argued, “a social theory of learning must… integrate the components necessary to characterize social participation as a process of learning and of knowing. These components include…the following: meaning; practice; community; and identity” (Wenger, 1998, pp. 4-5). Wenger’s (1998) comprehensive theory outlines the benefits of a community, whereby those included glean identity via mutual engagement, meaning making through experience, and engagement that fosters a sense of belonging and knowing. Relationship-based learning is a better building block for students and strengthens their identity.

Social capital is a key feature of the CoP construct. Enhancing an adolescent’s social capital is important to their reentry process and overall health outcomes. An individual’s relationships are what generate improved healthcare and educational access, and it is these improved social relationships that are considered part of a person’s social capital (McKenzie & Harpham, 2006). Building social connection is key to supporting depressed adolescents, so much so that “alleviating depression and interpersonal sensitivity and supporting social networks are the factors that psychiatric treatment should focus on in order to improve life satisfaction among depressive patients” (Koivumaa-Honkanen et al., 2009, p. 603). Even subtle and small experiences of a sense of belonging and connection can enhance a person’s well being and engagement (Walton, Cohen, Cwir, & Spencer, 2012). Improved social connectedness is particularly important following being discharged (Czyz, Liu, & King, 2012; Moses, 2011).

Another critical feature of the CoP construct is meaning making. Being hospitalized and then returning to school and home is a major life event. Regaining or building connections during this transition pose a significant challenge to teens. Tavernier and Willoughby (2011) explained that when meaning making occurred subsequent to a significant event in an adolescent’s life, the value from the event could be realized. Discovering ways in which
adolescents make meaning out of their experiences and their accounting of the degree to which being in the program helped to facilitate meaning making was an important part of this study.

Understanding adolescents’ experiences of support, intended to enhance peer relationships and staff-student relationships in a school-based CoP intervention, was key. This exploration was all in service of improving their ability to make meaning of what transpired and to improve their connections to school. Combined, the CoP and school connectedness constructs set the overall theoretical consideration of this research.

Psychosocial factors need to be addressed following discharge (Chung et al., 2008). This period, immediately following hospitalization, is when students are most at-risk of being re-hospitalized. Regaining academic and social traction after an extended absence can be difficult for any student, but students with mental and emotional challenges often struggle after being hospitalized (James et al., 2010).

Understanding the phenomenon experienced by adolescents reentering the public-school setting after psychiatric hospitalization proved both illuminating and useful. Specific attention was paid to adolescents’ experiences of transition programming, understood as a CoP, which was available at their school. Understanding the influence of this CoP on school connectedness and the experience of these teens was the theoretical framework for this investigation. With this problem of practice, these research questions, and the outlined theoretical framework in mind, the next step in the thesis is to review the relevant literature. Considering the specific challenges these adolescents face, this review helped to shape and inform this investigation.
CHAPTER TWO – LITERATURE REVIEW

Adolescence can be a time of great turmoil and struggle. This struggle can involve major emotional distress, and, at times, these struggles can be a matter of life and death. The National Institute of Mental Health (2010) reported that mental disorders disproportionately affected youth. At the local level, these disorders manifest in high school students becoming suicidal (Emerson Hospital, 2010), struggling to engage at school, and needing to be hospitalized or missing school for an extended period. However, while the need for inpatient services has increased dramatically (Blader, 2011), researchers have also found that the number and length of necessary inpatient services are decreasing (Butcher, 2012; Daniel et al., 2004; Geller & Biebel, 2006). This study sought to examine the phenomenological experience of adolescents who have reentered their public high school with the help of supportive programming. It investigated what elements of the BRYT programming were the most meaningful to students. It assessed ways in which the intervention offered supports students and how it helped fragile students to re-integrate into the school environment.

Given the absence of direct literature regarding this specific type of programming, this literature review presents the emotional needs of adolescents facing this kind of transition. These include issues specific to adolescent social emotional adjustment, the acute needs of at-risk adolescents, and the experience of joining a milieu, as well as issues presented by the processes of change and integration.

Study Contextualization: Why Mental Health in Schools?

As concerns rise to the level where teens need inpatient or significant treatment that prevents them from attending school, one of the benefits of this kind of treatment is the removal of the stressors associated with school (Moses, 2011). However, for many the eventual transition
back to high school may seem daunting or even impossible, and there are significant issues associated with teens encountering this vulnerable transition. A student’s emotional distress, coupled with concerns about disconnection from school, increased distance from peers, and concerns academic performance (Czyz et al., 2012; Eccles et al., 1997; McNeely & Falci, 2004), alongside the possibility of needing to be re-hospitalized (James et al., 2010), remain of critical importance. While short-term inpatient treatment helps to reduce the most imminent risk, the need for support usually extends beyond the time of discharge (Reid, 2009).

The BRYT model for supporting students in transition was developed in response to this critical problem of practice. Whether schools’ leadership should be responsible for teen’s mental health, they do have a responsibility to work toward success in school by accordingly supporting students during this transition is the school’s purview. While public schools’ leadership maintain their primary responsibility is academic in nature, the emotional and social support of the child should also be central (Flower et al., 2011; Noddings, 2005). Students returning to high school face significant challenges, so school staff members need to consider ways to best support this population. Even with the significant needs of this population, most schools do not have targeted programmatic services for students transitioning back to school from treatment. Therefore, there is a call to address the psychosocial needs of post-treatment adolescents with the intention of returning to school and to identify a staff member within the school to manage the necessary follow-up support (Carpenter-Aeby & Aeby, 2005; Clemens et al., 2011; Ferdinande & Colligan, 1980).

During the first 90 days immediately following a hospitalization, students remain highly at-risk of being re-hospitalized (Blader, 2004). Many of these students return to school and
remain at significant risk for suicidal ideation. In addition to managing suicidal ideation, the issue of connectedness to school is also important to an adolescent’s overall mental health, as psychosocial factors and connectedness to peers are important following discharge (Chung et al., 2008; Czyz et al., 2012; Moses, 2011). Schools’ leadership should find a way to establish connections and support for all students, including those struggling with mental health issues. Building connections between adults and students, as well as between peers, should be part of what schools attempt to facilitate.

Context, when studying issues of health, matters (Hooper, & Britnell, 2012). Therefore, it is important first to investigate programming that is taking place in a public high school, rather than an alternative educational setting. The school programs following the BRYT model are designed to support the needs of adolescents transitioning back to school from treatment, and while there is an ongoing multi-school, multi-year quantitative study of the model (White & Houle, 2016), to date, the model has not been written about in a peer-reviewed journal. Due to a lack of literature concerning adolescents reentering public school after absences for psychiatric treatment (Clemens et al., 2011; Simon & Savina, 2007, 2010), consideration of education settings and programming offered outside of the public school should be considered to situate this study regarding the most relevant literature available. However, there is a paucity of research demonstrating efficacy of interventions in alternative settings, as well (Flower et al., 2011; Kleiner et al., 2002). Developing evidence of the efficacy of programming that addresses mental health needs is critical (Brownson et al., 2009; Daniel et al., 2004).

1 “Suicide ideations are thoughts about suicide that may include the planning of suicide attempts. This cognitive process of suicide thought puts adolescents at a higher risk for following through and attempting and/or successfully committing suicide” (Waldvogel, Rueter, & Oberg, 2008, p. 110).
With schools being the leading deliverer of mental health services to adolescents (Farmer, Burns, Phillips, Angold, & Costello, 2003) and experts agreeing that improving evidenced based practice in schools is a key to improving the quality of supports for teens (Lyon, Charlesworth-Attie, Vaner Stoep, & McCauley, 2011), the importance of understanding the student’s experience of the BRYT model is clear. The BRYT model received the American Psychiatric Association’s Gold Achievement Award in 2014 for innovation (“A School Based Transition Program,” 2014). As the model begins to take hold at the state level, with 14% of Massachusetts public high schools adopting the model (White & Houle, 2016), and the national interest in the model is developing, there is an increased need for understanding the experiences of teens who have utilized this support.

Therapeutic support should enhance the “continuity of care” (Cameron, Birnie, Dharma-Wardene, Raivio, & Marriott, 2007, p. 25), thereby playing a key role within the health care of teens. While Cameron et al. (2007) conducted their research at a residential treatment facility that served adolescents as they returned from the hospital; their focus was on parents’ and staff’s qualitative and quantitative account of needs. This focus did offer insight into the needs of this population during the time of post-hospitalization, but it still did not offer adolescents a voice, and it did not address the needs of teens returning directly to their former school. The Brookline Mental Health Center developed the BRYT model to address the needs of students returning to their public high school after having been hospitalized, thereby creating a new way to provide continuity for teens. Over the past 6 years, this programming has been replicated in 38 public high schools in Massachusetts (White & Houle, 2016). As there exist no studies that directly address this transition or this programming, focus has now shifted to consider what the literature contributes to the needs of adolescents, and critical elements within the phenomenon of reentry.
**Literature Review**

**Social Emotional Adolescent Adjustment**

Gambone, Klem, and Connell (2002) articulated the importance of having at least one adult, beyond a family member, to whom an adolescent would go for guidance and emotional security as being critical to adjustment. The authors identified factors of importance to youth achieving healthy outcomes later in life. First, “the achievement of developmental outcomes – learning to be productive; to connect with adults, peers, and society’s institutions; and to navigate through diverse settings, relationships and the lure of risky behavior” (Gambone et al., 2002, p. 39). The second key element is “the availability of supports and opportunities – supportive relationships with adults and peers; challenging and engaging activities and learning experiences; and meaningful opportunities for involvement and membership” (Gambone et al., 2002, p. 40). Accordingly, relationships between adults and students matter greatly. Rud discussed the idea of hospitality: “The activity of receiving another person, listening to that person, and being open to what that person has to say” (as cited in Hansen, 2007, p. 167). This is essential to the concept that the student should be at the center of the teaching and learning experience.

Teachers need to recognize that the relationship with each student matters to the central mission of effective education. For better or worse, learning happens in the context of this relationship. Teacher and student work hinges on this relationship, ontologically, meaning that teaching and learning happen with the relationship as the essential and unavoidable vehicle for this process (Giles, 2011).

Feeling known and having a sense of connection is key to existence. The value of being known, being-in-relationship, exists in and beyond the teacher-student relationship. Adolescents
benefit from being known by family members and peers (Eccles et al., 1997). People are all necessarily relational; it is part of what it means to be human – to care what others think. When people are faced with difficult challenges, it can create anxiety and disconnection. As a supportive environment, a caring community can aid in the face of these challenges and promote learning. Noddings (2005) advocated for new priorities, which went beyond even Dewey’s (1990) notion of grounding the learner in the usual subjects. When considering teacher-student relationships, he stated, “Teachers not only have to create caring relations in which they are the carers, but that they also have a responsibility to help students develop the capacity to care” (Noddings, 2005, p. 18). Simply put, the skill gained by being a caring community member is essential to acquire, and it is essential to learning.

Yalom (1989), a preeminent teacher in the field of counseling, stated, “It’s the relationship that heals, the relationship that heals, the relationship that heals – my professional rosary” (p. 91). It is a part of the counselor’s job to find a way to connect with each client’s unique humanity to activate the benefits of the relationship. This challenge exists also for the teacher. To the extent that teachers find it difficult to connect with their students, their students’ performances will suffer (Gambone et al., 2002; Geller & Biebel, 2006).

Teachers need to focus on ways to build connection, especially with students who outwardly are rejecting their efforts. Specifically, social and emotional problems negatively influence their ability to build quality relationships with their teachers (Murray & Zvoch, 2011, p. 50). In this way, the teacher’s task is similar to the counselor’s. The teacher must find a way to improve connection – it is the relationship that teaches. Successful completion of high school is much more likely if a student maintains multiple connections and activities in the school (Finn, 1989).
Acute Needs of At-risk Adolescents

Considering the importance of relationships to all youth, when mental health concerns are present, the need intensifies. At every developmental stage, mental health affects ways in which people view themselves and world around them, which has a significant influence on decision-making and on one’s ability to cope (Gampetro, Wojciechowski, & Siarkowski-Amer, 2012). In the context of reentry, it will be important to investigate what students perceive as their needs based on how they view themselves, others, the world, their coping mechanisms, and what meanings they take from these experiences.

Being hospitalized and then returning to home and school is a major life event. Regaining or building connections during this transition should be viewed as a turning point. Turning points “are regarded as significant life experiences as individuals attribute changes in their behaviors and attitudes to these events” (Tavernier & Willoughby, 2011, p. 1). Tavernier and Willoughby (2011) explained meaning making occurred after the turning point, where the value of the event was realized. Teens, in facing this turning point, need to make sense of their experiences.

Adolescents with mental health care needs desire support with “personal and family relationships, education and vocational goals, health maintenance, and financial independence” (Gampetro et al., 2012, p. 29). Accordingly, the influence of the supportive programming on these relationships and goals should be included in the qualitative inquiry. When confronting untreated mental health disorders, youth struggle to learn effectively at school and to develop the social skills needed to lead healthy adult lives (Geller & Biebel, 2006).

Safety. For some students, their emotional struggle leads to their safety being at risk. Eleven percent of adolescent deaths are due to suicide (Minino, 2010); therefore, this issue remains a major concern for all charged in supporting youth. The many factors that increase risk
for suicide categorically include “individual, familial, socio-demographic, and life stressors. Each risk factor potentially increases the likelihood that an adolescent may attempt or commit suicide” (Waldvogel et al., 2008, p. 123). In these cases, inpatient hospitalization may be required to treat the acute needs of the adolescent. Still, when depression persists at discharge for adolescents who experience higher degrees of hopelessness and depression at the point of admission to the hospital, it leaves them more vulnerable to another suicide attempt (Brinkmann-Sull et al., 2000). In addition, most adolescents hospitalized for suicidal ideation or suicide attempt meet the criteria for more than one mental disorder (Righini et al., 2005). This comorbidity compounds the complicated process of supporting adolescents returning from treatment. Rones and Hoagwood (2000) confirmed that no programs in school targeted single mental health issues. This aspect is true with the BRYT model, as well. While students return from hospitals, their issues are varied, ranging from anxiety or depression to other major medical or mental issues, self-harm, substance abuse, or suicidality (White & Houle, 2016). Overall, the risks for this population are quite high, with 67% with suicidal behavior (ideation), and 38% making attempts within two years after having been hospitalized (Hayashi et al., 2012).

The hospital’s highly restrictive and safe environment is different from everyday living. While this difference may be key to guaranteeing safety, replicating the hospital environment in a public high school setting is not sustainable. However, there are elements of what takes place in the hospital that can guide consideration for supporting adolescents post-discharge. Multiple studies have shown that adolescents report that the most meaningful components of their inpatient treatment was peer contact and therapeutic support, which helped them acquire the ability to set achievable goals (Grossoehme & Gerbetz, 2004; Moses, 2011).
Post-Discharge Considerations at School

Once the most critical mental health issues are stabilized and adolescents are discharged, their continued struggle warrants intervention (Reid, 2009), as the first 30 days after discharge hold the highest risk of being re-hospitalized (James et al., 2010). A study out of Finland found that “alleviating depression and interpersonal sensitivity and supporting social networks are the factors that psychiatric treatment should focus on in order to improve life satisfaction among depressive patients” (Koivumaa-Honkanen et al., 2009, p. 603). Therefore, building social connection and functioning is key to supporting adolescents after discharge, and connection and functioning in school should be sought. Although depressive feelings in adolescents are linked more strongly to happenings in the home environment, there is a positive association between the social support of peer connectedness and increased self-esteem (Eccles et al., 1997). This finding shows that while social connections at school may not alleviate all sources of depressive moods, there are positive gains from improving social support. In all, social connections and functioning at school seem critical to a student’s recovery. King, Kerr, Passarelli, Foster, and Merchant’s (2010) longitudinal study found that improved functioning of an adolescent post-hospitalization was correlated independently to decrease significantly likelihood for attempting suicide 1-year following having been hospitalized.

The importance of connecting students with peers is further supported by the educational mandate to support students in their home schools whenever possible. Public schools are required under Chapter 766 (Massachusetts Department of Elementary and Secondary Education, 2016) to provide an education to all students that takes place, when possible, in the student’s community – which is considered the least restrictive environment. Chung et al. (2008) recommended residential treatment to meet post-discharge needs and reduce re-hospitalization
after an acute short-term in-patient stay for adolescents. They referred to residential programming’s ability to support psychosocial factors as part of this recommendation. This aspect aligned with an approach taken in Scotland for patients transitioning out of the hospital. Reynolds et al. (2004) researched the “transitional discharge model” (p. 82), where supports were offered to adults in the community post hospitalization. The model included peer support from former patients and significantly decreased the rate of re-hospitalization.

Residential programming, while less restrictive than a hospital, still represents a more restrictive educational setting because students are not attending their regular high schools (Froiland, 2011). Additionally, some students may be found eligible for special education services; however, the eligibility process can take 45 school days before services are in place. Thus, many students returning from hospitals re-enter their former high school – referred for special education services or not – and are expected to attend school with or without supports in place.

**Relating to Adults**

The quality of the relationship with adults engaged directly in supporting students at-risk is a primary concern. Anderson, Christenson, Sinclair, and Lehr (2004) studied dropout prevention strategies, and their results showed that student-adult relationships in school-based programming positively influenced student engagement at school, underscoring that positive relationships with adults were key to successful adolescent development. Given the long-known importance of the ability of counselors and teachers to connect and build relationships (Schwebel, Karr & Slotkin, 1959), focusing on students’ perceptions of the staff is critical. Building these relationships contributes to a student’s reintegration and academic success.
because social development, mental health, and academic achievement are closely correlated (Hoagwood et al., 2007; Scheel, Madabhushi, & Backhaus, 2009).

**Joining a Milieu**

In addition to these issues faced by teens transitioning back to high school post-discharge, there are some issues specific to the prospect of teens joining programmatic support in the process. The primary subjects of this investigation are those students who reenter high school within the context of the BRYT model, which is a milieu. The model provides short-term, academic, and clinical support in a classroom based milieu setting (White & Houle, 2016). Students receiving this support encounter a community of students engaging in the same challenge of reentry. By participating in the program, they are new members of the group that exists within the program. Thus, students using the milieu intervention programming join a smaller community group within their school. The students’ experiences adjusting to and joining in this formation was part of this inquiry. Accordingly, consideration of the literature of regarding the experience of becoming a new member of a group was considered.

**Effects of Changing Membership Within a Group**

The prospect of joining a group can often be a cause of great concern and anxiety for the new member (Yalom, 1995). “Groups rarely remain as static entities” (Cini, 2001, p. 3), and the changing and fluid census of reentry programming is not an exception. The community functions as an open group, with members joining and leaving, within the life of the group (Burnette & Forsyth, 2008; Choi, Price, & Vinokur, 2003; Cini, 2001; France & Dugo, 1985, Ziller, 1965). Open groups are found as creative and effective (Ziller, Behringer, & Goodchilds, 1962); specifically, newcomers are more likely to have an innovative influence within an open group (Cini, 2001).
The level of acceptance or rejection between existing members of the community and the new member directly influences an individual’s successful integration into the group. Rejection of newcomers can have a serious influence on a person’s sense of loyalty to the group, social identification, and how the member will integrate into the group, if at all (Matschke & Sassenberg, 2010; Sleebos, Ellemers, & de Gilder, 2006). Inclusive and positive interventions are the most appropriate in schools, where peer group rejection and negativity can be common (Sunwolf & Leets, 2004). This integration is of great concern to the efficacy of any intervention.

**Change and Integration**

There is scarce information available about programming from in-school or alternative education settings (Brownson et al., 2009; Daniel et al., 2004). While, there are several peer-reviewed articles concerning the reentry needs of students who have been absent due to a serious medical treatment, such as cancer (Prevatt, Heffer, & Lowe, 2000), this population is not identical to students returning from psychiatric hospitalization. More specifically, the stress of facing reentry amid the continued mental health struggle presents different risk factors. However, the issue of reentry is common to both populations, and there is a similar difficulty in research design and data. Prevatt et al. (2000) concluded that it might be necessary to utilize the single case study method to investigate the benefits of school reintegration programs and the change from treatment to school.

The process of re-entering high school post-hospitalization, when viewed as a transition, offers students the opportunity and challenge of facing change. Most disciplines that study transition hold that transition requires adaptation to change (Kralik, Visentin, & van Loon, 2006). How students encounter the changing stressors and how they adapt to the process of reentry is strongly correlated to their integration back into the school environment.
Change. Given the importance of the successful integration, why then is change so difficult? The three dimensions of attitudes, as described by Piderit (2000) (e.g., cognitive, emotional, and intentional), offers a useful framework for considering the resistance to change. The cognitive dimension refers to one’s beliefs about the change; the emotional is comprised of the individual’s feelings; and the intentional dimension refers to actions taken, for or against, the change (Piderit, 2000). Previous group experiences affect newcomers’ outlooks and the skills they bring to the new group (Moreland, 1985; Sunwolf & Leets, 2004). As adolescents change from the treatment environment into the school environment, careful consideration of how they report this as a change they experience is merited.

Integration. Levine and Moreland (1994) established a theoretical model of this integrative process called group socialization theory. The assumption within the model includes the multidirectional influence between individual and group. The affective, cognitive, and behavioral components of this change can be influenced by the group and the individual via the integration process. For Wenger (1998), this integrative encounter merges the past and the future of the individual’s previous identity and who they will become because of the community engagement. Imbedded in this complex meeting is that the identities of all involved are changed.

For Levine and Moreland (1994) three psychological processes underpin group socialization: evaluation, commitment, and role transition. With every new member, there is an initial evaluation of the value of the relationship. This relationship is multidirectional, in that both current and new group members assess what is to be gained from the relationship. Commitment, which is informed by the results of the evaluation, compares these gains to existing relationships and sources of similar gains, and role transition is a process of redefining the status of relationships and the labels, assuming the member fully integrates. Accordingly,
how a student’s relationships develop amid this transition remain of concern. Since the programmatic intervention offered includes socialization and relationships via the milieu, assessing their perceptions and commitments to integrate fully is germane.

Levine and Moreland (1994) explained that shared thoughts entail awareness of the group’s norms, members, and the tasks of the group: “Much of what newcomers must learn during socialization is embodied in the group’s culture, which includes a set of shared thoughts and a related set of customs” (p. 319). Customs include routines, jargon, stories of members, symbols, and rituals specific to the group, each of which are considered “behavioral expressions of culture” (Levine & Moreland, 1994, p. 319). For existing members, the prospect and integration of newcomers can be difficult, and trust can weaken within the group, as the perceptions of newcomers and how new they are negatively affects the group (Cimino & Delton, 2010; McCarter & Sheremeta, 2013). In the classroom setting, researchers found that the introduction of new peers created stronger allegiances among students who were already familiar (Lubbers, Snijders, & Van Der Werf, 2010, p. 500). These bonds could increase the tension between older and newer group members, but these remain of interest for this review as both new and old members were engaged in the practice of reentry.

**Community of Practice**

As Wenger (1998) stated, “Joining a community of practice involves entering not only its internal configuration but also its relations with the rest of the world” (p. 103). Keeping this in mind, when considering in-school interventions for groups of students, is key. The purpose of the BRYT programming was to facilitate students returning to full functioning within their schools. The process of learning is made meaningful when it is met with competence and success (Wenger, 1998). As the bonds formed strengthen the community, the ultimate competence
sought is full connection within the school environment, and the integrated development of the student’s identity. As Wenger (1998) noted, “The work of identity is always going on” (p. 154). As such, regardless of a member working toward assimilation to the community, further deepening their involvement or setting their sights on eventually leaving the community, the fluidity of negotiating one’s identity is constantly relevant.

Wenger (1998) espoused a CoP was a “a living context that can give newcomers access to competence and invite a personal experience of engagement by which to incorporate that competence into an identity of participation” (p. 214). In other words, in considering the BRYT programming a CoP within the school, students are engaged in the practice of reentry where their identity can develop as their competence increases. Theoretically, the constructs of his social theory of learning seemed a suitable framework for discussing the phenomenological experience students have in joining the BRYT programming.

**Summation of Literature Review**

Positive relationships in school are essential to academic success (Scheel et al., 2009). For at-risk students, this relationship is particularly necessary. Health and educational outcomes can be enhanced for all adolescents when they experience improved connection to their peers, their school, and the adults at school. Relationships and connectedness are key elements of youth development. Most importantly, students need to learn to be productive and connect with their schools (Gambone et al., 2002). Educators need to realize that the relationship is central to their effectiveness. This importance is because learning takes place in the context of the relationship, which represents a significant need for all students. At-risk students experience this need at a heightened degree because they endure higher amounts of hopelessness and depression. School programming that supports high-risk students should address these needs.
Due to the increase in students being hospitalized and the decrease in services available, the need for school-based support is heightening. The increasing mental health needs of students returning from psychiatric treatment must be met by public schools. While the more restrictive support of residential and hospital-based services may work, students should have the chance to succeed in the less restrictive public-school setting (Froiland, 2011). Without support, students are left to attempt this transition, while remaining at high risk of disconnection from peers and school, increased emotional struggle, and possible re-hospitalization. The CoP, provided by the BRYT programming, attempts to address these risks in a systematic way.

**Methodological Considerations**

The literature, considered in this review, utilized a range of methodological approaches and involved various populations, including teachers, counselors, and adolescents. The quantitative studies varied from, assessing trends in hospitalization and outcome data, as well as predictors of symptoms (Blader, 2004, 2011), to archival review of patient records and clinician summaries (Chung et al., 2008). There were several mixed method approaches that involved quantitative and qualitative analysis of already available data, such as previously conducted interviews from intake and exit meetings. These studies also included information about inpatient experience, as well as interviews with caregivers (Brinkmann-Sull et al., 2000; Carpenter-Aeby & Aeby, 2005; Chung et al., 2008; James et al., 2010).

Mixed methodology involved interviews and direct questions to adolescents and included some survey usage. Grossoehme and Gerbetz (2004) used a Likert scale to gauge adolescent experience of inpatient treatment. The meaningful part of treatment receiving the highest rating from patients was "being with other adolescents" (Grossoehme & Gerbetz, 2004, p. 593).
The most illustrative methodological approach reviewed was the use of semi-structured interviews. While Moses (2011) did include some survey questions, they primarily sought adolescents’ perspectives about brief psychiatric hospitalization utilizing face-to-face semi-structured interviews. Scheel et al. (2009) also used face-to-face semi-structured interviews to assess the academic motivation of at-risk students in a counseling prevention program, which was an exploratory study that allowed for meanings of academic motivation to emerge. Gampetro et al. (2012) conducted a qualitative exploratory study in a school-based health clinic using interviews focused on perceptions of the mental health care of adolescents. The researchers interviewed subjects only once. Clemens, Welfare, and Williams (2010) conducted semi-structured interviews with professionals regarding their perceptions of the transition that was the focus of this study. They employed a Consensual Qualitative Research Approach (CQR), which enlisted a team of researchers for the analysis of the data. As the lone researcher in my study, the semi-structured interviews seemed particularly of value, while the team approach for data analysis was unavailable.

Next Steps

The BRYT programming, which has grown to exist in 14% of public high schools in Massachusetts, represents a new approach to meet the needs of students reentering. While the quantitative outcomes of this model are currently being investigated, the initial findings signify it as a highly successful program (White & Houle, 2016). The available literature offered important information about research approaches pertinent to studying this high-risk population: “Future research is needed to understand first-hand accounts of adolescents’ mental health concerns and to offer ideas for the delivery of mental health care at school-based health clinics” (Gampetro et al., 2012, p. 24). Accordingly, assessing students’ perceptions of school connectedness,
connections to school adults, and peer connections, and the degree to which intervention
improves these essential factors was needed.

There was a paucity of data pertaining to adolescents’ reentry experiences and
programming that specifically targeted this population of students. The results of research that
included qualitative accounts of student experiences in the program should make a valuable
contribution to the field. Evaluating school services, though challenging, is important to inform
good practice, and justify funding (Gomby & Larson, 1992). Student services and administrators
who face supporting this population of students must have a better understanding of students’
experiences and the influence of the programming.
CHAPTER THREE – METHODOLOGY AND RESEARCH DESIGN

Methodology

This thesis entailed a qualitative exploration of students’ experiences with re-entering high school after psychiatric hospitalization. The research questions were the following:

1. What is the experience of adolescents re-entering high school after a psychiatric hospitalization?

2. How does the BRYT transition programming work with students reentering the high school after hospitalization, considering the BRYT model milieu program as a community of practice?

To understand these questions, methodologically, these were thought of as an exploration of reentry to high school after hospitalization and as an investigation of the students’ experiences of the related intervention programming. Student’s individual stories might vary in their experiences of this model of programming and the task of reentry. This exploration sought to construct a meaningful understanding of their experience and interpret the influence of the support programming. The desire to understand this lived experience firmly grounded this research in a constructivist-interpretivism paradigm. This paradigm holds that people’s reality is subjective and influenced by context and that “reality is constructed in the mind of the individual” (Ponterotto, 2005, p. 129). As the researcher, careful consideration of the dialogue with the participants was a critical component of understanding the phenomenon of reentry.

Given the scarcity of published information about adolescent perspectives on their treatment and outcomes, the value of qualitative research was clear: “We conduct qualitative research because a problem or issue needs to be explored” (Creswell, 2012a, p. 47). Utilizing the researcher as the data collection instrument is a central feature of qualitative inquiry, as well as utilizing open-ended and structured questions, can allow the researcher to look for meaning within the narrative (Maggs-Rapport, 2000). While there was ongoing quantitative research
underway regarding this programming (White & Houle, 2016), research directly seeking students’ lived experiences was absent from the literature.

**Research Design**

Having sought students’ voices and direct accounts of students’ individual lived experiences could give others the opportunity to learn more about the task of transitioning back to high school following psychiatric hospitalization. Students’ perspectives were previously absent from the literature. While there was a study underway (White & Houle, 2016) assessing quantitative outcomes regarding the BRYT programming, this investigation focused on the students’ stories, their understandings, and experiences. This research identified several themes, helping to make sense of the student’s experience. Starting with concrete descriptions of the lived situations from their first-person accounts, the reflective analysis moved from ideography to identifying more general themes about the experience (Finlay, 2009). Utilizing General Inductive Analysis (GIA) afforded the ideal flexibility, as it was designed to create meaning from the themes that emerge from the data (Thomas, 2006).

**General Inductive Analysis (GIA)**

The main goal of my research was to understand better how adolescents made sense of their experience returning to high school with the BRYT programming as support. Merriam and Tisdell (2015) outlined a basic qualitative study as suitable for research in the fields of counseling, psychology, and education. Merriam and Tisdell (2015) suggested this method for understanding how people “interpret their experiences … [and] what meaning they attribute to their experiences” (p. 23). GIA, as a basic qualitative approach, was the methodology chosen because of its flexible approach toward the acquisition and analysis of data, seeking to build understandings from observations, and because it was not based on testing hypotheses. It was
similar to grounded theory and phenomenology; however, these methodologies were not chosen, as these were more appropriate for in-depth descriptions and building new theory. While in its basic structure, all qualitative research is phenomenological with its foundation keying in on experience and interpretation (Merriam & Tisdell, 2015); however, engaging in a pure phenomenological design, with the goal of depicting the essences of a phenomenological experience, did not match the goal of this research, as well as the GIA approach.

The philosophical tradition that supported this qualitative research was informed by phenomenological philosophy. Given the social, emotional, and identity tasks articulated in the literature review, valuing and exploring the emotional and felt experiences of teens was key. This connected well with the method of general inductive analysis, in that it provided a pragmatic and immediately useful way of knowing through feelings. Phenomenological philosophy includes the core concept of *befindlichkeit*, one of Heidegger’s (1962) critical concepts about the meaning of being. Befindlichkeit is a complicated concept that is translated as one’s state of mind or where one “finds oneself” (Heidegger, 1962, p. 376). Another essential component of befindlichkeit is that the where is mostly found in one’s feelings. Heidegger (1962) contended human beings were necessarily relational; his landmark work, *Being and Time*, “is meant to be an exploration of the meaning of what it means ‘to be’” (Fox, 2011, para 20). This emphasis on the importance of meaning—derived from the phenomenon of living—supports the foundation that reporting of felt experience is a useful reference for the researcher. Put directly, what adolescents must say about their feelings and experiences is a valuable way of knowing and worthy of study.

Accordingly, this study utilized GIA, a practical qualitative approach, which helped to explicate the reentry experience and make adolescents’ voices central in the accounting of their lived experience. GIA provided the opportunity to analyze core themes that emerged from the
interviews with students (Thomas, 2006). This hermeneutical approach helped the researcher to make meaning of the experience and understand the most important themes about the experience of reentry, and the student experience within the BRYT programming model. Thomas (2005, 2006), who first named and categorized the GIA approach, outlined the core elements within GIA and a set of procedures for analyzing qualitative data, including inductive coding and the development of categories and themes. Accordingly, focus was placed on eight students, all with the same transition experiences (phenomenon), which resulted in gaining a better understanding of the underlying structure of the students’ experiences. First, the semi-structured interviews provided hours of raw transcript data. This inductive thematic approach allowed for a rich description to be obtained (Braun & Clarke, 2006) and a subsequent deep analysis. This process included first coding the data, then identifying themes that emerged, and eventually developing subcategories and categories. Because this area was under-researched, the presentation of themes within the data proved an effective approach for this research.

**Participants**

For this research, I sought participants through a purposeful process of criterion sampling (Devers & Frankel, 2000), where participants were identified based on predetermined criteria. Each participant was between 15 to 19 years old and had been hospitalized this school year (partial or inpatient) for at least 5 days where the primary concern was mood, anxiety, or depressive related symptoms. Demographically, White and Houle (2016) reported programs consisted of 63% females. By grade level, participants included 30% sophomores, 39% juniors, and 19% seniors. In addition, 55% of enrolled students have mood disorders, and 39% have anxiety disorders. Thus, selecting participants with anxiety or depressive issues was the most representative of the student experience within these programs. Each participant needed to have
participated in the BRYT programming for at least 3 weeks, thereby eliminating students who had just returned from the hospital who were too newly in their reentry experiences. Additionally, each student was a student at a public high school that had an established BRYT model programming, and the program had been in operation for more than one school year. This was key to understanding established programs that followed the model, rather than programs that might be emerging but did not have all the staffing and structural components of the program.

The next criterion was that the program’s clinical staff assessed and selected candidates as able to engage in the interview process without harm. Interviewing this vulnerable population required extra consideration pertaining to their wellbeing, and the criterion of their clinician assessing students’ abilities to participate safely provided additional protection. In seeking 6 to 10 subjects, it was my hope that this research would include students from diverse demographic categories, including race, gender minorities, and various socioeconomic statuses, and the results of recruitment and selection yielded eight subjects. Eight participants were randomly selected among the eligible population of students. A $30 gift card was given as a thank you to students for completing their participation in the study.

Recruitment and Access

Three Massachusetts public high schools were selected through a referral process from the director of the BRYT Consortium (Appendix A), which included consideration of almost 40 schools in Massachusetts. Dr. Paul Hyry-Dermith, the Director of a consortium of transition programs, and a group for staff from schools who deliver this programming were contacted about accessing schools to participate in this research. After he agreed to grant access, his consultation led to 15 schools being contacted. These schools included a range of inner city and
suburban public schools. Although there were students in the high school where I worked who would otherwise meet these criteria, by working with participants from multiple schools, the limitation of exclusively working in the researcher’s own “backyard,” as warned against by Creswell (2012b), was mitigated. Eventually, school leaders (Appendix B) and clinical directors (Appendix C) from four schools agreed to participate. Directors were then given guidelines for subject selection (Appendix D), and eventually three from these four schools agreed to participate, which yielded participants for this study. Potential candidates and parents agreed to be contacted, and recruitment letters (Appendix E) offering an opportunity for questions were utilized. Eventually, informed consent (Appendix F) and assent of minors (Appendix G) were obtained before interviews commenced.

**Data Collection**

Data for this study derived from semi-structured interviews. The interviews with students (Appendix H) included questions about their experiences with the BRYT programming, and these were developed based on my knowledge of the programming offered, as well as the issues highlighted in the literature review. At the outset, questions focused on general background information about the students: how long were they in the hospital, how long have they participated in the BRYT programming, and what were the primary issues that they faced socially and emotionally before coming to BRYT. The focus then turned to encouraging the student to tell her or his own story from the beginning by inquiring about how they learned of BRYT’s existence. Next, the student was asked for examples that could be shared about their lived experience within the program, and finally culminated with what meaning each derived from the experience. The interviews were conducted for up to an hour to provide ample time for participants to share their stories. Asking open ended, and then personalized follow-up questions,
provided an opportunity for each participant to give lengthy and comprehensive accounts of their experience (DiCicco-Bloom, & Crabtree, 2006). Students were offered the option to be interviewed in their school settings or in a nearby public library conference room. Each participant chose to be interviewed in their school setting, with a program staff member present during the interviews. The researcher conducted the interviews, and these were recorded for later transcription and analysis. The second round of interviews took place after initial coding, and themes were analyzed from the data. Asking more personalized follow-up questions about participants’ continued experiences, reflections, and learning gained from their experience helped to further understanding.

During the second interview, in addition to checking on themes from the first interview and receiving updates on participants’ ongoing experiences in their programs and high schools, consideration of the CoP construct was introduced and discussed with participants. One of the key elements from the CoP construct is that knowledge comes from participation. Wenger’s (1998) theory holds that when engaged in a mutual experience, a group of people can build identity and meaning through this process. Wenger articulated a social phenomenon that arose where there was sustained mutual engagement around a shared enterprise, which influenced social identity (Fox, 2011). Specific questions were asked connecting themes that emerged from the coding of the first interviews, as these connected and interact with Wenger’s (1998) theory and with the CoP theoretical framework.

Data Storage

Ensuring that all data were kept confidential, in accordance with both IRB approval, and in adherence with the ASCA’s (2016) ethical standards, was of crucial importance. The interviews were digitally recorded and professionally transcribed, and confidentiality was
ensured throughout. The records of this study are stored securely, utilizing password protection with the researcher’s computer, password protected Dropbox account, and locked individual files. No identifying information was kept with the data, and pseudonyms were used in all writing and data storage procedures. All hard copies of the data are kept in a secure and locked location in the researcher’s home. The data and the informed consent forms will be kept for 3 years after completion of the study, and then will be destroyed.

Data Analysis

The analysis began by reading and re-reading the semi-structured interview transcript data. Braun and Clarke (2006) suggested that careful reading and initial consideration of the data were appropriate first steps. With the intention of seeing what themes emerged from the data, the next step taken was to then code the data (Saldaña, 2013). The goal was to engage in a dialogue with the participant’s stories, which were situated in the context. The primary purpose of the study was not to test the particulars of a theory, but to learn about the participant’s experience. Systematically, the in-depth interviews were analyzed to determine the meaning making emerging from the data. Through reading, coding, and finding themes, each individual case was treated first as its own case. Thomas (2006) outlined GIA’s method, which started with a close reading of the text. From this close reading, I identified meaningful units and created categories and subcategories. These were often derived from “actual phrases or meanings in specific text segments” (Thomas, 2006, p. 241) before continuing the refinement of the core themes within the categories. Then, a model incorporating the most important categories and themes was developed. This part was undertaken to respect fully each participant as a separate and individual case. Therefore, bracketing the ideas from preceding cases, which might influence the initial analysis, helped in the valuing of each story (Thomas, 2005), and it served this GIA.
After the initial coding of an interview, I then conducted the second interview. This interview served to check themes with subjects, as well as receive updates on their continued experience. The coding process was then repeated after the second interviews. Eventually, the entire data set were analyzed to determine larger patterns and themes that emerged. The description of the most important themes and categories is presented in Chapter 4.

**Trustworthiness**

The opportunity to conduct follow-up interviews with each participant proved useful to verifying my understanding of the data from the first interview. The rich text descriptions provided from the semi-structured interviews. In addition, member checking added to the overall trustworthiness of this thesis.

A threat to the internal validity was researcher bias. Given that I had multiple years of experience working with students similar to those being studied, a biased analysis was possible. Accordingly, the second interview involved concentrating on and verifying initial thematic findings, and it provided an opportunity follow up with students continued understanding of their experience. Checking with research participants about their judgment of the accuracy of the initial interpretations enhanced trustworthiness (Creswell, 2012b). Lastly, the rich descriptions (Braun & Clarke, 2006) offered by the data was intended to provide the reader with detailed and direct information, with which to make her or his own assessment of the usefulness of the report. While these steps might not completely eliminate questions of trustworthiness or researcher bias, taken together, these should minimize these threats and help to validate the research and enhance its overall quality.
Protection of Human Subjects

A fundamental obligation of any investigator involved in research is the protection of human participants. The guiding principles of this protection include respect for persons, beneficence, and justice. Therefore, the guidelines, provided by the National Institute of Health, Northeastern University and the ASCA (2016) code of ethics, were adhered to during this study. No data were collected, and no contact was made with potential subjects before IRB approval was obtained. Extra care needed to be taken with those participants who were known to be from a vulnerable population. With this study, the existence of mental health concerns, present with each adolescent, added to the need to have protections in place. Accordingly, discussion of any potential risks occurred with participants and guardians. Care was taken to ensure all involved were informed, both verbally and in writing, of their rights to stop participation at any time during the interviews.

While no harm was expected because of participating, given the personal and emotional content that was likely to be shared, it was important to anticipate the need for support. I suggested that care providers (e.g., counselors and parents) follow up with each participant after a subject’s participation. Additionally, an additional adult was required to be present during the interviews.

As referenced, informed consent was obtained. Parents/guardians and students signed this consent 18 years or older, along with assent given from students under 18. To avoid any perception of coercion, I made it clear that the decision to participate or to not participate in the study was entirely voluntary and in no way affected their access to supports or educational programming. Lastly, confidentiality was maintained throughout all phases of the research. Protecting the identity of participants was a chief concern, and this protection included the use of
pseudonyms for all participants in the research, and none of the participating schools were named.

Corbin and Morse (2003) suggested that participation in interviews regarding sensitive topics contain little risk to subjects, and in fact the opportunity often mitigated any stressors to share one’s story with a non-judgmental, empathizing researcher. This worked in conjunction with the protective benefits of being allowed to not participate or opt out at any time, as well as the assurance of confidentiality, to provide protections for subjects. They argued that follow-up counseling was almost never indicated, even where research involved cases of subjects recalling traumatic events. That said, subjects in this study were from a vulnerable population, and therefore warranted these normal protections, as well as safeguards beyond these. In addition to some subjects being minors, potential struggles with emotional regulation were a part of what made these participants more vulnerable.

I conducted the interviews, with an adult witness. Follow up with participants and counselors after interviews provided an opportunity to identify any adverse effects or if additional supports were needed after the interviews. No negative emotional influence was reported. By putting these precautions in place, I believed that subjects could participate in the interview process and had the opportunity to share their story without harm.
CHAPTER FOUR – RESULTS

Adolescents who have been hospitalized for psychiatric reasons face significant challenges returning to their public school (Czyz et al., 2012; Savina et al., 2014). As the number of hospitalizations rise, schools’ leadership face the challenges of how best to support these students, as they attempt to get back on track both academically and emotionally, and a growing number of schools have initiated programming to address these concerns. The purpose of this study was to get a better understanding of students’ experiences returning to high school after being hospitalized and specifically to better understand their experiences in this model of programming. To achieve this objective two research questions were formulated:

1. What is the experience of re-entering high school, for adolescents, after a psychiatric hospitalization?

2. How does the transition programming work with students reentering the high school after hospitalization, considering the BRYT model milieu program as a community of practice?

Study Sites

The research for this study was conducted at three different high schools, each of which housed a BRYT program. The director of the BRYT consortium recommended 14 of over 49 schools in the consortium to be contacted. The 14 schools were in urban and suburban areas. Four schools signed agreements to participate, with three schools eventually yielding participating subjects. These three schools were public high schools averaging 1,000 enrolled students. Each of the three high schools in this study were suburban, and 2 of the 3 were notably less diverse than the statewide numbers (see Table 1).
Table 1

Race Demographics From Schools Within this Study and Across Massachusetts

<table>
<thead>
<tr>
<th>Public High Schools</th>
<th>White (%)</th>
<th>Black (%)</th>
<th>Latino (%)</th>
<th>Asian (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Statewide</td>
<td>66.8%</td>
<td>8.8%</td>
<td>16%</td>
<td>5.8%</td>
</tr>
<tr>
<td>School 1</td>
<td>59.9%</td>
<td>7%</td>
<td>14.3%</td>
<td>9%</td>
</tr>
<tr>
<td>School 2</td>
<td>81%</td>
<td>.9%</td>
<td>14.6%</td>
<td>.7%</td>
</tr>
<tr>
<td>School 3</td>
<td>89.1%</td>
<td>.5%</td>
<td>1.4%</td>
<td>7.6%</td>
</tr>
</tbody>
</table>


Two schools were situated as commuting suburbs of Boston, MA, and one school was in the western part of Massachusetts, a suburb of the city of Springfield, MA. Two of the schools were comprehensive high schools, which meant these educated students in both traditional liberal arts curriculum, as well as some specialized technical course work. One of the schools was a career and technical vocational high school, which meant students devoted more time intently on training and job readiness. Each school participated in the BRYT consortium, and each had programs that have been established for over a year.

**Study Participants**

The data, collected for this research, were acquired through two face-to-face interviews, with eight participants. Efforts were made to include students from diverse demographic categories, including race, gender minorities, and various socioeconomic statuses. The general characteristics requirements for subjects included being 15 to 19 years old; had been hospitalized this school year (partial or inpatient) for at least 5 days where the primary concern was mood, anxiety, or depressive related symptoms; had participated in BRYT programming for at least three weeks; and their clinician assessed them as able to engage in the interview process without harm.
Of the eight participants, five were female and three were male. Six of the eight identified as middle class, and two did not answer the question. One participant identified was a person of color who identified as bi-racial; one participant identified as Asian; and the remaining six identified as White. While 88% of the state’s public high school students identified as heterosexual (Best & Kahn, 2016), half of the participants in this study identified as heterosexual. One of remaining four individuals did not identify their orientation; one identified as gay; one as bi sexual; and one as pan sexual.

Pseudonyms were used for the eight participants throughout the report: Matt, Ashley, Charlie, Ya Ya, Di Di, Kelly, Derek, and Jenni. These included eight participants, ranging in ages from 15 to 19 years old, one ninth grader, two tenth graders, two eleventh graders, and three twelfth graders who were about to graduate high school.

**Matt**

Matt, 15 years old, was an athletic and well-spoken ninth grade boy. He had been hospitalized for depression and suicidal ideation and had spent significant time participating in the program at his high school. At the time of our interviews, Matt seemed interested in sharing his story. He reported that prior to and after his being in the hospital, he had numerous friends at the high school. His report also included that he achieved excellent grades in different high-level courses, including honors level work.

**Ashley**

Ashley, 16 years old, is a soft-spoken tenth grade girl on an Individualized Education Plan (IEP) who liked photo club and worked at a daycare after school several days a week. She had a ready smile, but was fighting a cough due to allergies during both of our interviews. Ashley had been hospitalized eight months earlier for depression and suicidal thoughts, and she
was cautious about the influence of talking too much about things that might be a significant trigger.

**Charlie**

Charlie was a 16-year-old with a lot of energy, infectious smile, and socially unsure. He reported not being sure about which friends could be counted on, and he missed school due to depression and suicidal thoughts. He was a computer programming shop student, with some significant learning issues, and he was previously on a 504 plan but now had an IEP. Before he was in the hospital, his social struggles had led him to fall behind academically.

**Ya Ya**

Ya Ya, at 16 and in tenth grade, was hospitalized for suicidal thoughts and actions, and she had already been in three different schools in two years due to her family relocation. “I don’t like people,” she stated. She reported being removed and withdrawn upon initially meeting most people, and she mostly kept her guard up until she really knew someone. Despite this, after just a few minutes of talking, Ya Ya was smiling and laughing, as she shared her experiences and participated openly in the interviews. She reported working hard to progress academically, and she was not on an IEP.

**Di Di**

Di Di was a 17-year-old junior girl, who was out of school in treatment twice this year. She struggled with significant depression, self-injury (cutting), and suicidality. In addition to being a strong student, she participated in a dance group at the school. She was interested and engaged in the interview process.
Kelly

Kelly was an 18-year-old senior girl, enrolled in cosmetology shop. She had five siblings, ranging in ages from 3 to 19. Kelly was out of school for 8 days in treatment for anxiety and depression, which consisted of both inpatient and partial day treatment. A willing and interested participant, Kelly answered all my questions openly. While she had a small set of closer friends at school, she reported feeling isolated from the school in general and was ready to graduate.

Derek

Derek, an 18-year-old senior, was a former athlete who did not play baseball this year. He was an HVAC shop student and was preparing to graduate by looking for work in his field. He was in treatment twice: once for significant depression and a serious suicide attempt. His demeanor was soft spoken, and he was the most reserved among all participants interviewed, but he seemed keen on connecting and answering most questions fully.

Jenni

A 19-year-old female, Jenni had two older brothers. During our interviews, she alternated between working on a 1,000-piece puzzle, and then on coloring in a mandala template. It was clear that these “distractions” helped her focus and openly participate throughout the interview process. Jenni missed school and was hospitalized due to anxiety and depression. Her absences also occurred due to just not getting out of bed, and sometimes needing to leave before the end of the day. Jenni was on a 504 and had maintained her strong academic standing.

Findings

Initial coding of the first interviews was completed prior to the second interviews. After the second round of interviews, coding was completed, and themes were identified amid the compendium of codes that emerged from all interview data. After in-depth analysis, three main
categories emerged, one with three subcategories. These categories were as follows: (a) return to school, (b) the reentry program, with three subcategories (i.e., academics, mental health, and relationships with students in the program); and (c) CoP with excerpts from the interviews, which would be included to help with the reporting and elucidation of the themes.

**Return to School**

Five main themes were identified in this category: (a) worried about friends, (b) “I was sick” versus “the whole story,” (c) worried about the work, (d) gaps in content, and (e) school is better than treatment.

**Worried about friends.** All participants commented on their relationships with friends, and how they anticipated their interactions would be with other students at school once returning from the hospital. The core issue in this theme was worry about what friends would ask and how to manage these interactions. Ya Ya, Kelly, and Jenni each indicated they were “nervous” about their returns to school in the context of friends. They did not know what friends would say and what they were going to say about their situation. Di Di, Matt, and Kelly each indicated specific concerns about conversations they were going to need to have. Part of these concerns centered around being asked directly by others about the nature of their absences. Participants were concerned about the level of detail they would or would not share regarding why they were absent and where they had been. Matt indicated he was worried that kids were going to ask where he was, and Derek indicated his concern about peers by stating that “word gets around.” All participants reported anticipation pertaining to needing to answer questions about what had happened and why they were absent, and this anxiousness preceded their return to school.

“I was sick” and “the whole story.” Upon returning to school, interactions with peers yielded various answers and outcomes. Di Di initially told friends who asked that she was
“taking a break from school.” This seemed to satisfy most of the students for whom she gave this response. This was similar for Jenni and Matt who initially addressed friends about why were absent. “I was out sick” were the exact words of both, which was effectively used as a steady initial refrain for managing inquiry from peers. Matt indicated that in some interactions he needed to add emphasis to his answer, “Yeah, really, really sick.” Charlie felt it was “hard not to give answers” and said people kept asking him for specifics and details that he did not want to share. He did state that some of his friends were protective of him and told others to stop asking. Ya Ya chose to give evasive incomplete answers. For instance, she simply said, “Reasons.” Issued as a stand-alone sentence and accompanied by a disdain-filled look, Ya Ya would repeat this response if asked again. This pugnacious approach effectively kept peer inquiry to a minimum.

Conversely, Derek reported that initially he did not want to talk about his struggles too much, but he eventually elected to tell his close friends “the whole story,” which he stated worked well for him. He went on to explain that the process of sharing openly was based on his determining that it was better than getting “caught up in a lie.” It also helped him figure out “who really cares” and to know which friends he could really trust and count on. Kelly’s worry about kids asking was previously accompanied by feeling some isolation in school. Where she reported this as a “major source” for her depression, she stated that some of these feelings with friends continued upon her return. Di Di felt that the process of returning to school was a time to make some changes in her peer group, and while this was hard, she felt it was important to do. For example, she described, “I’ve changed my friend group a lot since then to people who I enjoy more and people who I’m more comfortable around.” Kelly and Derek also noted similar
changes, though Matt reported that his friends were surprised that when he eventually told them more of his story, they were supportive and “nice about it.”

**Worried about the work.** While the duration of treatment-related absence from school ranged for participants from five school days to over two months, most students reported having significant worry about their schoolwork regardless of how long they were out. Every participant spoke about getting caught up in classes, and all but Derek spoke about the worry each had about this process. Derek reported more concern about peers compared to academics. Pertaining to classes, Derek put it this way: “It wasn't that hard actually. I kind of just went with it. I'm usually a go with the flow kid.” This ease was affiliated with the timing of his return, where he explained that he did not have that much make up work.

All other participants reported challenges in getting re-acclimated to school. Ya Ya indicated that her treatment team had attempted to obtain work from her school to complete while in treatment but this turned out not to happen in time for her to complete assignments before returning. “I was overwhelmed with all the work I missed” Kelly stated stressfully. Di Di said that her first stressor was primarily social, but that this eventually included academic concern. As she put it: “I have so much work to make up!”

**Gaps in content.** After their return, most of the concern was met with significant justification for this stress, except for Charlie and Derek. Charlie could get most of his work done while in treatment, even though he was still worried about it, and Derek’s time in treatment came at the end of a term, which made content and missing work less of a concern for him. Di Di commented on how hard it was having the gaps in her content knowledge. She reflected on having to work hard after having missed so much class. In high level classes, Di Di stated, "Even now that I'm totally caught up, it's hard because I missed a significant part of the classes.” This
statement was made during our first interview. By the second interview, the gaps in knowledge for Di Di eventually led to her electing to discontinue her Spanish class. Likewise, Ya Ya reported feeling too far behind in many of her classes. She eventually dropped her history and English classes due to gaps in her learning. These reductions in scheduled courses are further addressed in the accommodations section later in this chapter. Matt talked about how he “wasn’t very focused” when he returned to class. While this symptom needed to be managed, his report was that the gaps in his knowledge seemed to influence his ability to keep focused. Similarly, Ashley felt it was “hard to stay awake” when first back in class.

**School is better than treatment.** Participants felt more positively about being in school compared to being in treatment. Charlie reported that being back in school felt like a “second chance” and was appreciative of being out of treatment and back in school. Kelly reported significant concerns about being back in school: “So, like school kind of makes me feel isolated from people. Even though, I’m surrounded by people.” However, she went on to say that being out of the hospital, with outpatient therapy, was a positive step for her. Jenni was glad to be back in time to participate in school, particularly because it was her senior year. It was apparent that she felt an extra level of importance and pressure about being absent so close to the end of high school. Di Di and Matt were also pleased to return. Ya Ya’s misgivings about having switched schools and not feeling connected remained as she reentered, but even with her misgivings about school, she did not prefer to stay in treatment over returning to school.

**Summary.** The primary issues and stressors, faced by all students, remained present and challenging following their treatment in the hospital. The process of reentry to school involved considerable worry and challenges. Participants reported having significant worry about interactions with peers and worry about academic work while they were in treatment in the
hospital. These concerns were expressed in different ways, but the theme of nervousness and worry seemed palpable for most participants. In most cases, these concerns matched the reality of what students faced when reentering their school. Academic concerns materialized in significant gaps in content, with some students eventually not catching up in certain classes. While some students had some opportunity to do some work while still in the hospital, most students were faced with many assignments and lessons that had been missed during their extended absence from school.

In terms of social interactions, concerns about how to handle peer interactions were also warranted. Their close friends, as well as students they encountered, asked participants directly about their absences, and they wanted to know more about why they were out. Various paths of answering these inquiries were chosen. Some elected to report “I was out sick,” and others chose not to give any specific answer. In addition, some sooner than others eventually elected to give detailed responses, telling the “whole story” to their closer friends.

**The Reentry Program**

Each of the students participated in some form of initial meeting with program staff, where they learned about the program. Ashley recalled this meeting as generally positive enough for her to give the program a try. Each student, in their own way, stated that this meeting was where they learned of the existence of the program, and each student participated in the program for at least three weeks following the meeting. Every participant interviewed was still involved with the program at the time of the interviews. Jenni felt “they were glad” that she was back in school, and this contributed to her willingness to try the program. Matt felt that at first, he did not really need the program, but after the process in the meeting of hearing from the counselor, he stated that participating seemed like a “fine idea.” Charlie initially had thought that he would
receive individual counseling support and was somewhat surprised by the milieu nature of the program. Ya Ya was willing to “go in that direction” and try the program, despite her hesitance with meeting new people, and Derek was initially afraid of being outcast from kids in school due to his participation, but did agree to participate. Di Di reported that the intake meeting provided positive answers to her questions, and Kelly reported that when she learned of the program, it was a “weight lifted off my shoulders” and believed her participation in the program would make returning to school “less overwhelming.”

Findings about the experiences students had in the program are highlighted below. The discourse provided by students about their experience in the high school based post hospitalization program produced three subcategories with specific three themes each. The first subcategory was academic with the following themes: (a) “got work done,” (b) accommodations, and (c) relationships with teachers. The second theme was mental health, with themes, (a) “it’s about trying to stay afloat,” (b) “they talk me through it,” and (c) “I can always come.” The third subcategory was about relationships with other students in the program, including the themes, (a) you are not alone, (b) joining the milieu, and (c) “helping others helps me.”

Academic

“Got work done.” Matt’s simple statement was about his initial focus in the program. He was referring to the value of being in the program, and drawing a distinction between academic support and emotional support or social interactions while in the program. Ashley, Kelly, Di Di, Jenni, and Ya Ya all spoke similarly about their ability to complete work while in the post hospitalization program. Their committed effort was initially dedicated to the process of completing their current and make-up work, and this was facilitated in the program. Associated relief came from accomplishing work, for participants reported that the smaller setting provided
a place to focus more and feel more comfortable. Di Di specified the importance of teacher, tutor, counselor, and intern support in creating the right “atmosphere” in the room. Charlie and Kelly both referenced the encouragement they received to complete assignments while in the program room. Matt mentioned the benefit of having computers in his program room, as well as a smaller amount of people compared to in a regular study hall, and he referenced staff support, which helped to facilitate his work completion. He indicated that it was a combination of these factors that really mattered.

Having the support to get work done and getting back on track was quite meaningful for some. Ya Ya maintained her intention of accessing the program and getting caught up: “It’s quieter and I can just focus on getting my work done and turning it in on time.” She expressed joy when declaring her success:

I’m doing a lot better. My grades are slowly coming up and I just need a couple more credits so I can actually pass tenth grade and I can move on to the eleventh grade, even though I have to take some classes, but at least I would’ve passed tenth grade.

Ashley commented that the initial support she wanted from the program was with academic, organizing her work completion efforts. She also stated that this eventually shifted to her using the program more often for therapeutic support. Di Di’s reflection on the value of the academic support in the program clarified that “it helps children develop themselves as people and to do better in classes.” At the start of our second interview, Di Di had just come from completing her final exam for Chemistry. “I aced it!” She proclaimed about her success with this major end-of-year test, despite chemistry not being her favorite subject. Although she had felt concerned about being behind in chemistry, she indeed was back on track.

**Accommodations.** Related to being encouraged to complete work, while spending time in the program, were the different accommodations and adjustments that students referenced
being granted to them because of their participation in the program and their circumstances of returning from the hospital. All students reported being allowed to miss class as needed to be part of the program. Jenni mentioned that she was not “forced” to go to class, and counselors were more concerned at first about her overall wellbeing compared to her class attendance. Similarly, Charlie espoused the virtue of being supported throughout the day. Due to Charlie having caught up on work while absent, he did not need any reduction in or modifications to his workload.

Reduction in class assignments was a common accommodation utilized by students. This involved teachers eliminating some smaller homework assignments that were assigned as part of a larger product or assessment, as well as some modifications to some assignment requirements. Matt, Di Di, and Kelly talked about how teachers made decisions to reduce or change these less essential assignments. Matt said this helped to “ease him back in” to class. Ya Ya reported that teachers reduced the amount of assignments due and valued larger, year-end assignments more when calculating her course grade.

All participants referenced being given extensions on assignments when needed. This accommodation influenced both the assignments that were due while they were out, as well as the assignments with due dates occurring after their return to school. Even though the students had returned to school, they were granted more time to complete these. Students often found that they simply were not ready to complete these current assignments due to their lack of knowledge or exposure to content (additional classes were missed during this reentry phase); thus, extensions were needed. Derek mentioned that he used a “month of transition” time to get back on track.
The accommodations helped with students’ feelings about their workload. Kelly, Di Di, and Matt reported how helpful it was to have been given more time to complete projects. Kelly said it was “really reassuring” and that the extra time really mattered, in part because the accommodations worked, and this helped her believe in herself. For Kelly, while the extra time for making up work was granted, including extending the quarter end deadline, she still did almost all her assignments. Ashley, Matt, and Charlie said that the accommodations offered helped to lower stress. In addition to extensions, Matt referenced having some of his exams waived entirely. For example, Matt explained about being excused from an exam and some course work: “It was really nice to be able to ease back into school and getting my work done and stuff. If it was just like I had to do all this, it would have been difficult.”

Another key aspect and accommodation offered to each student was access the program during the school day. Specifically, even if they were otherwise scheduled for an academic class, students sometimes missed class to be in the program. "Sometimes just being in class is uncomfortable for me," stated Kelly. Even weeks after she had returned to school, this continued to be the case for Kelly. Derek, Ashley, and Kelly each referenced being in the program more and missing classes to do it, particularly when they were first back from treatment. Ya Ya, Jenni, and Charlie also spoke about missing some classes at different points during their transition. Jenni explained that she was not forced to go to class, and she was offered a more emotional focus: “It was more, ‘How are you doing?’” all while still not losing sight of her progress to graduation and getting essential work completed.

It was also clear that there was a focus on helping students return to class. Kelly reported that being "pushed out of my comfort zone" was "what I needed,” in referencing staff encouraging her to return to classes. This aspect appeared as a highly individualized
understanding that this student needed the push to go to class as part of working through her symptoms. Charlie and Derek cited similar experiences as Kelly. For example, Derek explained about the program staff: “People force me to go sometimes, but other times I just go willingly because they are going to send me up there. It's just for my good I guess.” Di Di and Jenni both referenced how peers in the program were part of their encouragement to attend classes. This will be presented further under relationships with other students in the program theme that follows. In all, the effort and struggle of attending classes during school day is an integral part of the reentry process in the program.

Even with these accommodations in play (extensions, missed class time, waived, or modified workload), some students required the additional accommodation of a reduction to their schedule. Ya Ya dropped her English course and her U.S. history course. Both courses would need to be taken later in her studies, as both courses were specified graduation requirements – meaning these specific courses were not elective credits. Di Di made initial attempts to continue in her Spanish course, but she eventually dropped this course with the intention of taking it the following year. In both students’ cases, it was determined that the gaps in their knowledge and what it would take to catch up was too significant to achieve.

**Relationships with teachers.** Throughout students’ transitions, a key part of being in the program is the liaison work of staff helping to facilitate students’ work completion and the implementation of accommodations. This process influenced students’ sense of their relationships with their classroom teachers. Jenni reported a desire to do all the work that she had missed. Jenni found that there was tension between her own aspirations as a student and needing to be "challenged" to accept the accommodations of a reduction in assignments in service of forging ahead and progressing toward graduation. Put another way, Jenni wanted to complete
every assignment – even the smaller less essential ones that teachers were willing to waive. Eventually, she accepted the recommendation to do less to progress. Jenni reported that she assumed teachers were frustrated with how far behind she was. While she never was told this directly, she was anxious and sensed the frustration on the part of her teachers, particularly around being out so much. Jenni reported that staff helped to “broker a relationship” with her teachers. Jenni felt because of her being in the program, her struggle was legitimized in the eyes of her teachers, “even though they didn’t know too much,” and this liaison work helped significantly. The process of reentry can be a slow one. Part of returning to full participation in school, regaining ability to be in full day classes, and not missing classes or partial days can take varying amounts of time, even months. Therefore, the negotiations with teachers, becomes part of a process that is ongoing.

Kelly reported a direct improvement in her relationship with her teachers, and that she felt “more comfortable” because ”most know I am in this program" and that her “teachers have a better understanding of how to accommodate.” “I think it is a gift when you know the teachers personally,” Charlie stated, and he felt this occurred because of support from program staff and because of their interventions.

**Summary.** From the first meeting where students learned about the program throughout their experiences in the program, academics were centrally addressed. Students understood the program as a place to complete academic work. This work was supported directly by the staff in the program; this included interns, clinical, and academic staff. Additionally, the program provided a smaller setting in which to complete make up work and current assignments. The indirect support was having the actual setting of the program to return to when being in class was
too overwhelming. Participants felt positive about how much they could accomplish and their relative success in getting back to class.

Accommodations were a critical component of the reentry program’s academic focus. The accommodations that were utilized ranged from the reduction of a student’s schedule, in which some students stopped taking selected courses with the intention of completing them later in high school, to the granting of extensions, the waiving of some assignments and assessments, and the as-needed access to the supportive program at any point during the school day. Most participants could get back on track academically in most or all of their courses with the help of the program, extra support from teachers, and these accommodations. In addition to their academic success, students referenced the influence on their relationships with their teachers because of the liaison work of staff. Several participants referenced the improved connection they felt with teachers that arose due to their involvement in the program and the implementation of the academic accommodations.

Mental Health

“I can always come.” Kelly’s statement pertained to the times when she needed emotional support throughout the school day. One of the essential features of the program is that students are allowed access to the program throughout their school day. This aspect differs from requiring an appointment to meet with guidance counselors, who are the primary emotional support available for students not in this type of program. Charlie talked about having the clinical team as a key element to the success of the program. Jenni, Charlie, Ashley, and Matt each referenced that the space was a comfortable place to be, and the comfortable room helped create a safe and inviting space. Matt stated that the “program helped a bunch,” and Di Di talked about
it being a “comfortable place to be… where you can share your sadness, and share your happiness.”

Di Di described the program as a safe space where she managed her emotions. She said,

You’re not forced to be happy; you’re not forced to be sad, you can be happy and sad at the same time. You can be however you want to feel or however you are feeling. You could be however you want to be or however you are, yeah… It helps to… not to put yourself in a victim role all the time or always be the happy person. You are allowed to be, who you want to be and who you are.

In other words, the program allows students to express themselves and work through whatever they are feeling. Di Di further described, “I just find it very supportive. It helps because you’re allowed to feel your emotions but also have support to be able to feel these emotions and go to class, or/and focus on work.” Di Di’s words helped to outline how the environment created in the program provided the space she needed to experience the full range of her emotions, which was an ingredient of her mental health recovery.

Derek and Jenni both talked about the importance of being able to use the program when they needed it, and Charlie referenced the “everyday” frequency of his use of the support. Kelly reported that this level of support made being in school “less overwhelming.” And for Ya Ya, the program was “a place to go” when she felt anxious.

"It’s about trying to stay afloat." Throughout the day, symptom management was reported as a critical challenge faced by students. Ya Ya took some time to share with me a song by the artist Russ, entitled “Titanic” (WeAreLyrics, 2015)\(^2\). “It’s about trying to stay afloat,” Ya Ya explained. It is a deep groove that contains a story about facing life’s stressors and declaring

\(^2\)Including this reference here to facilitate the reader’s opportunity to listen to the song.

one’s intent to persevere. Lyrics included choice lines, such as “But I know this ship just keeps on sinking, Gotta just keep on swimming, Hold on, I'm, coming to the, rescue, rescue, You know I'm coming with some vests too, vests too” and “Hopefully we good soon, It's never a bad time, To deliver good news, I know I'ma keep my head above water, I know I'ma pull this boat to the harbor.” Ya Ya explained how listening helped her with her emotions and exclaimed that “all my songs have this vibe.” Ya Ya shared that listening to music, while she worked in program, helped to calm her.

Several students referenced different skills or strategies that they utilized in the program to manage their symptoms. In fact, Jenni colored a mandala during our second interview, and during our first interview she was assembling a jigsaw puzzle while sharing her thoughtful answers. She said that both activities helped her stay focused and to stay calm. During her reflection on her participation in the program, she paused before responding to a question about what she wished she knew before she participated in the program. “How many puzzles I would be doing,” she exclaimed demonstrating her wit.

Ashley said that low motivation was a symptom that remained challenging. She explained that lower motivation caused a slip in her grades. She said that using a fidget toy and relaxing in the program were skills she developed and learned to manage her symptoms better. Ashley clarified, “They have fidgety toys and stuff. Sometimes, in class, if I’m having trouble focusing, I’ll come down and get something and bring it back to class. They have the relaxing area if you need to just take a break.” Jenni commented on the couches as a key place to relax. The presence of the couch distinguished the program room from a typical classroom in a high school.
Similarly, Di Di explained that her symptom management was about "learning to be able to pick yourself back up and keep going.” Di Di shared that her emotional struggle was still “up and down,” despite being on track academically and at this late point in the year. When stressors from home intensified, Di Di felt urges to cut. “It’s been rough” Di Di stated that this made it harder to focus at school. In a bit of levity, she made a pitch for a therapy dog and for the installation of a therapeutic garden, including “palm trees with monkeys.” Feeling empowered by her overall experience in the program, Di Di said she and another student wanted to make a difference for others. More on this element will be covered in the CoP discussion later in the chapter. Ashley explained, “You could always come down if you need to talk and check in. They have a lot of skills and things to help.”

"They talk me through it.” These powerful words were part of how Ya Ya explained the value of counseling and check-ins with staff. Specifically, she explained that adults helped with issues with friends, which caused a lot of anxiety for her. When Charlie referenced having clinical staff available as needed, he went on to explain that the check-ins helped “when I am stressed out,” and “they help me make smarter decisions,” which he further explained that this skill development was “so meaningful.” While Matt lamented that he wished his programs clinician did not get called out to meetings as frequently—thereby impacting availability— he did share this within the context of espousing the value of talking things through with her. He discussed how he had been developing skills to manage his symptoms better, even though family issues were the primary cause of his concerns, rather than school pressures.

Kelly explained that the skill she learned while in the hospital were “too basic.” But she then made clear that the academic and mental health support in her school program helped her more in learning to calm herself down. Part of Kelly’s point was that working on these skills
while in school was a more complex challenge compared to just working on skills while away in the hospital. Derek felt that the staff in the program helped support him in accessing skills that he learned in outside treatment. He spoke of the value being able to “practice my grounding” in a safe place while in the program. “They give good advice" and they are “nice and understanding” were part of Derek’s recounting of the program staff. He further explained how "get to talk when you need to” and that there are things to play with to "get your mind off things." Ashley commented on the importance of not denying her true feelings to herself and others and her resistance to using skills and support. She reported that this eventually led to her being re-hospitalized, which she referenced as a situation where her denial “backfired.” She reported being much more open to counseling and the utilization of skills to manage her symptoms.

**Summary.** Symptoms, including urges to engage in cutting, major stressors of anxiety and depression, as well as motivation deficits, the capacity to focus in class, and feeling able to attend class, are among those that persisted for these students, even after they had been discharged from psychiatric hospitalization. One of the key features of this kind of programming was that students had access to the program throughout the school day, even without an appointment. Students could access the program if the need arose, even when they otherwise had a scheduled class. The comprehensive availability and the comfortable welcoming environment were critical features that students outlined. In addition to these aspects, students cited the smaller number of people and access to staff as key features. Once in the program, students engaged skills as supported by the program or learned in the program to help assist them in managing their symptoms. Though mental health issues persisted for students, the program was a place where students came to try to reset and manage their symptoms, and the program’s staff was there for more directive interactive engagement when necessary.
Relationships with Other Students in the Program

Multiple participants talked about what it was like to join this new group of students and the process of becoming a member within this milieu. The social capital gained was evident, and the valuable influence of these relationships emerged as a common thread among participant’s commentary. Throughout the interviews, at different times, participants volunteered the importance of their connections with other students in the program and the nature of their relationships.

“You are not alone.” Matt reflected on value of others in the program. He went on to explain how much he benefited from realizing others were "dealing with the same stuff.” Every participant referenced the value of others in the program, some more directly. "I'm not alone in the battle that I'm fighting,” were Ya Ya’s words. Di Di expressed with relief how she felt it "makes me feel not alone,” and it was a "universal thing.” “We’re all here for a reason” were Kelly’s words explaining her understanding and appreciation of the similar struggles of her peers. She went on to say that this commonality helped her "relate to their emotions.” Jenni’s related statement, perhaps said it best:

The kids are really nice. Both in the same spot. You have different experiences but you’re both here. Having outside friends obviously is different and good. But having people who really -at least a little bit on some level - understand what you are going through and you know are there to support you even if you don't know them that well … I feel like I really enjoyed having that aspect.

Joining the milieu. Students entering the program, primarily reported arriving without knowing the other students in the program. “At first, I didn’t know anyone,” both Jenni and Di Di explained, describing that it was hard at first, but after they got to know people, it was nice. Di Di said she was a “little scared and intimidated” at first but then realized that joining was “very good.” She explained some of this early struggle was with a student whom she had some
initial tension. She said this quickly worked out with the help of program staff, and that it did not remain as a concern for her. Both students went on to talk about how now they really liked some of the other students in the program, and Charlie similarly referenced how he felt his friendships were growing stronger within the program. Kelly reported that at first, she did not think she would use the program because she did not know anyone. However, a short time later, Kelly said, "It was a process" getting to know others. She reported feeling more comfortable and glad to be in the program. While Derek did not claim significantly strong connections with other students in the program, he still referenced the result of joining the group by saying, "I like the people here so it’s all good."

Matt felt that the process of being a new member and the presence of other students was a key part of the program. "They all knew each other," said Matt, but then he added that it “didn’t take too long” to feel like he was part of the program. Matt further expounded that he was "not good friends or anything but we're friendly.” Matt referenced a part of having had the recent experience of joining the group at the hospital. He professed that the experience of being in treatment and knowing other kids in treatment broadened his willingness to interact with different kids once back in school. Matt reported an increase in his own empathy toward others along with a willingness to expand his own resources. Even Ya Ya, with her guarded stance toward new people found that joining this group eventually “allowed me to be more open really.”

“Helping others helps me.” Derek explained this aspect. Students support each other via being a part of the milieu in the program. Being the helper, for Derek, emerged because of having gone through what he had gone through in treatment, but also via his experiences in the program. Several other participants also realized this capacity achieved via their status as more experienced members within the program. "You get to share experiences" were Charlie’s words
when talking about not being the new kid in the program but now helping others. "You feel like you could help," were Matt’s words referencing having been in the program longer compared to newer participants.

Receiving help from other students was frequently referenced by participants. “They were there for me,” Derek declared. Kelly explained directly that at times of stress, she would receive encouragement from other students in the program, when stressed: “They say, ‘You can do it.’” Kelly also referenced times when she offered in kind encouragement in kind to other students in the program. Even if these connections were not necessarily on a deep level or led to full friendships, Kelly really appreciated these connections.

Another part of the direct help from peers in the program was around getting to class. Di Di explained a reciprocating phenomenon of friendship development and getting to class. Where the more peers helped each other get to class and do well, the better their friendships became, and vice versa – meaning the more they would help each other get to class. As Di Di put it, "It's a very empowering thing to be able to support somebody but also be supported.” Particularly as a senior, Jenni felt she could talk about different courses with students from younger grades, offered knowledge and encouragement to students in the program. Ashley did recount that this kind of encouragement was not always present. Sometimes, she explained, "We do the opposite of encouraging to go to class” because they were friends and just wanted to hang out instead. This was the only negative commentary any student shared about the milieu within the program.

Another component of students helping others was evident in a more indirect way. Several interviewees commented on the influence of seeing other students’ actions in the program, and referenced these as motivational, inspirational, or educational to their own development. When reflecting on other student’s success in the program, Di Di could believe
that her own success was possible. She specified that when others accessed their skills in the program, even though this might mean they were struggling, “It was comforting to see, when somebody is working hard, I usually feel motivated to work hard.” Similarly, Ashley described how another student had experienced an extended absence from his many advanced placement classes. Despite this issue, the student had managed to get caught up, which was directly inspiring for her. "I've seen him work on his stuff and I think, 'Oh, I should work on my stuff and catch up on my work.’” Jenni stated, “If they can do it, I can too” about garnering motivation from other students’ successes. Jenni went on to discuss the benefit of negotiating in-program relationships as helpful skill to develop for use with relationships and friendships outside of the program. “If you're not interacting with other people then you don't get to the point where you can interact with your friends again or interact with people in your class,” Jenni said about the value of having other students in the program.

Summary. Being a part of a program, where there are other students who have also been psychiatrically hospitalized and are somewhere in their process of reentry and getting back on track, proved a salient component of the program experience for students. Relationships with other students aided in the development of skills. Relationships with other students facilitated motivation, inspiration, and models of success that mattered to newer students in the program. While joining the group was initially daunting and a challenge for some, the process of becoming a member, and then a veteran member, led to an increased capacity to support other students in the program.

Learning that there were others in their school going through the same process, coming to know that they were not the only ones, and that they did not have to be alone through this transition resonated for all participants. The existence of the milieu reified this awareness by
providing a space where these relationships were activated. Students reported being supported by other students in the program, and supporting others. This included unambiguous emotional support, such as actually walking each other to class, and providing encouragement with the task of reentry and getting back on track.

**Community of Practice**

After the process of member checking regarding codes and themes being identified, and getting updated information on how participants were progressing in their school and program experiences, the construct of the CoP was introduced to participants. Wenger and Trayner (2017) stated, “A group of people who share a concern or a passion for something they do, and then learn how to do it better as they interact regularly” (para. 1). This sentence was chosen as an accessible way to introduce the concept, and their reactions and questions about it ensued.

“**Totally agree.**” Every participant indicated her or his agreement that their program was indeed a CoP. When asked about what he thought about his program being a CoP Charlie exclaimed “Totally agree.” “Definitely” was the word both Di Di and Jennie used, and Kelly declared it a “very good idea.” While Derek and Ya Ya’s confirmations were more yeses and nods, while "Oh, yes for sure!” was Matt’s contribution, indicating that he believed it was part of how the program works: "Everything is better as a group… singing, playing an instrument, sports.” Effectively, Matt’s point was that he could readily see the task of milieu-based reentry in this same vein.

**Identity, meaning making, and learning.** Students shared their experiences of what being a part of their program community meant to them. Charlie was quite direct about this, stating that the program "saved my life.” The “second chance” component he reported was related to the connection and safety he felt in the program. "I came out a stronger person," he
further explained. Derek’s reflection was that he was "more relational now." Ya Ya explained that her program “has made me understand more about who I'm becoming and how to accept it.” Di Di’s reflected similarly, "[the program] made me more comfortable with who I am and also with my issues that I have." Kelly’s perspective and sense of her situation had indeed changed. She had proclaimed her reflection as a “reality check.” When asked to clarify, she explained that high school is a small part of life:

[High school] seems really big when you are in it, it seems never ending, and it just seems that your whole life is right here but after my treatment and coming back I realized that I have a lot more life ahead of me.

This was the first time that Kelly had ever formulated or articulated this newfound perspective. Another component of what Kelly felt she learned in the program involved great confidence. She said she can "speak my mind" to teachers and was less anxious with other students. Similarly, Ashley felt that she had learned more about her own need to access skills and felt more responsible for her own choices. Jenni explained that she now felt more secure with her ability to manage her own stressors and symptoms, and was therefore more secure in her sense of self.

**School connectedness and belonging.** For a long time, Jenni felt, "I can't wait to get out of here" but had since grown attached to the community, particularly within the program. Jenni further articulated her sense that all schools needed programs like this. "The worst thing for students would be to be ignored by people that they think they should trust," said Jenni. All but one participant answered affirmatively when asked if they felt they were a part of the community in their program, and this experience was meaningful. Ya Ya was the one exception. While she explained various ways in which she was a part of the community and could see the CoP in action, she felt that previous experiences she had (she cited a previous experience on a cheer
team) were stronger. Matt, who had had strong connections on sports teams and with friends, still commented on how the program built additional connections for him within his school experience. Matt explained that sense of belonging: "It makes you feel you're a part of something." Ashley felt her time in the program was really a turning point, and she now felt more connected to her school as a result. Di Di’s efforts to establish a therapy garden encompassed key elements of a CoP. She intentionally worked to establish a way to support others, build community, and give back: “It feels empowering to be able to have your own space and to have a space where you know you can make a difference because you can definitely make a difference when you’re in BRYT.”

**Summary.** Embedded in the students’ program experience was the intended and felt support with the tasks of reentering high school after psychiatric hospitalization. The sense that students had joined a community of other students engaged in this same process led to students having a greater sense of connection and belonging with the program and with their schools. Students commented on how membership and affiliation with the program was part of how the program worked. They were learning skills and supporting each other in shared endeavors of getting back on track. When introduced to the CoP construct, every participant readily agreed that this was what they had participated in. Being a CoP was part of why the program was meaningful and a part of how it was helpful.

**Chapter Summary**

This chapter presented the findings that answer the two posed research questions. The experiences students have reentering high school after psychiatric hospitalization include significant concerns about academic achievement and social interactions. The academic concerns included issues with content and work completion, as did relationships with teachers. The social
concerns revolved around levels of disclosure, experiences of changing relationships, and the supportiveness of peers. Once in the transition program designed to support students with reentry, students described a process of joining the group, as well as various elements and benefits of how the program works. Staff support and student support were essential parts of the reentry program experience.

Liaison work with teachers, staff support around symptom management, and academic work were keys to how the program worked. Part of liaison work was the support and implementation of significant accommodations offered to students that proved to be essential to student’s academic recovery. The importance of having comprehensive access to the program and the ongoing mental health needs were reported. Additionally, the meaningful engagement with other students in the program, combined with development that occurred because of the overall experience indicated that the CoP construct proved a useful way to consider the program milieu.
CHAPTER FIVE – SUMMARY, CONCLUSION, FUTURE STUDIES, AND RECOMMENDATIONS

“My condition is good, but that was a real fire ball, boy!”

U.S. Astronaut, John Glenn, during reentry (CollectSPACE, 2016).

This study sought to understand the experience of high school students reentering their high school, with the support of BRYT model programming, after having been psychiatrically hospitalized. The objectives and theoretical framework, along with the qualitative methodology, were used to formulate the following research questions:

1. What is the experience of reentering high school, for adolescents, after a psychiatric hospitalization?

2. How does the transition programming work with students reentering the high school after hospitalization, considering the BRYT model milieu program as a Community of Practice?

This study explored the adolescent experience of reentering high school after psychiatric hospitalization. As the number of students facing the challenge of reentry is on the rise and a growing number of schools in Massachusetts have adopted the award winning BRYT program model to support students facing this challenge, increasing understanding of reentering students’ experience in this kind of programming is key. Participating high schools were first identified in consultation with the BRYT consortium coordinator for their possible inclusion in the study. Students determined able and eligible to participate in the study by clinical program staff were then selected randomly. Eight students, five female and three male, from various demographics, including multiple races and sexual orientations, were included in the study.

Having the opportunity to interview only eight students, helped me delve into their experiences of returning to high school and within the supportive programming. Each participant had the chance to tell her or his own story. The components of this chapter will be to propose...
conclusions drawn from the research findings, present implications for practice, and then to outline research opportunities.

**Conclusions and Discussion**

Three conclusions were derived from the research findings: (a) reentering high school after psychiatric hospitalization is an experience that produces academic and social stressors for students as they continue to manage symptoms; (b) BRYT reentry programming helps to support academic recovery, and mental health recovery, through relationship development and connectedness at school; and (c) BRYT reentry programs exist as CoP, where students’ identities and shared endeavors of reentry after psychiatric hospitalization are improved via meaningful engagement in the programmatic milieu.

**Conclusion 1**

The first conclusion of this research is that academic and social concerns mark the experience of students’ reentries to high school after psychiatric hospitalization, all while their mental health symptoms persist. Even with the supportive programming, successful support and reentry takes time. Every student interviewed maintained some level of connection with support from programming during the school year. During this time, their symptoms persisted, necessitating management. Their continued struggle with symptoms, as a finding, supports previous research about adolescents and their mental health trajectories following psychiatric hospitalization. Post-hospitalization, students’ continued struggles warrants intervention, with high rates of suicidal ideation and suicide attempts both requiring re-hospitalization (Czyz et al., 2012; Hayashi et al., 2012; James et al., 2010; Reid, 2009). Participants from this research reported their worry about the social and academic issues they would face after return, which were present while in treatment, and findings showed that these concerns proved warranted.
The social needs for adolescents’ post hospitalization were also noted in the literature (Koivumaa-Honkanen et al., 2009), and findings showed that connecting with peers remained a significant issue after discharge. This finding also matched with the known importance of peers recovering from mental health (Eccles et al., 1997).

Participants from this research outlined the stressors experienced in their relationships as they related to the process of reentry. Deciding how and at what level to disclose their treatment experiences and personal issues were of central concern after reentry. Most students needed to face multiple direct inquiries from friends about where they were and why they were out. Concerns about these interactions preceded their return to school, and these were a focus during students’ reentry efforts. Moses (2011) did find that peer support and feedback and gaining a sense that there were others experiencing similar struggles were rated as the most important parts of inpatient treatment for teens, and these issues were found as key concerns for participants as they reentered high school following inpatient treatment.

Participants reported their ongoing struggle with symptoms during reentry, amid a multitude of efforts to cope. Their anxiety and depression, urges to cut or engage in self harm, and general feelings of being overwhelmed, as well as their stressors in existence beyond the school environment, were significant issues during reentry. In addition to the challenges posed by peer relationships, the gaps in learned content and concerns about academic successes were also of primary concern for students returning. This finding was supported in the research, given that mental health and academic achievement are closely correlated (Hoagwood et al., 2007; Scheel et al., 2009). Findings in this research highlighted students’ struggle with their capacities to attend classes, their abilities to focus when in class, and overall deficits in motivation, each of which persisted during reentry and beyond.
Conclusion 2

The second conclusion of this research is that BRYT reentry programming helps students with their academic and mental health recovery and enhances their connections at school with teachers and peers. Participants reported significant support from program staff in gaining back academic ground, and managing their current scholastic demands. Additionally, reinforcing and teaching skills of symptom management were perceived as critical to mental health support during the reentry phase. While researchers have recommended that students be transitioned from hospitals into residential or a substantially separate school environments to support psychosocial factors (Chung et al., 2008; Reynolds et al., 2004), the environments created by BRYT programs address many of these same factors but in a the less restrictive (Froiland, 2011) location of the public school.

BRYT programs are constructed as comfortable and safe classrooms within the school, which are staffed with academic and counseling support intended to assist students in a milieu setting. Findings included participants referencing the program as a place where they could get work done and where they relied on this ability to get caught up with their work. The programs feature support designed to address the significant gaps in their content and aid students in the implementation of useful accommodations. Successful completion of high school is much more likely if a student maintains multiple connections and activities, including academic, within the school (Finn, 1989), and assisting students academically during this transition is a critical component of how the BRYT programming answers this need.

Significant accommodations were made for participants. These included the reduction of a student’s schedule, granting extensions, obtaining reductions in course assignments and assessments, and providing the students with unrestricted access to the program. The liaison
work of staff, such as helping to broker students’ relationships with teachers, proved essential to students’ academic recoveries in the program. Participants reported improved relationships with their classroom teachers as a result. In addition to these improved relationships, students could get back on track in most classes, and every student continued to progress toward graduation.

The presence of a dedicated classroom, as a safe environment, was found as an important part of participants’ experiences, with specific references to couches and a place to relax and address their stressors, anxieties, and other symptoms. The smaller size of the group allowed for more attention and an environment of safety where participants could be supported through counseling; this mattered to students’ experiences. Another key finding about the nature of this support was that it was available throughout the school day and accessible to students as needed, not just by appointment.

Gambone et al. (2002) articulated the importance of having at least one adult, beyond a family member, to support healthy adolescent adjustment. BRYT students uniformly valued the relationships they had formed with adults in the program. While Anderson et al.’s (2004) research pointed to the importance of trusting relationships with school staff for youth at-risk of dropping out, these current findings showed this was also a key element for previously hospitalized youth. Findings included reflections on the meaningfulness of these relationships with counseling staff. Assistance with accessing skills, adjustments to thinking and decision-making were essential skills offered through check-ins with counselors. Participants valued these relationships and cited these as a critical component of the program.

Carpenter-Aeby and Aeby (2005) and Clemens et al. (2011) articulated the need to address the psychosocial needs of adolescents being discharged by having the school identify staff to manage the follow-up support needed. BRYT program staff members are addressing this
need and the ongoing mental health issues found present for students during reentry. Helping manage their stressors and talking them through their challenges, whether academic, peer, or family related, shows how these counselors have become key adults in these students’ lives.

**Conclusion 3**

The third conclusion of this research is that BRYT reentry programs exist as CoP, where students come together through meaningful milieu engagement within the program, with the shared task of reentry after psychiatric hospitalization. Given the challenges facing students reentering high school after psychiatric hospitalization, the risks to students of becoming rehospitalized (James et al., 2010), and the increasing number of students needing this support (Blader, 2004, 2011), helping students with the task of reentry is vital.

Any group of people learning how to engage with a shared concern as they interact constitutes a CoP (Wenger & Trayner, 2017). Bringing students into a milieu setting together can address many of the complex needs faced by the reentering student. Students report that being grouped with other students, also facing this challenge, was fundamental to their support. Further support for viewing BRYT programming as a CoP came from participants directly. Every participant interviewed attested to the merit of considering the CoP construct when explaining BRYT. This consensus aligns with the finding that viewing BRYT programming as a CoP offers significant utility to understanding the benefits of the programmatic milieu.

**BRYT as CoP.** Students face the academic, social, and emotional challenges of reentering high school after psychiatric hospitalization. This is a daunting task when considering the imbedded fears related to sharing their story; however, students offered BRYT programming are not left to manage this process alone. When introduced to the program, findings show that students valued learning of the existence of others facing a similar challenge. Knowing that they
were not alone in the struggle to reenter high school and that there were other students in their school who have also been psychiatrically hospitalized mattered. Participants expressed relief from anxiety and feeling less overwhelmed. Furthermore, beyond knowing that others exist, the program brings them together into the location where these other students are within the milieu. Having a place to connect with other students with a similar experience mattered to participants’ experiences.

The enhancement of social connections is a critical part of how any CoP works (Wenger, 1998). These students, now within the BRYT program, become a collective with a common identified experience, and they are working on the common tasks involved with reentering high school and getting back on track. Over time their membership in the programmatic milieu becomes one of learning via participation. Some students reported building actual friendships within the program, and others simply benefited from the relationships as affiliations. An individual’s relationships are what generate improved educational access. It is these improved social relationships that are considered part of a person’s social capital (McKenzie & Harpham, 2006). Building social connections is key to supporting depressed adolescents (Koivumaa-Honkanen et al., 2009). Being together in the shared enterprise of reentry assisted students with that process. Findings showed that access to these affiliations helps students get and give direct advice and support from one another, as well as indirect inspiration and modeling. Participants were found to highly value the relationships formed within the BRYT community. Not only was their ability to reenter positively impacted, their identity as successful, persevering students was enhanced via this improved social connection.

Being grouped with students at different points of reentry aided students in forming relationships. These relationships were sources of encouragement, and students supported each
other in the development of symptom management skills, and in the task of getting back on track. This support included facilitating motivation, inspiration, and models of success from others within the community, even if deep friendships did not form. With previous studies pointing to peer contact and therapeutic support as two meaningful components of inpatient treatment (Grossoehme & Gerbetz, 2004; Moses, 2011), the findings from this study mirror the importance of those components. In addition to relationships with staff, participants in BRYT programming cited relationships with other students as a key component of their experience.

**Joining the CoP.** Becoming a member of the community is part of how the CoP is enacted. Literature references anxiety and concerns that can come from being a new member in a group (Yalom, 1995; Matschke & Sassenberg, 2010; Sleenbos et al., 2010; Piderit, 2000). Additionally, Levine and Moreland (1994) pointed to the change and integration process of socialization in to a community as involving interactional exchanges between the individual and the group. While it may be a concern to add this challenge to the existing concerns students have about reentry, participants in this study found this process pivotal. The experience of becoming a member and then a veteran member led to an increased capacity to support other students in the program. This aligns with Wenger’s (1998) explanation of a CoP as “a living context that can give newcomers access to competence and invite a personal experience of engagement by which to incorporate that competence into an identity of participation” (p. 214). Participants, by their membership in the milieu, improved their own practice of reentering school, and getting back on track. They improved their own management of symptoms, as well as their academic effort and participation.

While the specific stressors and symptoms varied among participants, the sense of the program membership mattering to who they are as individuals remained germane to each
participant. Membership in the program also enhanced students’ sense of connection and belonging within their school. Participants expressed that improved relationships with peers, and faculty at the school, resulted from their enrollment in the program, and that this process had impacted their own identities as successful students. The task of identity development is always an issue (Wenger, 1998). With participants identifying their own increased ability to help themselves and to help others, manifested as perseverance and participation, the elements of the CoP at work are clear.

Summary

Through analysis of the data, three main conclusions were drawn. First, findings further supported the view that students returning to high school after psychiatric hospitalization face specific challenges, both academic and emotional, and need support. The second conclusion is that this study found that BRYT programming helps students with their academic and mental health recovery, through relationship development and building connections at school. Finally, the third conclusion is that BRYT reentry programs exist as CoP, where students’ identities and reentry processes are enhanced because of meaningful engagement in the programmatic milieu.

Implications for Practice

The above conclusions hold multiple implications for practice. The findings are relevant to high school faculty and school administrators considering implementing BRYT programming, as well as schools currently implementing programs. Additionally, these findings should prove pertinent to graduate school counseling programs as they prepare students to enter the field, and these should enhance their consideration of this emerging transition programming model.

The first implication for the research is that the increasing numbers of students returning from psychiatric hospitalization need significant support. Knowing more about their significant
challenges renders the prospect of allowing students to attempt this difficult transition without this support untenable. “My condition is good, but that was a real fire ball, boy!”

(U.S. Astronaut, John Glenn, during reentry; as cited in CollectSPACE, 2016); this quote at the beginning of this chapter is in part referencing what is considered by many to be the most dangerous part of a space journey – reentry (SciShow Space, 2014; Zheng & Ahmed, 2013). The overlap in language helped to highlight this as a useful metaphor. Self-injurious behavior, anxiety, depression, and suicidal thoughts and actions are issues some public high school students cope with every day, and once students have been discharged from the hospital, these significant concerns often persist. The prospect of reentering school and getting back on track is a critical part of the journey. All evidence suggests a need for increased utilization of and support for the BRYT model, the program’s replication efforts, and a continued push to establish this programming across the country. The staff training and funding needed to implement this level of support will require federal, state, and district level interest and investment. Accordingly, having findings that include student voice in the discussion should help leverage this interest.

The second implication of this research is that it is necessary for schools to understand the value of relationships when considering the needs of at-risk adolescents. The successful connections that were forged within BRYT programming not only enhanced students’ relationships with program staff, but with their classroom teachers. In fact, the students’ overall connections to school were improved. In some cases, these connections were lifesaving. With the ongoing push to use test scores and numbers as a hallmark of standardization and education reform movements (Sahlberg, 2011), losing sight of the importance of the relationship as foundational to the educational mission cannot be accepted. Relationships with adults within the school, as well as supportive relationships with peers, proved pivotal to students successfully
negotiating reentry. These are the essential ingredients to learning and to mental health. Where some may be concerned about dedicating staff and resources to this population, these findings show that through relationships great gains and improvements can be realized.

The third implication of this research is that there is important method in the milieu. Considering a BRYT transition program to be a CoP could change how the BRYT model is discussed. In my previous exposure to the model, and nowhere in the literature, is the CoP construct used to describe this programming. The CoP construct has learning and educational theory at its seminal root (Lave & Wenger, 1991). This should only serve to enhance its utility for explaining the experience of how the program works. While some administrators or school leaders might bristle at the notion of cohorting at-risk students, the powerful influence and results of meaningful engagement found within the CoP should be weighed in counterpoint. The challenges of getting back on track are hard enough. Not having to go it alone is only part of the process. Being able to informally get and give support in a safe milieu setting extends the value of programming for students returning to school following psychiatric hospitalization.

Practitioner and Scholarly Significance

Since the age of 17, I had encounters with friends and teens who have struggled beyond what is deemed “normal,” where some of these peers experienced a significant period of hospitalization due to major stressors and serious symptoms. I have now been a school counselor for 18 years and attempting to support some of the most vulnerable students in the school has been a cornerstone of my career. In my experience working with students who have been hospitalized during the school year, I have come to understand that the challenge of getting back on track is in part of a result of a belief in a certain kind of story: “If I work hard, stay on track,
go to high school, I can go on to college or get a job and have a good life.” It can be thought of as an equation, A+B+C= D (a good life). For many, things can be this straightforward.

However, if a student has somehow gotten off track, (and for many, missing days of school while in a psychiatric hospital can easily been off track), then what? If students directly or indirectly conclude that since they have strayed from their linear path, they therefore cannot get caught up, and therefore no longer have a shot at a good life (by the aforementioned equation), then the risks of anxiety and depression can set in. As adults, people know that life often does not go according to plan, and life can easily go astray. However, if an adolescent draws this narrower conclusion, it can certainly add to their challenges of getting back to school, and it can potentially careen them into a suicidal level of despair.

The goal of this study was to hear directly from students about their experiences reengaging in school after psychiatric hospitalization. I had hoped for the opportunity to hear in their words their concerns and worries, and about the challenges they faced. I wanted to learn about what parts of the experience were meaningful to them, and what they thought worked throughout their involvement in the BRYT program. It was remarkable to hear students from different parts of the state, and from different programs, at times use the exact same language to explain their story. In part, this is a testament to the consistent application of the BRYT model. It suggests that when creating a program with fidelity to the model, which each of these programs have done, it will yield similar results. Moreover, hearing a relatively diverse set of students use what was at times the exact same language, signaled the salience of their words toward understanding the overall phenomenon of reentry.

I was honored to learn more about what these students have gone through. I was humbled by how open and willing the participants were. In some cases, students were eager to share their
story in the hopes that it could help promote this kind of programming. Their sense of connection
and the level of importance they placed on their participation in BRYT was so profound that
these participants wanted to do what they could to ensure others who might need it could have it.

By completing this research, I hope to share conclusions and findings, and
compassionately communicate students’ accounts in a way that is worthy of their sincerity and
the stories entrusted to me. I will share my results with colleagues from the BRYT Consortium,
in the hope that this will further their understanding of this meaningful work. I plan to take a
more active role in the replication efforts of BRYT, and I am willing to present findings at their
Annual Teens in Transition Symposium, which is dedicated to professional development for
schools involved with the model.

I plan to integrate my findings into my graduate school teaching. As an adjunct faculty
member, I can include innovations in clinical practice as part of the courses that I teach in the
Division of Counseling and Psychology, in the Graduate School of Arts and Social Sciences at
Lesley University. In addition to this work, I would be interested in presenting at state and
national conferences that address school mental health. With the quantitative results of the
longitudinal study spearheaded by Dr. White soon to be in print, it is my hope that the results
from my study will be the initial qualitative contribution to this important field.

Recommen_dations for Future Research

This study provides an initial exploration into the experience of students reentering high
school after psychiatric hospitalization, with the benefits of BRYT programming. These findings
address, in part, the significant absence of literature available about this phenomenon. There are
several areas where additional research would prove useful to understanding better the challenge
of reentry, and to help with the understanding of the BRYT model and its increasing replication across the country.

**Those Without Support**

This research included the voices of students who had reentered high school with the benefit of BRYT programming. Focusing on their experiences in the program, and understanding how it worked, was a key component of this exploration. Additionally, knowing participants had access to this support offered a level of protection if the interviews were distressing, and this was an important consideration for me as a researcher. It would be a useful complement to this research if future investigations could include hearing from students who are in the process of or have previously reentered high school but without the benefit of this programming. Counselors or education leaders who are working in schools without this programming could conduct this research. Having findings from students reentering without programmatic support could serve as a helpful point of comparison, as well as a reference point potentially in service of better understanding the justification for starting programs.

**More Voices Needed**

Eight participants are a relatively small number of voices to include regarding such an important topic. Even though this allowed for me to get in-depth accounts of their experiences, it does limit the generalizability of these findings. Additionally, participants were all from suburban schools, partly because programming and replication has been established mostly in suburban school districts thus far. The lack of a more diverse group of students is a noteworthy limitation to the findings presented in this research. Future research should include students from more urban and more rural settings. Beyond simply including a more representative sampling, future study should involve explicit focus on these schools. With racial and ethic minorities
receiving disproportionately lower quality mental health nationally (Alegria, Vallas, & Pumariega, 2010; Kelley, Moy, Stryer, Burstin, & Clancy, 2005), attending to the experiences of racial and ethnic minority youth who encounter the BRYT model remains critical. Additionally, one can experience stigma that occurs from mental health issues with more intensity when confronted by a person who already is enduring discrimination or prejudice (Gary, 2005). Accordingly, specific focus on the influence of stigma should be included in future research. As programs expand across Massachusetts, investigation with this more diverse population, specifically with programs in urban schools in Massachusetts and across the country, will be a vital addition to the scholarly understanding of this experience. It should prove of crucial importance to educators who endeavor to help all students. The next phase of this research would be to include the experiences of students from different states across the country.

**What About the Adults?**

While there was a significant absence of student voices as central in the research covering this specific challenge, there is only very little available in the literature about how adults view the task of reentry for students. Two specific perspectives from faculty worthy of exploration include (a) counselors and program staff and (b) classroom teachers and administrators. The students reported significant value and changes to these relationships, but exploring the adults’ perspective is still needed.

While participants from this study referenced how much they valued relationships with staff, relationships are indeed two-sided. The experiences of running this programming and becoming the primary support in the school for these students should be better understood. Including information from program counselors, academic support staff, and counseling interns, should be a focus of future study. Focus should be on how staff successfully supports skills that
students learn while in treatment. While this research found that students valued and relied on
this support, garnering a deeper accounting of this process from the adults involved could
improve our understanding of these relationships. Another pointer from these findings was the
practice of staff brokering relationships with classroom teacher on behalf of these students.
Understanding more about the specific intricacies of this consulting and liaison work on behalf
of this specific population would potentially contribute implications to practice.

Findings from this research indicated students felt improved relationships and connection
with their classroom teachers. Again, investigating the other side of these relationships could
prove beneficial. Do teachers view this the same way? What is the influence of the presence of
this programming on the faculty within the school? What is the influence on administrators?
While these questions did not fall within the scope of this thesis, exploring these aspects appears
as a logical next step. One of the specific academic components of participants’ experience was
their utilization of accommodations, which was perceived as being critical to their success.
Instilling classroom teachers’ perspectives into the analysis of the various accommodations
utilized and articulating a deeper understanding of accommodations recommended for this
specific population of students seems warranted.

Organizational Change

A final area of future research should be to focus on the task schools face in
implementing programs. BRYT program replication has grown from just six schools 7 years ago,
to almost 40 schools today. It is anticipated that many more schools will begin to implement the
BRYT model. Coupling the soon to be released quantitative study with this qualitative research
should aid in this growth. Understanding how this implementation is happening and how best to
do it is a logical next step in improving high schools’ abilities to support young people, as they
transition back to school. Organizational change research is prolific and suitable to harness in this analysis. Considering that body of scholarship to inform investigation of the specific implementation demands and the changes required of schools when establishing BRYT programming should commence.

**Conclusion**

With the incidences of students needing support returning to school from psychiatric hospitalization continuing to rise, public high schools need to know how best to support these students. This research highlighted how the BRYT program model worked to serve those students and to help schools better understand the challenges faced by students during reentry. The importance of relationships, both with faculty and peers, is shown as a foundational element of this successful intervention. The CoP theoretical construct contributed a useful framework for understanding the value of bringing students together to support them during reentry.
REFERENCES


To: XXXX_XXXXXXX @bXXXXXXXX.org

Dear Director of BRYT Consortium,

I am writing to request permission to contact members of the BRYT Consortium about potentially conducting research with students in their programs. Thank you for considering the possibility of granting me access. In order to proceed, I am seeking permission from you to contact clinical directors of the BRYT Consortium. To help you in your decision, I have included the following information.

I am interested in interviewing 6-10 students from among three or four programs that follow the BRYT model and have been running for at least one year. The purpose of this study is to better understand students’ experience in this programming as they transition back to high school. I am hoping to interview each student twice, and give them a chance to discuss their story, and the support that they have received. I will only be interviewing students whom program clinicians select as being able to engage in the process without harm. All participants’ identities will be protected with use of pseudonyms during the interview process as well as for the written document. I will ensure full confidentiality utilizing password protection on my computer. All data will be destroyed after three years.

Parents will be contacted first in accordance with Northeastern University’s ethical standards. Students will be made aware that even if their parents consent, their participation is completely voluntary, with the option to stop the interview or withdraw at any time. They will be given a $30 gift card to Amazon.com once their interview is complete.

Please contact me at simone.da@husky.neu.edu or 617-308-5591 with any questions that you have regarding this study or if you would volunteer your school for this study. You may also contact my advisor, the Principal Investigator, Dr. Corliss Brown-Thompson at co.brown@northeastern.edu with any questions.

If you have any questions regarding your rights in this research, you may contact Nan C. Regina, Director, Human Subject Research Protection, 960 Renaissance Park, Northeastern University, Boston, MA 02115. Tel: 617-373-4588, Email: n.regina@neu.edu. You are allowed to call anonymously if you wish.

If you agree to help with this study, please sign your consent with full knowledge of the nature and purpose of the procedures. A copy of this form will be given to you to keep.

____________________________Signature of BRYT Consortium Coordinator Printed Name and Date
____________________________ __________________Signature of Researcher Printed Name and Date
Dear Principal,
I am writing to request access to students in your school to conduct a research study. Thank you for considering the possibility of granting me access. To help you in your decision, I have included the following information.
I am interested in interviewing up to three students from the BRYT /INSERT NAME OF PROGRAM at your high school. Their stories will be included from students’ experiences from three of four area high schools. The purpose of this study is to better understand student’s experience in this programming as they transition back to high school. I am hoping to interview each student twice, and give them a chance to discuss their story, and the support that they have received. I will only be interviewing students whose counselor’s select as being able to engage in the process without harm. All participants’ identities will be protected with use of pseudonyms during the interview process as well as for the written document. I will ensure full confidentiality utilizing password protection on my computer. All data will be destroyed after three years.
In the event that students experience any stress as a result of sharing their story, I will be asking the program counselor of BRYT(INSERT NAME of SCHOOL SPECIFIC PROGRAM) to check in with students following the interviews or a staff member to possibly be present for interviews if students request.
Parents will be contacted first in accordance with Northeaster University’s ethical standards. Students will be made aware that even if their parents consent, their participation is completely voluntary, with the option to stop the interview or withdraw at any time. They will be given a $30 gift card to Amazon.com once their interview is complete.
Please contact me at simone.da@husky.neu.edu or 617-308-5591 with any questions that you have regarding this study or if you would volunteer your school for this study. You may also contact my advisor, the Principal Investigator, Dr. Corliss Brown-Thompson at co.brown@northeastern.edu with any questions.
If you have any questions regarding your rights in this research, you may contact Nan C. Regina, Director, Human Subject Research Protection, 960 Renaissance Park, Northeastern University, Boston, MA 02115. Tel: 617-373- 4588, Email: n.regina@neu.edu. You are allowed to call anonymously if you wish.
If you agree to grant me access to your school, please sign your consent with full knowledge of the nature and purpose of the procedures. A copy of this form will be given to you to keep.

____________________ Signature of Principal
____________________ Printed Name and Date
____________________ Signature of BRYT Clinical Counselor Printed Name and Date
____________________ Signature of Researcher
____________________ Printed Name and Date
Dear BRYT PROGRAM/NAME Clinical Director:

I am writing to request access to students in your school to conduct a research study. Thank you for considering the possibility of granting me access. In order to proceed, I will need permission from you and your school principal or lead administrator. To help you in your decision, I have included the following information.

I am interested in interviewing up to three students from the BRYT /INSERT NAME OF PROGRAM at your high school. Their stories will be included from students’ experiences from three of four other area high schools. The purpose of this study is to better understand students’ experience in this programming as they transition back to high school. I am hoping to interview each student twice, and give them a chance to discuss their story, and the support that they have received. I will only be interviewing students whom you select as being able to engage in the process without harm. All participants’ identities will be protected with use of pseudonyms during the interview process as well as for the written document. I will ensure full confidentiality utilizing password protection on my computer. All data will be destroyed after three years.

In the event that students experience any stress as a result of sharing their story, I will be asking the program counselor of BRYT(INSERT NAME of SCHOOL SPECIFIC PROGRAM) to check in with students following the interviews. I am requesting your support for students, possibly during interviews, and to check-in about any after affects. A staff member or an adult witness I bring will need to be present for all interviews. Additionally, I would like to give the students their choice of where the interviews will take place. Either in a conference room or appropriate office at your school or at a study room in the local public library.

Parents will be contacted first in accordance with Northeaster University’s ethical standards. Students will be made aware that even if their parents consent, their participation is completely voluntary, with the option to stop the interview or withdraw at any time. They will be given a $30 gift card to Amazon.com once their interview is complete.

The first step, if you agree to participate, is to present your principal with the attached letter regarding access to your school. Once I have have signed releases from you and your principal regarding participation in the study, I will provide you with next steps regarding participation. Please contact me at simone.da@husky.neu.edu or 617-308-5591 with any questions that you have regarding this study or if you would volunteer your school for this study. You may also contact my advisor, the Principal Investigator, Dr. Corliss Brown-Thompson at co.brown@northeastern.edu with any questions.

If you have any questions regarding your rights in this research, you may contact Nan C. Regina, Director, Human Subject Research Protection, 960 Renaissance Park, Northeastern University, Boston, MA 02115. Tel: 617-373-4588, Email: n.regina@neu.edu. You are allowed to call anonymously if you wish.
If you agree to help with this study, please sign your consent with full knowledge of the nature and purpose of the procedures. A copy of this form will be given to you to keep.

_________________________ Signature of BRYT Clinical Counselor/Director Printed Name and Date

_________________________ Signature of Researcher Printed Name and Date
APPENDIX D – GUIDELINES FOR SUBJECT SELECTION

Hello BRYT PROGRAM/NAME Clinical Director:

Thank you for your participation and support for this research. The following are a list of criterion regarding the selection of subjects for consideration for participating in interviews. It is my hope that this research can include students from diverse demographic categories including: race, gender minorities, and various socioeconomic statuses. I am seeking 6-10 subjects overall, so 1-3 from your school. The general criteria for students are as followed:

- 15-19 years old
- Have been hospitalized this school year (partial or inpatient) for at least 5 days where the primary concern was mood, anxiety or depressive related symptoms
- Have participated in your programming for at least 3 weeks
- You assess and select them as being able to engage in the interview process without harm

The process for contacting appropriate candidates will require parental consent and student assent. Please send the parents of appropriate candidates the attached recruitment letter for them to consider with their child. The parent can grant you permission for me to contact them or they can contact me directly from there. Only after I have contact with parents will a consent/assent forms be sent to the parent. Even if the parent consents, the minor will have the option to opt-out of the study, no questions asked.

If you have questions about the potential participation of a particular student please contact me at simone.da@husky.neu.edu or 617-308-5591. An additional adult needs to be present during the interviews. I am requesting your support for students, possibly during interviews, and to check-in about any after affects. A staff member from your program or an adult witness I bring will need to be present for their interviews.

Thank you again.

Best,
Daniel Simone, LMHC
Northeastern University Doctoral Student
Dear Candidate,
Thank you for taking the time to read this letter regarding participation in research at your school. Your (Insert name of school program) Counselor has determined that you may be an appropriate candidate for this study. The information provided below is to help you decide if you wish to participate. Please know that you do not have to participate if you do not want to, and if you decide to participate you can withdraw at any time.
The purpose of the study is to gain first hand accounts of students’ experiences returning to high school after being in the hospital. The results of which could inform educators about programming and how to help.
If being interviewed as part of this study is something you are interested in considering, please email me at simone.da@husky.neu.edu with your contact information and we can discuss any questions that you have regarding this study. If you contact me then we can discuss next steps, including consent forms and a more detailed explanation.
If you have any questions regarding your rights in this research, you may contact Nan C. Regina, Director, Human Subject Research Protection, 960 Renaissance Park, Northeastern University, Boston, MA 02115. Tel: 617-373-4588, Email: n.regina@neu.edu. You are allowed to call anonymously if you wish.
Signed Informed Consent for Parents

Informed Consent to Participate in a Research Study
We are inviting your child to take part in a research study. This form will tell you about the study, but the researcher will explain it to you first. You may ask this person any questions that you have. When you are ready to make a decision, you may tell the researcher if you want to participate or not. You do not have to participate if you do not want to. If you decide to participate, the researcher will ask you to sign this statement and will give you a copy to keep.

Why is your child being asked to take part in this research study?
We are asking your child to take part in this study because they have participated in the BRYT PROGRAM (Insert Program Specific Name) at their High School this school year, following at least 5 days in the hospital for treatment of mood, anxiety or depressive related symptoms.

Why is this research study being done?
The purpose of this research is to better understand student’s experiences of returning to high school following treatment, and their experiences of the support programming at school.

What will I be asked to do?
If you decide to take part in this study, we will ask you to participate in two interviews. You will be asked a straightforward set of questions about your experiences. The inquiry will be specific to your experience, and enable you to tell your story.

Where will this take place and how much of my time will it take?
The interviews will be scheduled at a time that is convenient for you. You can choose to be interviewed in an office or conference room at your school, or if you prefer we can meet in a study room at your local public library. An additional adult needs to be present during the first interview. This adult can be a staff member from your school program, your parent or guardian, or an adult witness whom I bring with me. This interview should take about one hour.
The second interview will take place about four weeks after the first. This interview will be an opportunity for us to follow-up about your continued experiences, and for me to check with you about what themes I heard from you during our first interview and to ask you follow-up questions. This interview will last no more that 60 minutes, but could be shorter.

Northeastern University, College of Professional Studies
Name of Investigator(s):
Principal Investigator, Dr. Corliss Thompson, and Student Researcher, Daniel Simone, LMHC
Title of Project: Getting Back to School – Understanding Adolescents’ Experience of Reentry in to School After Psychiatric Hospitalization
Will there be any risk or discomfort to me?

Although no major risks are expected, it is possible that sharing your personal story may cause you some discomfort. By giving you a choice of which adult witness, and the location for the interview I hope this will reduce potential discomfort or inconvenience for you. Additionally, I will inquire with you, and your program counselor two days after each interview to check on any unforeseen adverse effects from the interviews. Should you identify needing supports during the check-ins, I will notify your counselor and parent immediately. Also, you can discontinue the interview process at any time for any reason. With these precautions in place, it is believed that you will be able to participate in the interview process and have the opportunity to share your story without harm.

Will I benefit by being in this research?
There are no benefits associated with this study. However, you may enjoy the chance to reflect on your experiences and being a part of helping others better understand how to help.

Who will see the information about me?
Your part in this study will be confidential. Only I will see the information about you. No reports or publications will use information that can identify you in any way or any individual as being of this project. The audio recording will never have your name on it, and will be labeled with a pseudonym during the interview and transcription process as well as for the written document. I will ensure full confidentiality utilizing password protection on my computer. All data will be destroyed after three years.

In rare instances, authorized people may request to see research information about you and other people in this study. This is done only to be sure that the research is done properly. We would only permit people who are authorized by organizations such as the Northeastern University Institutional Review Board. Additionally, like with other confidential circumstances, the safety of you and other minors could require I report some of what is reported in the interview. Only in a situation of harm or abuse being caused to you, another minor, or vulnerable population would I be mandated to report.

What will happen if I suffer any harm from this research?
No special arrangements will be made for compensation or for payment for treatment solely because of my participation in this research. No significant harm is anticipated from your participating in the interviews.

Can I stop my participation in this study?
Your participation in this research is completely voluntary. You do not have to participate if you do not want to and you can refuse to answer any question. Even if you begin the study, you may quit at any time. If you do not participate or if you decide to quit, you will not lose any rights, benefits, or services that you would otherwise have as a student at your school.
Who can I contact if I have questions or problems?
If you have any questions about this study, please feel free to contact Daniel Simone, LMHC, at 617-308-5591, or simone.da@husky.neu.edu, the person mainly responsible for the research. You can also contact Dr. Corliss Thompson, co.brown@northeastern.edu, the Principal Investigator.

Who can I contact about my rights as a participant?
If you have any questions about your rights in this research, you may contact Nan C. Regina, Director, Human Subject Research Protection, 490 Renaissance Park, Northeastern University, Boston, MA 02115. Tel: 617.373.4588, Email: n.regina@neu.edu. You may call anonymously if you wish.

Will I be paid for my participation?
Once the interviews are completed I will present you with a $30 gift card to Amazon as a thank you.

Will it cost me anything to participate?
If we meet at your local public library, and there are costs for travel or parking, I will reimburse you these expenses.

Is there anything else I need to know?
You must be at least 18 years old to participate unless your parent or guardian gives written permission. If you are 15, 16 or 17 then I will request you signature in addition to your parent. Even if your parent agrees to your participation, as a minor you can decide not to participate now, or at any time during the study, no questions asked.

I agree to [have my child] take part in this research.

____________________________________________ ________________________
Signature of person [parent] agreeing to take part Date
____________________________________________ Printed name of person above
Thank you for thinking about participating in this research. The purpose of the study to learn of students’ experiences returning to high school after being in the hospital. You are being asked to participate in two 60 minute interviews. The questions will be straightforward. You can tell your story of returning to school. The results of the study can inform educators about how to help students.

This is voluntary. Even though your parent said you could do it, you still do not have to if you do not want to do it. In the event that you experience any stress as a result of sharing your story, I will be asking the program counselor to check in with you following the interviews. A staff member, your parent, or an adult witness I bring will need to be present for the interviews. Additionally, I would like to give you the choice of where the interviews will take place. It can be in a conference room or appropriate office at your school or at a study room in the local public library. I will protect your confidentiality, and will not use your name or identify you with written or recorded materials. Like with other confidential circumstances, the safety of you and other minors could require I report some of what is reported in the interview. Only in a situation of harm or abuse being caused to you, another minor, or vulnerable population would I be mandated to report.

Please sign below if you agree to participate in the interviews.

____________________________________________ _________________
Signature of person if you are 16 or 17, indicating Date of participant’s assent.

____________________________________________ ________________________
Signature of person who explained the study to the participant above and obtained assent.

____________________________________________ ________________________
Signed name of person above

____________________________________________ ________________________
Signed name of person above
APPENDIX H – FIRST INTERVIEW QUESTIONS

High School Reentry Post Hospitalization Experience
Q1 What year in school are you?
Q2 How long were you in treatment, and why were you there?
Q3 While you were still in the hospital, what were your feelings about returning to school?
Q4 Were there experiences you didn’t like about returning to school?
Q5 Were there experiences you felt were particularly positive about returning to school?
Q6 When you first came back to school, what was it like to be in classes?
Q7 When you first came back, how did you talk with your friends and classmates about where you had been?
Q8 What changes if any did you experience with your friends and teachers upon returning to school?
Q9 How have you been doing academically since you have returned?
Q10 How have you been personally since you have returned?
Q11 What has this experience of being in treatment and returning to high school meant to you?

BRYT Programming Experience
Q12 When did you first learn about BRYT?
Q13 Can you describe for me your experience of the intake meeting?
Q14 What were your first few days like in the program?
Q15 How long have you participated in BRYT programming?
Q16 Were there experiences in BRYT you didn’t like?
Q17 Were there experiences in BRYT you felt were particularly helpful?
Q18 Please tell me in your own words what it feels like to be in the BRYT classroom?
Q19 Are there things you know now about BRYT that you wish you knew when you were first in the program?
Q20 Can you describe for me your experience of working with adults in the Program?
Q21 How were the adults most helpful to you?
Q22 How could the adults have been more helpful to you?
Q23 Can you tell me your experience of connecting with other students in the program?
Q24 Do you feel having other students in the program who were also reentering was important to your getting back on track?
Q25 Can you describe your sense of being a part of the community of students also returning to school?
Q26 What if anything was difficult about joining this group of students?
Q27 Personally, what do you think is the most key part of BRYT?
Q28 Do you feel BRYT helped you change as a person?
Q29 What has this experience of reentering high school with the help of BRYT meant to you?
Q30 Do you feel BRYT has contributed to your identity?
Q31 If you could tell something to other students who may be needing BRYT, what would it be?
Q32 If you could tell something to other school leaders who are considering starting a BRYT program, what would it be?
Q33 Please describe how you are currently doing in school?
Q34 Do you have anything you wanted to talk about that we didn’t?
    Q35 Do you have any questions for me?