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Reengagement With Education: A Multidisciplinary Home-School-Clinic Approach Developed in Australia for School-Refusing Youth

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School refusal (SR) can result in decreased academic achievement, impaired social connections, and family stress. Current interventions for SR include behavioral and cognitive-behavioral treatments that are not always effective. Incorporating multidisciplinary work that includes therapeutic and educational interventions may enhance outcomes for youth displaying SR. The In2School program fosters a working partnership between mental health clinicians and teachers. It was designed to meet the needs of young people missing more than 50% of school in the previous 6 weeks due to mental health disorders, including anxiety or depression. This paper reports on an action research study in which the In2School program was piloted. Over a 14-week period, therapeutic and educational interventions were integrated into the learning environment via a transitional classroom to support youths' return to school. Outcomes of this program are reported for the first cohort of 7 youth. Of these youth, 6 returned to mainstream schooling with attendance levels being maintained for 6 months after completing the intervention. Progress was observed in mental health recovery, quality of life reports, increased social interactions with peers, and positive experiences at school. The preliminary results presented in this paper suggest that a multidisciplinary, home-school-clinic intervention holds promise for helping school-refusing youth to return to school.

The number of young people[1] disengaging from education is a growing concern. In the context of this paper, disengagement is defined as "detaching from school, disconnecting from its norms and expectations, … and withdrawing from a commitment to school and to school completion" (Balfanz, Herzog, & Mac Iver, 2007, p. 224). Factors linked to disengagement include, but are not limited to, socio-economic status, high family mobility, poor home-school relationships, mental health disorders, family dysfunction, and bullying (Centre for Community Child Health, 2013; Christenson, Sinclair, Lehr, & Godber, 2001). Disengagement from education can lead to school attendance problems (SAPs) for young people. Internationally, researchers have noted that SAPs continue to "represent critical public health problems for educators, health and mental health professionals" (Kearney, 2008, p. 465). In Australia, statewide data from the Victorian Department of Education and Training (DET) indicate that up to 10,000 young people from Years 9 – 11 [2] are disengaging from education each year (Cook, 2014).

SAPs impact youth through the loss of valuable educational opportunities and youth may find it difficult to maintain relationships with peers and school staff. Short-term effects include poor academic performance, family difficulties, and worsening peer relationships (Fremont, 2003; Henry, Knight, & Thornberry, 2012; Kearney, 2008). Long-term consequences of SAPs can include academic underachievement and school drop-out; employment difficulties; increased risk of psychiatric illness and general poor health; economic, social,

[1] The term young people or young person refers to both children and adolescents.

Keywords: school attendance problems; school refusal; mental health; education; multidisciplinary team

[2] In Victoria, Years 9 to 11 are the 3rd to 5th years of the 6 years of secondary schooling.

marital problems in adulthood; and likelihood of involvement in crime (Fremont, 2003; Henry et al., 2012; Kearney, 2008).

The current study focuses on one aspect of SAPs, namely, school refusal (SR). SR is a type of SAP characterized by emotional distress associated with school attendance (King & Bernstein, 2001) with many youths meeting diagnostic criteria for anxiety or depressive disorders (Heyne, Sauter, & Maynard, 2015). Berg (1997) defined SR as a reluctance and often outright refusal to go to school. The young person may prefer to stay close to parental figures and display emotional upset and/or somatic complaints when faced with attending school. Generally, these young people do not display antisocial behavior and they do not conceal their non-attendance from their parents. The specific problem of SR occurs for between 1–2% of youth (Egger, Costello, & Angold, 2003; Heyne & King, 2004), with the problem observed among 5–16% of clinic-referred youth (Heyne & King, 2004).

Responding to School Refusal

Responding to SR is time-consuming for teachers and other school staff and "can be a costly burden to the education system in terms of professional time" (Chu, Rizvi, Zendegui, & Bonavitacola, 2015, p. 317). SR also presents a considerable challenge to mental health professionals because treatment is frequently ineffective (Hella & Bernstein, 2012; Heyne et al., 2015).

In terms of clinical interventions that focus on the reduction of symptoms (e.g., anxiety, fear, depression, disruptive behavior), researchers have found that cognitive-behavioral strategies are the most empirically supported (Heyne & Sauter, 2013). However, a systematic review that examined psychosocial interventions for SR concluded that while improved school attendance may be achieved using cognitive-behavior therapy (CBT), there were no effects on anxiety outcomes at post treatment (Maynard et al., 2015).

One key limitation of the research investigating the efficacy of SR interventions is suggested by Maynard et al. (2015). They noted that there are "few rigorous trials of interventions for SR, particularly studies examining effects of interventions other than behavioral interventions or CBT" (p.42). They also noted that CBT interventions could be supplemented through the use of medication. However, results from studies of medication for anxiety-based SR have been ambiguous (Tyrrell, 2005). Moreover, a recent randomized control trial in Australia suggested that there was no difference in school attendance outcomes for adolescents treated with CBT alone, CBT plus fluoxetine, or CBT plus placebo (Melvin et al., 2017).

Hella and Bernstein (2012) reviewed a range of treatment options for SR including psychosocial treatment, psychosocial treatment with pharmacotherapy, pharmacotherapy, and inpatient treatment. They concluded that while these interventions offered some benefit, school attendance was not significantly improved for a substantial proportion of young people. They called for more attention to the benefits of school-based interventions, arguing that the best outcomes will occur when the clinician, parents, and school professionals work together as a multidisciplinary team. This echoes the suggestion made by others that SR interventions can be improved when there is clinical, educational, and family involvement (Dube & Orpinas, 2009; Walter, Hauptmann, Rizk, Lehmkuhl, & Doepfner, 2014; Wimmer, 2013). Similarly, Kearney (2016) argued that treatment for SAPs needs to involve parents, school personnel, therapists, and medical professionals.

Potential for Using Multidisciplinary Teams for SR Interventions

A systematic review of mental health interventions undertaken in schools revealed that teachers and mental health professionals worked in partnership 41% of the time (Franklin, Kim, Ryan, Kelly, & Montgomery, 2012). When professionals work together in multidisciplinary teams it provides them with the opportunity to target complex needs when delivering interventions for youth. Indeed, multidisciplinary collaboration has been found to be critical in improving youth mental health (Weist, Axelrod Lowie, Flaherty, & Pruitt, 2001). A meta-analysis of bullying interventions examining educator only, clinician only, and combined delivery found better outcomes for programs that used a multidisciplinary team approach (Vreeman & Carroll, 2007). Multidisciplinary work has also been found to improve social and academic outcomes for young people (Eber, Breen, Rose, Unizycki, & London, 2008).

There are broader benefits that accrue from multidisciplinary work, as well as potential barriers to working in this way. Multidisciplinary teams that involved staff from Child and Adolescent Mental Health Services (CAMHS) and school-based teachers benefitted not only youth but also professionals, with partnerships leading to a broader targeting of at-risk young people (Clarke, Coombs, & Walton, 2003; Pettitt, 2003). Pettitt (2003) noted that multidisciplinary partnerships led to improvements in child mental health, improvements in home-school relationships, an increased understanding of mental health by teachers, and an increased understanding of the school context for clinicians. The potential barriers associated with multidisciplinary work include a lack of clear referral pathways, limited contact between teachers

and CAMHS clinicians (Vostanis et al., 2010), potential duplication of work, and the time investment required for working together on cases (Pettitt, 2003).

A wraparound model enables the benefits of multidisciplinary work while addressing the associated barriers. The wraparound model is a philosophy of care within a defined planning process used to build constructive relationships and support networks among youth and their families. It originally emerged from work with young people and families in cases involving emotional and behavioral disorders (Eber et al., 2008). Such models are usually community-based, culturally relevant, individualized, strengths-based, and family-centered (Eber et al., 2009). Intervention plans are comprehensive and address multiple life domains across home, school, and community. The wraparound model is a well-suited tertiary model that delivers specific interventions to young people experiencing a highly disproportionate level of risk factors relative to protective factors (Eber et al., 2009).

The disproportionate level of risk factors can be seen in SR where there may be multiple domains of problematic functioning (e.g., mental health problems, academic problems, social problems, school disengagement). Using multidisciplinary teams within a wraparound model could enhance SR interventions because a range of professionals target psychological well-being, quality of life (QoL), family functioning, and school reengagement. In support of this, Wimmer (2013) argued that a comprehensive approach to SR that addresses individual, family, school, and community variables using a collaborative team-based process is needed.

In Australia there has been minimal research on the use of multidisciplinary teams to address SR. A search of publications between 1995 and 2016 yielded three publications about multidisciplinary interventions for SR in Australia. All three publications described multidisciplinary work undertaken within one specialist adolescent education and mental health setting (McShane, Bazzano, Walter, & Barton, 2007; McShane, Walter, & Rey, 2001; McShane, Walter, & Rey, 2004). Findings from this work suggested that the following four factors were helpful in supporting young people returning to school. First, conducting the intervention in a familiar yet controlled environment is beneficial for the young person as part of the reengagement process. Second, the complexity of SR can be better addressed by involving education and health staff. Third, the use of taxis to support attendance is helpful. Fourth, it is beneficial to have a clinician who is available to families outside of usual business hours, to involve the young person in formal and informal social activities and to manage mental health needs (McShane et al., 2007).

Some international publications point to the use of multimodal approaches in the treatment of SR, such as individual CBT alongside parent work and teacher psychoeducation (e.g., Heyne, Sauter, Ollendick, Widenfelt, & Westenberg, 2014; Reissner et al., 2015; Walter et al., 2014). Some of these approaches describe the use of multidisciplinary teams in the delivery of the intervention (i.e., Reissner et al., 2015; Walter et al., 2014). On the whole, however, there is a need for more research focused on multidisciplinary interventions that incorporate health and education settings within a wraparound model of care.

The In2School Multidisciplinary Pilot Program for SR

The In2School pilot program for SR treatment grew out of suggestions in the aforementioned literature that working in multidisciplinary teams could improve outcomes for youth with SR. It was developed in response to increasing SR referrals to Travancore School in Victoria, Australia. Travancore School is a special education setting with a focus on mental health. Specifically, the number of young people referred to Travancore School due to SR increased from 21 in 2009 to 47 in 2013 (16% versus 32% of total referred cases for all school-based issues; McKay-Brown, Dalton, & Nixon, 2013). Travancore School works in partnership with two tertiary-level mental health services: The Royal Children's Hospital Mental Health (RCH MH) and Orygen Youth Health. Teachers at the school provide educational services to young people receiving mental health intervention, including liaison with the youth's mainstream education setting to translate mental health recommendations into school-based interventions. For young people not attending school, the teachers provide outreach support, such as meeting with the young person and developing return to school plans to support school re-engagement.

Prior to the development of the In2School program, treatment for SR typically involved assigning a clinician and teacher to support a young person displaying SR. Mental health and educational interventions were undertaken by professionals, but it was not customary to work in a close partnership over an extended time. Moreover, involved professionals discussed the interventions that would be used, but there was no standardized approach to supporting the young person, their family, and the staff at the young person's school. In general, the youth's return to mainstream school was not sustained. Because the young people were outpatients of a tertiary-level mental health service, the base model of care chosen for In2School was a wraparound approach specifically designed for complex presentations at the tertiary level (Eber et al., 2009). The intention was to improve outcomes for SR youth.

The aim of the current paper was to evaluate the initial outcomes of the piloting of the In2School intervention. The main research question was: Does a multidisciplinary

team-based intervention for middle-years SR youth with a mental illness influence their reengagement with, and attendance at school? A supplementary research question pertained to secondary outcomes, namely: Does the intervention address the complex needs of SR youth, with respect to their mental health and social functioning, educational learning, and QoL? Middle years[3] youth were targeted because 90% of the young people at Travancore School who presented with SR between 2009 and 2013 were in the middle years of schooling. While SR can occur in children and adolescents of all ages, Heyne and Sauter (2013) noted that there are higher referral rates and higher rates of school absenteeism among SR adolescents relative to younger SR youth. Heyne and Sauter also suggested that treatment outcomes for older school refusers are poorer than those for younger school refusers. This supports the notion that there is a need for effective interventions for SR youth in the middle years.

Methods

Participants

Participants were referred to In2School by their mental health service clinician at RCH MH. Young people were included if they met the following criteria: (1) aged between 11 and 15 years; (2) met RCH MH intake criteria (youth with severe and complex mental health problems that create significant impairment and/or risk of harm to themselves and/or their families); (3) presented with SR based on (a) missing at least 50% of total school time for at least 6 weeks and/or (b) experienced severe difficulty attending classes for at least 6 weeks which was associated with significant interference in the young person's or family's daily routine and/or (c) frequent premature departure from school over a 6-week period; (4) met one or more of the following DSM-5 (American Psychiatric Association, 2013) mental health diagnoses: mood disorder (persistent depressive disorder and major depressive disorder), somatoform disorders, generalized anxiety disorder, separation anxiety disorder, or social anxiety disorder; (5) lived in the Hume/Moreland local government areas[4]; and (6) parents were aware that their child was not attending school, were committed to taking part in the study and working toward their child returning to a mainstream (regular) educational setting. The exclusion criteria were: (1) intellectual disability; (2) living in residential care; (3) diagnosis of conduct disorder, oppositional-defiant disorder, or reactive attachment disorder; and (4) not being proficient in the English language.

The first eight referrals meeting these criteria were consecutively recruited into the In2School program over a period of 1 month in 2015. One family withdrew from the program during the intervention because the parents did not support a return to full-time schooling for their child. The remaining seven young people and their families completed the full intervention program and information presented in the paper refers to these participants. They included three males and four females aged between 12 and 14 years ($M = 13.0$, $SD = 0.8$). During the 6 weeks prior to referral, two young people had been attending school 1–2 days per week, one was attending less than 1 day a week, and four were not attending school at all. The duration of difficulty attending school ranged between 3–24 months ($M = 13.2$ months).

With respect to primary diagnoses, five youth were diagnosed with social anxiety disorder, one with depressive disorder, and one with generalized anxiety disorder. Some participants were diagnosed with more than one disorder. Secondary diagnoses included autism spectrum disorder ($n = 2$; 3 other youth received this diagnosis while participating in In2School), obsessive-compulsive disorder ($n = 1$), and selective mutism ($n = 1$). Mental health assessments were conducted by RCH MH clinicians from various allied health professions, classified as Grade 2 or Senior Clinician at the time of participant recruitment. All seven youth confirmed that they would like to return to school, even though some spoke of being overwhelmed by the idea.

Approval to conduct the study in a school setting was received from the Department of Education and Training Victoria. Human Research Ethics Committee (HREC) approval was also received from The Royal Children's Hospital and The University of Melbourne.

Measures

The primary outcome measure was school attendance. Attendance data was collected during the intervention and for 6 months after the youths' return to mainstream school. The data was collected by the In2School teachers during the intervention and by the teachers from the mainstream school following the intervention. Recent studies conceptualize successful outcome as 80% school attendance or higher (e.g., Melvin et al., 2017; Reissner et al., 2015; Wu et al., 2013) but in the current study the benchmark was set at 70% school attendance or higher across the 6-month follow-up period. Attendance data for SR youth referred to Travancore school indicated an average attendance rate of 25% before treatment, so a rate of 70% or higher after intervention was held to be clinically significant.

[3] In Victoria, middle years span the 6th year of primary school to the 2nd year of secondary school; these youth are often between 10 and 14 years of age.

[4] The geographical area was limited because the main funders of the project provided services in these areas.

Secondary outcome measures addressed mental health and social functioning, educational functioning, and QoL. Mental health and social functioning were included because youth recruited into In2School presented with mental health problems. Educational functioning and QoL were included because anxiety-based mental health disorders can impact educational achievement and school engagement (Gren-Landell, Tillfors, Furmark, Bohlin, Andersson, & Göran Svedin, 2009; Van Ameringen, Mancini, & Farvolden, 2003). The measures of secondary outcomes were administered pretreatment and posttreatment. Posttreatment was defined as 16 weeks after the commencement of phase one of the intervention.

Mental Health and Social Functioning

The Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA; Pirkis et al., 2005) is a 15-item clinician-rated measure designed specifically for use in the assessment of consumer outcomes for youth attending mental health services. Domains assessed include specific aspects of a young person's health and social functioning (e.g., behavioral problems, impairment, symptomatic problems, and social problems) and environmental aspects related to a lack of information or access to services (Gowers, Whitton, & Harrington, 1997). Scores of 2, 3, or 4 on any domain are considered clinically significant and indicate an area that may need intervention. This measure has good interrater reliability, evidence of discriminative validity, good sensitivity, and sound convergent and concurrent validities (Gowers, Bailey-Rogers, Shore, & Levine, 2000).

The clinician-rated Children's Global Assessment Scale (CGAS; Shaffer et al., 1983) provides a global measure of the level of functioning in young people on a 0–100 scale. Lower scores are indicative of more clinically severe levels of emotional and behavioral functioning. For example, a global score of 1–29 suggests the use of specialist inpatient services and a score between 30–69 suggests the use of specialist mental health services. This measure demonstrates adequate interrater and test–retest reliability (Bird, Canino, Rubio-Stipec, & Ribera, 1987).

The Strengths and Difficulties Questionnaire (SDQ; Goodman, 2001) is a 25-item behavioral screening questionnaire for young people aged 3–16 years. It is completed by both the parent and the young person. The 25 items are divided into five scales: emotional symptoms, conduct problems, hyperactivity/inattention, peer relationship problems, and prosocial behavior. This measure has good interrater and test–retest reliability (Goodman, 2001).

Educational Functioning

Educational functioning was assessed using the Motivation and Engagement Scale–High School version (MES-HS; Martin, 2014a). The MES-HS is a 44-item self-report questionnaire that measures both adaptive and maladaptive factors related to learning behaviors that are linked to school engagement. It measures three adaptive cognitive dimensions, three adaptive behavioral dimensions, three impeding/maladaptive cognitive dimensions, and two maladaptive behavioral dimensions. When working with the young person these dimensions are referred to, respectively, as booster thoughts, booster behaviors, mufflers, and guzzlers (Liem & Martin, 2012). The instrument has strong psychometric properties, including internal and external construct validity (Liem & Martin, 2012). The measure has not been used with SR youth with mental health disorders but there is a scoring option for non-normative groups, using the individuals' raw MES scores instead of the Motivation Quotient (MQ) scores (Martin, 2014b). For each dimension, scores are converted to a letter grade: A-grade is excellent, showing an area of strength; B-grade is good and can grow into an area of strength; C-grade suggests that some extra work is needed; and D-grade suggests that relatively more work is needed (Martin, 2014b).

Quality of Life

QoL was measured using the KIDSCREEN-27 (The KIDSCREEN Group Europe, 2006) and completed by both the parent and young person. The KIDSCREEN-27 assesses a young person's health and well-being and it is applicable for healthy and chronically ill children and adolescents aged 8–18 years. There are five Rasch-scaled dimensions: physical well-being, psychological well-being, autonomy and parents, peers and social support, and school environment. Respondents' scores are calculated for each dimension and compared across intervention time points to assess change. The KIDSCREEN-27 has good construct validity across all dimensions (The KIDSCREEN Group Europe, 2006).

Additional Measure

While not used as an outcome measure, the School Refusal Assessment Scale (SRAS-R; Kearney, 2002) was used to assess the function of the youths' school refusal, to inform intervention planning. The SRAS-R is a 24-item measure with four subscales representing four functions of the refusal to attend school: avoidance of school-based stimuli that provoke negative affectivity, escape from aversive social/evaluative situations, pursuit of attention from significant others, and pursuit of tangible reinforcement outside of school. Child and parent versions of the SRAS-R are available and show good test-retest and interrater reliability, and evidence of concurrent validity (Kearney, 2006). The two highest subscale scores were taken to represent the primary and secondary functions.

Table 1
Summary of Key Tasks Undertaken During Each Phase of the Program

Phase	Therapeutic work	Education work	Activities undertaken by teachers and clinician in partnership
One (up to 4 weeks)	• Hand over and joint session with previous clinician • Therapeutic goal setting • Review mental health/SR history • Screening for additional clinical assessments • Parent meetings • Consider medication review • Family therapeutic support • Individual therapeutic sessions with young person commences	• Educational goal setting • Rating stressful school situations • Screening for additional educational assessments • Contacting schools for educational history • Development of ILP • Family communication and liaison • Family educational goal setting	• Engagement and rapport building • Program expectations with parent and child • Working in transitional classroom • Assessing appropriateness of school placement • Coaching to get youth to attend transitional classroom • Home visits (if required) • Travel training
Two (up to 10 weeks)	• Specialist assessments • Individual parent work • Medication/psychiatrist review • Care coordination • Family therapeutic support	• Full time attendance at *In2School* classroom • School liaison • Curriculum development and delivery • Positive support plans • Positive behaviour classroom interventions • Implement and review ILPs • Community based excursions • Family communication and liaison	• Evening parent group series • Classroom group program • Family phone support • Home visits (if required) • Psychoeducation session for partner school staff • Return to school plans • Travel training • Commence process of enrolment and transfer to new school (if required)
Three (up to 6 weeks)	• Individual therapy continues • Medication/psychiatrist review • Plan for discharge or transfer of care • Referrals to community • Family therapeutic support	• Individual education support at partner school for young person • Final education report • Transfer to outreach team (if required) • Professional learning re educational strategies for teachers at partner school	• School meetings • Attending partner school with youth • Support partner school staff • Daily check-in with school and family • Program review and evaluation • Further psychoeducation partner school staff as required

Note: ILP = Individual Learning Plan.

Procedure

The In2School program was developed by a steering group of researchers, teachers, and mental health clinicians with expertise in SR. The program was designed to have three phases, each with a specific objective and set of tasks. The literature on SR interventions informed each of the three phases of the In2School program. The first phase (up to 4 weeks long) is the introduction, and it focuses on the administration of mental health and educational assessments, building rapport between the young person and each team member, and gradual introduction to the classroom. Phase two (up to 10 weeks long) is the classroom and therapeutic intervention phase, involving young people attending the In2School classroom 4 days a week for up to 10 weeks. During this phase participants are engaged in education and therapy based on team members' analysis of their needs as assessed during phase one. Phase three (up to 6 weeks long) involves a supported return to the mainstream school setting. The key tasks of each phase are outlined in Table 1 and described below.

Personnel involved in the delivery of In2School included: a senior social worker with a broad range of clinical skills (including CBT and systemic therapy) and two teachers (with combined teaching experience of 20 years, including experience working with young people displaying SR).

The In2School program was underpinned by an action research methodology. It used a cyclical model of inquiry, action, and reflection to evaluate and plan for each new cohort of young people. As is typical of action research, the model is continually refined. In practice, and in keeping with the philosophy of a wraparound model, the interventions were individualized for each young person based on assessment measures and their educational and mental health needs. Implementation of each phase also included some flexibility in delivery to address the needs of the participants and their families. In this way, the action research was considered emancipatory. Emancipatory action research is a research methodology committed to social change that aims to be empowering and transformative for researchers and participants alike (Ledwith, 2005). This approach has been used in health and education settings and is compatible with a wraparound model of support. It focuses on collaboratively investigating an identified issue or problem from practice (Zuber-Skerritt, 1996), then moving through several cohorts to transform this practice. In the case of the current study, the practice to be transformed was working in a multidisciplinary team with young people who are school refusing.

Phase One

Participants were recruited in phase one and informed consent was obtained from parent(s) and the young person. Youths needed to demonstrate a commitment and motivation to return to school. This was initially discussed by the clinical case manager when presenting the program to the young person and their family and again by the In2School team during an information meeting with the family as part of the recruitment process. While some young people initially presented with lowered motivation, they had the opportunity to spend time thinking about possible risks and benefits of engaging in the program before making a decision. Baseline assessment was undertaken using the primary and secondary outcome measures. The young person's Care and Recovery Plan was co-developed between the In2School program clinician, the young person, and their family. Individual therapy commenced during this phase.

An Individual Learning Plan (ILP) was co-developed between the In2School program teachers and the young person. In order to better target the educational interventions, the function of the young person's SR was assessed via the SRAS-R (Kearney, 2002). This measure allowed the teachers to be aware of school-based barriers to engaging with education. By understanding the function of the refusal to attend school, teachers could target the development of specific skills such as help-seeking when feeling anxious about completing tasks (for the function "avoidance of school-based stimuli that provoke negative affectivity") or working in a group (for the function "escape from aversive social/evaluative situations"). The SRAS-R results (see Table 2) indicated that five young people scored highest on Function 1 (avoidance of negative affect). For four young people, scores on Function 2 (escape from social evaluation) were within 0.5 points of Function 1, reflecting a mixed functional profile. For two other youth, the scores on Function 1 and Function 3 (pursuit of attention from significant others) were also within 0.5 points of each other.

The MES-HS helped the young person become aware of their learning behavior strengths and barriers. Goals were developed to support self-confidence, valuing school,

Table 2
Combined Youth and Parent Scores (from 0 to 6) on the School Refusal Assessment Scale-Revised at Pretreatment

SRAS-R *(N=7)*	Avoidance of negative affect	Escape from social evaluation	Attention-getting behavior	Positive tangible reinforcement
Case A	4.75	2.66	3.25	0.75
Case B	4.83	2.08	3.00	1.67
Case C	4.17	5.00	3.00	0.83
Case D	4.83	4.58	2.17	0.92
Case E	4.58	4.65	5.42	2.75
Case F	5.42	5.42	5.58	1.75
Case G	3.66	1.83	1.50	1.83

Note. SRAS-R = School Refusal Assessment Scale – Revised.

being focused on learning, planning study, and trying hard (Martin, 2014b). Other educational assessments, not discussed in this paper, were used to develop an academic curriculum at an appropriate level for each young person.

When attendance at the In2School classroom commenced, participants worked individually in one-to-one lessons with the program teachers. Sessions lasted approximately 1 hour and involved short learning tasks and playing games. The In2School classroom was referred to as a transitional classroom because it was used to provide an interim space where the young people were prepared for a return to mainstream school. Initially, for most young people, there were up to four such lessons over approximately 2 weeks (i.e., 4 hours of school over 2 weeks). Thereafter, young people completed lessons in dyads and triads over a subsequent 2-week period. The activities included a combination of playing games, undertaking academic work, and going out for lunch.

During phase one a suitable mainstream partner school was identified for the young person to transition to during phases two and three. In the first instance, it was the intent of the program team to help the young person return to the school they were attending prior to commencing In2School. If this was not possible (e.g., because of a breakdown in the school/family relationship or a bullying issue that could not be resolved) the program team worked with the family to identify a different partner school.

Phase Two

During phase two participants transitioned fully into the transitional classroom and this happened individually for each young person. Some young people attended full-time immediately, while others needed to increase their attendance in a more gradual fashion. For example, some youth attended four half days in the first week, followed by three half days and one full day the following week. The transitional classroom aimed to provide a space to support young people to reengage with a classroom setting, learn and practice social skills, and spend time with peers. It also provided a safe, consistent, and contained environment in which participants could engage with their educational and therapeutic recovery plans. Once the full-time program commenced, lessons included independent learning projects, social skills, coping skills, literacy, math, art, and physical education. The young people also spent one day each week "out and about" with teachers. During this time they undertook an activity in the community to foster their social connection and help them learn how to travel independently on public transport. The young people attended school Monday between 10:00 a.m. and 3:00 p.m. and Tuesday to Thursday between 9.00 a.m. and 3.00 p.m. Fridays were allocated to additional individual therapy sessions and the commencement of exposure to partner schools.

The clinician continued to provide individual therapy to the young people during phase two. Therapeutic procedures included cognitive therapy together with other techniques such as exposure therapy, social skills education using the Social Thinking framework (Winner, 2003), psychoeducation, behavior modification using reinforcement, and narrative-informed practice. Interventions such as social skills training and psychoeducation were also undertaken in the classroom with the teachers and clinicians working in partnership. This permitted the young people to learn skills in situ and facilitated the transfer of skills to the partner school setting. This also enabled the clinician to observe how the young people reacted to different situations (e.g., being asked a question by the teacher in front of the group) and to immediately prompt and support specific coping skills, following up with the young person during subsequent individual sessions.

Behavior modification strategies included the use of visual timetables and classroom expectations linked to reward schedules. Unhelpful behaviors were also replaced with functionally equivalent desirable behaviors. An example of this is the unhelpful behavior of refusing to enter the classroom in the morning and requesting to go home, being replaced with the communication skill of letting the teacher know they are feeling anxious and requesting to have 5 minutes to use their relaxation training before entering the classroom. Narrative-informed practice focused on working with the young person to externalize their problems. As such, a young person might look at their anxiety as an unwelcome visitor and the clinician would guide them through a series of activities where they speak to the problem, discuss how it impacts them physically and emotionally, and work out ways to manage it effectively. This work might include the use of drawings and stories.

Staff from partner schools were provided with psychoeducation about SR and information about the identified functions of SR for the young person in question. Some young people began transitioning to their partner school between 2 and 5 weeks after commencing full-time attendance in the transitional classroom. These young people had expressed their readiness to attempt a graduated return to their partner school. For instance, a young person attended one half day at their partner school to participate in preferred subjects, while spending the rest of the time in the transitional classroom. Young people who were not spending any time at their partner school after 5 weeks' full-time attendance in the transitional classroom were encouraged to participate in a more nuanced graded exposure to the partner school. For example, the young person was encouraged to commence with an initial visit to the school grounds out of hours, progressing to a short meeting at school with an identified

supportive staff member. Graded exposure steps were tailored to each individual.

Parent commitment to the program was an inclusion criterion and involved attending evening groups, parent sessions with the clinician, and a willingness to change some parenting practices and adopt new and different strategies to support their child. Parent work occurred during a 5-week group program of 1-hour evening sessions during phase two. Topics covered included: understanding SR and the functions of SR according to the SRAS-R; sleep hygiene; boundary setting and parenting styles; emotional blocks for parents; keeping parents accountable; and parent/family morning routine. Additional parent work and family therapy were included as required and based on the clinical judgement of the mental health clinician. These sessions were generally well attended. However, some single parents had difficulty attending all sessions.

Phase Three

Phase three involved continued parent support and the young person's graded return to the partner school until they were attending the partner school full-time. During this phase the program teachers and clinician provided extensive outreach support to each young person and staff at the respective schools. This involved supporting the parent to get the young person to school, visiting the young person at the partner school to continue to problem solve academic or social/emotional difficulties, and liaising with key staff involved in the process of returning to school. Staff from the partner school were coached to employ support strategies for the young person during their return to the partner school. Examples of support strategies include a structured check-in time with an identified school support person, prompting the young person to use coping skills, supporting the young person to seek out safe spaces when they needed a break, and maintaining effective home-school communication.

Data Analysis

Descriptive statistics have been used to summarize demographic data pertaining to the cohort to date. Due to the small sample size, primary and secondary outcome measures were analyzed via means and standard deviations of aggregated data.

Results

The data presented here are drawn from the first cohort of participants in In2School (n = 7). Aggregated results are reported and where individual results are presented each young person has been assigned a case from A – G. Data are based on pretreatment functioning and, unless otherwise stated, functioning at posttreatment (i.e., 16 weeks after the commencement of phase one of the intervention). Thus, posttreatment assessment occurred in the period in which it was anticipated that the young person would have returned to the partner school full-time.

Limited follow-up data was available at the time of writing this paper. However, HoNOSCA data was available 4 months subsequent to each youth's return to the partner school. At this time the youth were either discharged from the RCH MH service or had transitioned to a new clinician in the community mental health service within the hospital. Follow-up data on school attendance was collected six months after the return to the partner school.

Primary Outcome

Across the seven youth, attendance during the weeks spent in the transitional classroom ranged between 45% and 97% (M = 85%, SD = 12.3). Once the graduated transition back to the partner school was completed, all seven participants were attending school 5 days a week. After 10 weeks at the partner school, one young person had a relapse and their parent enrolled them in a distance education program. By the 6-month follow-up, the average attendance for five young people ranged between 70% and 95% of the time (M = 82.6%, SD = 10.1). The other young person averaged 69% attendance during the 6 months since returning to the partner school, falling just short of the 70% success criterion. Soon after this time, one of the six young people who had been attending school regularly started disengaging from school (i.e., attendance became erratic and their mood worsened). In response, the partner school provided increased support for the family and helped the young person attend a general practitioner to access pharmacological and mental health support. In the four weeks following this additional support, the young person increased their school attendance again.

Secondary Outcomes

One of the secondary outcomes was mental health together with social functioning. The clinician-rated HoNOSCA was used to ascertain changes in the young person's general health and social functioning after participation. Table 3 presents HoNOSCA scores. For all scales, there was an overall decrease in scores suggesting improved mental health and social functioning for young people. The two domain scores that showed the greatest decrease were behavior and social functioning.

A measure of global mental health and social functioning was the CGAS. CGAS scores showed minimal change after the intervention. Pretreatment scores ranged from 31 – 50 (M = 43.7, SD = 6.2) and posttreatment scores ranged from 38 – 55 (M = 47.0, SD = 5.7). CGAS

scores range from 0 – 100 with scores between 1 – 29 representing severe functioning. As such, the young people in the current study demonstrated moderate functioning in most areas at pre- and posttreatment.

Mental health and social functioning were also assessed via parent and youth responses to the SDQ (see Table 4). There was an aggregate reduction (from borderline to normal levels) between pre- and posttreatment with respect to overall difficulties. Parent reports indicated reductions from pre- to posttreatment in emotional stress, behavioral difficulties, hyperactivity, and peer problems, but no change with respect to kind and helpful behavior. Youths' reports indicated improvement in all areas, including kind and helpful behavior.

Table 3
HoNOSCA Scores at Pretreatment, Posttreatment, and Follow-up

HoNOSCA (*n*=7)	Pre-treatment		Post-treatment		4-month follow up *	
	mean	(s.d.)	mean	(s.d.)	mean	(s.d.)
Clinical score	20.25	(4.95)	17.28	(3.77)	10.71	(3.19)
Behavior	3.57	(2.37)	4.28	(2.13)	1.86	(1.46)
Impairment	1.85	(1.77)	1.14	(2.03)	0.71	(1.25)
Symptoms	4.71	(1.11)	5.00	(1.14)	3.00	(1.41)
Social functioning	10.14	(3.02)	6.85	(1.34)	5.14	(1.57)

Note: HoNOSCA = Health of the Nation Outcome Scales for Children and Adolescents.

* HoNOSCA data is collected at discharge from the service so the data was collected 4 months after post treatment rather than at 6 months with other follow up data.

Table 4
Youth and Parent Reports on the Strengths and Difficulties Questionnaire at Pretreatment and Posttreatment

	Pre treatment		Post treatment		Change in score
	mean	(s.d.)	mean	(s.d.)	
Young person (*n*=7)					
Overall stress	18.17	(6.75)	14.50	(5.50)	3.67
Emotional stress	5.50	(2.07)	3.83	(2.48)	1.67
Behavioral difficulties	2.67	(3.01)	2.00	(1.26)	0.67
Hyperactivity and concentration difficulties	6.17	(2.78)	5.50	(3.39)	0.67
Difficulties getting along with other children	3.83	(2.56)	3.17	(1.77)	0.66
Kind and helpful behavior	4.67	(4.08)	6.33	(2.50)	-1.66
Impact of difficulties on young person	4.00	(2.44)	1.83	(1.60)	2.17
Parent (*n*=7)					
Overall stress	19.43	(5.31)	13.29	(3.49)	6.14
Emotional stress	7.57	(2.22)	5.00	(.81)	2.57
Behavioral difficulties	2.86	(2.26)	1.43	(1.71)	1.43
Hyperactivity and concentration difficulties	4.43	(2.63)	3.86	(1.34)	0.57
Difficulties getting along with other children	4.57	(2.99)	3.00	(2.58)	1.57
Kind and helpful behavior	5.71	(3.09)	5.00	(2.76)	0.71
Impact of difficulties on young person	6.57	(3.45)	4.14	(2.47)	2.43

Table 5
Motivation and Engagement Scale Scores and Letter Grades for Each Young Person

	Global Booster Thoughts		Global Booster Behaviors		Global Muffler		Global Guzzler	
	pretreatment (Global grade)	postreatment (Global grade)	pretreatment (Global grade)	postreatment (Global grade)	pretreatment (Global grade)	postreatment (Global grade)	pretreatment (Global grade)	postreatment (Global grade)
Case A	92 (B)	98 (A)	92 (A)	97 (A)	67 (C)	35 (B)	18 (C)	16 (C)
Case B	55 (D)	63 (D)	36 (D)	44 (D)	76 (D)	73 (D)	32 (B)	25 (B)
Case C	61 (D)	66 (D)	50 (D)	55 (C)	44 (B)	51 (C)	59 (D)	25 (B)
Case D	52 (D)	60 (D)	33 (D)	36 (D)	44 (C)	41 (C)	72 (D)	61 (D)
Case E	15 (D)	24 (D)	20 (D)	19 (D)	14 (A)	20 (A)	36 (C)	66 (D)
Case F	79 (C)	*	82 (B)	*	66 (C)	*	50 (C)	*
Case G	74 (C)	*	31 (D)	*	30 (A)	*	34 (B)	*

* Missing data.

Table 6
Quality of Life According to Youth and Parent Reports on the KidSCREEN-27 at Pretreatment and Posttreatment

Young person (n=7)	Pre treatment		Post treatment		Change in score
	mean	(s.d.)	mean	(s.d.)	
Physical Well-being	12.14	(4.67)	13.33	(5.85)	1.19
Psychological Well-being	19.43	(4.07)	25.00	(4.33)	5.57
Autonomy and Parent Relation	26.29	(4.42)	26.60	(6.58)	0.31
Social Support and Peers	8.86	(7.64)	9.67	(6.71)	0.81
School Environment	7.71	(4.71)	13.67	(3.38)	5.96
Parent report (n=7),					
Physical Well-being	9.57	(1.90)	14.17	(3.25)	4.60
Psychological Well-being	14.57	(3.04)	24.50	(4.13)	9.93
Autonomy and Parent Relation	24.57	(2.50)	26.83	(4.44)	2.26
Social Support and Peers	6.86	(2.85)	10.17	(5.60)	3.31
School Environment	7.00	(1.89)	14.00	(2.19)	7.00

Educational functioning, measured via the MES-HS, is shown in Table 5. For most young people the scores for motivation boosters (adaptive cognitions and behaviors) increased, indicating improvement. For the other dimensions—motivation mufflers (impending/maladaptive cognitions) and guzzlers (maladaptive behaviors)—a decrease in raw scores indicated improvement. However, results in these domains were mixed; some young people showed improvement while others showed little change or a worsening of functioning.

QoL data is presented in Table 6. Most improvement was evidenced in youth and parent reports of psychological wellbeing (viewing life positively, being satisfied with life, feeling emotionally balanced) and school environment (feeling happy at school and doing well). Other dimensions of QoL similarly increased, according to the reports of the parents and young people.

Discussion

The In2School program was developed using a wraparound model to improve outcomes for a first cohort of SR youth. Preliminary outcomes suggest that the wraparound model, using teachers and a clinician working in partnership within a transitional classroom, may be a promising intervention to help SR youth return to mainstream school. Five of the seven young people had high levels of school attendance 6 months after their return to mainstream school. In this way, they met the benchmark for the primary outcome measure. One young person had attendance just below the benchmark level but this could still be considered a notable achievement because they had not attended school for 6 months prior to commencing the In2School program. Six months after return to mainstream schooling, one young person was no longer attending school due to complex family issues that required ongoing therapeutic support. This young person was actively involved in distance education and satisfied family expectations by participating in daily lessons from home.

The mental health and social functioning of young people participating in In2School improved, alongside improvements in their school attendance. This was observed in clinician-rated health outcome measures. While statistical tests of change were not appropriate to this small sample, the overall mean reduction on the total HoNOSCA scores suggested an improvement above what is normally found in clinical outcomes. As a comparison, two Australasian studies of youth with anxiety disorders reported clinically significant pre-post decreases in HoNOSCA scores, and the decreases were smaller than those observed in the current study (McShane et al., 2007; Tokolahi, Em-Chhour, Barkwill, & Stanley, 2013). The fact that participants in those studies had lower overall impairment scores prior to intervention, relative to youth in the In2School cohort, could be taken to suggest that the interventions of the In2School program were influential in reducing the impact of the youth's mental health problems. Reports from parents and young people in the In2School program also indicated adaptive changes (e.g., SDQ scores), suggesting that the psychological wellbeing of the young people had improved across the course of the intervention.

It could be argued that the mental health problems of the youth who participated in the In2School program had served as a barrier to regular school attendance prior to participation in the intervention. It may have been their participation in the In2School program which was instrumental in improving their mental health and level of coping, such that they could reengage with the mainstream school setting. To test this idea, a randomized controlled trial of the In2School intervention needs to be conducted, making use of mediational analysis (e.g., do improvements in mental health occur prior to improvements in school attendance).

There was less evidence of change in youths' learning behaviors, and wide variation in scores on the various

dimensions of this construct. The role of academic competence needs to receive more attention in SR research (Lyon & Cotler, 2007), especially given that difficulty performing in certain situations (e.g., oral presentations, group work, exams) can contribute to SR (Wimmer, 2013). Research suggests that when motivated and engaged, a young person can achieve better marks at school, work more effectively on difficult schoolwork, understand more of their schoolwork, and enjoy school more (Martin, 2014a). The booster thoughts and booster behaviors scales used in the current study indicated some improvements in the areas of learning focus, persistence, self-belief, and task management, but improvement was not observed for mufflers and guzzlers. Mufflers reflect characteristics such as anxiety, failure avoidance, and uncertain control, while guzzlers reflect characteristics of self-sabotage and disengagement. The current findings regarding mufflers and guzzlers align with a study by Maric, Heyne, de Heus, van Widenfelt, and Westenberg (2012), in which SR youth reported higher levels of negative automatic thoughts around personal failure compared to a general population sample.

A possible explanation for the lack of improvement in mufflers and guzzlers, despite SR youths' participation in the In2School program, is that there was insufficient intervention regarding negative thinking and self-talk. The development of young people's learning behaviors needs to be considered as part of the action research methodology in future iterations of the In2School program. A more intensive focus on developing helpful cognitions may be required. Thus, while positive mental health outcomes might be achieved via In2School, ongoing cognitive therapy may be required to help reduce characteristics such as failure avoidance in the school environment.

The current study was the first to evaluate QoL in relation to the treatment for SR. Our decision to measure QoL was influenced in part by the fact that mental health disorders have a deleterious impact on QoL (Gren-Landell et al., 2009; Van Ameringen et al., 2003). Furthermore, SR is associated with family dysfunction (e.g., Carless, Melvin, Tonge, & Newman, 2015; Ingul, Havik, & Heyne, 2018), which has been associated with QoL in populations with other mental health issues (LaFrance et al., 2011; Predescu & Şipoş, 2017). The reports of parents and young people in the present study indicated that the greatest areas of improvement in QoL were psychological well-being and school environment. It is possible that the In2School program, which includes the provision of positive and enjoyable classroom experiences, contributed to an improvement in QoL. The transitional classroom, a safe space to learn how to reengage in an educational setting, may have helped youth cope with school, feel better about themselves, and develop positive relationships with teachers. In support of this, the young people who participated in Bloom's (2007) separate classroom for school phobic youth reported that having that space was supportive, and it encouraged high rates of attendance.

Parent Involvement

Studies suggest the importance of parent involvement in SR treatment (Carless et al., 2015; Heyne & King, 2004; Heyne & Sauter, 2013; Tolin et al., 2009). In the In2School wraparound model, parents are helped to play a crucial role as the key providers of support at home, particularly around their child's school attendance. During the parent sessions, some parents were observed to have difficulty setting routines and boundaries in the home, and they needed additional support with this. This was specifically evident in relation to school attendance. For example, the parent whose child disengaged from school after completion of the program had found it difficult to change their parenting behavior when the young person had trouble with school attendance. The parent vigorously challenged the therapist's suggestion that the refusal to attend school may be linked to parenting behaviors. This may explain, in part, why the young person started refusing to attend school soon after the intensive support of the In2School program was removed. Another parent felt unable to help her son initially, but was then able to embrace the support and strategies recommended via In2School. In this case, increased parental empowerment was potentially influential in the young person being able to attend school full-time. Indeed, prior studies have found a link between parenting self-efficacy and SR (Carless, Melvin, Tonge, & Newman, 2015) and between parent participation in SR treatment and an increase in self-efficacy for managing SR (Heyne, Sauter, Van Widenfelt, Vermeiren, & Westenberg, 2011). Future evaluation of the In2School program would benefit from an evaluation of the temporal changes in parent self-efficacy and increased school attendance.

Wraparound Model

A key part of the In2School program is the wraparound model, which makes use of a multidisciplinary team to prepare young people for a return to mainstream educational settings. Previously, barriers to school return among SR youth have included teachers' lack of opportunity to contribute to the care plan, and an undervaluation of teachers' expertise by mental health professionals (Rothi & Leavey, 2006). By contrast, the wraparound model associated with the In2School program encouraged the multidisciplinary team to share their knowledge, expectations, and support plans. It emphasizes a collaborative approach to strengthen the intervention. This collaboration involves a partnership between the young person, family, clinician, and teacher in order to

develop suitable goals for mental health and education. These goals are then communicated to key personnel in the partner schools. Moreover, the clinician was welcomed to visit the classroom setting and teachers could attend relevant therapeutic sessions. As part of the model, teachers provide academic and environmental accommodations for the partner schools, and the clinician helps school staff understand youths' mental health issues and coping strategies. Conceptually, the collaborative wraparound approach of the In2School program is likely to have a positive impact on outcomes for SR youth.

There are also barriers that can hinder the implementation of a wraparound model. In the current study, these included the lack of timely communication of relevant information between RCH MH and Travancore School, and limited time for collaboration between professionals. These barriers have been noted in other studies examining the interface between education and mental health services (Burkey, Kaye, & Frosch, 2014; Cooper, Evans, & Pybis, 2016; Rothi & Leavey, 2006; Vostanis et al., 2012). Another barrier to implementing the wraparound model was the lack of shared access to information due to differing protocols and electronic recording systems across organizations. This complicated the sharing of clinical and educational information which was necessary for collaborative planning of group sessions and the development of intervention materials. Spong, Waters, Dowd, and Jackson (2013) also described systemic issues that can make collaborative work difficult, such as the absence of protocols and processes for collaborative work. Future iterations of In2School will be enhanced via better alignment of health and education systems for record keeping and file sharing.

Limitations

There are various limitations to the current study that warrant consideration. First, the findings are based on a small sample. This will be ameliorated as data is gathered from subsequent cohorts participating in In2School. Second, there was no examination of the impact of different interventions (e.g., CBT, social skills programming, educational interventions) on the primary and secondary outcomes. A third, related point is that various phases and key tasks associated with the intervention have been specified, but it is unclear whether the positive outcomes should be ascribed to the intervention method as a whole or to specific phases or tasks of the intervention. In keeping with action research methodology, it would be helpful to examine individual cases using a case study design and qualitative data (e.g., participant interviews using a grounded theory approach). Using multiple data sources (e.g., young people, parents, clinicians, and teachers) and triangulating these via cross-validation could yield different insights about key aspects of the intervention, increasing the credibility of the current findings (McMillan & Schumacher, 2010). Finally, there was no comparison group to determine whether the outcomes for young people who participated in In2School are similar or different to the outcomes for those SR youth receiving standard care through RHC MH and Travancore School.

Conclusion

In2School is a program that includes established cognitive and behavioral interventions for SR, together with an outpatient classroom program, parent groups, attention to social skills, provision of psychoeducation for staff at partner schools, and intensive outreach support to facilitate the young person's return to the partner school. Most important, it has as its center a multidisciplinary education- and health-focused partnership. Initial findings based on this piloting of the In2School program suggest that a wraparound model for SR intervention may support return to school while improving young people's health outcomes and QoL. To be confident about the impact of the content and process of the In2School intervention, comparative studies need to be conducted (e.g., intervention versus wait-list or nonwraparound models of intervention). As an interim step, results need to be replicated across cohorts. To that end, data from future cohorts of young people in the In2School program will contribute to the research base required to establish the replicability of these pilot results. Longer-term evaluation of the program in relation to participants' sustained attendance at school will be evaluated in future research.

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