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Collaborative School–Hospital–Family Intervention in Psychological Crises of Medical Interns——From the Perspective of Holistic Governance

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Abstract: Clinical internship is a critical stage at which medical students face a high incidence of psychological risk. At present, medical colleges, teaching hospitals and families each act on their own when carrying out psychological crisis intervention, displaying the typical features of fragmented governance. Taking holistic governance theory as its analytical framework and employing literature review and policy text analysis, this paper examines the fragmented realities confronting psychological crisis intervention for medical interns along three dimensions: the rights and responsibilities of the actors involved, the flow of information, and intervention procedures. On this basis, it constructs a three-stage school–hospital–family collaborative intervention mechanism of "pre-placement early warning — graded in-post intervention — recovery follow-up", and proposes supporting safeguards in terms of institutional articulation, capacity building, digital platform construction, and assessment and incentives. The study provides a theoretical reference and a practical pathway for medical colleges and teaching hospitals seeking to resolve the difficulty of coordinating psychological education in internship settings.

Keywords: Holistic Governance; Medical Interns; Psychological Crisis Intervention; School–Hospital–Family Collaboration; Fragmentation

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Clinical internship is an important transitional stage in which medical students convert theoretical knowledge into clinical practice competence, and it is also a special period in which psychological pressure and occupational stress are superimposed upon each other. Compared with the on-campus study stage, medical interns must confront patients' suffering and scenes of death, handle complex doctor–patient relationships and adapt to high-intensity shift rotations, while at the same time bearing the practical pressures of postgraduate entrance examinations and employment competition. Existing surveys indicate that the stressors of medical students during internship are concentrated in four categories — academic, financial, clinical practice and interpersonal — that detection rates of stress generally exceed 60%, and that mean single-factor BSSI scores are all above 3 points[1]. Ill-matched to this relatively high level of psychological risk is the fact that, at present, psychological crisis intervention for medical interns is driven mainly by universities acting as a single agent, while teaching hospitals and families participate insufficiently; no mature or effective system of collaborative intervention has yet taken shape among the multiple actors.

In 2023, the Ministry of Education and sixteen other departments jointly issued the Special Action Plan for Comprehensively

Strengthening and Improving Student Mental Health Work in the New Era (2023–2025), which explicitly requires that the country "improve the mechanism of multi-department linkage and the collaborative education mechanism among schools, families and society", with particular attention to student groups such as interns whose external environment has changed[2]. This provides the policy basis for multi-actor collaborative intervention in the psychological crises of medical interns. In implementation, however, such key issues as the pathways of information sharing among school, hospital and family, the articulation of intervention procedures and the division of rights and responsibilities still lack a systematic and workable operational scheme.

Domestic scholarship has already produced fairly rich results on psychological crisis intervention for university students. Drawing on ecosystem theory, Huang Chunyan et al. constructed a five-dimensional collaborative intervention system encompassing family, school, community, medical institutions and government, in an effort to resolve the structural contradictions of psychological crisis intervention[3]; Cai Zhiyong drew on psychoanalytic theory to explain the internal mechanisms by which psychological crises arise, and on that basis proposed strategies for the prevention of and intervention in university students' psychological crises[4]; Cai Lili explored pathways of family–school–community collaborative education in terms of defining the actors involved, enriching the content and expanding the methods, thereby helping to cultivate protective factors against psychological crisis among university students[5]. In the field of medical education, existing research focuses largely on surveys of the mental health status of medical students: Ji Wenping et al. surveyed students at medical colleges in Anhui Province and confirmed a significant association among depression, internet addiction and insomnia[6]; Tian Linqing et al. conducted a follow-up survey of stomatology interns and found that participants' depression, anxiety and stress scores in the late period of the internship were significantly higher than in its early and middle periods[7].

A comprehensive review of the existing literature reveals two conspicuous gaps. First, most studies treat medical students as a homogeneous population and pay insufficient attention to the distinctive features of students' psychological development in the particular setting of clinical internship. Second, although some studies do mention multi-actor collaborative intervention, they largely remain at the level of macro-level principles and lack any in-depth analysis of the operating logic of collaboration or of practical procedures. Accordingly, this paper addresses two core questions: in the clinical internship setting, why does psychological crisis intervention by school, hospital and family fall into the predicament of fragmented governance? And, drawing on holistic governance theory, how can an operable school–hospital–family collaborative intervention mechanism be constructed? The study employs literature review and policy text analysis, and undertakes theoretical construction at the normative level on the basis of existing empirical findings and policy documents.

1. Analytical Framework: Holistic Governance Theory and Its Applicability

1.1 Core Tenets of Holistic Governance Theory

Holistic governance theory originated in the United Kingdom in the 1990s and was systematically expounded by Perri 6 in his work Holistic Government. The theory constitutes a reflection upon, and a correction of, the problems generated by the New Public Management movement: New Public Management advocated decentralized competition and specialized division of labour and, while raising administrative efficiency, also gave rise to such governance difficulties as departmental barriers, information silos and the fragmentation of public services. Taking citizens' needs as its value orientation, holistic governance emphasizes breaking down organizational boundaries through cross-agency coordination and resource integration so as to deliver seamless, integrated public services[8].

The core connotations of holistic governance may be summarized along three dimensions. At the level of governance objectives, it foregrounds holistic thinking and a preventive orientation directed at root causes: it moves beyond the narrow pursuit of optimal performance by any single department, seeks the systemic resolution of public problems, and shifts from after-the-fact disposal to advance prevention. At the level of governance structure, it promotes cross-departmental coordination and integration, relying on institutionalized mechanisms of cooperation to achieve an organic unity of objectives, information and action among different actors. At the level of governance instruments, it values information technology as a carrier and regards digital platforms as an important support for information exchange and collaborative decision-making. It should be noted that holistic governance does not negate specialized division of labour; rather, it achieves re-integration on

the basis of that division, the key lying in institutional arrangements that accommodate the interests of multiple parties while lowering the costs of cooperation.

1.2 The Rationale for Applying Holistic Governance to Psychological Crisis Intervention for Medical Interns

Introducing holistic governance theory into research on psychological crisis intervention for medical interns is not a simple transplantation of theory; it derives from the high degree of congruence between the practical problem and the theoretical core.

First, the causes of psychological crisis among medical interns are compound and systemic, and no single actor can govern them effectively. Interns' psychological pressure stems both from the high-intensity work and doctor–patient conflicts of the clinical setting and from internship assessments and pressures of further study and employment on the school side, while also being shaped by family economic circumstances and family expectations; it is thus a psychological risk formed by the coupling of multiple factors. The school, the teaching hospital and the family can each grasp only a partial picture of a student's psychological state, and the multi-actor coordination and integration advocated by holistic governance fits the governance requirements of such compound problems.

Second, the fragmented character of current intervention practice corresponds closely to the very problems holistic governance is designed to address. School, hospital and family each manage one segment; blurred rights and responsibilities, severed information flows and disjointed intervention procedures are precisely the typical manifestations of fragmented governance. The analytical perspective of holistic governance makes it possible to clarify how this fragmentation is generated and thus to propose targeted pathways of integration.

Third, the segmented model of medical training provides a real-world field for the implementation of holistic governance. The training of medical students is divided into two discrete stages — theoretical teaching on campus and clinical internship off campus — and these two settings objectively give rise to a break in management. The notions of whole-cycle and seamless governance advocated by holistic governance offer practical guidance for bridging the management gap between psychological education on campus and psychological intervention during the internship stage.

At the same time, the limits of localizing the theory should be squarely acknowledged. Holistic governance grew out of Western public administration and is directed primarily at problems of coordination among government departments. Transferring it to educational governance, and to mental health education in particular, requires local adaptation. This paper does not adopt the theory wholesale; rather, it draws on its core anti-fragmentation stance and its "coordination–integration" analytical paradigm in order to analyse and reconstruct the school–hospital–family collaborative intervention system for psychological crises among medical interns.

2. The Fragmented Reality of Psychological Crisis Intervention for Medical Interns

From the standpoint of holistic governance, the fragmentation besetting psychological crisis intervention for medical interns is concentrated at three levels: the rights and responsibilities of the actors, the flow of information, and intervention procedures.

2.1 Fragmentation of Rights and Responsibilities

Under the existing management system, the boundaries of rights and responsibilities among universities, teaching hospitals and families in psychological crisis intervention lack clear institutional definition. Internship agreements signed between universities and teaching hospitals mostly concentrate on clinical teaching arrangements, attendance management and safeguards for personal safety, and seldom address the division of rights and responsibilities in mental health education and crisis intervention, leaving an institutional void in the articulation of school–hospital–family management. Universities bear the principal management responsibility yet are far from the front line of the internship and find it difficult to monitor interns' psychological states continuously and dynamically; teaching hospitals possess the on-site conditions for early identification of psychological risk, but their work centres on clinical instruction and they pay insufficient attention to interns' mental health; families obtain information about students' psychological states with a marked lag, and the timing of their involvement is often late.

The drawbacks of blurred boundaries of responsibility are exposed most sharply during the golden window for handling a psychological crisis. When an intern displays signs of serious psychological crisis, the three parties are prone to wait and shift responsibility onto one another, which can easily squander the optimal window for intervention and allow the crisis to deteriorate further.

2.2 Fragmentation of Information Flow

Information sharing is the foundation of dynamic prevention and control of psychological risk, and an important precondition for implementing holistic governance. In practice, school, hospital and family have yet to establish regular channels of communication; the information held by each party remains mutually isolated, forming information silos.

Universities hold the most complete psychological records of students, covering psychological assessment results since enrolment, counselling records and the materials of heart-to-heart talks conducted by counsellors. Before students take up their internship posts, the school transfers to the teaching hospital basic personal data, family background and academic and in-school performance, but psychological information is generally not passed on at the same time. Even in the few cases where the school verbally advises that particular students merit attention, it does not disclose such key details as psychiatric history, the causes of the problem or the level of risk.

Teaching hospitals hold immediate, front-line behavioural information about interns, but that information is scattered. Supervising clinicians can directly observe interns' learning state, emotional reactions and interpersonal interactions, and are therefore important agents in the early identification of psychological risk. Yet when supervising clinicians notice something abnormal, they usually report it first to the hospital's department of science and education rather than contacting the university counsellor directly. Because of the departmental rotation system, some supervising clinicians, reckoning that the intern is about to leave their department, choose to discontinue follow-up or even refrain from initiating the reporting procedure at all. Even when information is submitted to the department of science and education, there is a time lag in its transmission from hospital to university, so that no continuous and traceable record of risk monitoring can be formed; moreover, clues to risk are readily lost during the handover between rotations.

Families hold private background information about a student's personality traits, formative experiences and major family upheavals — an important basis for analysing the deeper causes of a psychological crisis — yet they are frequently overlooked by the intervention system. In most cases parents do not take the initiative to report a student's psychological fluctuations to the school or hospital; more often they become passively involved in intervention work only after the student has developed manifestly serious problems and the school has contacted them.

2.3 Fragmentation of Intervention Procedures

At present, school–hospital–family collaboration is largely confined to emergency disposal after a crisis has erupted. No regular working mechanism covering the whole chain of prevention, intervention and recovery has yet been formed, and the closed loop of psychological risk prevention and control contains multiple breaks.

Before the internship begins, universities mainly conduct internship mobilization and safety education, with insufficient integration of content on psychological risk early warning and on psychological guidance for adapting to the internship; the hospital's departmental orientation stresses medical norms and departmental discipline, while mental-health-related training is absent; and at the family level there is likewise a lack of psychological preparation geared to the clinical internship stage.

Faced with interns who are already experiencing psychological distress, the three parties lack norms for graded and classified collaborative handling. Mild adaptation problems, falling short of the threshold of a "crisis", are easily overlooked by all parties; moderate psychological distress is mostly addressed separately by counsellors or supervising clinicians acting independently, without mutual exchange of information, so that intervention measures may even conflict with one another; and once a severe psychological crisis has occurred, the parties can only rely on hastily convened consultations, with no standardized contingency plan for handling it.

The handling of a psychological crisis is not a one-off event. After receiving professional treatment and returning to the internship post, a student still requires long-term recovery support. In reality, however, schools are apt to misjudge a student as fully recovered and reduce the level of attention; hospitals, out of concern about risk, adopt an avoidant attitude towards

returning interns; and families, lacking professional knowledge, cannot provide scientifically sound support — with the result that intervention is absent during the recovery stage.

3. Constructing the School–Hospital–Family Collaborative Intervention Mechanism

Addressing the fragmentation of psychological crisis intervention for medical interns, and drawing on the integrative logic of holistic governance together with the characteristics of the clinical internship stage, this paper constructs a three-stage school–hospital–family collaborative intervention mechanism of "pre-placement early warning — graded in-post intervention — recovery follow-up".

3.1 The Pre-placement Early Warning Stage

The core objective of pre-placement early warning is to complete the screening and assessment of psychological risk before interns take up clinical posts, to integrate the basic information held by the various parties, and to shift the intervention model from passive emergency response to active prevention. At this stage the university takes the lead: one to two months before the internship begins, the university's psychological centre administers a dedicated psychological assessment to all interns using standardized scales such as the SCL-90, SDS and SAS. Drawing together multiple sources of material — scale results, on-campus counselling records, counsellors' routine judgements and academic performance — psychological professionals conduct a comprehensive evaluation, classify interns into low, medium and high risk levels, and establish an initial psychological risk record for each intern. The determination of risk level should rest on comprehensive professional assessment rather than on scale scores alone, and students should be fully informed of the purpose of the assessment and the uses of their data, so that their right to know is safeguarded.

Once risk records have been established, the focus turns to the problem of limited information sharing among the three parties, strictly observing the two ethical principles of informed consent and minimum necessary disclosure[9], so as to balance the needs of collaborative intervention against the protection of student privacy. A graded information-sharing mechanism is adopted: for low-risk students, only a general reminder is given to the hospital's department of science and education, with no disclosure of specific assessment data; for medium-risk students, once their informed consent has been obtained, a notice is sent to the supervising clinician of the relevant department indicating that particular attention is warranted and specifying the areas of concern, without disclosing specific diagnoses or assessment details; for high-risk students, and on the premise that the student or their legal guardian consents, the university communicates fully with the teaching hospital and the family in order to work out jointly the arrangement of internship posts and a protective plan.

At the same time, the teaching hospital reviews high-stress departments such as emergency medicine, critical care medicine, oncology and paediatrics, and draws up a list of high-pressure departments. When allocating internship rotations, and provided that the talent-training programme is still satisfied, the hospital moderately adjusts the rotation order for medium- and high-risk students and shortens continuous internship time in high-pressure departments, thereby lowering the probability of triggering a crisis at the environmental level. Families are required to cooperate with the university by providing background material on the student's personality traits, family relationships and recent major life events, so as to assist comprehensive risk assessment.

3.2 The Graded In-post Intervention Stage

Graded in-post intervention is the core link of the entire mechanism. According to the severity of the psychological problem, three levels are distinguished — mild psychological stress, moderate psychological distress and severe psychological crisis — each matched with a differentiated mode of school–hospital–family collaborative handling.

Mild psychological stress: this manifests chiefly as difficulty in adapting to the internship, work-related anxiety and short-term low mood, while the student is still able to complete clinical internship tasks normally. At this level the emphasis falls on day-to-day care by the teaching hospital: supervising clinicians flexibly adjust workloads and embed psychological support within the process of clinical instruction. The university continuously pushes popular-science resources on mental health through online platforms, and counsellors conduct at least one online or offline exchange per month to keep track of interns' adaptation. Families focus on emotional companionship and reduce pressure relating to further study and employment. The core objective is early identification and early guidance, preventing pressure from accumulating. A monthly system of

information exchange between counsellors and supervising clinicians is established to keep both sides abreast of students' psychological dynamics.

Moderate psychological distress: this manifests as persistent low mood, self-negation and avoidance of social contact and clinical work, together with negative thoughts, but without any clear risk of self-harm. Once assessment establishes moderate psychological distress, a tripartite consultation system is immediately activated. Led by the university's psychological centre, with the participation of the supervising clinician or science and education administrator from the teaching hospital and of the student's parents (with the student's consent), an online or offline consultation is held to assess the student's psychological state comprehensively and to formulate an intervention plan jointly. The hospital may adjust the rotation department and work tasks as appropriate in order to reduce environmental stressors; the university's psychological teaching staff provide one-to-one professional counselling and periodically re-assess the student's psychological state; and parents improve their mode of communication and strengthen emotional support. The consultation produces a written record that specifies each party's responsibilities and the points at which re-assessment is to occur; re-assessment is generally conducted every two weeks, and the intervention plan is adjusted dynamically in the light of actual circumstances.

Severe psychological crisis: this involves immediate safety risks such as a risk of self-harm or harm to others, a severe depressive episode, or complete inability to take part in the internship. Upon discovering signs of crisis, the teaching hospital immediately suspends the student's clinical work and arranges dedicated accompaniment to safeguard personal safety; on receiving notification, the university's psychological centre promptly conducts a professional crisis assessment and, on the basis of its results, initiates referral to a mental health institution; and parents are required to arrive on site as soon as possible to take part in the response. Where hospital treatment is required, the three parties jointly escort the student, while the university simultaneously handles the formalities for deferring the internship and protecting the student's enrolment status, so as to allay the student's concerns about academic progress. Complete records of the response are retained, and internal information is properly controlled so as to protect the student's privacy and avoid improper dissemination.

It should be noted that mild, moderate and severe psychological states form a continuous and dynamic spectrum with no absolutely clear boundaries. A student's psychological state changes in both directions in response to the external environment and to social support, so risk levels must be updated dynamically in the course of intervention, avoiding rigid management by labelling.

3.3 The Recovery Follow-up Stage

The conclusion of a psychological crisis incident does not mean that intervention work is finished. After receiving professional diagnosis and treatment and returning to the clinical internship post, a student still faces a relatively high risk of relapse, so a regular mechanism of recovery follow-up must be established.

Recovery follow-up is coordinated by the university's psychological centre and implemented jointly by the teaching hospital and the family. The university's psychological centre conducts periodic psychological assessments, continuously tracks psychological dynamics and iteratively refines the support strategy; supervising clinicians continue to observe the student's emotions and social functioning and report any abnormality immediately; and the family pays particular attention to sleep, diet and emotional changes and maintains regular communication with the counsellor. Through this three-way linkage, the risk of relapse is reduced and whole-cycle mental health protection is put into effect.

The key difficulty to be resolved at this stage is adaptation upon returning to the post. Interns who return to clinical work after recovery must not only readjust to the rhythm of clinical practice but also cope with the practical pressures of excessive attention from others and of catching up on internship progress. All parties must therefore follow the process of readaptation continuously and help the student make a smooth transition.

4. Safeguards for Implementing the Collaborative Intervention Mechanism

The effective operation of a collaborative intervention mechanism depends on comprehensive institutional and resource support. This paper constructs a supporting system of safeguards along six lines: institutional contracts, personnel and organization, information technology, resources and funding, intervention capacity, and supervision and incentives.

4.1 Institutional and Contractual Safeguards

Institutional contracts are the foundation on which collaborative intervention proceeds in an orderly fashion. Universities should specify the rights and responsibilities of school, hospital and family in detail within internship cooperation agreements, improve graded contingency plans for handling psychological crises, and define standardized procedures for risk reporting, psychological assessment, school–family linkage and sustained support, thereby closing the management loopholes of the existing system.

4.2 Personnel and Organizational Safeguards

Universities and teaching hospitals should each designate a permanent liaison officer for collaboration, so that clues to psychological risk circulate rapidly. When a crisis occurs, a dedicated intervention task force composed of teaching administrators from the university and the hospital is formed, so that responsibility for handling the crisis is assigned to specific individuals.

4.3 Safeguards for Information Exchange and Digital Technology

A secure and controllable channel for information flow among the three parties should be built, together with a dynamic ledger of interns' psychological risk, implementing graded and dynamic management. The boundaries of information sharing must be clearly drawn so as to reconcile the needs of collaborative intervention with student privacy and the ethics of confidentiality in psychological counselling, thereby averting ethical and legal risks in the intervention process.

4.4 Resource and Funding Safeguards

Universities should establish dedicated funding for the mental health management of students on off-campus internships, so as to support cross-regional communication, tripartite consultations and psychological training for supervising staff. The university's psychological centre should act as a professional backstop, providing remote professional guidance on cases reported by teaching hospitals and opening a channel for the emergency referral of high-risk students to local mental health institutions.

4.5 Safeguards for Tiered Intervention Capacity

Tiered and classified training should be provided to the different parties in order to raise their competence in psychological intervention and to relieve the apprehension and anxiety they feel when confronted with a psychological crisis[10]. For counsellors, training should strengthen the capacity to identify risk among students interning away from campus and to handle cases collaboratively with multiple parties; for supervising clinicians in hospitals, dedicated training should be offered in identifying psychological risk and reporting clues; and for parents, popular-science materials on mental health should be distributed to heighten the family's sensitivity to risk indicators and its capacity to cooperate.

4.6 Safeguards for Supervision, Evaluation and Reciprocal Incentives

A mechanism for supervising and reviewing collaborative intervention work should be established. Positive incentives such as the selection of outstanding internship bases and the joint construction and sharing of teaching resources can be used to mobilize teaching hospitals' initiative in taking part in psychological intervention; and case reviews of crises already concluded should be held in order to refine the tripartite handling process continuously.

5. Conclusions and Prospects

The practical contradictions in school–hospital–family collaborative intervention in the psychological crises of medical interns are, in essence, a problem of fragmented governance. Universities, teaching hospitals and families belong to different management systems; information is mutually isolated and workflows are severed, so that no concerted educational force can be formed and numerous blind spots remain in the prevention and control of psychological risk. Taking holistic governance theory as its analytical tool, this paper has examined the three manifestations of fragmentation, constructed a three-stage school–hospital–family collaborative intervention mechanism of "pre-placement early warning — graded in-post intervention — recovery follow-up", and proposed supporting safeguards in terms of institutions, personnel, technology and funding.

The value of this study lies at two levels. Theoretically, it introduces holistic governance into research on the mental health of medical interns and offers a new analytical perspective for understanding the difficulties of multi-actor collaboration. Practically, the intervention mechanism and safeguards proposed here are highly operable and may serve as a reference for medical colleges and teaching hospitals in improving the relevant institutional arrangements.

The study nevertheless has certain limitations. As normative theoretical research, the collaborative mechanism proposed rests on theoretical deduction and literature analysis and has not yet been tested in practice. Subsequent research could select medical colleges and teaching hospitals for action research, test the mechanism's effectiveness with empirical data, and refine the scheme through iterative practice. In addition, this paper focuses primarily on the three actors of school, hospital and family, and has not yet incorporated such other actors as mental health institutions and communities; future work could extend the scope of research on multi-actor collaborative intervention accordingly.

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