School Reintegration Following a 90-Day PRTF Placement:

Attendance as an Indicator

of System Alignment and Emotional Readiness

A Dissertation

Presented to

The College of Graduate and Professional Studies

Department of Special Education

Slippery Rock University

Slippery Rock, Pennsylvania

In Partial Fulfillment

of the Requirements for the Degree

Doctor of Education (Ed.D.)

by

Andrea L. Taylor

Proposed Graduation May 2026

COMMITTEE MEMBERS

Committee Chair: Jeremy Lynch, Ed.D.

Slippery Rock University

Professor of Special Education

Committee Member: Deanna Sintobin, Ed.D.

California University of Pennsylvania

Director of Special Education

Committee Member: Christopher William Tarr, Ed.D.

Slippery Rock University

Senior Licensed Professional Care Manager

ABSTRACT

This qualitative multiple-case study examined the experiences of six students reintegrating into public school following discharge from a 90-day Psychiatric Residential Treatment Facility (PRTF), focusing on how emotional readiness, transition planning, school-based supports, family engagement, and cross-system coordination influenced post-discharge attendance. Grounded in ecological systems theory and trauma-informed education, the study framed attendance not merely as presence, but as an early indicator of reintegration stability and system alignment. Data from parent interviews, school records, and PRTF documentation were analyzed thematically, revealing that successful reintegration was linked to proactive transition planning, consistent and layered supports, strong family-school communication, and alignment between student readiness and school expectations. Attendance declines often reflected gaps in supports or misalignment, whereas fragmented communication and unmet emotional needs contributed to absenteeism and sometimes re-hospitalization. The findings underscore the need for formalized transition protocols, enhanced collaboration across educational and mental health systems, and sustained trauma-informed supports, highlighting attendance as a multidimensional, system-sensitive indicator of reintegration success.

Keywords: psychiatric residential treatment facility (PRTF), school reintegration, attendance, emotional readiness, transition planning, trauma-informed education, ecological systems theory, student engagement

DEDICATION

To my children, Jillian Leigh Taylor and Nathan James Taylor,

Through your own example, you have taught me to keep striving, to keep growing, and to never settle for less in any part of my life. Your strength, determination, and the love you show me every day inspire me more than words can fully express. I am endlessly proud of you and forever grateful to be your mom.

All my love, always.

To my grandfather, Clifford E. Shuffstall,

Born in 1928, you left school after eighth grade and served in the Army from 1946-1949. Decades later, you returned to complete what you started, earning your GED and graduating from the Crawford Central School District in 1983 at the age of 55. You instilled in all of us the importance of education - earning a degree or certification to better ourselves - and your grandchildren and now great-grandchildren have followed that path. Your determination and commitment to lifelong learning continue to inspire me. You are right; they can't ever take it away from us.

To my past, present, and future students, especially those facing hardship, challenging home lives, or circumstances that often leave them overlooked. To the students who walk a different path, whose voices are often unheard, may this be a reminder that your potential is seen, your journey matters, and support is always possible.

ACKNOWLEDGMENTS

I would like to express my sincere gratitude to Dr. Jeremy Lynch, Dr. Deanna Sintobin, and Dr. Christopher Tarr for your kind words, guidance, and support throughout this journey; it truly has been a process. Your insight, patience, and feedback challenged me to grow.

I am especially thankful to my parents, Bill Shuffstall and Cindy Nicolls, who have been in my corner my entire life. From our beginnings at Slippery Rock University in 1971 to this moment, your support and example are the reasons I have reached this academic milestone.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

CHAPTER 1: INTRODUCTION

Adolescent mental health and school participation in the United States have become two increasingly urgent priorities. Approximately one in five adolescents meets the criteria for a clinically significant mental health disorder requiring professional treatment (Rose et al., 2021). These youth often face various ailments that lead to educational disruptions, including chronic absenteeism, declining academic performance, and behavioral challenges. In extreme cases, psychiatric crises, and the need to enter PRTFs are frequent events. PRTFs employ staff on-site 24 hours a day who devote their efforts to therapy and psychiatric care. Federally under Medicaid, PRTFs are intended to be non-hospital settings offering 24-hour inpatient psychiatric care to patients under age 21, but this varies by state and provider. PRTFs are key resources for adolescents with serious emotional disturbances, providing intensive psychiatric care in non-hospital residential settings.

The inconsistencies in the definition of PRTFs arise because of state regulations and licensing requirements, and facility integration practices differ. Several states license PRTFs within medical facilities to streamline psychiatric care for youth. This setup deviates from the federal model of a non-hospital, community-based residential environment.

The facility examined in this study, while labeled and licensed as a PRTF, is structured within a hospital-based behavioral health unit. It is situated between a model of acute inpatient and long-term residential care. In this case, integration into a hospital setting means that the therapeutic environment, staffing models, and discharge planning may differ from those of stand-alone residential interventions.

Due to these structural differences, this study's findings may not be entirely applicable to all PRTFs nationwide, particularly those that do not operate in non-hospital, freestanding settings. For this study, the term ‘PRTF’ encompasses various residential treatment facilities that

provide intensive psychiatric and behavioral health services to youth, including models that extend beyond the federal definition. Still, this contextual information is helpful for understanding the nuances of care models that span several treatment definitions and underscores a further need when defining and evaluating youth psychiatry treatment delivery systems.

While the PRTF is designed to help stabilize mental health, it is unclear what impact placement in such a setting has on school re-entry, including attendance. One common proxy for measuring school reintegration is attendance. This chapter introduces the study investigating how students were affected by attending a 90-day PRTF once discharged as measured by school attendance.

Background of the Study

In the early 2000s, PRTFs were developed as an addition to the levels of care introduced under Medicaid guidelines for children under 21 with serious emotional disturbances (Rose & Lanier, 2017). Admission requires evidence that less restrictive, community-based services are insufficient. An intensive set of therapeutic interventions, medication management, and a structured environment facilitated by a multidisciplinary team are implemented. However, despite their widespread use, PRTFs' long-term effectiveness, especially regarding educational reintegration, remains unclear (Lanier et al., 2020). Participation rates often rely on school attendance as a key indicator. The findings suggest that consistent school attendance indicates therapeutic progress and improves academic gains and emotional adjustment post-discharge (Clemens & Welfare, 2011; Marraccini & Pittleman, 2022). However, there are few published empirical studies that specifically examine post-discharge school attendance outcomes after a youth's discharge from a PRTF.

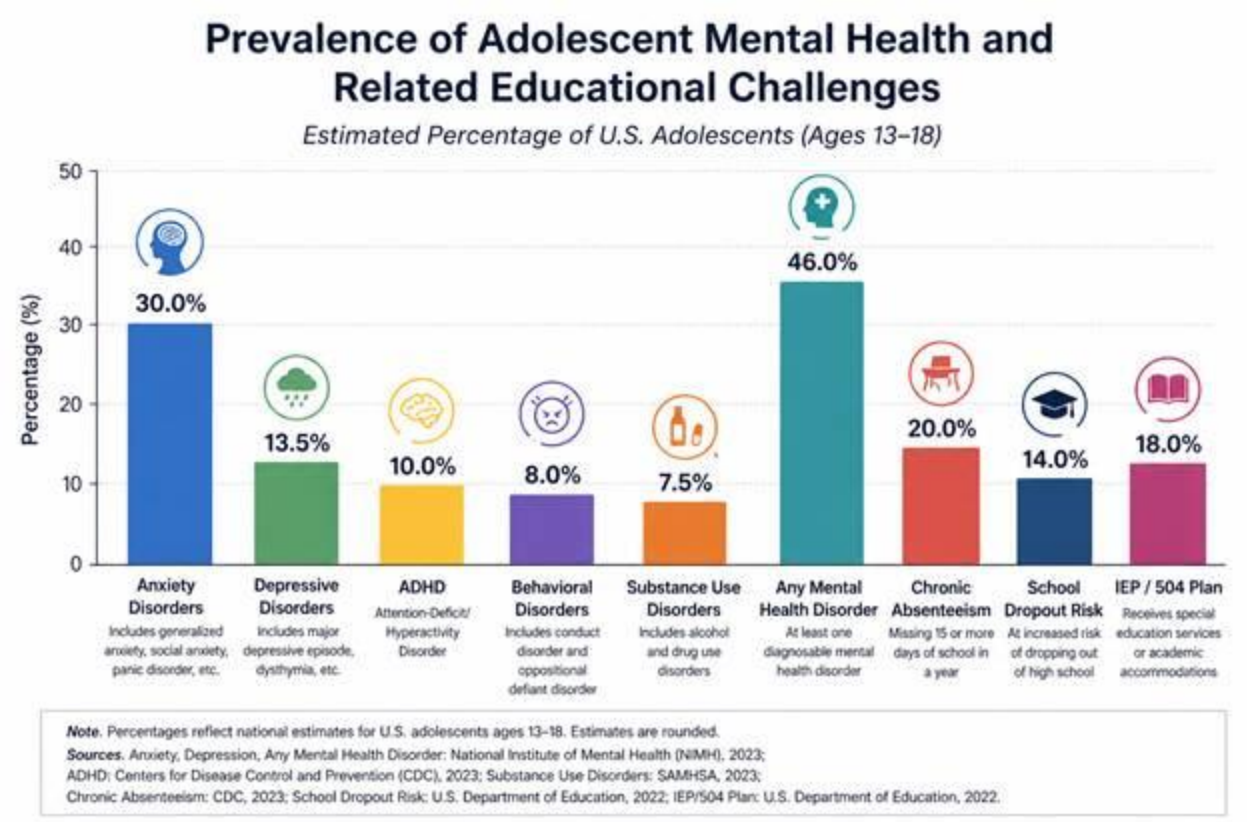
Statement of the Problem

PRTFs focus on stabilizing youth with psychiatric needs, and their return to a school environment can be problematic. After discharge, students may encounter barriers to academic success such as stigma associated with psychiatric conditions, lack of educational intervention, and persistence of mental health issues. These barriers may very well interfere with school attendance, an important indicator of return to school. However, research addressing the association between PRTF care and post-discharge school attendance patterns is limited. Without knowing these consequences, schools and treatment programs do not have the data they need to develop sound transition supports.

This study uses school attendance as a main outcome measure reflecting the student's successful and unsuccessful return to school. A student's attendance at school is not just physical presence; rather, it would be a proxy for emotional readiness, systems supports, and engagement in learning, all of which are central to both theories. This alignment supports the emphasis on attendance as an important vantage point from which to view post-PRTF trajectories.

Figure 1

Prevalence of Adolescent Mental Health and Related Educational Challenges



Note. Mental health prevalence estimates are based on data from the National Institute of Mental Health and the Centers for Disease Control and Prevention. Educational indicators, including chronic absenteeism, dropout risk, and IEP/504 plan eligibility, are based on reports from the U.S. Department of Education and the National Center for Education Statistics.

Purpose of the Study

The purpose of this study is to determine whether placement in a 90-day PRTF has an impact on later school attendance following discharge. The study seeks to determine whether attendance improves, declines, or remains constant. Attendance will also provide insight into how quickly students reintegrate into society and how society accommodates their return.

Research Question

Primary Research Question: How does participating in a 90-day PRTF affect student participation once discharged, as measured by school attendance?

Significance of the Study

This study contributes to the limited literature on educational outcomes following psychiatric residential treatment. The research is helpful because using regular attendance as an early indicator of integrating back into society offers concrete benefits for those involved in discharge planning and educational transitions. It also reflects how formal education both creates opportunities for those who require psychiatric care and enables them to benefit from these opportunities. The decision to restore out-of-home care for troubled students under formal educational conditions should be made with reference to the students' needs. Educational policy, discharge procedures, and school-based support programs tailored to the needs of youth transitioning from PRTFs must reflect this reality.

Delimitations

The present study includes the following delimitations:

(a) students discharged from a 90-day PRTF program,

(b) outcome will be assessed during the first 60 days post-discharge, and

(c) brick-and-mortar school setting.

Limitations

This study is subject to several limitations. First, attendance was used as the primary outcome measure and may not fully capture broader dimensions of student engagement, such as academic performance, emotional investment, or classroom participation. Second, the findings may not be generalizable to youth in other residential, outpatient, or alternative treatment settings, as this study focuses specifically on students discharged from a 90-day PRTF. Third, outcomes may have been influenced by variability across school districts, including differences in policies, available supports, and reintegration practices. Together, these factors may limit the transferability of findings beyond the specific context of this study.

Definition of Key Terms

- PRTF (Psychiatric Residential Treatment Facility): A non-hospital setting offering intensive psychiatric services for youth under 21 with serious emotional disturbances.
- Attendance: Physical presence in school, measured by the number of days present during a designated time.
- School Reintegration: The process of re-entering and participating in a traditional educational setting following psychiatric hospitalization or residential treatment.
- Engagement: The behavioral, emotional, and cognitive involvement of a student in academic activities.
- Discharge Planning: A collaborative process initiated during residential treatment to prepare the student for return to the community and school.

Summary

This chapter discussed a crucial need to address the effect of PRTF placement on post-discharge school attendance. One factor to consider is whether PRTF involvement predicts post-exit student attendance. Another aspect is the background, purpose, and significance of the study while introducing the guiding research questions and conceptual frameworks. The chapter concluded by addressing key definitions and methodological considerations. Chapter 2 will provide a detailed review of the literature on PRTFs, school attendance, and reintegration outcomes.

CHAPTER 2: LITERATURE REVIEW

Adolescent mental health and educational functioning have become increasingly urgent in the United States. Approximately one in five adolescents meets criteria for a clinically significant mental disorder (Rose et al., 2021). These youth frequently experience educational challenges such as chronic absenteeism, poor academic performance, and behavioral challenges. When youth experience psychiatric crises, some are admitted to PRTFs. The purpose of this study is to examine the effects of a 90-day PRTF stay on school attendance post-discharge. Attendance is conceptualized in this study as an early, observable indicator of reintegration, reflecting both emotional readiness and the degree of alignment across educational, familial, and clinical systems following discharge.

Psychiatric Residential Treatment Facilities: What They Are, What They Are Not, and For Whom

In the early 2000s, PRTFs emerged as the newest federally approved Medicaid level of care for children under 21 with serious emotional disturbances (Rose & Lanier, 2017). To be admitted, it must be determined that less restrictive, community-based care is insufficient. This led to the development of a new category of care offering 24-hour supervision, therapeutic intervention, medication management, and crisis stabilization within a structured, multidisciplinary team. The treatment model involves a multidisciplinary team (MDT) including psychiatrists, psychologists, social workers, and educators (Liberman et al., 2001).

These 24-hour PRTFs offer intensive therapeutic care for children and adolescents suffering from severe emotional, behavioral, or psychiatric challenges. They are intended for those who cannot be safely served in less restrictive settings. Strengths of PRTFs include individualized treatment planning, the combination of psychiatric and educational services,

strength-based skill development, and family participation in treatment. These settings focus on getting youth ready to return to the community, using therapeutic interventions and a coordinated discharge plan (Centers for Medicare & Medicaid Services [CMS], 2020).

Empirical evidence suggests that PRTFs can reduce psychiatric symptom severity and improve social and behavioral functioning during treatment. They also create and reinforce coping skills and raise levels of social and academic functioning. Research shows that 50–70% of children improve significantly by the time they are discharged from inpatient treatment, especially with family participation and strong aftercare support (Sowers & Epstein, 2019). Treatment is more likely to be successful in the long term if follow-up supports are provided on an outpatient and community-based basis to minimize relapse and readmission.

PRTFs occupy a critical position within the continuum of care, bridging the gap between acute inpatient hospitalization and community-based outpatient services. They are an alternative to inpatient psychiatric hospital treatment, which is often too restrictive for many patients but bridges the gap between acute or subacute community-based services.

Despite their intended role, PRTFs remain subject to significant controversy. They have seen growing popularity since the 1970s (Ebesutani et al., 2011), but the results remain mixed. Lanier et al. (2020), in a meta-analysis of 47 studies, reported inconsistent long-term benefits, high rates of readmission, and wide variability in care quality. There is also ongoing concern for overuse, inappropriate admissions, the overuse of restraints, and the absence of trauma-informed paradigms and frameworks (Lanier & Rose, 2017; Herbell & Ault, 2021).

Admission demographics reflect systemic inequities, with Black and Native American children, as well as those in foster care being disproportionately represented (Rose & Lanier, 2017). These disparities highlight the need for targeted interventions that address racial and

socioeconomic factors in the treatment and reintegration process. Frequent PRTF placement predictors are trauma-related diagnoses, psychotropic medication use, behaviors, and child welfare system involvement (Rose et al., 2021).

Since student participation in school has been reported as one of the most tangible and practical indicators of school re-entry success post-discharge from a psychiatric or residential treatment setting, attendance has always been present in the academic literature (Substance Abuse and Mental Health Services Administration, 2009). School attendance has long been recognized within academic literature as a practical and observable indicator of student functioning following psychiatric treatment. Clemens and Welfare (2011) have argued that adherence to school attendance legislation and early and scheduled re-entry into the classroom are key factors in promoting recovery and reintegration. Their results emphasized that parental involvement in ensuring attendance after hospitalization can critically contribute to the stabilization of students' academic pathways.

A systematic review by Midura et al. (2023) further emphasized that monitoring attendance at follow-up is commonly embedded in good practice for transition care planning post-discharge. Return-to-school attendance rates are often adopted as a measure of reintegration quality in transition planning models. Similarly, Preyde et al. (2017) indicated that adolescents experience returning to regular school attendance as their vital concern and need in their return to in-person school after psychiatric hospitalization.

In another significant contribution, Marraccini and Pittleman (2022) identified that students' capacity to return to regular in person attendance reflected emotional readiness coupled with school-based support structures. Attendance functions not only as an indicator of school re-entry, but also as an early behavioral signal of emotional stability and the effectiveness of

school-based support structures. Tougas et al. (2022) confirmed that transition programs reporting higher post-discharge attendance rates were strongly associated with better long-term mental health outcomes.

Moreover, Preyde et al. (2021) specifically described attendance patterns as the "first visible sign" of successful reintegration, arguing that improvement in daily school presence often precedes academic achievement or full psychosocial recovery. LaFleur et al. (2017) evaluated a school-based transition program and used attendance improvements post-discharge as their primary success metric. Likewise, youth-centered evaluations conducted by Preyde et al. (2018) supported attendance as a standard for measuring intervention effectiveness.

Collectively, these studies suggest that while broader emotional, behavioral, and academic outcomes remain vital, consistent school attendance post-discharge stands as an essential, immediate, and quantifiable indicator of successful school reintegration. This body of research underscores the importance of coordinated discharge planning that includes concrete attendance goals and the ongoing monitoring of students' school participation in the critical months following their release from psychiatric or residential care.

Historical Context and Policy Milestones Shaping PRTFs

With the public establishments changing and money from the federal government for subsidization drying up after the 1970s, many children were uncared for at community level. This led to the development of a new category of care; Medicaid's level for people under 21 who have a mental health need high enough that they could not be handled on an outpatient or local basis yet not sick enough to require full-time hospitalization. It was a middle position between a hospital and community residential care. PRTFs provided a hybrid model combining structured psychiatric care with community-oriented treatment goals; they were well-structured and even

more intense in psychiatric environments, and if public funds were forthcoming, Medicaid would reimburse them.

States vary in how they implement PRTFs. Some were independent residential facilities. There are some notable differences in practice between regions. In others, they were part of hospitals and on a scale much larger than normally necessary. This blurred the boundary between acute treatment and long-term stay facilities. The buildings also reflected local resources, state policy, and Medicaid. Today, these differences affect the way treatment is completed and whether returning students go back to their home school receive support from there.

Recent policy changes include this kind of change as well. Today, an increasing number of states have begun adding community-based facilities to their already overcrowded collection of medical possibilities.

These historical circumstances became the driving force behind PRTFs and represent contradictory sentiments between institutional care and community survival.

Education Within PRTFs: Services and Supports

Students in PRTFs are entitled to a Free Appropriate Public Education (FAPE), including access to special education services (ELC, 2024). However, the quality and adequacy of educational support are highly variable. While some PRTFs have instruction linked to an Individualized Education Plan (IEPs), others do not employ licensed teachers or have academic ties with home school districts (Herbell & Ault, 2021).

Therapeutic Models Supporting Reintegration

Cognitive Behavioral Therapy (CBT), Dialectical Behavior Therapy (DBT), and the Neurosequential Model of Therapeutics (NMT) are the key intervention approaches in PRTFs that aim to address the various, yet underlying, mechanisms that lead to school participation.

CBT primarily targets maladaptive cognitions and school-related anxiety that lead to avoidance behaviors. DBT strengthens emotional regulation and interpersonal functioning and diminishes behavioral disruptiveness that disrupts school involvement. NMT concentrates on neurodevelopmental regulation and seeks to restore the physiological stability needed to facilitate continued participation in structured learning environments. These models, taken together, promote reintegration because they both target internal psychological barriers as well as regulatory capacities required for sustained school attendance.

Integrated approaches that combine CBT or DBT with NMT principles appear to be the most effective. These models address both emotional-behavioral readiness and neurodevelopmental regulation, which together help remove barriers to regular school participation and support smoother academic reintegration post-discharge.

Though CBT, DBT, and NMT are well-regarded interventions for emotional and behavioral functioning, the only influence they may have on school attendance post-discharge is also based on their ability to address some of the internal boundaries that can lead to chronic absenteeism. For example, CBT, by emphasizing the reframing of negative thought patterns and increasing coping skills, directly focuses on decreasing avoidance patterns that are sometimes referred to as school anxiety or school withdrawal associated with more significant depression symptoms. The results of Heyne et al. (2015) showed weekly attendance rates improved for students with generalized anxiety types of presentations after they had completed a CBT intervention, indicating that those students were becoming aware of anxious thoughts regarding school situations and therefore, become more frequent attendees.

Similarly, DBT not only improves emotional regulation and distress tolerance, which impacts behaviors involving behavioral outbursts and interpersonal conflicts; these are common

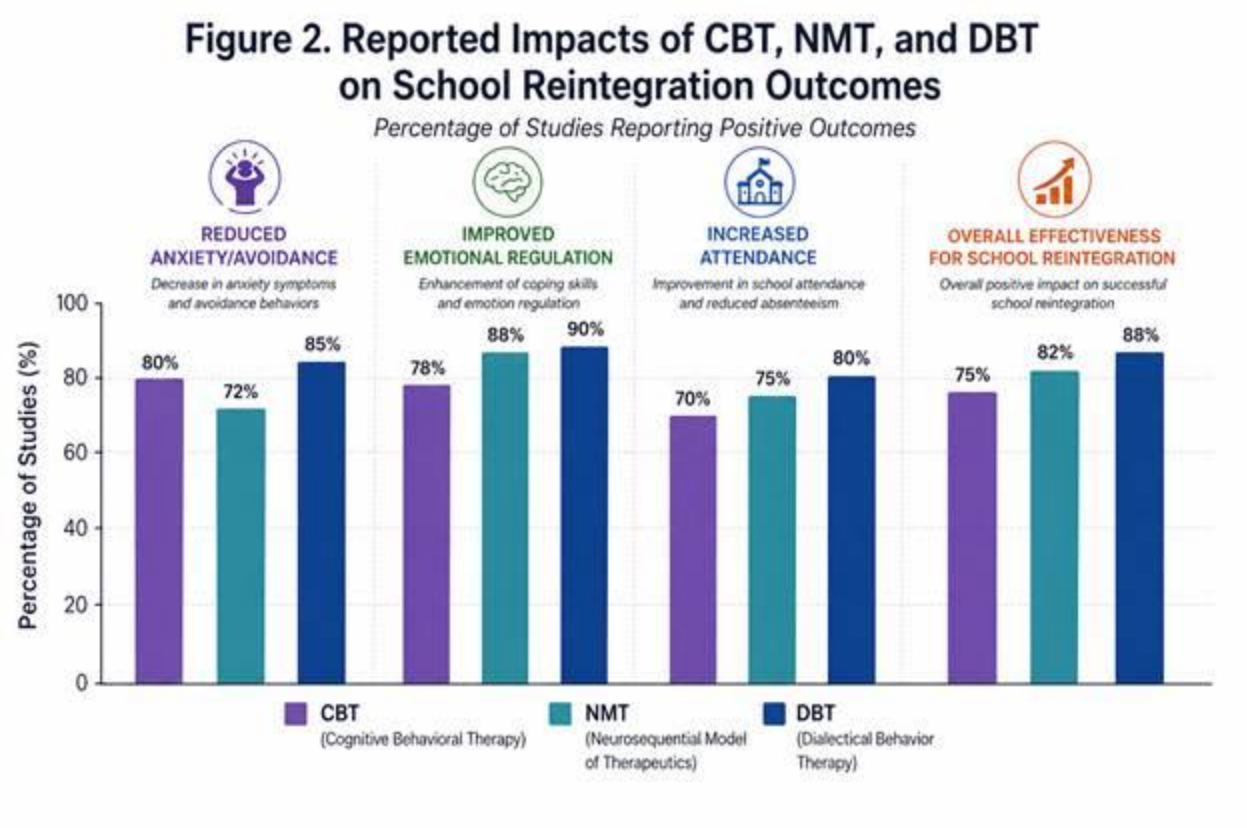
reasons for school avoidance or disciplinary exclusion. McNichols (2016) found that adolescents who completed DBT treatment had 30% fewer unexcused absences in the three months after residential discharge and offered their peer aspects of DBT treatment as reasons for the improvement, along with behavioral stability as potential outcomes.

NMT's initial target is non-regulated brain regulation before expecting cognitive performance to occur. Such a sequence of steps breaks the stress cycle into separate behaviors that can be managed in academic settings. Viljoen (2018) reported that students who received NMT-informed interventions had 68% to 84% higher attendance at the secondary school level over the first 60 days post-discharge, signifying better self-regulation supported learning participation.

In the context of school attendance, each kind of therapeutic model has its own unique role. CBT targets maladaptive thought patterns and school-related anxiety, helping students reframe negative impressions of school to reduce avoidance behaviors. DBT strengthens emotional regulation and distress tolerance. It gives students the ability to manage overwhelming feelings that might otherwise lead to school refusal or disciplinary issues. NMT traces the neurological impact of trauma by supporting regulation and relational connection; these are core capacities needed for sustained classroom participation. Together, these models stabilize emotions, mental flexibility, and physiological regulation. These are essential for improving school attendance after psychiatric treatment. The relative impacts of therapeutic approaches on key reintegration outcomes are summarized in Figure 2.

Figure 2

Reported Impacts of CBT, DBT, and NMT on School Reintegration Outcomes



Note. This figure represents a conceptual synthesis of literature examining the effects of Cognitive Behavioral Therapy (CBT), Dialectical Behavior Therapy (DBT), and the Neurosequential Model of Therapeutics (NMT) on school reintegration outcomes, including reduced anxiety and avoidance, improved emotional regulation, and increased school attendance. These patterns are supported by research on cognitive-behavioral interventions for anxiety and school refusal, emotion regulation frameworks in dialectical behavior therapy, and neurodevelopmentally informed approaches to behavioral and emotional functioning, including work by Aaron T. Beck, Marsha M. Linehan, and Bruce D. Perry. Findings are presented to illustrate relative areas of impact rather than precise quantitative effect sizes.

Difference in Model Effectiveness

Recent research has shown a difference between effective and ineffective educational service models in PRTFs. Programs that offer individualized educational plans, use evidence-

based teaching strategies such as trauma-sensitive education, and incorporate treatment and academic instruction tend to have better outcomes (Dwyre, 2022; James et al., 2013). On the other hand, facilities that prioritize mental health treatment alone at the expense of robust academic programming, or where education is impersonal and regimented, often face higher dropout rates and attainment of discharged students is poor beyond the short term (Van Horn, 2009; Ferris, 2019). It is still an issue that some PRTF systems provide little or no educational services, particularly for students with disabilities; this remains a critical concern (Cannon, 2011). Integrated, flexible, and sensitive to trauma education emerges as a high point of youth success.

Educational Model Effectiveness in PRTFs

The quality and design of educational models within PRTFs varies across different facilities. This often separates academic success from total failure. The difference between effective and ineffective educational models often illustrates the difference between successful reintegration and continued disengagement. Effective programs intentionally integrate trauma-informed educational practices, structured transition planning, and interdisciplinary collaboration between clinical and educational staff. Trauma-informed practices including predictable routines, specific sensory regulation, strategies and flexible pacing help students manage emotional triggers while developing trust in educational settings. Modeled interventions (e.g., Bridge for Resilient Youth in Transition, White et al., 2017) have produced positive results from using therapeutic support as an integral part of everyday educational engagement to improve student perceptions of safety and increase post-discharge. Starting a structured transition planning process early is no less important. Creating academic portfolios, working with home schools, and family-centered meetings must take place. These factors help to ensure that students return

to school with adequate accommodation and a clear path forward.

Interdisciplinary collaboration on effective models means clinicians, teachers, and case managers meet regularly to discuss differentiated therapeutic and academic goals allowing for real-time support as students prepare for discharge. Excellent models share components such as coordinating with the home school and communication to ensure planned return and that factors are in place to help students attend consistently and the continuum of supports is connected. Ineffective educational models lack sensitivity to trauma, impose rigid and nondifferentiated curricula, do not consider transition planning, and isolate education from clinical care. These contexts often include disorganized and fragmented education and have significantly lower post-discharge attendance and engagement.

Effective Educational Models

In PRTFs, several studies point to specific elements of the educational program associated with successful reintegration when a resident is discharged. Ferris (2019), for example, found that PRTFs with individualized educational plans and an academic support component embedded in treatment reported higher graduation rates and smoother time reintegrating back into the home school. Facilities which treated education as a core component of therapy, rather than secondary, allowed students to continue making academic progress in treatment.

Similarly, James, Alemi, and Zepeda (2013) found that evidence-based educational strategies, such as Positive Behavioral Interventions and Supports (PBIS) and trauma-informed learning environments, were linked to better academic performance and lower rates of behavioral incidents. These interventions emphasized emotional safety, good, clear consistent behavioral

expectations, for both staff and classmates, and personalized learning; the result being a high degree of student engagement.

Leadership practices within the facility also influence educational success. Dwyre (2022) reported that PRTFs with collaborative, student-centered leadership, where administrators helped make students dream for themselves in concrete details, vocational training as well as flexible academic pathways were actively supported, and teacher-clinician communication worked well above average, reported much higher educational continuity and results.

Ineffective Educational Models

Conversely, inflexible and poorly constructed educational practices often hinder student progress in PRTFs. According to Van Horn (2009) standardized, one-size-fits-all curriculum models that do not meet students' mental health and cognitive profiles have been linked to increased dropout rates and failure to recover academic credits. Several other institutions, whose structures were primarily oriented towards behavior management without the education programming tailored to the diverse stages of adolescents' development, failed to meet youths' developmental needs.

Cannon (2011) discussed the legal and policy concerns, stating that many PRTFs systematically refuse to follow the requirements of IDEA and ADA, especially for students with disabilities. This neglect of education needs has led to regression in academic skills and expanded equity gaps for marginalized youth.

Further, Galvin (2020) showed how educational staff and clinical teams functioned in silos with minimal interdisciplinary coordination, compartmentalizing the learning process. This division led to a weak continuity of academic services, contributing to additional challenges of entering public schools.

Successful models recognize the correlation of mental health and academic success and take a combined, trauma-informed, and individualized approach.

Failed models often treat education as an afterthought and do not meet their legal duty, let alone cater to the youth's interests.

For student success following discharge, educational planning must be seen as an integral part of treatment planning rather than an isolated domain.

Although the type and quality of educational services available within PRTFs influence academic paths, these in-facility interventions represent only one part of a youth's reintegration journey. Successful post-discharge school participation comes from more than the educational experience during residential placements; it also depends on various internal and external components after discharge.

Effective and Ineffective Educational Models Connection to Attendance

Trauma-informed supports are inclusive, integrated, and collaborative in the school and home environments and will produce environments where students feel safe, important and understood in education. This educational model of education is not only effective but also will result in strong integration. These aspects help directly promote consistency in school attendance by minimizing classroom anxiety, building relationships, and opening pathways to reintegration. In contrast, ineffective models composed of rigid discipline, lack of mental health integration, and minimal family engagement can exacerbate avoidance behaviors, trigger re-traumatization, and contribute to chronic absenteeism. By highlighting these contrasts, the study underscores how educational environments play a pivotal role in either promoting or impeding attendance following discharge from a PRTF. The next section will explore the individual mental health,

family, and school-based factors that, when combined, affect students' attendance and engagement outcomes post-discharge from a PRTF.

Post-Discharge Reintegration and Attendance Patterns

While PRTFs are designed to stabilize teenagers psychiatrically, the successful return to school requires a deliberate, coordinated process. Friesen et al. (2005) found that youth returning from residential treatment with structured reentry plans, such as IEP transitions, counseling, and school-based support, had significantly higher attendance and better outcomes in other respects. For example, wraparound services involving the family and both school and mental health providers have been shown to be more associated with more positive outcomes (Rosenblatt & Woodbridge, 2003). However, students deprived of these supports often struggle with reintegration, leading to truancy, behavioral referrals, or dropout (Lanier et al., 2020). Barriers include stigma, disrupted routines, and under-resourced schools that are poorly prepared to meet the academic and behavioral needs of returning youth.

Attendance Versus Engagement

The constructs of attendance and engagement are often combined in literature. The two are different but also strongly linked in terms of behavior. Attendance refers to the student's physical presence in school; this is an observable, trackable behavior. Engagement is not as obvious as attendance is. It involves emotion and cognitive effort, and active participation in learning activities (Lam et al., 2023; Ardill, 2024).

Schools should use attendance after post-PRTF as a baseline to indicate if a student is re-entering educational routines and reconnecting with school systems. It offers a practical, real-time indicator to determine who is at risk of disengagement.

Attendance alone does not ensure meaningful participation, as engagement involves cognitive, emotional, and behavioral involvement in learning. True reintegration demands engagement, which combines attendance and is shaped by internal factors (e.g., emotional regulation) and external supports (e.g., relationships, mental health services). Research (Kearney & Graczyk, 2022; Keppens, 2023) confirms that while attendance predicts academic outcomes, engagement better explains persistence and long-term success.

A tiered understanding is necessary:

- Attendance is the initial, measurable reentry point.
- Engagement is a deeper, long-term educational goal.
- Tracking both provides a holistic view of reintegration progress for students discharged from PRTFs.

Attendance as a Measure of Engagement and Reintegration

Attendance has historically been a useful proxy for student success. Odell started developing a link between academic success and class attendance in 1923. Ardill (2024) and Lam et al. (2023) took this view beyond and used the difference between attendance and engagement (defined as active, meaningful participation) to differentiate between the two. Attendance is a predictor of academic achievement and engagement. Kearney and Graczyk (2022) further reconfirmed this perspective, framing absenteeism as a multidimensional and multilayered issue of trauma, family dysfunction, institutional bias, and peer dynamics. Students who miss more than 10% of school days will experience the negative effects of academic failure, behavioral problems, and emotional detachment.

Those findings also solidify how valuable the attendance measure is. Keppens (2023) has confirmed that both truancy and health-related absenteeism are related to educational attainment.

In addition, disciplinary suspension was associated with lower graduation rates which cannot be ignored when considering this question of outcomes in the context of PRTFs.

Pre-PRTF Attendance and Academic Challenges

Before being sent to PRTFs, most students demonstrate significant attendance challenges. These challenges often stem from persistent health problems, trauma exposure, school suspensions, a lack of a stable place to live or a consistent guardian (Jay et al., 2023). According to Kearney and Graczyk (2022), there are several attendance obstacles in addition to setting the stage for those discussed so far, including transportation, lack of food, digital divides, and school discipline policies.

Students involved in child welfare services are at a heightened risk. Lanier and Rose (2017) found that being placed in foster care, having a substantiated history of maltreatment, and receiving Temporary Assistance for Needy Families (TANF) were all significant predictors of PRTF admission. In this group, nearly 42% met criteria for psychiatric disorder. In short, what leads to residential treatment is often school disengagement, together with multi-system failure.

Chronic Absenteeism to PRTF Admission

Empirical evidence shows a consistent developmental path that prolonged non-attendance may indicate increasing need for psychiatric support later, such as residential treatment units. Chronic absenteeism can sometimes indicate a child's struggle with psychiatric issues in addition to family instability or systemic barriers, which, if unaddressed, can escalate to the point of requiring intensive psychiatric intervention.

In a longitudinal study, Rose and Lanier (2017) found that absenteeism, often tied to emotional disturbance diagnoses, significantly predicted later admission into PRTFs. Their findings indicate that youth with repeated absences often exhibited compounded risk factors,

including trauma exposure and unmet behavioral health needs, solidifying absenteeism as both a symptom and predictor of deeper systemic dysfunction. Similarly, Lanier, Feely, and Fraser (2021) also conducted research showing that the compound risk factors for a pattern of repeated absences in young people often included exposure to trauma and behavioral needs which went unnoticed. There are also cases where absenteeism is both a symptomatic and predictive indicator of system breakdown.

Bealke and Anderson (2006) in their report to the Early Intervention Planning Council, point out that frequent absenteeism is one of three early warning signs for students who are likely to require a higher level of psychiatric care. Their findings suggest that early intervention programs targeting attendance patterns might significantly change these children's trajectories and keep them in regular school placements rather than the more restrictive alternatives. Also, according to Colyer et al. (2012), lack of school stability, exemplified through chronic absenteeism or transfers from one school to another, correlates with mental health breakdown and the eventual PRTF admission among youth in state custody systems. Their research makes clear that attendance breaks often function as both a cause and an effect of escalating mental health crises.

Together, these studies suggest that chronic absenteeism serves as a sign that will flag students who may soon require a higher level of psychiatric intervention. Dealing with attendance challenges early through school-based mental health supports, comprehensive family involvement, and trauma-informed educational practices may significantly lessen the need for care at PRTF levels.

Interaction of Internal and External Variables Leading to PRTF Admission

Chronic absenteeism was found to play a role in the eventual PRTF admission process, as a continuum that is not linear or static, but rather a result of intricate, dynamic interplay of internal and external environments. There is a need to recognize the interaction in such settings for the design of early supports and interventions to avoid these restrictive placements.

Internal factors, such as emotional dysregulation, anxiety, depression, trauma responses, and behavioral disorders, directly impact a student's ability to attend and engage in school. As determined by Rose and Lanier (2017), students with underlying mental health problems often initially present attendance issues which can quickly escalate if internal struggles remain unrecognized and untreated. Symptoms like school refusal, somatic complaints, and school disengagement are early behavioral expressions of internal distress (Lanier, Feely, & Fraser, 2021).

However, internal vulnerabilities do not exist alone. They are compounded by external factors such as family instability, socioeconomic difficulties, lack of school-based mental health services, and exposure to systemic inequities. Bealke and Anderson (2006) found that when external supports like family involvement, consistent school environments, and access to community mental health services are missing, students' internal problems often get worse, leading school attendance into further turmoil.

Moreover, Colyer et al. (2012) pointed out that systemic issues, including the disruption of living arrangements for foster children, punitive school discipline practices, and insufficient trauma-informed education models in their schools combine to create an atmosphere where chronic absenteeism and disengagement are at risk. These stressors can increase the pressure and

trauma experienced by vulnerable young people, overwhelming even mild internal challenges, and accelerating mental health deterioration.

The interaction between internal and external factors is both cyclical and mutually reinforcing. Just as internal psychological problems cut school attendance and engagement, the adverse external environment worsens these internal struggles. Over time, this bidirectional relationship can end in acute crises where young people are hospitalized for psychiatric interventions such as PRTF admission.

To summarize, addressing chronic absenteeism leading to PRTF admission will necessitate a twofold approach. First, increasing internal mechanisms in students/youth with trauma through therapeutic approaches, such as CBT, DBT, and NMT, and second, reinforcement of environmental support systems for individuals at home, school, and in the community.

As academic studies have shown repeatedly, structured school reentry programs significantly enhance attendance rates of youth transitioning from psychiatric or residential treatment centers. Like the existing programs are early, tailored interventions, including academic and behavioral support and school-based mental health services.

Frensch, Cameron, and Preyde (2009) assessed community-based adaptations for youth in residential treatment. Their results found that youth who made the transition with organized support services that included mental health follow-up and academic monitoring had greater improvements in school attendance and academic performance than youth wtih peer-based supports. This research serves to underscore the need for health and education to proceed hand in hand immediately on discharge.

Similarly, Tougas et al. (2022) reviewed several specialized reintegration models, such as the Bridge for Resilient Youth in Transition (BRYT) and UCLA's ABC Program. These models aim to improve school climate and reduce absenteeism. The BRYT model places licensed clinicians directly into school settings to provide daily emotional and transitional counseling. This exemplifies how embedding therapeutic services within schools can raise attendance and encourage academic re-engagement.

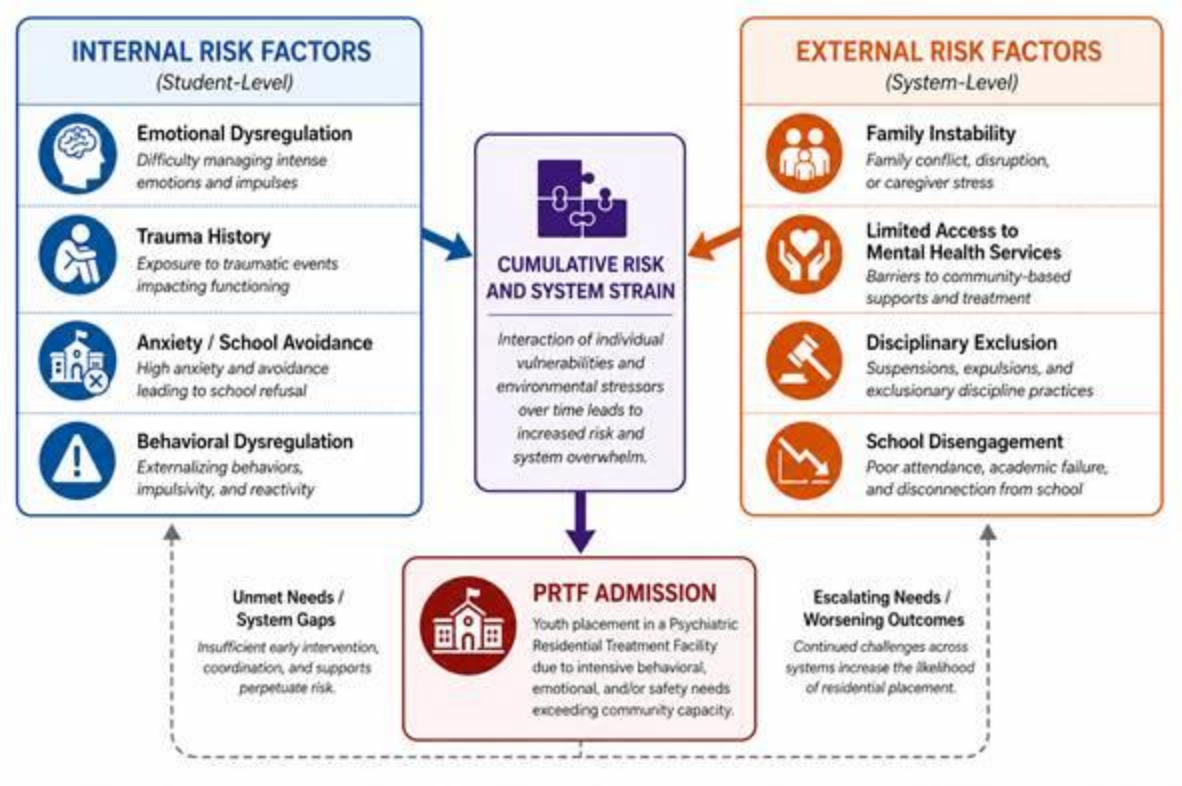
Yearwood and Abdum-Muhaymin (2007) added to their evidence by examining structured day programs for suspended or expelled youth, populations with high overlap in psychiatric service histories. These programs, which mixed academic remediation with social-emotional learning interventions, saw dramatic jumps in regular attendance and boosted school completion rates among participants.

Additionally, Underwood and Knight (2006) reviewed group home care and post-release interventions, finding that youth who received post-treatment academic support services had higher school attendance rates than those without such services. Their analysis stresses that effective reintegration must address both the student's emotional recovery and educational stability.

Altogether, these studies demonstrate the need for multi-tiered reintegration supports, which include school-based mental health services, flexible academic programming, and family engagement, to address attendance outcomes after psychiatric or residential discharge. Those programs that postpone educational reentry planning or have clinical and academic efforts separated have poorer outcomes and should emphasize an early start and multidisciplinary effort.

Figure 3

Internal and External Risk Factors Contributing to PRTF Admission



Note. This figure represents a conceptual synthesis of internal (e.g., emotional dysregulation, trauma history) and external (e.g., family instability, limited access to mental health services, disciplinary exclusion, and school disengagement) factors associated with admission to psychiatric residential treatment facilities, based on Rose and Lanier, Lanier, Feely, and Fraser, and Colyer et al..

Barriers to Effective Reintegration

Although structured reintegration programs offer some hope to students transitioning out of psychiatric care, many young people still face substantial difficulties. It is crucial to understand the barriers that sabotage successful reintegration, ranging from mental health relapse and family instability to school-based stigma and lack of support services, for developing and sustaining positive educational outcomes.

Despite strong planning, peer-induced stressors quickly undermined reintegration. Mental illness relapse remains one of the most significant challenges; once again, students slip into more traditional environments, emotional instability and unresolved clinical needs often remain (Lanier et al., 2020; Marraccini & Pittleman, 2022). This is compounded by instability within family systems; research shows that inconsistent caregiving environments, lack of parental support, and socioeconomic stressors seriously hinder sustained school participation (Rose & Lanier, 2017; Hogan, 2018).

Social stigma also emerges as a critical barrier. Students returning to school after psychiatric hospitalization often deal with peer rejection and bullying upon return to school, making them increasingly anxious and unable to attend classes (Clemens & Welfare, 2011; Marraccini & Pittleman, 2022). Institutional barriers within schools further complicate reintegration. Many educational environments lack the necessary mental health support services or fail to implement transition accommodations set out in discharge planning, leading to disengagement (Tougas et al., 2022; Frensch et al., 2009).

In addition, if the student leaves school without an individualized program, or if the program falls short (Tougas et al., 2022; Cannon, 2011), they will face both academic and therapeutic continuity problems. The problem is that academic reentry is difficult when even schools are not flexible. There are strict attendance codes, little leeway for mental health needs, and harsh disciplinary measures can discourage students instead of supporting their gradual reintegration (Kearney & Graczyk, 2022; Yearwood & Abdum-Muhaymin, 2007). Stigma often leads to renewed attendance challenges, delaying successful reintegration even more.

The second of these findings suggests that in-PRTF educational programming itself must be both effective and its own catalyst for further change. Even so, successful problem solving

across levels is an ongoing task of incorporating necessary institutional reforms as well as family and clinical assistance.

Influences on Post-Discharge Attendance

Whether patients will attend post-discharge clinic appointments is influenced by both internal and external factors. Internally, mental health status, emotional regulation, and self-efficacy are essential (Rose & Lanier, 2017). Inputs from the outside community such as caregiver involvement, availability of outpatient services, condition of the child's school climate, if applicable, and type of the services being delivered to a child with regards to their IEP heavily affect outcome (CDC, 2025; Kapp et al., 2015).

Family participation is one of the most definitive predictors of success. Kapp et al. (2015) and Ebesutani et al. (2011) found that the children of families who participated in treatment and discharge planning had higher hopefulness and school reentry success. Therapeutic foster care has also been demonstrated to be an effective post-discharge intervention that reduces recidivism (Rose et al., 2021)

Brick-and-Mortar Schooling: Attendance Tracking and Analysis

This study focuses on students returning to traditional, in-person schooling rather than virtual or cyber models. In these brick-and-mortar environments, teachers can track attendance and provide structured engagement opportunities. Ardill (2024) found that in-person students with higher workshop attendance performed better academically than their peers, reinforcing the value of physical school presence as a measurable indicator.

Conceptual Model: Pathways from PRTF to School Reengagement

This study is guided by a conceptual framework that integrates Ecological Systems Theory (Bronfenbrenner, 1979) and the Trauma-Informed Education Framework (SAMHSA,

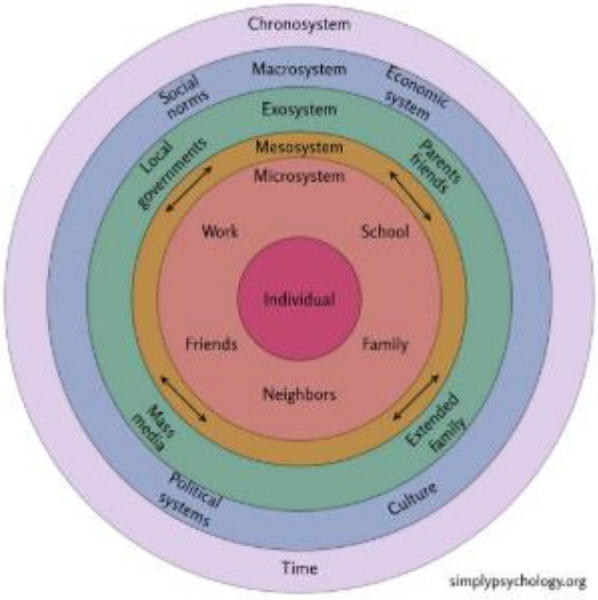
2014). These are not fixed, testable theories. Focusing on the relationship between people and their broader environment, both theories stress that individual development grows out of everyday settings associated with interlocking systems such as family stability, school climate, peer relationships, mental health services, and institutional responses. Likewise, trauma-informed models emphasize how adverse childhood experiences, including psychiatric hospitalization, can disrupt a student's sense of safety, trust, and belonging, all essential to regular school attendance.

Ecological Systems Theory and the Trauma-Informed Education Framework are utilized in this study to conceptualize the impact of internal factors such as emotional regulation and trauma history, as well as external systems such as school supports, family engagement, and educational environments on post-discharge school attendance impact a student's outcomes. This integration facilitates the analysis of how familial and school environmental contributors influence emotional and academic reintegration, while also considering how trauma affects a student's ability to engage with these systems.

Bronfenbrenner's Ecological Systems Theory is centered around the idea that as humans grow, there are five interconnected environmental systems surrounding the person that influence growth and behaviors (Guy-Evans, 2020). Development is related not only to individual traits of each individual but to how the individual operates within external systems including family, school, community, and society. Bronfenbrenner's Ecological Systems Theory provides a framework for understanding how multiple environmental systems interact to influence student development and reintegration outcomes (see Figure 4).

Figure 4

Bronfenbrenner's Ecological Systems Theory



Note. This figure illustrates Bronfenbrenner's Ecological Systems Theory, which conceptualizes human development as occurring within a set of nested, interacting environmental systems, including the microsystem, mesosystem, exosystem, macrosystem, and chronosystem, each influencing individual outcomes through dynamic and reciprocal relationships. Adapted from "Bronfenbrenner's Ecological Systems Theory," by Saul McLeod, 2023, Simply Psychology (https://www.simplypsychology.org/bronfenbrenner.html).

On the other hand, many teenagers get over this stage without developing serious problems. This is especially true for adolescents whose families have been dealing with social services over extended periods of time. The concept of 'family' ceases to make sense when it just does not work; and those meanings are hard to recover even if they do exist at all. This framework highlights that, because of trauma, whether due to abuse or neglect, hospitalization or instability, neurological growth, emotional regulation and cognitive functioning are all disrupted, which are vital for schooling (SAMHSA, 2014). In trauma-informed schools, teachers view behavioral and attendance problems as responses to overwhelming stress, rather than signs of resistance or disengagement. Key principles in the framework are emotional and physical

security, relational trust, student voice and choice, and multi-stakeholder supports that are culturally competent (Overstreet & Chafouleas, 2016). These principles are particularly relevant for students returning to school from PRTFs, who may be hypersensitive, weak in coping mechanisms, and anxious about whether they will be able to establish a rapport with the members of the school. Using the framework of trauma-informed education enables predictable routines. Environmental triggers were reduced by each student's therapeutic progress, as well as their ongoing clinical needs. In the study, the framework helps interpret attendance data by linking absence or presence of trauma-responsive practices in schools and students' post-discharge school participation. By starting with the student's lived experience as well as relational dynamics in reintegrating classrooms, the trauma-informed education lens reveals not only obstacles to regular school attendance but also facilitators.

Bronfenbrenner's Theory endorses attendance as the measure of an environment's integration and its system's operability. Through a trauma-informed lens, attendance is a form of sensitive, behavior-based post-trauma recovery and relational stability. These dual theoretical bases raise attendance from a basic procedural consequence to a developmentally important and outcome-relevant indicator of student success post-discharge.

The conceptual framework serves as a lens for identifying and analyzing the pathways from PRTF participation to reintegration outcomes, particularly attendance, as a direct measure of school reengagement. This approach maintains a practical orientation by connecting consistently with actual variables and settings found in real life.

This study is based on a conceptual framework integrating Bronfenbrenner's Ecological Systems Theory (1979) with the Trauma-Informed Education Framework to examine how participation in a 90-day PRTF affects post-discharge school attendance. Ecological Systems

Theory highlights how student attendance is affected not just by individual characteristics (e.g., mental health, emotional regulation), but all the systems around them (family, school, service providers, and policy environments). Disruptions in any of these systems, such as poor discharge planning or undesirable school climates, can make reintegration difficult.

The emphasis of the Trauma-Informed Framework is that trauma-induced scenarios directly affect learning and behavior, and that reintegration must prioritize emotional safety, relational trust, and consistent routines. From this lens, attendance is not just compliance but requires an emotional state of readiness and response from the system.

The framework for this study is informed by these perspectives about attendance. Together, these perspectives treat attendance as a multidimensional indicator and a reflection of a person's strength to withstand internal psychological factors and a community's ability to provide positive reinforcement. This framework shapes the study's design and interpretation by linking attendance outcomes directly to the alignment of trauma-informed, multi-system supports.

Building on these frameworks, this project operationalizes school attendance as a real-time behavioral indicator of system alignment and emotional readiness during reintegration. Whereas Ecological Systems Theory describes how multiple systems work in concert to influence development, this study focuses on attendance to capture how effectively those systems function in coordination following discharge.

The trajectory from school attendance problems to PRTF admission reflects a complex, dynamic interaction between vulnerable internal psychological factors and external systemic factors. Emotionally, students may be dealing with emotional dysregulation, trauma symptoms, anxiety, or depression that initially disrupt their ability to attend and participate in school

consistently (Rose & Lanier, 2017; Lanier, Feely, & Fraser, 2021). Attendance difficulties often arise as one of the first observable symptoms of deeper mental health challenges. What drives the escalation of these internal conflicts rather than offsetting them is the failure of external support systems; these include stable family environments, school-based mental health services, and positive peer relationships to buffer and lessen these internal struggles that drive escalation (Bealke & Anderson, 2006; Colyer et al., 2012).

Emotional distress reduces school engagement, while absenteeism isolates students from protective school-based resources, intensifying psychological symptoms. Environmental risks, such as school exclusion, disciplinary action, or unstable foster care placements, further destabilize youth already at risk (Kearney & Graczyk, 2022; Tougas et al., 2022). Over time, increasing failures across systems of care and education escalate both emotional crises and disengagement from school altogether, culminating in the need for highly restrictive, intensive interventions like PRTFs.

Within this conceptual framework, school attendance functions dually; first, it shows trouble in the emotional or wider system, and second, if not addressed immediately, it will simply create a rapid decline. Chronic absenteeism serves as an early warning signal which indicates which adolescents may be at risk of a future psychiatric crisis. It proves that an integrated early intervention strategy that reinforces internal coping mechanisms and supports outside networks is needed. Starting early with absenteeism means not only improving the value of education, but it is also a key point for disrupting long-term trends towards psychiatric residential care.

The interaction between clinical, educational, and systemic factors influencing post-discharge reintegration can be conceptualized across several interconnected domains. Admission

factors include elements such as trauma history, special education needs, and involvement in foster care or child welfare systems. During the PRTF placement, students receive in-treatment supports, including academic instruction, therapeutic interventions, and family engagement. Discharge planning involves structured transition meetings, coordination with the receiving school, and referrals for ongoing outpatient or community-based services. Following discharge, post-discharge variables such as school climate, access to mental health services, and peer dynamics continue to influence reintegration. These interconnected factors ultimately contribute to observable outcomes, including attendance, engagement, academic performance, and behavioral stability.

This study makes several critical contributions to the existing literature on PRTFs, school reintegration, and attendance outcomes. First, it addresses a significant empirical gap. Although much is known about mental health needs among youth placed in PRTFs, few studies have explicitly looked at school attendance as a measurable, short-term post-discharge reintegration outcome. Most prior research has focused either on long-term mental health outcomes or on generalized measures of functioning (Lanier et al., 2020; Rose & Lanier, 2017), leaving attendance patterns, a vital indicator of successful reintegration, underexplored.

Second, this study clears up the confusion brought about through lumping attendance together with engagement and highlights their differences. More importantly, attendance is one early measurement used to evaluate reintegration difficulty. In doing so, this research extends existing models of school reintegration by proposing a layered framework. Attendance is therefore seen both as a symptom of internal and external structural defects and as a convenient early post-discharge monitor for changes in these deficiencies (Lam et al., 2023; Ardill, 2024).

Third, the research builds on earlier models to show how attendance and related disruptions occur. It brings together evidence from mental health education and child protection literatures to explain why students with good academic skills, but who are psychologically unstable are eventually pushed out of schools into psychiatric residential treatment settings. While practitioners in the field know this well and refer to it, not all the derailed pathways have been spelled out. This research traced these steps explicitly, presenting a comprehensive conceptual framework practitioners can use to plan early intervention against children at risk.

Finally, the project makes a practice-oriented contribution by suggesting that school data post-discharge can serve as a low-cost, readily available monitoring tool for identifying students who require an increased support system. This helps bridge the present disconnect between clinical discharge planning and school-based service provision. This is in line with demands in the literature for more actionable, cross-system cooperation between mental health providers and educational institutions (Tougas et al., 2022; Marraccini & Pittleman, 2022).

The study adds to the literature not only by solidifying strategies for reintegration but also by providing concrete recommendations aimed at improving educational outcomes for a vulnerable community.

Research Gaps and the Need for Longitudinal Data

While PRTF settings are costly, and children are placed within them, few studies track long-term educational outcomes in children after discharge. Lanier et al. (2020) pointed out that there were no longitudinal studies to track attendance after 90 days or to subdivide reports by special education status. There is no consensus on which criteria are most appropriate for discharge or what the school's role in post-PRTF success must look like. The research also has yet to compare the results for general versus special education students. These two groups of

students work along different pathways and are offered various services throughout a school with few comparisons to point in the same direction even though special education is the one system that is generally providing divergent pathways and supports throughout a child's educational experience. These distinctions are important in intervention design.

Implications for Practice

The 90-day placement at a PRTF helps stabilize psychiatric symptoms; however, it cannot guarantee reconnection with the school environment. Post-discharge attendance depends on systemic, relational, and behavioral factors. PRTFs are for young people who struggle with severe mental health issues. A unified approach that is trauma-informed and family-centered is needed from educators, clinicians, and policymakers, who all share an understanding about how trauma not only affects families but their children as well.

Schools should receive clear discharge summaries with academic and behavioral recommendations. Districts should establish transition teams involving guidance counselors, special education staff, teachers, mental health supports, and case managers. Creative pathways to flexible attendance and graduation and alternative attendance policies are particularly important for students with chronic conditions or trauma histories (Kearney & Graczyk, 2022). A multi-system strategy, rooted in equity, collaboration, and individualized planning, is required to transform the post-PRTF experience from disengagement to empowerment.

CHAPTER 3: METHODOLOGY

A qualitative multiple-case study design was selected to enable an in-depth, contextual analysis of how participation in a 90-day PRTF influences students' school attendance patterns following discharge. Understanding the reintegration experience is essential, as it is complex and affected by the interaction of mental health status, educational supports, family dynamics, and school responses. The first six eligible cases were selected to allow for cross-comparison and identification of both common and divergent reintegration patterns. Special education students receive formalized supports such as IEPs, while informal or school-wide services are used by students without such IEPs; comparing these distinct groups may provide insight into how varying levels of structural support relate to attendance outcomes. This design is appropriate to the exploratory nature of the central question: "How does participation in a 90-day PRTF affect school attendance post-discharge", but also, how it facilitates the development of relevant insights for educators, clinicians, and policymakers serving students across diverse populations.

Rationale for Data Sources

To conduct a comprehensive analysis of how participation in a 90-day PRTF influences post-discharge school attendance, this study utilizes qualitative data sources to support triangulation and enhance interpretive depth; this includes semi-structured interviews, IEP documents, and clinical case notes provide a unique perspective on the student's process of reintegration and allows for a more refined interpretation of attendance outcomes. Semi-structured interviews with parents or guardians provide rich narrative data regarding perceptions of student readiness, emotional barriers, support quality, and school climate. This approach allows attendance patterns to be interpreted not just as behavioral records, but as reflections of

underlying reintegration processes. IEP documents were reviewed to assess what types of transition supports, accommodations, and reintegration planning are in place for students with special education needs. This allows for an evaluation of how formalized educational supports facilitate or constrain student participation in school. For general education students, equivalent transition documents or reentry plans were analyzed. Finally, clinical case notes from the PRTF setting will provide critical contextual information on each student's treatment focus, progress during placement, discharge recommendations, and any identified risk factors for school disengagement. Together, these data sources triangulate the factors influencing post-discharge attendance, linking clinical, educational, and personal realms to identify key facilitators and barriers to students returning to and remaining in school. This multiple-case study design allows for a thorough investigation of the central research question: How does participation in a 90-day PRTF affect school attendance post-discharge?"

Research Design

This study is a qualitative multiple-case study with descriptive quantitative support in the form of attendance data. While attendance provides measurable indicators of school participation, it does not capture the emotional, relational, or systemic factors influencing reintegration. A qualitative approach allows for examination of these contextual dynamics, offering insight into why post-discharge attendance patterns occur.

Research Setting and Broader Context

The setting for the study is a large, rural public school district in central Pennsylvania. As of the 2023–2024 academic year, the district includes six schools: one high school (grades 9–12), one middle school (grades 5–8), and four elementary schools (grades K–4). Approximately 3,257 students attend the district with a student-teacher ratio of 12.81:1.

The district is mostly Caucasian, with minority enrollment around 10%. Economically, around 71.2% of students are economically disadvantaged. The district provides a range of programs, such as Advanced Placement courses, career, and technical education through partnerships with institutions like a technical school, and a virtual academy to meet diverse learning needs.

Participants and Sampling

This study utilizes a purposeful sampling approach, which is appropriate for qualitative case study research, where depth of understanding is prioritized over statistical generalization. The current study is best served by purposeful sampling in that it allows for selection of interviewees who experienced residential treatment in a PRTF and returned to a brick-and-mortar school. The goal of this sampling approach is not statistical generalization, but analytical depth and the identification of meaningful patterns across cases.

Patton (2015) argues that purposeful sampling is best when researchers need to "select cases that will yield information of almost demonstrable saliency to the inquirer" (p. 264). Based on this principle, participants were selected based on recent completion of a 90-day PRTF placement and return to in-person schooling.

This sampling approach strengthens the qualitative design in several important ways. It ensures variation across relevant participant characteristics, enabling comparison across different reintegration experiences. It also allows for meaningful comparative insights between students with differing levels of educational support, such as those receiving special education services and those in general education settings. Additionally, the approach enhances the credibility of the findings by selecting participants who can provide detailed perspectives on both outcome

measures, such as attendance, and process-oriented factors, including emotional readiness, support systems, and perceptions of reintegration.

In focusing on those most familiar with the reintegration process, purposeful sampling ensures that both qualitative and quantitative types of data collected are directly aligned with the study's research questions and theoretical frameworks.

The main participants are six students who completed 90 days in the PRTF placement and returned to in-person schooling in their home district. Preferably, these participants will be three special education students and three general education students. The first six eligible participants who met inclusion criteria were selected to examine how varying supports, identities, and requirements influence post-PRTF schooling. Such a small sample, chosen purposefully to vary, is entirely consistent with the traditions on depth and diversity that qualitative and mixed methods critics argue for today (Patton, 2015; Creswell & Poth, 2018).

Research shows that special education students, particularly those with emotional and behavioral disorders (EBD), often face greater reintegration barriers, including greater stigma, more restrictive environments, disciplinary exclusion, and limited access to appropriate services (Kern et al., 2017; Lane et al., 2005).

By contrast, general education students may return with less formal support in place, relying more heavily on school climate, relationships, and informal accommodations. Including both groups allows the researcher to compare how access to individualized supports (e.g., IEPs, behavioral interventions) influence reintegration and attendance outcomes.

This design supports:

- Theoretical contrast across systems of support (trauma-informed vs. general education),
- Ecological validity, by reflecting diverse educational realities post-discharge,

- Pattern identification in how different educational pathways interact with psychiatric history, school readiness, and attendance recovery.

As Miles, Huberman, & Saldaña (2014) note, including "conceptually contrasting cases" in a small sample allows for analytic generalization, the ability to draw robust insights across types, not populations.

Overall, the sample will use the first six eligible participants meeting inclusion criteria. Students will be selected based on the following criteria:

- (1) completed a continuous 90-day admission in the designated PRTF
- (2) returned to an in-person brick and mortar school setting following discharge
- (3) have either an active IEP or are identified as general education student

Exclusion criteria consist of post-discharge students who transitioned to full-time virtual or alternative education settings post-discharge or those without reliable post-discharge attendance data. A sample size of no more than six students enables an in-depth look at the experiences of everyone through a combination of semi-structured interviews, attendance records, and school reintegration materials.

Data will be collected across multiple points in time, including:

- students' pre-PRTF academic and attendance histories will be collected as part of the regular intake process
- a narrative description of the PRTF stay
- the discharge planning process
- the reintegration phase into school, including the services, supports, and outcomes observed after reentry

This comprehensive design strengthens findings by triangulating across the various systems that influence school attendance following PRTF discharge.

A clear schedule will be in place to handle cases in which originally selected students do not meet the entrance criteria or drop out, move away, or for any other reason become unavailable, in order that study integrity can be maintained and continuity preserved.

Pre-screening Process

All potential participants must undergo a preliminary eligibility check that uses three items of the inclusion criteria, as indicated by:

- Discharge from a PRTF in the past year,
- Currently attending a brick-and-mortar school,
- Attendance data is not available without consent,
- And willingness to participate (with consent/assent).

Data Collection

Data were collected from multiple sources to support triangulation and enhance the credibility of findings:

Interview: Semi-structured interviews with parents and/or guardians to explore the reintegration experiences of youth.

Reviewing IEP files and discharge summaries to disclose the planning, accommodations, and services.

Field notes were maintained to document contextual observations and researcher reflections that informed data interpretation.

Data Analysis

The qualitative data were analyzed using thematic analysis, as outlined by Braun and Clarke in 2006. This analysis includes familiarization to data, coding, theme generation, revision, naming, and reporting. The constant comparative method was used to clarify themes from cases including comparisons between special and general education students. Quantitative attendance will be overlaid with the qualitative themes to connect participants' experiences with their post-discharge attendance outcomes.

Hospital-Based Psychiatric Residential Treatment Facility (PRTF)

The PRTF associated with this study is a hospital-based behavioral health unit that is part of a regional health network centrally located in Pennsylvania. This hospital offers an acute child and adolescent program for those adolescents aged 8-18 who experience severe emotional and behavioral health challenges unmanageable at the community level.

Based in a general hospital setting, this PRTF serves as a hybrid between acute stabilization and long-term residential treatment. This model of care differs from traditional, standalone PRTFs, which may impact treatment, discharge planning, and reintegration processes into educational settings.

Pre-PRTF Academic and Attendance History

Before admitted to the PRTF in the study, the student typically had common abnormal academic and attendance patterns prior to placement. Many of these students have a history of chronic absenteeism, behavioral referrals, suspensions, or brief psychiatric hospitalizations. The academic records of students are often treated as having poor academic performance, with gaps in instruction and no consistency of participation. This is a pattern often associated with a history of trauma or emotional disturbance, or undiagnosed mental health conditions. While some students have an IEP or Section 504 Plan before they are admitted, the extent to which these are

implemented or monitored at different schools and districts varies. Such pre-existing problems provide a context in which school attendance is already a potentially weak and complex behavior even before residential treatment begins.

Description of the PRTF Stay

The study is in central Pennsylvania within a 90-day hospital-based PRTF. This facility serves adolescents aged 8 to 18 years old with serious emotional and behavioral health needs that call for extensive psychiatric support. The PRTF combines characteristics of both acute care and long-term residential treatment. Depending on their grade level expectations, daily therapeutic services, medication management, and academic instruction are provided based on grade-level expectations. The use of educational programming has served to keep them moving forward rather than letting them fall behind.

The program's therapeutic approaches include Cognitive Behavioral Therapy (CBT), Dialectical Behavior Therapy (DBT), and the Neurosequential Model of Therapeutics (NMT). These are designed to target emotional dysregulation, trauma symptoms, and avoidance behaviors; factors that research has shown all contribute to negatively affecting attendance rates. The program's multidisciplinary team includes licensed therapists, psychiatrists, certified teachers, nursing staff, social workers, education staff, and behavioral health staff who collaborate to stabilize them and prepare them to re-integrate into local school and community settings.

Relevant Policies

- Several federal and state policies come together within this study:

- Individuals with Disabilities Education Act (IDEA): insists that students with disabilities have a right to a Free Appropriate Public Education (FAPE) with lessons tailored to their individual needs.
- Section 504 of the Rehabilitation Act: Prohibits discrimination on the basis of disability and requires schools to provide reasonable accommodations for eligible students.
- Medicaid Regulations: Define eligibility and services for PRTFs. Community-based alternatives must be declared insufficient before a patient can be admitted.
- Pennsylvania Department of Education (PDE) Guidelines: Provide frameworks for student assistance, reintegration, and support services, although specific pathways through which people move after hospitalization vary from one district to another for post-PRTF transitions.

The interplay of all these policies affects how students transition from PRTFs back into their home districts. It depends on factors such as whether one can develop an IEP for the student, the availability of support services, and overall strategies for reintegration.

Consistency with the Sample Strategies

When replacing participants, the replacement will mimic the original sample group (e.g., general or special education) to ensure comparative balance across cases.

In this way, the study can see declines in reintegration experiences. This strategy of contingency ensures that as research remains possible, it is still sticking to its deliberate sampling framework and not deviating ethical responsibility.

Given the sensitive nature of this study, which focuses on reintegration experiences and attendance outcomes for students released from PRTFs, strict protocols have been put in place to ensure that all participants' confidentiality is respected. Such procedures are entirely consistent

with regulatory requirements and can be considered to embody an ethical approach towards research.

Confidentiality of School Records

All identifiable data were removed prior to analysis, and participants were assigned numbers to protect confidentiality (e.g., names, home address/data, etc.) before records are made. Each participant will be assigned a random identifier, and no personal information (e.g., names, student numbers, or the schools they are affiliated with) will be linked to the identifiers in any analysis or report.

Because personal narratives and interview data are included in this research, extra care will be taken to anonymize qualitative answers.

This includes:

- Omitting or changing anything which even only indirectly would help someone who knew the person to determine who he/she is;
- Using pseudonyms or codes in transcriptions and written reports;
- Making sure that testimony is changed to protect identity while keeping its authentic feel.

All participants will be informed that they can skip any question or withdraw from the study at any point without suffering negative consequences. This is particularly important, both for maintaining the study's ethical integrity and because of the extreme vulnerability of the population involved.

Data Storage and Access Control

All digital data will be stored on encrypted devices and protected by a password. Physical materials such as consent forms or field notes will be stored in a locked file cabinet that is closed except for the primary investigator and co-investigator. If used, audio recordings will be only for

transcription purposes and then deleted permanently after the accuracy of its transcription has been confirmed. That applies to handwritten first-person in site reports as well. Access to raw data will be restricted to the primary investigator and co-investigator.

Oversight and Compliance

This study has received, or will be submitted to, approval by Slippery Rock University's Institutional Review Board (IRB). All procedures conform to professional ethics in research with vulnerable populations of youth, particularly those who have on record been traumatized and/or suffered psychiatric treatment. During the entire study, care will be taken to see that everyone involved is properly treated with courtesy and respect. Their rights must remain intact; their privacy shall not be invaded.

Discharge Planning Process

Discharge planning begins within the first weeks of treatment and continues throughout the youth's stay. The process is coordinated by the PRTF's MDT, usually led either by a social worker or a discharge coordinator. Clinical summaries, medication recommendations, therapy progress reports, and education status updates are all major parts of discharge planning. Family members or guardians are routinely brought into the process, as well as representatives from school districts, child welfare agencies, or juvenile justice systems are invited to participate in transition planning. However, when the PRTF and schools communicate, it is often unclear through formal written communication. Some districts actively collaborate to support students in their return; others may not get such care or only a notice that their student will return. This inconsistency can lead to gaps in service continuity. Students needing regular follow-up care such as behavioral support, counseling, or academic modifications following discharge will also suffer from the disruption of one system to another.

Reintegration Process at School

Following discharge, students return to their home schools where the quality of reintegration support varies. Ideally, the reintegration process is handled by a multidisciplinary reentry meeting that includes school administrators, counselors, special education personnel, and family members. During this meeting, teams may revise IEPs or initiate new evaluations. Sometimes they will establish behavioral intervention plans. In some cases, students return to school gradually, with daily check-ins from a counselor or access to school-based mental health services.

But reintegration is not equal. Some students return to school without a structured plan, and others may encounter teachers or administrators unaware of their recent past as patients at a psychiatric hospital. In addition, stigma, insufficient training in trauma-informed practices, and limited staffing can all lead to problems with an effective support network. As a result of these barriers, many students experience a return to disciplinary issues, truancy, and more complete disengagement from the educational process after leaving a PRTF.

The qualitative data sources used in this study were selected to provide a comprehensive understanding of student reintegration experiences and their relationship to attendance outcomes. Table 1 summarizes each data source, its purpose, and its connection to attendance as an indicator of reintegration.

Table 1

Overview of Qualitative Data Sources and Their Relevance to Attendance Outcomes

Data Source	Purpose in Study	Key Content Areas Reviewed	Connection to Attendance Outcomes
Interviews (Parents/Guardians)	To examine subjective experiences and perceptions related	- Perceptions of school readiness - Barriers to attendance	Provides insight into emotional, relational, and systemic factors influencing student

	to student reintegration and school readiness	- Post-discharge supports - Transition satisfaction	motivation, anxiety, and capacity to attend school
IEPs and Transition Documentation	To evaluate formal school-based planning and structured supports for reintegration following PRTF discharge	- Attendance-related goals and accommodations - Behavior Intervention Plans - Mental health supports - School reentry strategies	Demonstrates how institutional planning addresses attendance barriers and the extent to which supports are implemented
Clinician Notes (Treatment Summaries, Discharge Reports)	To analyze therapeutic progress and discharge planning processes that prepare students for school reentry	- Therapeutic approaches (CBT, DBT, NMT) - Indicators of readiness - Family involvement - School coordination in discharge plans	Provides evidence of skill development and transition planning that influence student engagement and attendance stability

As shown in Table 1, multiple data sources were used to triangulate findings and capture the complexity of reintegration across systems. Interviews with parent or guardian provided insight into experiences and perceived barriers, while school-based documentation and clinical records offered evidence of formal supports and readiness indicators. Together, these sources allowed for a comprehensive analysis of how emotional, systemic, and structural factors influence attendance during the post-discharge period.

Data Collection Instruments

The research is designed to take qualitative case studies one step further. To this end, the study employs an array of data collection instruments that capture both narrative and descriptive data elements to support a robust design for such studies. Semi-structured interview protocols will guide conversations with parents or guardians. This will ensure consistency across interviews but at the same time leave open a measure of scope or interest for each individual participant. Questions will be built on the study's conceptual framework, foregrounding student experiences, school reintegration, and all influences on attendance. An attendance tracking form

will be developed in a spreadsheet format, so that pre- discharge and post- discharge patterns of student attendance can be formally recorded. At the same time, this form will have certain variables built in including items such as Present on Days, Excused (or why/how many absences) days missed and Late Arriving/Tardy to match up with federal legislation and best practices. Also, included will be more than one measure of transitional planning support. For example, a validated tool or checklist such as a school reintegration planning rubric or fidelity checklist may be necessary to measure the presence and quality of documented transition supports. Taken together, the instruments offered provide both structured and flexible ways to trace the complicated trajectories of young people coming out of care at PRTF sites. The semi-structured interviews, IEP reviews, and attendance data will be analyzed to explore how structural support systems influence school attendance post-discharge. By combining these data sources, the study will identify key factors affecting reintegration and attendance outcomes.

Data Analysis Procedures

Quantitative attendance data provide objective indicators of school participation, including presence, absence, and re-engagement patterns. However, these data do not capture the underlying factors influencing student behavior. Qualitative analysis of interviews, IEPs, transition plans, and clinical notes provides insight into the emotional, relational, and systemic conditions shaping attendance outcomes. By integrating these data sources, this study offers a comprehensive understanding of both the patterns and underlying mechanisms of reintegration following PRTF discharge.

Qualitative Thematic Analysis

Braun and Clarke's six-phase framework for thematic analysis will be applied to the study of qualitative data. This allows for the identification, organization, and interpretation of

patterns in qualitative databases to be systematically explored. This method is both flexible and stringent. The aim of this study is to investigate how PRTFs affect student attendance post-discharge after a 90-day period.

Phase 1. Familiarization. First, the researcher becomes familiar with the data. Read and re-read all the student interview transcripts, IEPs, reentry plans, and clinical discharge summaries. The investigator will take rough notes first, too, dividing the data and documenting initial impressions on school readiness, emotional regulation, and family support.

Phase 2. Creating preliminary codes. At this point, significant blocks of text will be arranged in both deductive and inductive forms. These will arise naturally from the data in the case of inductive codes, but will be informed by the study's theoretical framework and research questions if they are deductive codes will be applied uniformly across all data sources, and may cover factors such as "feeling anxious about going back to school", "insufficient help with school assignments", or "successful transition interviews".

Phase 3. Identifying Themes. The data are then scanned for recognizable themes that represent broader meaning structures; for example, when a code reads "disorganized reentry plan," "teachers not told of discharge instructions," and "parent-school miscommunication". This phase is about looking for how the functions and auspicious states interrelate with student attendance consequences

Phase 4. Reviewing Themes. Themes are reviewed and refined via the examination of their coherence across individual cases as well as their validity with the overall dataset. If themes prove too general, overlapping, or unsupported by evidence, they are revised or thrown out altogether. From comparison to cross case, especially between students in special education

compared to those not so identified, we determine that our themes are sound meeting standards set for them.

Phase 5. Defining and Naming Themes. Every theme will be defined clearly to convey its essence in its entirety. To concisely represent the themes' content, a set of descriptive labels will be developed to be explicit about each theme's relevance to return to education after discharge.

Phase 6. Making The Report. The final stage also requires creating a presentation that brings together each of themes, notes, and quotes from participants' examples taken from the documents with what one person does or says to support this theme. The final part of this stage will see analysis findings contrasted through the lenses of ecological systems theory and trauma-informed education to show how layers of influence distort students return to education post-discharge. Going beyond the immediate aftermath of trauma on students under treatment in a school speaks to broader implications.

This method of thematic analysis helps the study examine beyond phenomena on the surface and uncover the major contextual and relationship factors that contribute to school attendance outcomes following psychiatric residential treatment.

Trustworthiness was established using the criteria of credibility, transferability, dependability, and confirmability (Lincoln & Guba, 1985). Credibility was strengthened by using data from a variety of sources such as interviews with parents, examination of IEPs, and clinical discharge summaries. The collection of data from multiple frames ensures a fuller and more accurate picture of the reintegrating experience.

Transferability was supported through detailed descriptions of the research context, participants, and settings. This enables readers to determine at an early stage whether any of the

findings might in principle apply to their own area. This is especially important given the unique structure of hospital-based PRTFs compared to traditional residential facilities.

Dependability will be supported by maintaining an audit trail that records all decisions made during data collection, coding, and theme development.

Finally, confirmability will be strengthened by practicing reflexivity throughout the research process. The researcher will maintain a reflexive journal to document potential biases, assumptions, and reactions during data collection and analysis. This reflective process ensures that interpretations remain grounded in participants' narratives rather than researcher preconceptions.

Together, these strategies will ensure that the study's findings are trustworthy, rigorously developed, and meaningfully connected to the experiences of students reintegrating into school following discharge from a 90-day PRTF.

In the quantitative attendance data that will follow discharge from a 90-day PRTF, qualitative insights can be utilized to clarify and explain the observed patterns of behavior. The thematic analysis will provide insight into not only why children with mental illness might not attend school, but also the social, economic, and systemic factors influencing attendance.

Ethical Considerations

This study will adhere to all ethical standards for human subjects' research, with strict measures in place to protect participant privacy, manage sensitive data securely, and ensure compliance with Slippery Rock University's Institutional Review Board (IRB) protocols.

For participants' privacy, they will be assigned pseudonyms and codes to protect their identities. Following the de-identification process, all personal identifiers such as names, school affiliations, or district information will be removed from any transcripts or documents

whatsoever. Direct quotes included or paraphrased in the final report will be carefully reviewed to ensure they cannot be traced back to individual participants. To guard against negative consequences for those who are under the age of majority (minors) or who receive special educational services, no demographic or narrative information that might lead to accidental identification will be included in their cases. Informed consent will be obtained from all participants, and they will be made aware of their right to withdraw at any time without consequences. This ensures transparency and respects participant autonomy throughout the research process.

For data security, all audio files used for interviews will be stored on a password-protected, encrypted computer connected to an external hard drive that is available only to the principal investigator. After the transcription and verification of the audio data are complete, the files will be deleted immediately. Backup copies of anonymized data will also be kept on another password-protected, encrypted external hard drive that will be stored in a locked cabinet. Hard copies of the signed consent forms as well as any printed data must be stored without exception in a locked file cabinet located in a secure office area. Personal cloud services or unencrypted devices will not be used to store any data.

Full approval from Slippery Rock University's IRB will be obtained from all adult participants. Informed consent forms will be signed by all adult participants. Information presented during the consent process will clarify that participation is voluntary, that participants may withdraw at any time without penalty (e.g., by saying "please stop" or refusing to answer), and the purpose and scope of the study. Research activities will be carried out strictly in accordance with procedures approved by the IRB, for instance, including limits to confidentiality and mandated reporting requirements if participants divulge harm to self or others.

CHAPTER 4: RESULTS

This chapter presents findings from a qualitative multiple-case study examining school reintegration following discharge from a PRTF. The purpose of the study is to examine how participation in a 90-day PRTF influences student reintegration as measured through school attendance, and to identify the emotional, behavioral, and systemic factors associated with more stable or disrupted transitions. The findings are intended to inform educators, school leaders, and mental health providers working to strengthen post-discharge stability and engagement for students returning from intensive psychiatric treatment, regardless of special education eligibility.

Qualitative data were gathered from six student cases, each representing a different reintegration trajectory. Key data sources included parent or guardian interviews, data from school records (attendance data, IEP documentation when applicable, and transition notes), and educational and clinical notes. Analysis of cases revealed patterns related to student readiness for reentry, emotional and behavioral functioning, school-based supports, family engagement, and attendance. In line with the conceptual framing of this study, attendance is both a descriptive outcome and an early indicator of emotional readiness.

Findings are separated into three sections: (1) individual case studies, (2) cross-case analysis, and (3) thematic synthesis. First, case-level findings are summarized for each student one at a time, paying consistent attention to attendance patterns, readiness indicators, reentry supports, and perceptions of parents. Second, the cross-case analysis aggregates patterns across cases and finds five themes explaining why reintegration stabilized some students and deteriorated for others within the first 30–60 days post-discharge. Third, results are briefly linked

to the study's conceptual framework Transition Theory (Schlossberg, 2011) and Ecological Systems Theory (Bronfenbrenner, 1979) to help situate student experiences within wider systems of support and preview findings to be developed next in Chapter 5.

The following section describes how data were analyzed to generate both case-level and cross-case findings.

Within-Case and Cross-Case Qualitative Analysis

Data were analyzed by using both within-case and cross-case qualitative analysis. Each case was examined using structured coding related to attendance, readiness, supports, and parent perceptions. The patterns were then compared across cases using cross-case synthesis to identify common themes explaining reintegration stability and instability. Attendance data were assessed descriptively and analytically as indicators of emotional readiness and system alignment during reintegration. Following within-case analysis, cross-case synthesis was conducted to identify recurring patterns and themes. Attendance data were analyzed descriptively and interpreted analytically as indicators of reintegration stability and system alignment. This approach allowed for examination not only of what occurred across cases, but also why reintegration stabilized for some students and deteriorated for others.

Multiple-Case Study Summaries

Case Study #1 (IEP: Specific Learning Disability). Student #1 is a 14-year-old boy in 9th grade who has an Individualized Education Plan (IEP) for a Specific Learning Disability and was re-enrolled to his home public school after being discharged from the PRTF. The student, at home living with his mother and siblings, was admitted to the PRTF for aggression and conflict at home. He stepped down to the PRTF from a recent inpatient admission. He has had eight inpatient admissions since age 12 related to aggression.

Regarding home school district placement, he had a supplemental level of learning support prior to admission. His early reintegration displayed brief engagement followed by rapid destabilization. He went to school for about two weeks and then started to refuse to go, missing an entire month of instruction. His parent credited this to overwhelming anxiety and emotional overwhelm stating he was, “OK for about two weeks and then missed a whole month and ended up inpatient again.” In this instance, the decline in attendance was associated with poor emotional readiness and precipitated an inpatient stay within the first 30–60 days.

For reentry supports, the student had access to a resource room; however, the parent described the overall transition as insufficiently planned and poorly aligned to his readiness needs. She said the student “didn’t feel supported because he didn’t feel ready to be discharged (from the PRTF),” and said the school appeared unprepared for his return and unclear about his academic functioning. “They weren’t prepared for him to go back to school and weren’t sure what level he was school-wise,” she said. The primary barrier was identified as academic-based.

He was “feeling overwhelmed with the amount of work he had to do,” and she questioned whether this reflected curriculum mismatch or reduced capacity due to emotional strain. Her description stressed that he was “working through trauma and wasn’t ready to be discharged,” mentioning that “it took him a long time to open up and make progress (at the PRTF) and then was sent home.”

After his mid-spring discharge, the student received family-based services, which the student’s mother said were beneficial because providers “checked on his progress.” While those services ended in August, trauma-focused therapy began just prior to the opening of the new school year. He also received medication management. By mid-fall, the student had entered a

partial placement program and was continuing trauma-focused therapy at the time of data collection.

Parent perceptions illustrated a marked dissatisfaction with how the school handled the transition, particularly in terms of consideration of emotional readiness and grief-related needs. She said schools should implement stronger mental health support systems for students who have transitioned away from PRTF settings, especially those dealing with the loss of a parent saying, "He needed more time to deal with the loss and grieving of losing a parent and not punish the kids/parents." The post-discharge time was "very stressful," and she felt the need to send him to school, because of attendance standards she had to follow. "Because of so many days of school absences, I felt compelled to send him to school," his mother said. Another aspect of the instructional intervention was the focus on a cyber platform while at the PRTF which, she also indicated, was inappropriate due to his auditory processing needs on his IEP. "The cyber platform didn't work," she said. In a broader tone that frustrated her, she identified one support at a school that was particularly helpful stating, "The school social worker really helped a lot."

From the PRTF, the educational transition summary of the student included the following: OVR completed application; a weekly Google Meet meeting with his home school district representative (learning support teacher and guidance counselor), the student and PRTF education coordinator; educational report including his grade report, returning daily schedule, behavior report, and progress monitoring for IEP goals.

Through an analytical lens, Student #1 is a clear example of (a) limited proactive transition planning, (b) attendance as an early indicator of reintegration deterioration, (c) low emotional readiness and anxiety as the principal barrier for student #1, and (d) negative perception among his parent is indicative of misalignment and reactive system response.

Case Study #2 (IEP: Emotional Disturbance; Secondary: Autism). Student #2 is a 16-year-old 10th-grade girl who was discharged from the PRTF with a primary disability of Emotional Disturbance and secondary diagnosis of autism spectrum disorder; she returned to a full-time emotional support program in a specialized alternative education school. Before admission, she received full-time emotional support.

Since her 90-day discharge was after the school year ended, the transition occurred over summer break (therefore allowing for planning and gradual adjustment) from early July through the summer. Outpatient services established include outpatient therapy and medication management through telehealth. In early August, the student, parent, and school team met for a reenrollment meeting to review supports and create expectations. Her mom called it an effective process and one that the school "did a great job by holding a reenrollment meeting in person where (the student) and I could meet the building people and see the staff and schedule." The mother stressed excellent communication, saying she was "kept in the loop and never wondered what was going on." She said the student had "no indications of anxiety" and she had no school refusal or behavioral disruption at school when she returned.

Reentry supports were also tiered and structured to include a life-skills resource room, a CARES (Crisis, Assessment, Response, and Evaluation Services) behavior plan, integrated behavioral health services that included a licensed school therapist, behavioral therapist, and community coordinator as well as the provision of ongoing family-based therapy. Prior to the start of the school year, a revised IEP was developed with input from both student and parent. While the transition meant adjusting to "a different structure and routine," attendance was steady and engagement high. Other supports including peer mentoring, engagement in a music outreach

program, a point-based incentive system with off-campus privileges, and a team-oriented school culture enforced stability and helped sustain participation.

A significant clinical history led to the admission of the student to the PRTF, including six previous inpatient hospitalizations in three years associated with suicidal ideation, exposure to traumatic events, and impaired impulse-control. Despite this complexity, her discharge was marked by stable academic functioning and school participation. As of review, the records of preadmission school included three excused absences, five unexcused absences, and no tardies, as well as a 80%–97% grade span. During the discharge process from the PRTF, the grades stayed consistent (93%–96%), which illustrates the positive impact of structured routines and supports. She did not meet the criteria for Extended School Year services. The student was connected to the Office of Vocational Rehabilitation (OVR) during PRTF placement. Family engagement was a protective factor, with continued participation in family-based services and the pursuit of outpatient and school supports.

Student #2 is an example of a stable reintegration trajectory, with proactive transition planning, strong school–family communication, and a coherent, joined-up ecosystem of therapeutic and behavioral supports. As the parent described it, the student felt “very supported returning to school.” On the other hand, her clinical history and dual disability profile point toward a continued vulnerability and reiterate continuity of support even though early reintegration was stable. From the PRTF point of view, in anticipation for discharge, the student was provided with an education summary including her academic progress, OVR completed application, behavior report, and progress monitoring for her IEP goals. The student, the parent, and school received the same cohesive information from the PRTF education coordinator. The

student and PRTF education coordinator also met via Google Meet with the home school district representative once a week for the month before discharge.

Student #2 demonstrates (a) a strong proactive plan for transition, (b) steady attendance as a marker of readiness and system alignment, (c) emotional regulation facilitated by layers of services, (d) embedded therapeutic and behavioral supports, and (e) high parent satisfaction resulting from clarity in communications.

Case Study #3 (General Education at Admission; Evaluated During treatment; IEP: Emotional Disturbance). Student #3 is a 6th grade, 12-year-old student who returned to her public school from being discharged from the PRTF. Her discharge came at the very beginning of summer break. When admitted, she was a general education student who was assessed during her PRTF placement and qualified for special education services, under the primary disability category of Emotional Disturbance, which shows ongoing social-emotional and behavioral needs. She came to the PRTF with substantial instability, including placement in a group home through Child and Youth Services (CYS) and three inpatient psychiatric hospitalizations within the previous year, notably immediately before the PRTF admission. Her relationship with her mother is very volatile. Cognitive evaluation of the subject demonstrated a Full-Scale IQ of 81. She did not have a Behavior Intervention Plan and did not qualify for Extended School Year services; however, she was scheduled to receive itinerant emotional support upon her return. The placement with the PRTF, however, was a good chance for stability, as she began to function academically (87% to 95%), which could make effective use of structural and therapeutic help.

Variability was also affected by family context. The student received coordinated services including outpatient therapy, Intensive Behavioral Health Services (IBHS), case management, and family-based services. Guardianship was shared between grandmother and

mother, with caregivers reporting greater emotional stability in the grandmother's home. The guardian observed that "most conflicts occur when she is at her mother's home," indicating that environmental instability contributed to dysregulation.

The student was discharged during the summer and returned to the public school in the fall; there she showed an initial ability to adjust. When discharged, the student, school, and guardian received a grade and behavior report as well as progress monitoring of IEP goals. Her guardian documented no school refusal or anxiety and said transition planning had been well-planned. A multidisciplinary team meeting preceded reentry, and the guardian explained that the school "had it all ready" for her return. Supports included access to a resource room, counseling services, and coordination with an outside agency to support both the student and family. The guardian reported high satisfaction, noting the student felt "very supported" and rating the transition "5 out of 5," with school communication/support also rated "5."

Prior to her most recent admission, her academic engagement and attendance varied along with her emotional functioning. At the start of the school year, she earned a majority of A and B grades, suggesting periods of sustained involvement when she was well. As the emotional challenges intensified, grades dropped quickly, falling from 33 percent to 100 percent in physical education and 33 percent to 75 percent in core subjects. Her guardian (maternal grandmother) stated that "her grades fell when things started getting tough once more emotionally," suggesting the need for emotional regulation which leads to academic engagement. Student attendance reported the same instability, including 21.5 absences throughout the school year, and approximately 40 days of homebound instruction due to mental health needs. The guardian described this period as a time in which "she just could not manage being in school every day."

Even with rigorous preparations and early engagement, peer-induced stressors quickly undermined reintegration. Bullying was, from the guardian's perspective, the most significant hindrance to participation; she said that "she never had a problem going to school." Peer conflict led to emotional distress and disengagement. The guardian said she felt the PRTF foundation was strong. "The PRTF did great and all was done, and I just had to show up" for the transition meeting, yet peer conflict disrupted progress quickly. "It was unfortunate because all was in line, but it didn't take long before the student had a meltdown," said the guardian.

After starting back to school in brick and mortar, in mid-October the student was re-admitted to an inpatient facility and then a Residential Treatment Facility (RTF). Analytically, Student #3 reflects a vulnerable reintegration trajectory in which strong planning and coordinated supports were not sufficient to offset the destabilizing impact of peer conflict combined with ongoing emotional vulnerability and family stressors. As the guardian summarized, "she does best when things are structured and calm," showing the importance of sustained emotional support, stable environments, and coordinated school mental health collaboration for long-term reintegration.

Student #3 demonstrates (a) strong transition planning with early stability, (b) attendance and engagement vulnerability emerging after initial return, (c) readiness as dynamic and context-dependent, and (d) peer environment as a destabilizing factor that can overwhelm otherwise coordinated supports.

Case Study #4 (IEP: Emotional Disturbance). Student #4 is a 16-year-old male 10th-grade student with an IEP, who transferred to another public high school after being discharged from the PRTF stemming from a change in guardianship. He was admitted due to aggression and conflict in the home. He was admitted to the PRTF from a recent inpatient admission. At the

PRTF, he received admitting diagnoses of autism spectrum disorder and ADHD, and his IEP identifies Emotional Disturbance as his primary disability category. A Full-Scale IQ of 76 was measured cognitively. The student is provided with itinerant emotional support and learning support services according to his combined academic and social–emotional needs. A school staff member stressed that predictability is essential, saying, “he needs consistent emotional and academic structure to stay regulated and engaged.”

The student presented unstable attendance and emotional functioning before admission. He accumulated 28 absences between the beginning of this school year to his early December PRTF admission, including 11 unexcused absences; the remainder were medically excused, including time associated with an acute inpatient hospitalization. His parent explained that “his attendance (preadmission) really started slipping when his behaviors and emotions became harder to manage,” reflecting the relationship between emotional dysregulation and school participation.

During the PRTF placement, transition planning included future-oriented supports. The student was connected to OVR through the completion of a Pre-Employment Transition Services request. Upon discharge, the PRTF education coordinator provided documentation intended to support continuity and school reentry. The education coordinator described, “everything was prepared ahead of time so the home district would know exactly what supports and information were needed.” Discharge materials included the OVR Early Reach permission slip, a cyber progress report, a school calendar structured to differentiate medication schedules for school and non-school days, trade school information, a nursing plan, and educational documentation (grades, attendance, behavior reports, and IEP goal progress monitoring).

Prior to the PRTF admission, the student lived with his biological father and brother and then one and a half years ago, he was moved to his biological mother and stepfather and younger half-siblings. After being discharged, he returned to his biological father.

When discharged, community-based services include Family-Based Mental Health case management, individual therapy, and medication management. “Services continuing after discharge helped keep things more stable at home and with school,” mentioned the parent, emphasizing continuity of care.

At school, the student received IEP accommodations, mentoring, tutoring, and guidance counselor support when moving toward higher participation in general education. Attendance improved post-discharge; however, motivational issues persist (e.g., lack of engagement, independence, and motivation). Medication-associated sleep disturbance also disrupted alertness and functioning. Inadequate communication between school and family was reported to have resulted in inconsistent communication, and staff observations of behavior which displayed increasing defiance and a demand for clearer expectations and consistent support. As the parent put it, “he responds best when expectations are clear and supports are consistent.”

Student #4 represents a reintegration trajectory shaped by pre-admission instability, complex diagnostic presentation, and ongoing functional needs that require sustained academic, behavioral, and transition-focused supports. While discharge planning and vocational linkage were strengths, continued vulnerability was evident in engagement challenges and communication gaps, underscoring the importance of consistent implementation and aligned expectations to support long-term stability.

Student #4 demonstrates (a) attendance instability linked to emotional dysregulation pre-admission, (b) the stabilizing role of structured supports post-discharge, and (c) the role of communication consistency in sustaining reintegration gains.

Case Study #5 (General Education at Admission; Evaluated During treatment; IEP: Emotional Disturbance). Student #5 is a 14-year-old, 7th-grade female who entered the PRTF as a general education student and was evaluated for special education services during her placement. She qualified for special education services under the primary category of Emotional Disturbance. Cognitive assessment indicated a Full-Scale IQ of 107, reflecting average intellectual functioning. She has a Behavior Intervention Plan and did not qualify for ESY. The student's clinical profile is complex.

Prior to admission, the student lived with her father, grandmother, and younger sister; her mother was displaced. Both her mother and father were legal guardians. The father noted that "she tends to do better when things are calm and predictable at home," suggesting environmental stability as a contributing factor in regulation.

Home district documentation listed diagnoses of Major Depressive Disorder, Generalized Anxiety Disorder, Autism Spectrum Disorder, and ADHD. Her PRTF admission followed an extensive mental health history that included six prior inpatient psychiatric hospitalizations and ongoing self-injurious behavior. During the PRTF placement, records documented repeated aggression toward peers and staff and incidents of property destruction. A staff member explained that "there were frequent times when she became overwhelmed and responded with aggression," and an incident report was completed following aggressive behavior toward a classroom teacher, reflecting persistent dysregulation even in a structured setting.

Behavioral instability was met with academic progress. At discharge, the PRTF provided transition materials intended to support continuity, including the OVR Early Reach permission form, behavior grading reports, academic progress documentation, and IEP goal progress monitoring. The education coordinator said, “The goal was to make sure her home school had everything needed so supports could continue without interruption,” demonstrating an explicit plan to help coordinate discharge.

Post-discharge, Student #5 returned to an Intermediate Unit (IU) school setting. During the early phase of reintegration, she demonstrated strong motivation for learning and consistent attendance, with no reported school refusal or anxiety. Her mother stated she was “fine with it and happy to return,” and the family described the transition as smooth. School supports included a resource room, a behavioral point system with incentives, and therapeutic services. The mother perceived supports positively, stating the school “did all they could for her reentry and provided anything needed,” and the mother rated school support 5 out of 5, indicating the student felt supported.

Nonetheless, while attendance was stable, behavioral instability intensified over weeks. The student began to show more signs of dysregulation including violent tendencies towards staff, leaving the school building without permission, and exhibiting unsafe impulsive behaviors. The parent stressed that attendance was not the main issue, declaring that the student “loved school and her schoolwork” but significant behavioral dysregulation was preventing stability. A dramatic behavioral incident was a turning point: after an argument over an additional prize from the reward prize box, the student fled the building, was apprehended by police and spat at an officer. She was removed from the education program and committed to a youth detention

center, where a judge ordered a 90-day psychological/behavioral evaluation. Later, she returned to court due to ongoing concerns and was evaluated at a state hospital.

On the other hand, parent perceptions were mixed, with the mother observing that communication had been with the father. The parent suggested better transferability of academic credits between placements for consistency of education during treatment and transition to reentering society.

From an analytical standpoint, Student #5 presents a case of a reintegration profile with heavy needs, and early attendance stability did not lead to continuity with reintegration stability. Although immediate support and motivation were present, emotional and behavioral regulation remained the main obstacle. In the words of a school staff member, "she is capable academically, but emotional regulation is the biggest challenge." This case highlights that attendance alone may obscure elevated levels of risk when behavioral dysregulation persists and underscores the requirement of ongoing intensive behavioral/therapeutic action and multi-level communication effort across systems.

Student #5 highlights (a) the distinction between attendance stability and reintegration stability, (b) the significant role of regulation and behavioral supports, and (c) the importance of coordinated communication across school, family, and behavioral health systems during escalation.

Case Study #6 (Section 504 Plan at Admission; Evaluated During treatment; IEP: Emotional Disturbance). Student #6 is a 15-year-old, 10th-grade male who transitioned to a therapeutic school placement following discharge from the PRTF rather than returning to his prior public school, where he had presented with selective mutism. He entered the PRTF with a Section 504 Plan and through a parent-signed permission to evaluate during placement qualified for an IEP

under the primary disability category of Emotional Disturbance; he became eligible for itinerant emotional support.

The student also had a multifaceted developmental and clinical history as well as diagnosis, including early autism spectrum disorder and subsequent Oppositional Defiant Disorder, Post-Traumatic Stress Disorder, selective mutism, childhood emotional abuse, and substance-related concerns with a history of cannabis use disorder and alcohol/tobacco use. He had been hospitalized at least three times for psychiatric admissions and outpatient medication management prior to being admitted to PRTF. He attended public school until third grade, was homeschooled for a while, then returned to public school through 10th grade. Immediately prior to his PRTF admission, he became involved in the juvenile justice system following a ten-day suspension for making a bomb threat and possession of a knife, after which he was adjudicated to a juvenile detention center.

The student joined the PRTF in June. Transition planning consisted of OVR Pre-Employment Transition Services, with discharge documentation including a grade and behavior report, to facilitate continuity. The education coordinator stated, “everything was prepared so the next school would understand his needs and supports right away.”

The student presented with stable attendance (missing 0–2 days) and without refusal or anxiety concerning return throughout the pre- and post-discharge period. On discharge, he joined a therapeutic school that did not have a formal transition plan; however, therapeutic and behavioral supports were built in throughout the school day including individual and group counseling; a structured behavior plan; a modified routine with a shortened schedule; access to a quiet space; and school-based psychiatric care. Outpatient therapy was also arranged to support continuity.

The parent felt the reintegration was positive and supportive, finding that he "felt very supported returning to school" and rated the level of support 5 out of 5. She continued, "he adjusted better than we expected once he had the right supports in place." Adjusting overall remained stable; however, medication continuity was a struggle. She noted that "the most difficult part of the transition was getting his medications refilled and maintaining continuity of care" and emphasized the importance of school-based mental health access, "having access to psychiatric care when needed made the biggest difference."

Analytically, Student #6 represents a stable reintegration trajectory characterized by consistent attendance and engagement despite significant clinical and legal complexity. In this case, embedded therapeutic and psychiatric supports functioned as stabilizing mechanisms, compensating for the absence of a formal transition plan, and supporting sustained participation. Student #6 illustrates (a) attendance as a marker of readiness and system alignment, (b) embedded therapeutic supports as protective, and (c) parent perceptions reflecting strong coordination when access to care is responsive.

School-Based Supports for Reentry

Across cases, school-based supports differed in their type, intensity, or setting across the cases, but the most meaningful differences were not focused on what supports were provided, but on when and how consistently supports were implemented during early reintegration. Supports included academic accommodations (such as resource rooms, modified schedules), behavioral supports (point systems and behavior plans), counseling and therapeutic services, and coordinating with community mental health providers. Schools differed most starkly in whether supports were put in place proactively as a part of a structured reentry process or were applied reactively once attendance or behavioral concerns escalated.

Findings suggest that in cases that were proactive (e.g., Students #2 and #3 initially; and Student #6 through embedded therapeutic programming), schools used systematic processes like reenrollment or team meetings and communicated expectations clearly with families. Supports were layered and predictable, giving students a consistent schedule and emotional scaffolding during the first weeks after they returned. One parent emphasized the importance of readiness and predictability through proactive planning. “Everything was already in place before she came back; it didn’t feel rushed or confusing” (Parent, Case 2). This alignment appeared to facilitate emotional regulation and consistent attendance.

In cases deemed delayed, reactive or inconsistently implemented (e.g., Student #1; Student #4 when communication gaps were identified; and Student #5 during escalation), reintegration was perceived as unclear, slow, and increased emotional or behavioral instability by their parents, with such supports being activated after attendance or behavior was already compromised. One mother said, “There really wasn’t a plan; it all felt reactive once he started missing school” (Parent, Case 1). In each of these cases, delayed or inconsistent support created crisis-response cycles, rather than prevention. These findings suggest that the timing and consistency of support implementation function as critical mechanisms in shaping reintegration trajectories.

Together, from a systems perspective, these patterns reflect the importance of mesosystem coordination within Ecological Systems Theory. This suggests school supports were most protective when they were proactively designed, layered, and sustained through early reintegration, particularly the first 2–4 weeks. When there was delayed or inconsistent provision of supports, students were more likely to disengage early, and families and schools were more likely to enter crisis mode, rendering stabilization more challenging.

Parent Perceptions

Parent perceptions of reintegration served as indicators of system coordination and communication across school, family, and treatment contexts as opposed to separate and interlinked reactions to transition. Across the cases, the relationship between parental satisfaction and communication (Parent, Case 2 and 6) between schools, families, and mental health providers was most widely and consistently found to be clear, frequent, and responsive. Parents who perceived themselves to be engaged and informed were more confident in the reintegration process and described transitions as smoother. For instance, one parent emphasized the stabilizing impact of clear communication. “I always knew who to call and what the plan was and that made a big difference” (Parent, Case 6).

Conversely, parents described frustration and uncertainty when communication was inconsistent or delayed and often felt responsible for coordinating systems (Parents Case 1; communication gaps in Parents 4 and 5) One parent said the process was reactive and burdensome. “It felt like everything was happening after the fact, instead of helping him before things fell apart” (Parent, Case 1). These perceptions co-occurred with student disengagement, attendance disruption, or escalation in behavioral and emotional needs.

For parents across cases, perceptions around communication emphasized that it was not only an information tool, but also a stand-in for systems alignment and accountability. When cross-system communication was consistent and proactive, parents perceived reintegration to be more stable and coordinated. When communication was fragmented, families experienced added strain and supports were more likely to be delayed or inconsistently enacted, thereby contributing to reintegration instability. Within Ecological Systems Theory, communication represents a critical mesosystem process linking family school, and treatment environments. When

communication is fragmented, system alignment weakens, increasing risk for destabilization during reintegration.

For cross-case comparison, Tables 2 and 3 summarize the patterns across the six cases. Table 2 discusses the attendance trajectories, readiness indicators, and reentry supports during the early post-discharge period, revealing variation in reintegration stability. Table 2 presents parent perceptions, representative quotes, and interpretive alignment with the study's conceptual frameworks. In a manner consistent with the analytic approach of this study, attendance is interpreted not solely as an outcome measure, but also as an early behavioral indicator of emotional readiness and system coordination during reintegration.

Table 2 summarizes a detailed overview of the attendance patterns, readiness indicators, and reentry supports for each student, which highlights the key themes that emerged in the cross-case analysis.

Table 2

Attendance Patterns, Readiness Indicators, and Reentry Supports Across Cases

Case	Attendance Pattern	Readiness Indicators	Reentry Supports	Outcome
1	Initial attendance followed by extended absence; transitioned to partial placement	Low readiness; anxiety and emotional overwhelm	Resource room; limited proactive planning; partial placement	Attendance instability; transition to alternative placement
2	Consistent attendance	High readiness; emotionally regulated	Reenrollment meeting; CARES plan; therapy and behavioral health coordination; incentive system	Stable reintegration
3	Initially stable, then disrupted due to peer conflict; re-admitted by mid-October	Moderate readiness initially; destabilized by bullying and family stressors	Team meeting; resource room; counseling; outside agency coordination	Reintegration disruption; re-hospitalization

4	High absences pre-admission; improved post-discharge	Variable readiness; medication-related sleep and engagement issues	IEP accommodations; mentoring; tutoring; guidance support; OVR linkage	Improved attendance with ongoing support needs
5	Stable attendance initially; later placement disruption due to behavioral escalation	High motivation initially; persistent difficulty with emotional regulation	IU school program; behavioral incentive system; therapeutic supports; discharge coordination	Reintegration breakdown; placement change
6	Stable attendance (0–2 absences)	Moderate readiness supported by therapeutic environment	Therapeutic school with embedded counseling and psychiatric care; outpatient therapy	Sustained attendance stability

Note. Attendance is interpreted as an early behavioral indicator of emotional readiness and reintegration stability during the first 30–60 days post-discharge.

As shown in Table 2, students with higher levels of emotional readiness and coordinated supports demonstrated more stable attendance patterns, while those with lower readiness or fragmented supports experienced disruptions, including re-hospitalization or placement changes.

Table 2 illustrates that reintegration trajectories varied across cases; however, consistent patterns emerged between attendance, emotional readiness, and system coordination. Students with more emotional readiness and proactive, layered supports were more consistent with students (e.g., Students #2 and #6), with higher levels of attendance and engagement. In contrast, cases characterized by low readiness, delayed supports, or contextual stressors (e.g., Students #1 and #3) demonstrated early vulnerability, often occurring after a brief period of initial stability.

Table 3 presents parent perceptions, representative quotes, and their interpretation through the study's conceptual frameworks.

Table 3

Parent Perceptions, Representative Quotes, and Framework Interpretation

Case	Parent Perceptions	Representative Quote	Interpretation (Framework Alignment)
1	Dissatisfied; perceived reactive supports and lack of preparedness	"There was not a plan; it felt reactive once he started missing school."	Lack of coordination across systems reflects mesosystem misalignment, increasing risk when emotional readiness is not matched to school expectations
2	Very satisfied; strong communication and proactive planning	"I was kept in the loop and never wondered what was going on."	Effective communication and coordination across systems supported alignment, contributing to stable reintegration
3	Satisfied with planning; concerned about peer environment	"Everything was in line, but it did not take long for the student to melt down."	External peer-related stressors within the school microsystem disrupted reintegration despite structured planning
4	Mixed; valued supports but noted communication inconsistencies	"He responds best when expectations are clear and supports are consistent."	Inconsistent communication across systems limited the effectiveness of supports, impacting reintegration stability
5	Mixed; praised supports but noted uneven communication	"She loved school and her schoolwork."	Initial engagement masked underlying emotional regulation challenges, indicating the need for sustained and coordinated supports
6	Positive; emphasized responsiveness and access to care	"Having access to psychiatric care when needed made the biggest difference."	Embedded therapeutic supports within the school microsystem enhanced regulation and contributed to sustained stabilization

Note. Parent perceptions functioned as indicators of system coordination and communication across school, family, and treatment contexts. Framework interpretations draw on Ecological Systems Theory (Bronfenbrenner, 1979) and Transition Theory (Schlossberg, 2011).

As shown in Table 3, parent perceptions closely reflect the level of system alignment experienced during reintegration. Positive perceptions were associated with proactive communication and coordinated supports, while dissatisfaction often reflected fragmented systems and mismatches between student readiness and school expectations.

The findings further indicate that the timing and consistency of supports were as influential as the type of supports provided. Stable trajectories through early intervention were

seen in proactive supports deployed before or immediately after reentry, whereas reactive or inconsistent supports were correlated with attendance drop-off, behavioral escalation, or placement disruption. Across cases, attendance did serve as an early behavioral indicator of alignment with reintegration, particularly within 30–60 days of discharge.

Cross-Case Analysis

Themes were derived through coding, pattern comparison, and cross-case synthesis to ensure analytic consistency across cases. Although case summaries outline reintegration trajectories of each individual, cross-case analysis points to trends between students, contexts, and supports. Five themes were identified across all six cases that illustrate how student readiness and anxiety, school-based practices, and cross-system coordination impacted reintegration after discharge from a PRTF. These themes clarify not only what occurred across cases, but why reintegration stabilized some students and deteriorated for others during the first 30–60 days post-discharge.

Together, descriptive and cross-case findings revealed five interconnected processes shaping reintegration during the first 30-60 days. These findings suggest that reintegration stability is not determined by a single factor, but by the alignment of multiple systems operating during a critical transition process.

Theme 1: Transition Planning

Analytic definition. Transition planning is the extent to which reentry supports were provisioned proactively (before return or immediately upon return), rather than on an emergent basis (attendance or behavioral issues). This concern encapsulates the conflict between the proactive transition structure and the crisis-driven response.

Evidence across cases. Structured planning was observed in cases (i.e., Students #2 and #3 initially) in that they were re-enrolled or had team meetings, had advance clarification of supports, and active communication with families. One parent explained the advantage of being prepared, stating, “Everything was already in place before she came back; it didn’t feel rushed or confusing” (Parent, Case 2). Student #1, on the other hand, was described as returning without meaningful readiness planning, with supports seen as reactive, stating, “There really wasn’t a plan; it all felt reactive once he started missing school” (Parent, Case 1). Although formal transition planning was limited for Student #6, embedded therapeutic programming functioned as an immediate support structure, partially compensating for the absence of a formalized reentry plan.

Why it matters. Transition planning helps avoid uncertainty and foster early alignment among adults supporting the student. When planning is scarce or delayed, schools and families often fall into crisis-response cycles after disengagement starts, decreasing the likelihood of achieving stabilization in the most vulnerable early weeks.

Taken together, this theme suggests that transition planning functions as a critical factor in reintegration stability. Within Ecological Systems Theory, this reflects the importance of system alignment across contexts. Additionally, from the perspective of Transition Theory, this finding highlights how timing, readiness, and support availability shape adjustment during transition.

Theme 2: Attendance as an Indicator

Analytic definition. Across the six cases, attendance served as an observable measure of reintegration stability and emotional functioning At school, these attendance patterns mirrored the fit between student coping capacity and school demands, as well as whether supports were timely enough to prevent avoidance and disengagement.

Evidence across cases. Stable attendance was most notable when readiness and supports were aligned (Students #2 and #6). Instability in attendance was associated with anxiety, contextual stressors, or delayed supports (Students #1 and #3); and, in a different case, Student #5, who had stable attendance but behavioral escalation. Importantly, attendance declines generally occurred after an initial adjustment period (e.g., Student #1's two-week return; Student #3's initial stability followed by bullying-related decline in attendance).

Why it matters. Attendance was an early warning sign of destabilization. Monitoring attendance closely during the first month can help schools and families identify emerging misalignment between readiness and supports before academic failure or rehospitalization occurs.

Taken together, this theme suggests that attendance as an indicator functions as a critical factor in reintegration stability. Within the Ecological Systems Theory, this reflects the importance of system alignment across contexts. Additionally, from the perspective of Transition Theory, this finding highlights how timing, readiness, and support availability shape adjustment during transition.

Theme 3: Readiness and Emotional Regulation

Analytic definition. Readiness is a student's ability to re-enter school routines and demands, including emotional regulation, coping ability, anxiety tolerance, and confidence in managing academic and social expectations. Readiness mediated the association between supports and outcomes: supports were less effective when readiness was low, and even moderate supports could be sufficient when readiness was stronger.

Evidence across cases. These student profiles (Students #2 and #6) were linked to consistent attendance and engagement. In Student #1, readiness was consistently reported to be low on account of grief, trauma, and overwhelm ("he was working through trauma and wasn't ready to

be discharged"). Student #3 demonstrates readiness as dynamic as initial adjustment was stable; readiness rapidly deteriorated as bullying and family stress escalated. Student #5 exhibited high involvement and motivation, but steady regulation difficulty compromised stability in these behaviors.

Why it matters. Reintegration is not solely academic access; it requires emotional readiness. If readiness is underestimated or taken as fixed, reintegration plans may emphasize classroom placement without adequate regulation supports, increasing the risk of avoidance, behavioral escalation, and rehospitalization.

Taken together, this theme suggests that readiness and emotional regulation functions as a critical factor in reintegration stability. Within the Ecological Systems Theory, this reflects the importance of system alignment across contexts. Additionally, from the perspective of Transition Theory, this finding highlights how timing, readiness, and support availability shape adjustment during transition.

Theme 4: Therapeutic and Behavioral Supports

Analytic definition. Therapeutic and behavioral supports are strategies to scaffold regulation and engagement (such as access to counseling, behavior plans, reinforcement systems, predictable routines, and embedded mental health supports). These supports were most protective when systematic, reliable, and coordinated across settings.

Evidence across cases. With the application of layered supports (Students #2 and #6), reintegration was more stable. Student #6 shows how embedded therapeutic programming can stabilize engagement without a formal transition plan. In contrast, Student #5 suggests that as behavioral dysregulation escalates, typical school supports may be insufficient without sustained

intensive intervention and cross-system coordination. Student #4 staff emphasized that success depended on consistent expectations and support.

Why it matters. Therapeutic and behavioral supports help to reduce unpredictability and support gradual re-engagement. Inconsistent implementation can compound anxiety and dysregulation during an already vulnerable adjustment period, increasing the likelihood of crisis escalation.

Taken together, this theme suggests that therapeutic and behavioral supports functions as a critical factor in reintegration stability. Within Ecological Systems Theory, this reflects the importance of system alignment across contexts. Additionally, from the perspective of Transition Theory, this finding highlights how timing, readiness, and support availability shape adjustment during transition.

Theme 5: Parent Perceptions of Communication

Analytic definition. Parent perceptions expressed systems working and mesosystem congruence such as clarity of roles, follow-through, and coordination between the family, school, and mental health providers. Trust in parents was a measure of cohesive or fragmented systems.

Evidence across cases. Parents who described a robust form of communication reported more successful reintegration and increased confidence (Students #2 and #6). One parent has said, “I always knew who to call and what the plan was and that made a big difference” (Parent, Case 6). In contrast, inconsistent or reactive communication (Student #1; and communication gaps in Student #4 and Student #5) meant parents were confused and stressed, feeling the responsibility of coordinating systems themselves.

Why it matters. Reintegration requires adult alignment. Students experience predictability and less stress at school where families, schools, and providers regularly communicate with each other. In fragmented communication, families may be the dominant coordinators increasing

burden and slowing down meaningful intervention. Collectively, these cross-case findings suggest that reintegration stability was not determined by any single factor, but by the alignment of student readiness, structured supports, and coordinated system response during the early weeks following discharge.

Taken together, this theme suggests that parent perceptions of communication functions as a critical factor in reintegration stability. Within the Ecological Systems Theory, this reflects the importance of system alignment across contexts. Additionally, from the perspective of Transition Theory, this finding highlights how timing, readiness, and support availability shape adjustment during transition.

Summary

This chapter presented findings of a qualitative multiple-case design study of school reintegration post-discharge from the PRTF. Across six cases, reintegration stability during the first 30–60 days following discharge was influenced by students' emotional readiness, the presence of structured transition planning, the availability and consistency of therapeutic and behavioral supports, and coordinated communication among schools, families, and mental health providers.

Attendance functioned as an early behavioral indicator of system alignment and student readiness, with declines often signaling emerging mismatch between student needs and the timing or consistency of supports. Importantly, attendance alone did not fully capture reintegration stability, as some cases demonstrated behavioral or emotional escalation despite consistent attendance.

Cross-case analysis identified five overarching themes: transition planning, attendance as an indicator, readiness and emotional regulation, therapeutic and behavioral supports, and parent

perceptions of communication. These all accounted for why reintegration both stabilized for some students and declined in others. Case-wise, trends indicate that the most stable reintegration was when supportive structures were set in place, layered, and maintained throughout the initial weeks of return and when adults across systems had defined roles, follow-through, and communication. Instability was more likely to occur when readiness was fragile, supports were delayed or inconsistently implemented, and peer or family stressors were amplified. This misalignment led to disengagement, behavioral escalation, and in some cases rehospitalization.

Chapter 5 develops these findings through the lens of the study's conceptual frameworks, and by providing an interpretation of implications for educational practice, PRTF programming, family engagement, policy development, and further research.

CHAPTER 5: DISCUSSION, IMPLICATIONS, AND CONCLUSIONS

This chapter explains the findings presented in Chapter 4 within the context of existing literature and the study's guiding conceptual frameworks. Specifically, this chapter examines students' reintegration into public school following a 90-day placement in a PRTF with attention to attendance, engagement, emotional readiness, anxiety, school-based supports, and family involvement. The findings indicate that a multi-system collaboration and trauma-informed practices function as essential conditions for successful reintegration, rather than supplementary supports. Reintegration is not a single event after discharge, but a time-sensitive, system-dependent process. The results emphasize the interrelationship among mental health functioning, social-emotional learning, and academic engagement, supporting the premise that reintegration is a dynamic, systemic process rather than an isolated post-discharge event.

This qualitative multiple-case study examined the influence of emotional readiness, structured transition planning, school-based supports, family engagement, and cross-system coordination on post-discharge attendance and engagement. Attendance was conceptualized as an indicator of emotional stability, systemic alignment, and preparedness for reintegration. In addition, this study analyzed the extent to which school policies, individualized education plans, and community resources interact with therapeutic interventions for successful reintegration. The chapter begins with a summary of findings, followed by alignment with the research questions and interpretation through broader theoretical perspectives. Then, the study combines the findings with evidence from case studies, presents implications for schools, PRTFs, families, and policy, describes its limitations, and shares its contributions.

This chapter also examines the conditions that explain reintegration success or failure under a multi-system framework and moves beyond purely descriptive summaries to provide interpretive analysis. Specifically, it examines how emotional readiness, transition planning, and system coordination interact during the first 30-60 days following discharge; a period identified in this study as a critical window for reintegration stability. This chapter includes a summary of findings, alignment with research questions, interpretation through conceptual frameworks, implications for practice and policy, limitations, and conclusions.

Summary of Findings

Findings indicate that students' reintegration experiences were diverse but consistently shaped by three conditions: emotional readiness, well-structured transition planning, and collaboration across multiple systems. Attendance functioned as an early behavioral indicator of reintegration stability, capturing both students' emotional functioning and the alignment of systemic supports. Students who returned to school prior to emotional stabilization were more likely to exhibit school refusal, disengagement, or require rehospitalization.

The results support the literature in noting that emotional regulation and anxiety management are key in maintaining engagement in school over time (Marraccini & Pittleman, 2021). As highlighted here, reintegration is an active, dynamic, systemic process shaped by individual readiness and coordinated supports, rather than a post-discharge experience. However, failure of cross-system communication can result in breakdowns where receiving schools are unaware of ongoing emotional vulnerabilities. This finding reveals a critical gap in current reintegration planning, implying that interventions cannot rely on assumed readiness or generalized discharge criteria. Students who returned to school prior to achieving sufficient emotional stabilization were more likely to demonstrate school refusal, disengagement, and

rehospitalization. In contrast, students whose return was supported by structured transition planning and coordination supports demonstrated more stable attendance and engagement. Five interconnected themes were identified through cross-case analysis:

- Emotional readiness
- Vulnerability during the first 30–60 days post-discharge
- Structured transition planning
- Communication and cross-system coordination
- Family involvement

These findings suggest that reintegration outcomes are most strongly influenced within the 30-60 days following discharge. The reintegration outcomes are not primarily determined by characteristics alone, but by the degree to which systems align during a critical transition period. During this period, attendance instability, emotional regression, and system misalignment were among the rapidly apparent issues, highlighting that the time of support, not simply its presence, is critical to reintegration success. Early alignment of student readiness and systemic supports is essential for reintegration stability. Attendance served as a sensitive behavioral indicator of these factors. Students who returned prior to achieving emotional stabilization were more likely to experience school refusal, disengagement, or rehospitalization, confirming prior literature linking emotional regulation and anxiety management to consistent school engagement (Marraccini & Pittleman, 2021).

Active collaboration among schools, families, and treatment teams supported parents' confidence and student participation, which follows the ecological view that student development occurs through interactions between the microsystems and mesosystems

(Bronfenbrenner, 1979). The school climate, peer relationships, and access to mental health resources also impacted students' resilience and successful reintegration.

Together, these results make an important contribution to the existing literature by demonstrating that attendance functions as a real-time indicator of this alignment, providing educators and practitioners with a mechanism for early identification of reintegration instability. This changes reintegration from a discrete event to a time-sensitive, system-dependent process, where an early alignment between emotional readiness and coordinated supports dictates the path of reintegration. This research provides evidence that attendance functions not merely as an outcome, but as an early behavioral signal of system coherence or breakdown, offering practitioners a measurable indicator for timely intervention.

The first 30–60 days after discharge is identified through this study as a defining condition of reintegration success, and it is then identified as a key phase during which coordinated, intensive, and proactive intervention across school, family, and treatment systems is needed.

These findings indicate that reintegration failure is not primarily a student-level issue, but an issue of timing and coordination between system-level supports.

Findings Aligned with Research Questions

Research Question 1

What were students' experiences with school reintegration post-discharge from a PRTF?

School reintegration emerged as an ongoing emotionally complex process shaped by both student-level readiness and the responsiveness at a systemic level. Students were not simply returning to school; they were reentering academic, social, and emotional demands that required coordinated support.

Across cases, students who returned without emotional stabilization demonstrated school refusal, academic disengagement, and, in some instances, rehospitalization. In contrast, students with aligned support and readiness showed more stable attendance and participation. These differing trajectories were not explained by prior severity of needs, but the degree of alignment between emotional readiness and environmental supports at the time of return.

Case Evidence and Analysis:

Student #1: Returned with anxiety, consistent parent involvement, and a structured plan for reentry into school. Resisted some classes initially but eventually returned to full attendance. This case illustrates how the interaction of emotional readiness and microsystem supports (family and school staff) fosters positive reintegration trajectories.

Student #2: Returned before stabilization and dealt with fragmented communication with school and PRTF. A breakdown in emotional readiness was shown to correlate with both rapid disengagement and partial rehospitalization; when alignment is not achieved, students are at increased risk of disengagement and instability. This occurs when systemic context fails to align with their emotional well-being.

Student #5: Used peer support and family check-ins to move smoothly through classroom routines. In this case, the mesosystem is the mediator, and Bronfenbrenner's (1979) ecological principle is that when the environment is varied, developmental consequences can be altered.

Interpretation: These findings indicate that reintegration extends beyond discharge plan. Rather, reintegration is a dynamic interaction between student readiness and system supports. Early experiences serve as a pathway towards further engagement and stability. These patterns suggest that school reintegration after PRTF discharge is best understood as a negotiated adjustment process. Students were not simply reentering classrooms; they were reentering a set

of academic, emotional, and social demands that required coordinated scaffolding. The critical factor was not whether students returned to school, but whether the systems surrounding them were prepared to support that return. The findings complement the literature by indicating how reintegration is determined by how well systems surrounding the student translate discharge into functional school reentry; that matters because it shifts the focus from how students return to school toward how systems enable successful reintegration. There was no uniform experience of reintegration because support structures were not aligned. These patterns reflect variation in mesosystem functioning, where the strength of connections between school, family, and treatment systems shaped reintegration outcomes. Where these connections were aligned, reintegration stabilized; where they were fragmented, instability emerged early.

Research Question 2

What conditions influence attendance and engagement after discharge?

Attendance and engagement were influenced by emotional readiness and timing of support implementation. Other key factors included the quality of transition planning, clarity of expectations, and access to coordinated intervention during the early reentry. In this study, attendance functioned as an early observable sign of reintegration stability, reflecting the interaction between emotional functioning and system effectiveness. OBJ

Across cases, attendance did not function solely as a measure of compliance or participation but reflected the interaction between emotional functioning and the effectiveness of support structures. When supports were aligned with student needs, attendance tended to remain more stable. When supports were delayed, insufficient, or were poorly coordinated, attendance frequently became unstable before other signs of failure were formally recognized.

Case Evidence and Analysis:

Student #3: Attended class regularly, few absences, graduated reentry process, aligning therapies and active parent engagement. This illustrates the importance of planned transition and appropriate coordination to help in the stabilization of reintegration.

Student #4: Missed a few days in the first two weeks as initial school's expectations were not aligned with the therapy plan. Attendance was better following coordinated modifications, a manifestation of how patterns of early attendance are sensitive to alignments across systems.

Student #6: At first, missing school often because of absence of peers that supported him and unclear instruction. Placement in an emotional support classroom and discussion with school staff demonstrated the incremental reintegration as demonstrated by the role that the microsystem (students and staff) and mesosystem coordination played in the support needed for engagement.

Interpretation:

There are two ways this finding adds to the literature. First, this finding reinforces the existing literature demonstrating the role that emotional regulation and anxiety management in sustained school participation. Second, it shows that attendance is especially helpful because it reveals when emotional and systemic conditions are no longer aligned. This means we should not consider only attendance as a backward-looking outcome measure but prompting deeper examination of readiness, support adequacy, and system coordination. Because attendance often declines shortly after discharge, the question is not merely "Why is this student absent?" but rather, "Which part of the reintegration system is failing?" This reframing displaces the responsibility from student deficit to systemic responsiveness.

Research Question 3

To what extent do school-based supports and multi-system coordination impact reintegration outcomes?

Findings indicate that school-based supports and multi-system coordination had a direct and substantial impact on reintegration outcomes. Cross-system collaboration was not an added benefit or a best-practice enhancement; it functioned as a structural condition supporting reintegration stability. Where communication among schools, families, PRTFs, and related providers was active and consistent, students demonstrated more stable attendance, fewer disruptions, and more coherent support. Where that communication was limited, delayed, or fragmented, instability often followed even when individual supports were in place.

Case Evidence and Analysis:

Student #1: IEP accommodations were coherent with interventions, supported in weekly school-PRTF check-ins. Result: attendance was maintained with no school refusal demonstrating that mesosystem integration applies trauma-informed care principles.

Student #2: PRTF/receiving school communication was limited, which resulted in disconnection at an early stage and partial rehospitalization. As this case shows, the gaps in systems can undermine students' preparedness. Successful cross-system readiness requires closer alignment among systems.

Student #5: Coordinated supports with family, school, PRTF, and consistent peer mentoring helped to reduce barriers to reintegration. This suggests that multi-level involvement in interventions at the school-level increases the success of school-based interventions and reduces vulnerability in initial stages.

Interpretation: These findings challenge models of reintegration that emphasize individual student recovery without attention to system coordination. Treatment completion alone did not

ensure stabilizing reintegration; nor did placement in schools guarantee meaningful involvement. Rather, the findings are a comment on how reintegration may hinge on whether the adults operating in separate systems share responsibility for continuity. This is a meaningful contribution, because it exposes a common issue in practice, when systems assume that they are contributing to the transition effectively, and no one takes responsibility for making the transition function together. This work demonstrates that coordination is a condition that is both supportive and essential for successful reintegration.

Synthesis Between Research Questions

In all six cases the data is consistent with the following:

- Emotional readiness is a necessary but not sufficient condition for reintegration success.
- Attendance is an indicator of both emotional stability and systemic alignment.
- Strong multi-system coordination that incorporates organized transition preparation, family involvement, and school-PRTF communication is critical to moderate the impact of readiness and predicts engagement outcomes.
- Early post-discharge interventions (within 30–60 days) are critical, as misalignment throughout this time can lead to disengagement or rehospitalization.

These findings combined support a systemic, dynamic model of reintegration. Reintegration outcomes were influenced by interplay between internal readiness, relational support, and structural coordination. This model moves beyond linear assumptions in which discharge leads to return and adjustment. Instead, the findings suggest successful reintegration occurs when the timing, support, communication, and emotional need remain aligned from the earliest phase of transition.

Emotional Readiness and Early Post-Discharge Vulnerability

One of the most important findings of this study is that emotional readiness was central to reintegration stability and functioned as both a predictor of attendance and a condition for effective use of school-based supports. Returning students who returned prior to achieving emotional stabilization demonstrated elevated levels of school refusal, anxiety-related disruption, and rehospitalization, which suggests that premature reintegration can weaken the necessary support structures that are there. This finding does not indicate a deficit in student readiness; rather, it highlights that reintegration processes often treat discharge completion as a proxy for readiness. This gap is important because it assumes emotional readiness rather than systematically assessing readiness. Clinical discharge criteria do not necessarily reflect readiness for school reintegration, particularly given the academic, social, and behavioral demands of school environments.

The first 30-60 days following discharge emerged as the most vulnerable phase of reentry. Ecological Systems Theory (Bronfenbrenner, 1979) explains why this is a period of increased vulnerability. Interactions among members of the microsystem: family, school personnel, peers, and treatment staff were especially significant. Inconsistent communication or unclear expectations increased the risk of disengagement, but preemptive family involvement and structured school accommodations contributed to attendance and emotional regulation.

This suggests that emotional readiness is usually presumed and not systematically evaluated in practice, revealing a core gap and potential area of concern in reintegration planning that can lead to early instability. Early post-discharge vulnerability is critical to reintegration success. This study highlights how premature return without tailored supports can undermine otherwise considered interventions. These findings extend the literature by demonstrating that emotional readiness is frequently assumed, as opposed to systematically gauged during school

reintegration practices and within aligned supports, undermines otherwise effective treatment gains.

Coordinated Supports and Cross-System Collaboration

Another major finding of this study is that coordinated support across systems was essential to achieving reintegration stability. Successful reintegration was more likely when all support systems cohesively communicated and shared responsibility for transition planning. These protective factors included inter-system collaborative work and coordinated supports. Regular communication among school personnel, PRTF staff, families, and community agencies facilitated predictability, responsiveness, and continuity of support.

The core principles of Trauma-Informed Education where predictability, individualized support, and safety reduce stress and support engagement. This study extends the literature by demonstrating that trauma-informed practices are insufficient when implemented in isolation. Their effectiveness depends on coordinated implementation across systems. This gives the rationale for why the coordination of systems stabilizes reintegration outcomes (SAMHSA, 2014).

The Transition Theory (Schlossberg, 2011) perspective provides further insight into the relevance of individual coping resources, quality of support given, and timing of transition to adjustment in transition periods. Clear communication channels and accessible school resources ensured smoother reintegration through structured transition plans, and poor coordination was associated with disrupted attendance, increased anxiety, or rehospitalization. The alignment of individualized education plans with therapeutic strategies improved positive outcomes. Supports that were proactive and synchronized with the student's adjustment phase were associated with more stable outcomes. When communication, expectations, and supports were misaligned,

reintegration instability followed. This places cross-system collaboration as inherent to a successful reintegration process, rather than a best practice.

These findings characterize cross-system coordination as a structural prerequisite for successful reintegration, necessitating intentional planning, shared responsibility, and continuous communication.

Case Evidence:

Students whose IEP accommodations matched therapeutic strategies had better transitions.

Disrupted attendance was common because of lapses in communication, and schools were not well-informed as to what kinds of individualized supports would be necessary for early reintegration.

Conceptual Frameworks Revisited

Three frameworks guided the interpretation of findings. First is the Ecological Systems Theory (Bronfenbrenner, 1979). With this theory, reintegration outcomes depended on interactions within the microsystem (family, peers, school personnel) and mesosystem (coordination among systems). The Ecological Systems Theory was particularly helpful in helping show how reintegration was influenced by interactions across settings rather than focusing on student-related dynamics. The success of reintegration was determined by the operation of the microsystem family, peers, school staff, daily routines, and the mesosystem, which is the quality of connections between those settings. Cases in which families, schools, and treatment providers were able to communicate successfully were more likely to produce consistent attendance and engagement. Fractured or poorly communicated cases underscored how weak mesosystem links can destabilize reentry, even when individual supports are in place.

So, the framework helps account for why reintegration must be seen as relational and systemic rather than solely individual. While Ecological Systems Theory explains multi-system influence, this study extends its application by using attendance as a real-time behavioral indicator of mesosystem alignment during reintegration.

Next is Trauma-Informed Education (SAMHSA, 2014). This framework leans on predictable routines, safe environments, and individualized supports facilitated emotional stabilization and engagement. Trauma Informed Education explained why predictability, safety, responsiveness, and individualized support are necessary for reentry. Students coming back from PRTF settings often found themselves coping with ongoing emotional vulnerability, heightened anxiety, or difficulty tolerating stress. In this context, trauma-informed supports were not mere therapeutic processes but practical mechanisms for reducing overwhelm and supporting participation. The findings suggest, however, there is a limit to trauma-informed practice where it is confined to isolated classrooms. And its full value depends on coordinated implementation across the systems that shape the student's day-to-day transition experience.

Last is the Transition Theory (Schlossberg, 2011). Reintegration trajectories were shaped by the timing of supports, availability of coping resources, and quality of support systems. Transition Theory also explained why timing and quality of support were so important. Students' results were a product not just of support being present in that moment, but also whether it was available when they were most vulnerable. The theory also indicates how individuals interpret and navigate transitions as they relate to available supports and coping resources. In this study, reintegration tended to be more successful when supports were proactive rather than reactive, when expectations were calibrated to readiness, and when adults recognized transition as a process that required tracking and adjustment.

These frameworks together emphasize that reintegration is a dynamic, systemic process, and it is not solely determined by one's individual level of readiness. Stability arose in contexts in which emotional readiness, organized school-based supports, involvement of families, and inter-agency coordination were aligned. Used together, these frameworks highlight an important interpretive point: each of these frameworks is useful, but none is fully sufficient in isolation. The Ecological Systems Theory describes the relational and structural aspects of reintegration. Trauma-Informed Education explains the importance of safety and responsiveness.

Transition Theory discusses timing, adaptation, and coping. The study's findings suggest that successful reintegration requires all three dimensions working together. Emotional readiness without coordination was insufficient. Support without trauma-informed responsiveness was insufficient. Planning without attention to transition timing was insufficient. Stability emerged only when these dimensions were aligned in practice.

Synthesis of Findings

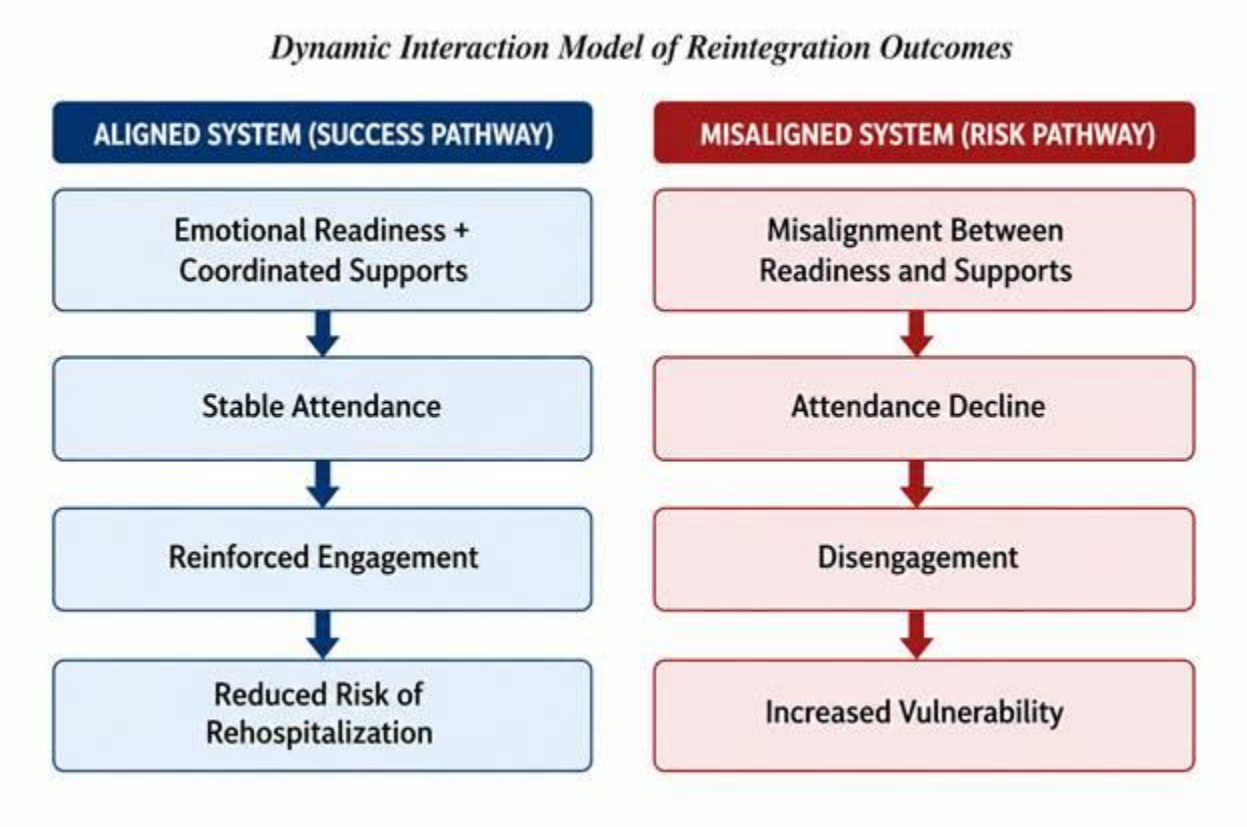
In all six cases, successful reintegration outcomes arose by the interaction of emotional readiness, structured transitional activities, family involvement, cross-system collaboration, and access to community supports. Attendance functioned as a behavioral indicator of emotional functioning, system alignment, and support effectiveness. Attendance disruptions indicated emotional dysregulation, insufficient supports, or breakdowns in communication between systems. Reintegration stability is highest in those who experienced alignment between timing, intensity, and consistency of emotional preparedness and structural supports, underscoring the necessity of a systemic approach to post-discharge adjustment.

The interaction between emotional readiness and coordinated supports plays a central role in determining reintegration outcomes. Figure 5 illustrates the dynamic pathways through

which alignment or misalignment between these factors influences attendance, engagement, and overall stability following discharge.

Figure 5

Dynamic Interaction Model of Reintegration Outcomes



Note. This figure illustrates the dynamic interaction between emotional readiness and coordinated supports in shaping school reintegration outcomes. Alignment between readiness and supports is associated with stable attendance and sustained engagement, while misalignment is associated with attendance decline, disengagement, and increased vulnerability to rehospitalization.

As shown in the figure, alignment between emotional readiness and coordinated supports is associated with stable attendance and reinforced engagement, which contribute to reduced risk of rehospitalization. In contrast, misalignment between these factors is associated with early

attendance decline, leading to disengagement and increased vulnerability. These patterns reinforce the role of attendance as an early behavioral indicator of reintegration success and highlight the importance of coordinated, system-level supports during the critical post-discharge period.

These findings shift the focus of reintegration to a system-level implementation-based perspective rather than an individual student outcome. This model captures the overarching contribution of the study namely that reintegration is not best understood as a post-treatment outcome to be observed after discharge. Instead, it is a system-dependent process that must be actively constructed during the early reentry period. These findings then change the emphasis from student adjustment alone to the quality of system implementation surrounding that adjustment.

Implications

For Schools

- Assess students' emotional readiness and mental health needs prior to full academic reintegration.
- Implement layered supports within the first 30 days post-discharge.
- Establish formal communication protocols with families and treatment providers.
- Monitor attendance as an early indicator of emotional functioning and systemic reintegration stability, not just an outcome.

For PRTFs

- Provide detailed discharge planning with documentation of academic progress, behavioral supports, emotional regulation strategies, and reintegration recommendations.

- Conduct formal transition meetings with receiving schools and relevant community agencies.
- Conceptualize discharge as the beginning of a continuum of care, ensuring follow-up supports during early reintegration.
- Align discharge decisions with demonstrated emotional readiness benchmarks, rather than predetermined length-of-stay expectations, to reduce premature reintegration risk.

For Families

- Actively participate in transition planning meetings.
- Monitor early attendance and engagement, reinforcing coping strategies, consistent routines, and gradual academic exposure.
- Anticipate the first month's vulnerability and watch for early warning signs of regression or school refusal.

Implications for Policy and Future Research

- Develop standardized reintegration protocols for students returning from residential psychiatric treatment.
- Expand school-based mental health services to support early stabilization.
- Conduct multi-site research examining long-term outcomes, student perspectives, and attendance and emotional readiness as predictors of reintegration stability.

Limitations

This study included six cases, limiting generalizability; however, the goal was analytic depth rather than statistical generalization. Data were primarily drawn from parent and school perspectives, which may not fully capture student experiences. Variability across schools and treatment settings may also influence outcomes. Additionally, the focus on the first 30-60 days

limits conclusions about long-term reintegration trajectories. These limitations suggest the need for future research incorporating student voice and longitudinal analysis. These limitations suggest findings should be interpreted within the context of parent-reported and case-based data and may not fully capture student perspectives.

Conclusion

The current study contributes to the literature by reframing school reintegration following PRTF discharge as a time-sensitive, system-dependent process that emerges from the alignment of emotional readiness, coordinated supports, and early intervention. Across cases, successful reintegration was not attributed to discharge or student effort. It came about when schools, families, and treatment providers collaborated in coordinated ways to ensure that discharge resulted in a supported return to school. In the absence or delay of that coordination, early instability often follows.

One of the most significant findings in this study is that emotional readiness was frequently assumed rather than systematically assessed. This assumption created a disconnect between treatment completion and functional school reintegration and made students susceptible in the first phase of return. The study also shows that attendance is not just a descriptive educational yardstick; it is an initial behavioral indication of whether emotional functioning is aligned with system supports. Attendance provides practical tools for practitioners in recognizing reintegration strain prior to more serious breakdown. These findings demonstrate that discharge is not equated with readiness for school, showing that discharge is not enough to provide stable transition into school without coordinated system-level alignment.

Identifying the first 30 to 60 days following discharge as a critical intervention window, this study moves reintegration from reacting with reactive measures to proactively. The findings

shift the central question from whether students return to school after PRTF discharge, but whether the systems around them are set up to accept them in terms that facilitate stability, engagement, and continued adjustment. Accordingly, reintegration success should not be interpreted solely as an outcome of individual readiness. It is the outcome of a well-coordinated approach across family, school, treatment, and community levels. When those systems are coordinated, students are more ready to continue showing up, participating, and staying on track. In the absence of such coordination, reintegration remains fragile and highly susceptible to early instability. This study positions reintegration as a shared systems responsibility, requiring intentional coordination across educational, clinical, and family contexts to support meaningful and sustained student outcomes for students.

Cross-case analysis identified several key themes influencing reintegration outcomes following discharge from a PRTF. Table 4 summarizes these themes, the patterns observed across cases, and their implications for school reintegration.

Table 4

Cross-Case Themes, Key Findings, and Implications for School Reintegration Following PRTF Discharge

Theme	Key Findings Across Cases	Implications for Reintegration
Emotional Readiness	Students who demonstrated emotional regulation and stability at discharge maintained more consistent attendance, while those with unresolved anxiety or dysregulation experienced early attendance decline	Reintegration planning must include explicit assessment of emotional readiness rather than assuming readiness at discharge
Transition Planning	Proactive and structured transition planning (e.g., reenrollment meetings, coordinated supports) was associated with stable reintegration, while reactive or delayed planning led to attendance disruptions	Schools and PRTFs should implement formalized transition protocols that begin prior to discharge and include all stakeholders

System Alignment (Communication & Coordination)	Strong communication between families, schools, and mental health providers supported consistent attendance and engagement; fragmented communication contributed to instability	Reintegration success depends on alignment across systems, requiring ongoing collaboration and shared responsibility
School-Based Supports	Layered supports (e.g., resource rooms, counseling, mentoring, therapeutic services) were associated with improved attendance and stability; inconsistent or insufficient supports led to disengagement	Schools should provide sustained, individualized supports during the first 30–60 days post-discharge
Peer and Environmental Factors	Peer conflict and environmental stressors disrupted reintegration even when planning and supports were in place	Reintegration planning should account for peer dynamics and environmental risks within the school setting
Attendance as an Indicator	Attendance patterns reflected underlying emotional readiness and system alignment; early declines often signaled emerging reintegration challenges	Attendance should be monitored as an early warning indicator to guide timely intervention and support adjustments

As shown in Table 4, reintegration outcomes were shaped by the interaction of emotional readiness, transition planning, and system-level coordination. Attendance emerged as a critical indicator of reintegration stability, with early patterns reflecting the degree of alignment between student needs and available supports. These findings highlight the importance of coordinated, proactive, and sustained supports during the initial post-discharge period.

References

Ardill, A. (2024). *School reintegration strategies following psychiatric residential treatment. Routledge*.

Beck, A. T. (1976). *Cognitive therapy and the emotional disorders.* International Universities Press.

Braun, V., & Clarke, V. (2006). *Using thematic analysis in psychology. Qualitative Research in Psychology, 3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Bronfenbrenner, U. (1979). *The ecology of human development: Experiments by nature and design*. Harvard University Press.

Cannon, J. (2011). Educational outcomes for youth in residential treatment programs. *Journal of Child & Adolescent Behavior*, 39(4), 212–223. https://doi.org/10.1007/s10826-010-9401-3

Centers for Medicare & Medicaid Services. (2020*). Psychiatric residential treatment facilities (PRTF) overview*. U.S. Department of Health and Human Services. https://www.cms.gov/

Clemens, E., & Welfare, L. (2011). School reintegration after psychiatric hospitalization. *Children & Schools,* 33(2), 77–85. https://doi.org/10.1093/cs/cdr003

Colyer, S., et al. (2012). Youth residential treatment: Outcomes and challenges. *Child & Youth Services Review*, 34(5), 983–990. https://doi.org/10.1016/j.childyouth.2012.01.010

ELC. (2024). *Educational rights and access for youth in residential treatment.* Educational Law Center.

Heyne, D. A., Sauter, F. M., & Maynard, B. R. (2015). Moderators and mediators of treatments for youth with school refusal or truancy. In M. Maric, P. J. M. Prins, & T. H. Ollendick

(Eds.), *Moderators and mediators of youth treatment outcomes* (pp. 230–266). Oxford University Press.

Kearney, C. A., & Albano, A. M. (2004). The functional profiles of school refusal behavior: Assessment and treatment implications. *Journal of Child Psychology and Psychiatry*, 45(2), 401–413. https://doi.org/10.1111/j.1469-7610.2004.00241.x

Kearney, C. A., & Graczyk, P. (2022). School attendance and engagement: Systemic and psychological perspectives. *School Psychology International,* 43(1), 5–23. https://doi.org/10.1177/01430343211036543

Lam, C., et al. (2023). Attendance versus engagement: Implications for student outcomes in post-hospitalization reintegration. *Journal of Special Education Leadership*, 36(3), 45–60.

Lanier, P., Feely, M., & Fraser, M. (2021). Predictors of PRTF admission and post-discharge outcomes. *Children and Youth Services Review,* 128, 106–139. https://doi.org/10.1016/j.childyouth.2021.106139

Lanier, P., et al. (2020). Effectiveness of psychiatric residential treatment for youth: A meta-analysis. *Journal of Child and Adolescent Psychiatric Nursing*, 33(2), 65–74. https://doi.org/10.1111/jcap.12234

Liberman, R., et al. (2001). Multidisciplinary team approaches in residential treatment: Best practices. *Residential Treatment for Children & Youth,* 18(3), 11–33. https://doi.org/10.1300/J007v18n03_02

Marraccini, M. E., & Pittleman, D. (2022). School reintegration outcomes following inpatient and residential psychiatric treatment. *Children & Schools,* 44(1), 23–34. https://doi.org/10.1093/cs/cdab035

McLeod, S. (2023). *Bronfenbrenner's ecological systems theory.* Simply Psychology. https://www.simplypsychology.org/bronfenbrenner.html

Miller, A. L., et al. (2007). Dialectical behavior therapy for adolescents with high-risk behaviors: School-based adaptations. *Cognitive and Behavioral Practice*, 14(3), 243–253. https://doi.org/10.1016/j.cbpra.2007.05.001

Perry, B. D. (2006). Applying principles of neurodevelopment to clinical work with maltreated and traumatized children: The Neurosequential Model of Therapeutics. In N. B. Webb (Ed.), *Working with traumatized youth in child welfare* (pp. 27–52). Guilford Press.

Perry, B. D. (2013). *The Neurosequential Model of Therapeutics (NMT) in clinical practice*. Child Trauma Academy. https://childtrauma.org/nmt

Preyde, M., et al. (2017). Educational reintegration following psychiatric residential treatment: A longitudinal study. *Canadian Journal of School Psychology*, 32(2), 100–118. https://doi.org/10.1177/0829573516677682

Rose, S., & Lanier, P. (2017). Residential treatment for youth: Policy and practice perspectives. *Children and Youth Services Review,* 81, 343–351. https://doi.org/10.1016/j.childyouth.2017.08.024

SAMHSA. (2009). *The transition to adulthood for youth with serious mental health conditions.* U.S. Department of Health and Human Services.

Schlossberg, N. K. (2011). *The challenge of change: The transition model and its applications.* Springer.

Sowers, W., & Epstein, I. (2019). Outcomes of psychiatric residential treatment for youth: A review of effectiveness and sustainability. *Journal of Child and Adolescent Psychiatric Nursing,* 32(2), 65–74. https://doi.org/10.1111/jcap.12232

Viljoen, L. K. (2018). *Using a Neurosequential Model of Therapeutics (NMT)-based behavior plan in elementary schools* (Master's thesis, University of British Columbia). https://open.library.ubc.ca/soa/cIRcle/collections/ubctheses/24/items/1.0371927

Wotring, J., & Stroul, B. (2010). *Residential treatment for youth: Policy, funding, and outcomes.* National Technical Assistance Center for Children's Mental Health.

Appendix A

IRB Approval and Ethics Documentation

Slippery Rock University of Pennsylvania
Institutional Review Board
104 Maltby Avenue, Suite 005
Slippery Rock, PA 16057
724-738-4846
irb@sru.edu

September 9, 2025

Dr. Jeremy Lynch
Special Education

RE: Protocol Approved
Protocol # 2026-003-88-B
Protocol Title: Post-Discharge School Attendance Following 90-Day PRTF Treatment

Dear Jeremy:

Thank you for your new IRB submission. The Institutional Review Board (IRB) of Slippery Rock University has received and reviewed the above-referenced protocol utilizing the expedited review process. The IRB has approved the protocol under the "expedited" category.

You may begin your project as of September 8, 2025. Your approved protocol will expire on September 7, 2026. You will need to submit a Progress/Final Report at least 7 days prior to the expiration date. Please remember that all research must be conducted as described in the submitted approved materials. If any changes need to be made, a Change to Protocol Form must be submitted to the IRB Office for review and approval. A final report is required upon the closure of your research study. These forms can be on the IRB webpage, https://www.sru.edu/offices/institutional-review-board/how-to-apply-to-the-irb.

We appreciate your conscientious adherence to protecting the rights and welfare of human participants. If you have any questions or concerns, please contact the IRB Office by phone at (724)738-4846 or via e-mail at irb@sru.edu.

Sincerely,

Betsy Kemeny

Betsy Kemeny, Ph.D., Vice-Chairperson
Institutional Review Board (IRB)

Appendix B

CONSENT TO PARTICIPATE IN RESEARCH

POST-DISCHARGE SCHOOL ATTENDANCE FOLLOWING 90-DAY PRTF TREATMENT

Invitation to be Part of a Research Study

You are being invited to participate in this research study because our admissions team reviewed recent cases and identified you as meeting the study's criteria:

- You are the parent or legal guardian of a child who completed a 90-day stay in a Psychiatric Residential Treatment Facility (PRTF) within the past 12 months.
- Your child has since returned to a brick-and-mortar school setting (such as a district-run or charter school).
- You are at least 18 years old.
- You can read and communicate in English well enough to understand the consent process and participate in a recorded interview.
- You are willing to provide informed consent to participate in this study.

If you choose to take part:

- You will participate in a confidential Zoom interview lasting about 10–15 minutes.
- During the interview, you will be asked about your child's return to school after discharge from the PRTF.
- Topics will include school attendance, transition planning, and any supports or challenges your child experienced.
- Your input will help researchers better understand how to improve school reintegration for other students returning from residential treatment.

Important Information about the Research Study

Things you should know:

- This is a research study, and your participation is completely voluntary.
- The purpose of the study is to explore how a 90-day stay in a Psychiatric Residential Treatment Facility (PRTF) affects a student's school attendance and reentry experience.

If you choose to participate, you will:

- Complete a one-time, 10–15-minute Zoom interview with the researcher from a private location of your choice.
- Be asked to share your perspective on your child's attendance and school reintegration
- Be asked for your consent to allow the researcher to access and review existing records, such as your child's attendance summaries, reentry/transition plans, IEPs, or clinical discharge documents, if available.
- Risks include possible emotional discomfort when discussing your child's mental health or educational experiences. You may skip questions or stop the interview at any time. •
- There are no direct benefits to you, but your participation may help improve school and treatment practices for other students and families navigating PRTF discharge and school reentry.
- Participation is entirely voluntary. You may choose not to take part or to withdraw at any time without penalty or loss of benefits. Choosing not to participate or changing your mind and deciding you no longer want to participate will have NO affect your child's access to future services. Please take time to read this entire form and ask questions before deciding whether to take part in this research project.

What is the Study About and Why are We Doing it?

This study examines how participation in a 90-day PRTF affects a student's school attendance after discharge. The research focuses on parent perspectives to identify patterns in attendance and understand supports and challenges during the school reintegration process. What Will Happen if You Take Part in This Study?

If you agree to participate:

• You will complete a one-time Zoom interview lasting approximately 10–15 minutes with the co-investigator.

• You may also be asked to provide existing documents such as your child's attendance records, IEPs, reentry or transition plans, or discharge summaries.

• Interviews will be audio-recorded and transcribed. All identifying information will be removed, and your responses will be stored using a participant ID code.

Sensitive Information: Some of the interview questions may involve sensitive or emotionally difficult topics. For example, you may be asked to reflect on: • Your child's behavior and emotional state before, during, and after the PRTF stay • Challenges faced when your child transitioned back to school • Experiences with school support (or lack thereof), such as IEP implementation, staff communication, or disciplinary responses • How the hospitalization affected your child's academic engagement or daily attendance You may skip any question that you do not wish to answer, and you may stop the interview at any time without penalty.

How Could You Benefit From This Study?

There are no direct benefits to you. However, sharing your experiences may help improve school reentry supports and policies for students returning from PRTFs.

What Risks Might Result From Being in This Study?

Risks are minimal but may include:

- Emotional discomfort discussing your child's experiences
- Accidental disclosure of identifiable information

These risks will be minimized by:

• Allowing you to skip any questions or end the interview at any time

• Assigning participant codes and removing all identifying information

• Storing all data in encrypted and password-protected locations

How Will We Protect Your Information?

• Interviews will be recorded and transcribed, then deleted.

• Documents will be de-identified and coded.

• Only the researchers will access the data.

• All records will be stored securely on password-protected systems or locked cabinets.

• No names or identifying info will appear in reports or publications.

What Will Happen to the Information We Collect About You After the Study is Over?

Your data will be stored securely for 3 years and then permanently deleted. No identifying information will be retained after the study concludes.

What Other Choices do I Have if I Don't Take Part in this Study?

If you choose not to participate, there are/are no alternatives. Choosing not to participate will not affect your relationship with the school, PRTF, or access to services in any way. Your Participation in this Research is Voluntary

It is totally up to you to decide to be in this research study. Participating in this study is voluntary. Even if you decide to be part of the study now, you may change your mind and stop at any time. You do not have to answer any questions you do not want to answer.

If you decide to withdraw before this study is completed, any data collected up to that point (including interview transcripts and submitted documents) will be retained in de-identified form unless you specifically request that it be removed. There are no anticipated circumstances under which your participation would be terminated by the principal investigator without your consent.

Contact Information for the Study Team and Questions about the Research

If you have questions about this research, you may contact [redacted]

Contact Information for Questions about Your Rights as a Research Participant If you have questions about your rights as a research participant, or wish to obtain information, ask questions, or discuss any concerns about this study with someone other than the researcher(s), please contact the following: Institutional Review Board Slippery Rock University 104 Maltby, Suite 302 Slippery Rock, PA 16057 Phone: (724)738-4846 Email: irb@sru.edu

Your Consent

By signing this document, you are agreeing to be in this study. Make sure you understand what the study is about before you sign. I/We will give you a copy of this document for your records. I/We will keep a copy with the study records. If you have any questions about the study after you sign this document, you can contact the study team using the information provided above. I understand what the study is about and my questions so far have been answered. I agree to take part in this study. I understand that I can withdraw at any time. A copy of this signed Consent Form has been given to me.

Printed Participant Name Signature of Participant Date By signing below, I indicate that the participant has read and to the best of my knowledge understands the details contained in this document and have been given a copy.

Printed Name of Investigator Signature of Investigator Date

Zoom Interview Recording Release Form: We request the use of audiotape/videotape material of you as part of our study. We specifically ask your consent to record the Zoom interviews for data analysis purposes only. No audio/video material will be used for news releases, professional publications, websites and pictorial exhibits related to our study. We also emphasize that the appearance of these materials on certain media (websites, professional publication, news releases) may require transfer of copyright of the images.

I do...

I do not... Give unconditional permission for the investigators to record the Zoom interview of me so that it may be used for data analysis purposes only.

Print Name Participant Signature Date

Appendix C

Parent/Guardian Questions: Post-PRTF School Attendance Experience

Section 1: Background Information

1. What is your child's current grade level?

   ☐ K–2 ☐ 3–5 ☐ 6–8 ☐ 9–12

2. What type of educational support does your child receive?

   ☐ General Education only

   ☐ 504 Plan

   ☐ Individualized Education Program (IEP)

   ☐ Not sure

3. Was your child enrolled in the same school before and after the PRTF stay?

   ☐ Yes ☐ No ☐ Not sure

Section 2: Attendance Patterns

4. Approximately how many days of school did your child miss in the 30 school days before their PRTF admission?

   ☐ 0–2 days ☐ 3–5 days ☐ 6–10 days ☐ More than 10 days

5. Approximately how many days of school did your child miss in the first 30 school days after discharge?

   ☐ 0–2 days ☐ 3–5 day ☐ 6–10 days ☐ More than 10 days

6. Did your child demonstrate school refusal or anxiety about returning to school post-discharge?

   ☐ Yes ☐ No ☐ Somewhat

Section 3: Transition Planning and School Support

7. Did the school provide a reentry or transition plan for your child before or after discharge?

   ☐ Yes ☐ No ☐ I don't know

8. Which supports were provided upon your child's return? *(Check all that apply)*

   ☐ Counseling/mental health check-ins

   ☐ Modified class schedule

   ☐ Academic support (e.g., tutoring, resource room)

   ☐ Behavior support plan

   ☐ Peer support or mentoring

   ☐ None of the above

9. On a scale of 1 to 5, how supported did your child feel returning to school after the PRTF stay?

   1 (Not at all) 2 3 4 5 (Very supported)

10. On a scale of 1 to 5, how satisfied were you with the school's communication and support during the transition?

    1 (Not at all satisfied) 2 3 4 5 (Very satisfied)

Section 4: Open-Ended Questions

11. What were the biggest challenges your child faced when returning to school after the PRTF stay?
12. What school-related supports helped the most with your child's attendance or engagement?
13. What would you recommend to schools or treatment centers to improve the reintegration process for other families?