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The Link: An Alternative Educational Program in the Netherlands to Reengage School-Refusing Adolescents With Schooling

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Facets of school life affect the development and maintenance of school refusal (SR). These facets will warrant attention during intervention for SR. This paper considers a range of school-related factors associated with SR, grouped according to five domains of school climate. It also describes school-based interventions for SR in the form of alternative educational programs (AEPs). The paper then presents the Link, an AEP for Dutch adolescents with SR. The Link offers an educational setting that addresses school-related factors associated with SR. After participation in the Link, adolescents are helped to return to a more typical educational setting. Based on a review of 30 case files, we provide an account of adolescents who have participated in the Link. Often, these adolescents displayed chronic and severe SR, met criteria for anxiety or depressive disorders, and were diagnosed with an autism spectrum disorder. The Link process is illustrated via a case vignette. Thereafter, the role of AEPs in the treatment of SR is discussed.

Ideally, school is a place where youth[1] feel safe, are engaged in learning, and interact with peers. When school falls short of this ideal it may become difficult for some youth to attend school. Difficulty attending can lead to intermittent or continuous absence. In turn, absenteeism jeopardizes academic development (Carroll, 2010) and social-emotional development (Malcolm, Wilson, Davidson, & Kirk, 2003). It also puts youth at risk for early school dropout (Calderon et al., 2009; Christle, Jolivette, & Nelson, 2007). Longer-term problems associated with dropout include unemployment, imprisonment, ill-health, and marital problems (Kearney, 2016).

School refusal (SR) is one type of school attendance problem (SAP), alongside other types such as truancy and school withdrawal (Heyne, Gren-Landell, Melvin, & Gentle-Genitty, 2018). Berg and colleagues (Berg, 1997, 2002; Berg, Nichols, & Pritchard, 1969; Bools, Foster, Brown, & Berg, 1990) defined SR using the following criteria: (a) reluctance or refusal to attend school, often leading to prolonged absence; (b) usually being at home during school hours rather than concealing the problem from parents; (c) the presence of emotional upset at the prospect of attending school (e.g., somatic complaints, fearfulness) or more generally (e.g., anxiety or depressive disorder); (d) an absence of severe antisocial behavior, beyond the youth's resistance to parent attempts to get them to go to school; and (e) a history of parent efforts to secure their child's attendance at school. Criteria b, c, and d help differentiate between SR and truancy because truancy is often regarded as absenteeism occurring without parents' knowledge, there are frequent reports of correlations between SR and internalizing behavior, and externalizing behavior is more commonly associated with truancy than with SR (Heyne et al., 2018). Criterion e helps differentiate between SR and school withdrawal because the latter is characterized by parents' ambivalence or opposition toward the child attending school (Kahn & Nursten, 1962). SR, the focus of this paper, occurs for between 1% and 2% of school-aged youth (Egger, Costello, & Angold, 2003; Heyne & King, 2004). Estimates of SR among clinic-referred youth range between 5% and 16% (Heyne & King, 2004).

Adolescence is an important developmental period with respect to SR. First, referral for treatment is more common among adolescents relative to children (e.g., Last & Strauss, 1990; McShane, Walter, & Rey, 2001). Second, adolescent SR is associated with higher rates of absenteeism and fear, and a more complex clinical presentation (Heyne, 2018). Third, there are indications that treatment may be less effective for adolescents. While

[1] The term "youth" is used to refer to children and adolescents.

Keywords: school refusal; school-related factors; alternative educational program; adolescence; autism spectrum disorder

age effects have not been examined in large studies, numerous smaller studies of CBT for SR (Heyne, 1999; Last, Hansen, & Franco, 1998) and non-CBT for SR (Prabhuswamy, Srinath, Girimaji, & Seshadri, 2007; Rodriguez, Rodriguez, & Eisenberg, 1959; Valles & Oddy, 1984) point to inferior outcomes for adolescents relative to children. This contrasts with studies of CBT for youth anxiety whereby adolescents do not show poorer outcomes (Bennett et al., 2013; Kendall & Peterman, 2015). The contrast may signal differences between anxiety disorders and SR, with respect to the nature and treatment of these problems (Heyne, 2018). Fourth, treatment for adolescent SR may need to differ from treatment for childhood SR (Heyne & Sauter, 2013; Heyne, Sauter, Ollendick, van Widenfelt, & Westenberg, 2014). In particular, greater consideration may need to be given to the role of the school context during treatment. According to Galloway (1985), SAPs are increasingly influenced by school-related factors as youth grow older. Secondary school presents adolescents with a larger and more complex environment involving multiple teachers, moving between classes, and needing to function more autonomously (Steinberg, 2005, cited in Holmbeck, Devine, Wasserman, Schellinger, & Tuminello, 2012). This likely explains the increase in SR when youth transition from primary to secondary school (Thambirajah, Grandison, & De-Hayes, 2008). For vulnerable youth, the increased demands associated with secondary schooling may contribute to SR.

School-Related Factors Associated With School Refusal

The separation anxiety theory was the dominant etiological theory of SR for a long time, emphasizing anxiety associated with leaving the parents rather than anxiety about going to school (Pilkington & Piersel, 1991). Pilkington and Piersel argued for a shift in research, to emphasize "the possible causal attributes of the school system and personnel in the etiology and maintenance of SR" (p. 300). Research has begun to focus on school-related factors. In a recent study, youths' perceptions of peer relations at school and teachers' classroom management were examined for their relationship with SAPs (Havik, Bru, & Ertesvåg, 2015). School factors were found to be more strongly related to SR[2] than truancy. Steinhausen, Müller, and Winkler Metzke (2008) similarly reported that SR youth[3] "suffered most from the school environment," relative to truanting youth and youth without a SAP (p. 9). Havik et al. (2015) even argued that "school factors … most likely play a significant role in SR regardless of individual or parental risk factors" (p. 234).

Drawing on the SR literature and the broader literature on SAPs, we consider school-related factors that may pose a risk for the development or maintenance of SR. These factors are considered within the framework of "school climate." School climate refers to the "quality and character of school life" (Cohen, McCabe, Michelli, & Pickeral, 2009, p. 182) and it has been divided into five domains: (a) order, safety, and discipline; (b) academic outcomes; (c) social relationships; (d) school facilities; and (e) school connectedness (Zullig, Koopman, Patton, & Ubbes, 2010).

Order, Safety, and Discipline

In a study of psychosocial factors associated with SAPs, Egger et al. (2003) found that SR youth attended dangerous schools more often than truanting youth or youth without SAPs. Havik, Bru, and Ertesvåg (2014) interviewed parents of school refusers (10–18 years old) about school factors held to be associated with their child's SR. Themes that emerged from the parents' accounts were changes in routines, lack of predictability (e.g., less structured lessons), and noisy classrooms.

Academic Outcomes

The domain of academic outcomes refers to youths' performance as well as youths' perceptions of the academic program (e.g., meaningfulness of the curriculum; Zullig et al., 2010). In McShane and colleagues' (2001) description of SR adolescents referred to a psychiatric unit, academic difficulties were one of the major stresses related to the onset of SR, occurring for almost one-third of the adolescents. Academic difficulties[4] experienced by SR adolescents were predictive of poorer educational and occupational adjustment 3 years after treatment (McShane, Walter, & Rey, 2004). Fear or anxiety related to academic performance is also associated with SR. Gullone, King, Tonge, Heyne, and Ollendick (2000) found that fears of failure and criticism were among the most common fears reported by clinic-referred SR youth. Egger and colleagues' community study (2003) revealed that performance anxiety was more common among SR youth compared to truanting youth and youth without SAPs.

While academic difficulties and performance anxiety can be viewed as individual characteristics rather than school-related factors, they highlight the importance of school staff carefully monitoring SR youths' academic progress and anxieties, and providing extra support as required. The importance of school staff providing

[2] The authors used the term "school refusal related reasons for nonattendance."

[3] These were youths who endorsed a questionnaire item about being very afraid or often afraid of going to school.

[4] Academic difficulties included below-average academic performance or the need for remedial or special education.

support in these areas is underscored by Havik and colleagues' (2014) study in which the parents of SR youth suggested that their child's anxiety could have been reduced by adapting academic requirements (e.g., not having to read aloud or stand in front of the class).

Social Relationships

The domain of social relationships refers to contact with peers and with school personnel (Zullig et al., 2010). Hendron and Kearney (2016) included the constructs "student interpersonal relationships" and "student-teacher relationships" in the questionnaire they used to study school climate and absenteeism. They found that both constructs were negatively related to absenteeism severity.

Contact With School Peers

Four community-based studies of SR support the notion that SR is associated with poor interpersonal relationships with peers. Egger et al. (2003) found that SR youth experienced more difficulty making friends, relative to truanting youth and youth without SAPs. Steinhausen et al. (2008) reported that preadolescent and adolescent SR youth (11–17 years) felt less accepted by peers relative to their truanting counterparts. Ingul and Nordahl (2013) compared anxious adolescents attending school with anxious adolescents refusing to attend school and found that the latter group had fewer close friends. Havik et al. (2015) found a direct relationship between SR and the experience of social isolation at school; the relationship held for youth at secondary school but not for youth at primary school.

Interviews conducted with SR youth and their parents also point to the potential negative impact of having few positive peer relationships at school. In the study of Place, Hulsmeier, Davis, and Taylor (2000), most SR adolescents reported feeling socially isolated at school. Havik and colleagues' (2014) more recent study based on parent interviews confirmed the notion that SR youth had few friends at school.

Bullying is a specific form of problematic peer contact. Several studies of SR youth attest to high rates of bullying. Egger et al. (2003) and Havik et al. (2014) found that approximately one-third of SR youth experienced bullying. This rate was significantly higher than the rate for truanting youth and the rate for youth without SAPs (Egger et al., 2003). Havik et al. (2015) found that there was a direct relationship between SR and being bullied, both among primary school youth and secondary school youth. Ingul and Nordahl (2013), on the other hand, found that anxious adolescents refusing to attend school experienced less bullying than anxious adolescents attending school. They attributed this to the fact that the adolescents attending school spent more time there and were thus more exposed to aversive situations with peers.

Once SR is established, anxiety about recurrent bullying is likely to impact the transition back to school. According to Place et al. (2000), SR adolescents who had been bullied were anxious about it happening again if they reengaged with school. Grandison (2011) reported that the expectation of recurrent bullying negatively influenced SR adolescents' transition from a short stay school back to mainstream education. It is apparent that treatment for SR likely requires ongoing effort to protect the young person from bullying.

Contact With Teachers and Other School Staff

Steinhausen et al. (2008) reported that SR adolescents (14–17 years) and truanting adolescents felt more controlled by their teachers (e.g., treated like small children), relative to adolescents without a SAP. When parents of SR youth were interviewed by Havik et al. (2014), some attributed their child's SR to the teachers' frightening behavior (e.g., harsh and aggressive responses). Most parents emphasized that it was difficult for their child to handle discontinuity in teaching staff, such as when there are multiple teachers or substitute teachers. Half of the parents also mentioned that teachers did not possess enough expertise regarding SR. This resonates with earlier findings about school personnel not receiving enough training on SR (Archer, Filmer-Sankey, & Fletcher-Campbell, 2003). Insufficient knowledge may limit the capacity of school staff to respond to SR youth in an understanding and supportive manner.

Teachers' influence is also exerted via their classroom management. Havik et al. (2015) tested the relationship between SR and the quality of teachers' classroom management (i.e., academic and emotional support, monitoring, following up on nonattendance, predictability). Some of these aspects of classroom management overlap with other domains of school climate (e.g., predictability pertains to order, safety, and discipline) but most refer to the student-teacher relationship. The relationship between SR and teachers' classroom management was found to be indirect; it was mediated by youths' social isolation and being bullied. The authors suggested that classroom management may influence risk for SR via its effect on student-student relationships. When school level was taken into account, a direct relationship between SR and classroom management was found for secondary school students but not for youth in primary school. It was argued that increased academic demands during secondary school may render teacher support even more important for reducing school-related stress and thereby reducing SR.

School Facilities

School facilities refers to the physical environment of the school (e.g., environmental noise, tidiness of the school, and the school's decoration; Zullig et al., 2010).

Low school attendance has been associated with the poor condition of school buildings (Durán-Narucki, 2008) while high attendance has been associated with smaller school size (Bracey, 2001). There is limited research on the relationship between school facilities and SR. One exception is the study by Archer et al. (2003) in which teachers and other education professionals held that school size and layout contributed to SR: "Pupils [with SR] were anxious about moving around the school, coping with long crowded corridors and going into specific places such as the canteen or classrooms" (p. 13). In Havik and colleagues' (2014) study, some of the parents of SR youth noted that their child had difficulty with chaotic or noisy surroundings (e.g., physical education lessons or changing rooms). These parents suggested that their child would benefit from a smaller school and smaller class size, including physically smaller rooms, because it contributes to a greater sense of predictability within school.

School Connectedness

School connectedness refers to youths' eagerness to learn, feeling valued for their contribution within school, and having positive feelings about school as a whole (Zullig et al., 2010). Anecdotally, SAPs have been associated with "inadequate praise for student achievement and attendance" (Kearney & Spear, 2014, p. 166). Empirically, SAPs among high school students were associated with a sense of not being treated with respect at school (Ingul, Klöckner, Silverman, & Nordahl, 2012).

Regarding SR, parents of SR youth stressed the importance of someone within school appreciating their child (Havik et al., 2014) or believing in them (Nuttall & Woods, 2013). In Steinhausen and colleagues' (2008) study, SR youth reported fewer possibilities to participate (e.g., being asked for their opinion before teachers made decisions), relative to a control group of youth without SAPs.

Alternative Educational Programs for SR

The preceding section points to relationships between SR and various aspects of school climate. In turn, this signals the need to address school-related factors when treating SR. In cases of adolescent SR, interventions focused on school-related factors may be especially important because adolescence is the period in which SR is more severe and complex, school-related factors are held to play a greater role in SAPs, and treatments may be less effective. One strategy for comprehensively addressing school-related factors is to temporarily accommodate SR youth in a school setting adapted to their needs. Various alternative educational programs (AEPs) have been developed to treat SR in adolescence. These programs are often employed as Tier 3 interventions for youth with chronic and severe absenteeism (Kearney & Graczyk, 2014). Prior to Tier 3 intervention in the form of an AEP, staff within the mainstream school setting may have trialed Tier 2 interventions with little to no effect. In the following section, we review the key elements of five AEPs reported in the literature. These AEPs were dedicated to the treatment of adolescent SR or provided a service to vulnerable adolescents with social-emotional problems, some of whom displayed SR.

Grandison (2011) reported on a Short Stay School (SSS) program in England for youth with medical and mental health needs, most of whom were SR adolescents. The SSS intervention was provided prior to the SR adolescents' transition back to mainstream education. It involved six weekly progress evaluations in meetings with the young person, their parents, the SSS head teacher and learning mentor, and personnel from the mainstream school. Plans regarding reintegration to mainstream schooling were made during these evaluations. School-related anxiety was addressed via graded exposure to the SSS and then to mainstream education (Thambirajah et al., 2008). Among the factors held to positively influence the transition back to mainstream schooling were phased and personalized reintegration, as well as collaboration between parents, school staff, and the staff of the SSS (Grandison, 2011).

Another initiative from England is the Alternative Provision for Vulnerable Pupils (APVU), a classroom with low student-to-teacher ratio. Nuttall and Woods (2013) described the case of an adolescent female (14 years) with anxiety-based SR who attended the APVU after a 2-year absence from mainstream education. Via interviews conducted with the young person, parent, school staff, and other professionals, Nuttal and Woods learned that the following factors were associated with the adolescent's improved school attendance and diminished school-related anxiety: the quiet surrounding and small class size, the individualized approach for achieving educational goals, the teacher's support, gradual increase in attendance at the APVU, linking school-work to personal interests and future profession, positive social contacts with classmates, arranging suitable transportation to and from school, and close collaboration with other professionals involved.

A third initiative from England is described in Preece and Howley's (2018) report of an AEP for adolescents with an autism spectrum disorder (ASD) and anxiety-based absenteeism.[5] The AEP was located in a small building and operated by a service for students not attending mainstream school because of complex medical or mental health conditions. It aimed to prepare adolescents for reengagement with education, but it is

[5] The authors associated the term "anxiety-based absenteeism" with "school refusal."

not clear whether the reengagement was to occur after a specified amount of time in the AEP. Attention was devoted to the provision of an autism-friendly surrounding (e.g., very structured classroom layout, with clarity about the functions of the different areas). The outcomes for seven adolescents with ASD and anxiety-based absenteeism were measured quantitatively (e.g., attendance data) and qualitatively (e.g., interviews with family members, the adolescents, staff from the AEP, and external professionals). The AEP was reported to have had a positive impact on the adolescents' reengagement with schooling. That is, attendance improved and adolescents were engaged with an educational curriculum. The factors held to contribute to the positive outcomes were as follows: an adapted learning environment (e.g., small class size, individual work); setting individual goals for curriculum, transition, personal/social, and attendance; being flexible and creative in adopting good practice approaches for ASD and SR; the consistent approach by all staff involved (e.g., using common terminology, having clear criteria for inclusion); open communication with parents and other involved professionals; and close collaboration with all persons involved.

Sometimes AEPs are employed in conjunction with mental health services for youth displaying SR. McShane, Bazzano, Walter, and Barton (2007) described the Australian-based Sulman Program, an adolescent mental health and education program located at a special education high school adjoining a psychiatric unit. The special education high school served as the AEP. The Sulman Program was developed to better meet the needs of socially anxious adolescents with anxiety-based SAPs.[6] Three days per week, across the school year, adolescents participated in a multimodal program tailored to individual needs (e.g., graded exposure to public transport and to various social situations). A mental health professional was available within the school setting to engage the youth in activities and respond to their social, emotional, and practical needs. An uncontrolled evaluation indicated significant improvement in the social and personal functioning of 24 adolescents. Most of these adolescents (71%) passed the school year during their stay at the AEP. According to the authors, the instrumental factors were the controlled nature of the school environment and the provision of taxi transport to the facility. The latter increased motivation for attendance, in part by reducing uncontrolled social situations on public transport that could lead to nonattendance.

In Germany, Walter and colleagues (2010) provided support to adolescents with chronic anxious-depressive absenteeism via inpatient mental health services and access to a school for special education. The special education school served as an AEP. Treatment within the inpatient clinic spanned 8 weeks on average (ranging from 2–18 weeks). The services included adolescent-, parent-, and teacher-focused interventions. In severe cases (i.e., complete school absence for more than 3 months), intervention included attendance at the AEP. The AEP was located near the inpatient unit and employed teachers with expertise in educating youth with psychiatric disorders. Placement in the AEP was regarded as short term (length unspecified), with the aim that adolescents would return to mainstream education as soon as possible. The authors' observational study of 147 adolescents revealed improved attendance and a decline in mental health problems by 2-month follow-up. In a subsequent paper, Walter, Hauptmann, Rizk, Lehmkuhl, and Doepfner (2014) reported on 36 adolescents included in the treatment program, 25 of whom (69%) had been enrolled in the AEP. At posttreatment, 2-month follow-up, and 9-month follow-up the number of students in need of the special school setting was 11 (31%), 9 (25%), and 6 (17%), respectively. The authors contended that a small group of chronically absent adolescents "may need a specific school setting, including small class sizes and specially-trained teachers, over many months to achieve a successful school attendance" (p. 186).

Characteristics that are common to some of the aforementioned AEPs are small class size, a structured classroom/school environment, individualized instruction, support and mentoring, close collaboration with the parents, and an interdisciplinary approach. All but the last characteristic is found in Tobin and Sprague's (2000) summary of effective strategies in AEPs targeting antisocial behavior, school failure, and dropout. Because AEPs have these characteristics, they can be used to promote social interaction and reduce bullying. For example, small class size facilitates closer observation by teachers and faster response to student interaction; the predictability afforded by a structured classroom environment may increase students' confidence for social interaction; and teachers as mentors can help motivate students to engage in social interaction. Another characteristic of AEPs is that participating youth often experience similar difficulties. Thambirajah et al. (2008) argued that this is important in addressing social isolation among SR adolescents: "The presence of a small but similar-minded group provides safety for the school refuser in trying out new skills and practicing dealing with situations and people they previously avoided" (p. 117). While the characteristics of AEPs can contribute to increased social competence and confidence in that setting, there is a need for supplemental strategies in the setting to which the student will transfer after the AEP (Tobin & Sprague, 2000). For

[6] The authors used the term "anxiety-based SAPs" instead of SR.

example, the transition from an AEP for SR youth to a more typical educational setting necessitates strategies to promote social interaction and protect from bullying in that new setting.

Two of the AEPs reviewed above reported on the co-occurrence of SR and ASD. SR and Asperger's syndrome co-occurred among 13% of youth in McShane and colleagues' (2007) Sulman Program. All of the youth with anxiety-based absenteeism who participated in Preece and Howley's (2018) study were admitted because of an ASD diagnosis. The risk for SR among youth with ASD is suggested by two studies. Kurita (1991) found that SR was more prevalent among youth with a pervasive developmental disorder with or without intellectual disability, relative to youth with intellectual disability alone (27% and 8% respectively). More recently, Munkhaugen, Gjevik, Pripp, Sponheim, and Diseth (2017) revealed that youth with ASD were at increased risk for school refusal behavior (i.e., school refusal or truancy) when compared to typically developing peers. Because SR youth with developmental disorders are in need of special educational methodologies (Nishida, Sugiyama, Aoki, & Kuroda, 2004), and AEPs provide a setting in which these methodologies can be implemented, AEPs may play an important role in helping adolescents with SR and ASD to reengage with education.

The Link Program

Following is an account of the Link, an AEP in the Netherlands to help SR adolescents (12–19 years) with or without ASD to reengage with schooling. After describing Link interventions we present data on its participants and provide a case vignette, highlighting the way in which this AEP is being used to address school-related factors associated with SR.

History

The Link was established in August 2007 within a special education secondary school for adolescents with internalizing and/or neurodevelopmental disorders like ASD. In the Netherlands, youth enter secondary school after 8 years at primary school, by which time they are usually between 11 and 13 years of age. School attendance is compulsory until the age of 16 (or 18 if a satisfactory qualification has not yet been achieved). Secondary schools are differentiated according to levels of education varying from vocational training to pre-university secondary education. Allocation to levels is based on the advice of primary school staff, informed by the child's performance during primary schooling and standardized national tests. Dutch law does not currently recognize home schooling as an alternative for compulsory education.

Most adolescents (approximately 90%) in the special education school where the Link was established were diagnosed with ASD. The school climate was tailored to accommodate the needs of ASD adolescents, but school staff believed that further support was needed for adolescents refusing to attend school. A new class was therefore established, constituting an AEP. It was named "the Link" to refer to its role in linking SR adolescents back into an educational experience at the AEP, and thereafter into a mainstream or special education school. Various Link programs now operate in the Netherlands. In this article we report on the Link in Almelo, a semi-urban region in the east of the Netherlands. The Link in Almelo currently comprises two classes servicing 25 secondary schools (13,000 students) within the region.

Referral

Referral to the Link is customarily made by staff from the adolescent's original school (a mainstream or special education school) when staff feel ill-equipped to address SR or their prior efforts to help the SR adolescent have been unsuccessful. With the permission of the adolescent and parents, the school provides an educational psychologist from the Link with a student file (e.g., history of attendance and difficulties at school, diagnostic profile).

Adolescents are offered a place at the Link if the presenting SAP fulfils Berg's (2002) criteria for SR. The Link was not developed to meet the needs of truanting adolescents, adolescents engaging in other antisocial behaviors, or those experiencing psychotic symptoms, severe suicidal behavior, chronic medical problems (e.g., epilepsy), or intellectual disability (IQ < 70). Youth with ASD are welcome at the Link. Adolescents not living at home may participate if they are enrolled at one of the schools in the region and if transport to and from the Link can be arranged. Link staff do not escort adolescents to the program.

Intake

An educational psychologist at the Link screens referrals and conducts an intake interview with the parents, staff from the referring school (henceforth "original school"), and, on most occasions, the adolescent, depending upon the adolescent's ability to take this step at this time. During the interview, SR is assessed by gaining each party's perspective on the problem, obtaining information about the activities the adolescent engages in when not at school, asking about prior efforts to resolve the problem, and learning about the adolescent's educational and occupational ambitions. Information about the Link program is also provided at this time.

Following the intake interview the Link's school-based social worker visits the adolescent and parents at home. This provides insight into the home situation and an opportunity to ask family members about the involvement

of other organizations or professionals. The educational psychologist and school-based social worker then decide whether the Link is the most appropriate intervention for the SR adolescent at this time (e.g., the Link is deemed inappropriate if the adolescent and parents are not convinced that the Link is a suitable option for them). Assuming the Link is appropriate, preparations are made for the adolescent's commencement at the Link. Contact is made with other professionals who are involved (e.g., a therapist working with the adolescent) and with educational authorities (e.g., attendance officers), to explain the role of the Link and discuss practical issues (e.g., the possibility of the adolescent attending therapy during school hours). Parents are supported in arranging transport to the Link and a detailed plan is made with the adolescent and the parents for the first day there (e.g., an appropriate starting time, where the teacher will meet the adolescent on arrival, and activities the adolescent will engage in during their first hours at the Link).

Intervention

To help adolescents reengage with schooling, the Link program focuses on reducing school-related anxiety and normalizing school attendance. The three key interventions that characterize the Link are: (a) an adapted educational setting; (b) adoption of a CBT orientation by members of the Link expertise team (specialized teachers, educational psychologists, and a school-based social worker); and (c) collaboration between Link staff, the adolescent, parents, and all other involved professionals. Families are advised that the adolescent will participate in the Link for a period of 6 to 12 months. In most cases the adolescent participates for 9 to 12 months. Within this time they will be fully reintegrated into a subsequent school (whether it be their original school or another school deemed more suitable). In the following sections, we describe the three key interventions of the Link.

Adapted Educational Setting

Characteristics of the setting redress a range of school-related factors associated with the development and maintenance of SR. For example, adolescents are helped to reengage with an academic curriculum via individualized instruction within a structured, supervised, and supportive environment. This is likely to be beneficial for adolescents who have had academic difficulties or are anxious about their performance. The small and secure setting is also used to promote safe social interaction, countering the bullying and social isolation that is often experienced by SR youth. For example, adolescents are helped to very gradually participate in social activities that are increasingly demanding. Table 1 presents a full account of the characteristics of the educational setting, conceptualized according to five domains of school climate.

CBT orientation. The Link is principally an educational facility and not a treatment facility. As such, CBT as a form of therapy is not conducted at the Link. Rather, CBT principles inform the way in which members of the Link expertise team approach their work with the adolescents. For example, during the intake process and the associated home visit, the Link's educational psychologist and school-based social worker provide the adolescent and parents with psychoeducation about SR, including the possibility that the adolescent will experience emotional distress during their first days at the Link. Link teachers help the adolescents understand the physiological signs of anxiety and the short- and long-term costs associated with avoiding school when feeling anxious. Behavior management strategies are also employed in the classroom (e.g., socially reinforcing the adolescent for attendance at the Link).

Graded return to school is common in CBT protocols for SR (Heyne, Sauter, & Maynard, 2015) and in most of the aforementioned AEPs. It is also an important aspect of the Link program. Once adolescents start at the Link they are expected to attend at least some part of every day, gradually increasing the amount of time spent there. Reengagement with another educational setting following participation in the Link is also graduated in most cases. That is, attendance at the Link decreases as attendance at the subsequent school increases. The Link teachers help the adolescents prepare for reintegration to the subsequent school. They encourage adolescents to gradually face school-related fears while still at the Link (e.g., participating in a game, asking a question in class, taking a test), working together on the steps to be included in fear hierarchies (e.g., observing cooking lessons or sitting in on group discussions before increasing the amount and type of participation in such activities).

Simple cognitive interventions are employed ad hoc. For example, when the teacher hears an adolescent verbalize self-downing or noncoping thoughts (e.g., "I can't do any of this work; it's all too hard"), the adolescent is supported in identifying more helpful cognitions.

Collaborative approach. Collaboration is typical in AEPs and it is inherent to the Link program. The adolescent, parents, Link staff, staff from the original school, therapist, and regional student attendance officer work together on the goal of re-engaging the adolescent with schooling. This requires considerable coordination. Table 2 summarizes the many ways in which these parties collaborate.

Table 1
The Educational Setting Inherent to the Link, According to Five Domains of School Climate

(i) Order, safety, and discipline
- Predictability/structure (e.g., fixed schedules, teacher always present)
- Situated in a quiet, supervised corner of the school
- Adolescents rarely need to move between different classrooms during the school day
- Upon arrival, adolescents may engage in preferred activities (e.g., drawing)

(ii) Academic outcomes
- Adolescents start with reduced school-time (usually one hour per day), increasing weekly
- Adolescents use books and (adapted) curriculum from their original school
- Adolescents start with a preferred subject; subjects are added as attendance increases
- Adolescents receive individual instruction and support while working on their subjects
- Tests/homework are added once adolescents reengage with the schooling process
- Practical subjects (e.g., cooking, sport) are offered when adolescents are ready
- Teachers monitor adolescents' academic progress
- Adolescents are helped to address fears associated with academic performance

(iii-a) Contact with school peers
- Teachers encourage and help adolescents to learn from each other
- Adolescents are helped to address social anxiety (e.g., gradually increasing group interaction)
- After each theoretical lesson there is a break for a group activity (e.g., playing a game)
- Teachers foster social interaction (e.g., inviting an adolescent to join a conversation)
- Teachers model social skills (e.g., asking about adolescents' weekend, apologies)
- Bullying prevention (e.g., adolescents are helped to be accepting, there are no youth with behavior problems)

(iii-b) Contact with teachers and other school staff
- Consistency in teaching staff (e.g., no substitute teachers)
- Teachers have knowledge of SR, anxiety, depression, and autism
- Each adolescent has a mentor (a Link teacher) for regular chats about schooling issues
- Teachers develop, monitor, adapt adolescents' unique goals (e.g., attendance, socially)

(iv) School facilities
- Class setting used exclusively by Link students, each with their own desk
- The Link has its own entry and classes are close to amenities (e.g., toilets)
- Extra rooms nearby (e.g., for adolescents not yet able to enter the classroom)
- Maximum of 10 students per class

(v) School connectedness
- Teachers demonstrate acceptance of adolescents and respond calmly
- Adolescents are praised for attendance and achievement of goals
- Adolescents are involved in making decisions (e.g., regarding goals, future education)
- Adolescents are helped to appreciate that others in the group experience similar difficulties
- Teachers have time available to get to know the adolescents well

Description of the Link Participants

Eighty-four adolescents were accepted into the Link between August 2007 and November 2015. Approval to gather descriptive data via file review was granted by the ethics committee of the Leiden University Institute of Psychology. Thirty families (36%) provided consent for researchers to access their files. The 30 adolescents (12 males, 18 females) were 12–17 years of age (M = 15.2; SD = 1.3) upon entry to the Link. All were of Dutch origin and 77 percent came from a two-parent family. There were no differences between those who provided consent and those who did not with respect to gender, χ^2 (1, N = 84) = 0.31, p = .58, or age, t (82) = -1.20, p = .23.

At the start of their secondary schooling, 18 adolescents[7] (62%) were enrolled in schools offering a higher level of education and 11 (38%) were enrolled in schools offering moderate to low levels of education.[8] By

[7] Data on school level were available for 29 adolescents.

[8] High levels of education included the Dutch educational levels designated vwo, havo, and vmbo-tl/havo. Moderate to low levels of education included the levels designated vmbo-tl, vmbo-gl, vmbo-kb, vmbo-bb, and pro (practical vocational education).

Table 2
The Collaborative Approach Inherent to the Link

Coordination
- The Link expertise team manages the process of increasing attendance at the Link
- Teachers discuss the adolescents' progress weekly with the Link expertise team
- Six-weekly multidisciplinary evaluations with parents, Link mentor and educational psychologist, staff from original school, external therapist if involved, and regional student attendance officer; adolescent is usually present during last part of the meeting

Contact with parents
- Home visit by school-based social worker after the intake interview
- Parents are supported with practical issues (e.g., transportation)
- Parents and adolescents are introduced to the teachers prior to commencement at Link
- Parents meet teachers when bringing the adolescent to the Link during the first week
- Teachers contact the parents when there are difficulties at school (e.g., the child is absent)
- Teachers maintain weekly contact with parents (e.g., email)
- In multidisciplinary evaluation, parents are asked about their child's progress at the Link

Contact with regional student attendance officer (SAO)
- SAO participates in multidisciplinary evaluations to review and discuss attendance
- SAO contacted by Link mentor / educational psychologist if attendance problems arise
- SAO can take disciplinary action (e.g., if progress stalls or the family refuses extra support)

Collaboration with external treatment facility
- Psychosocial treatment via external facility continues during Link program
- If psychosocial treatment not yet in place, Link arranges for a therapist to visit the Link
- Link-based observations inform the case formulation prepared by external/consulting therapists
- Link provides context for practising skills learned during treatment (e.g., social skills)
- Contact between Link mentor and external therapist (monthly, and often more frequently)
- Therapist at multidisciplinary evaluations discusses progress in therapy and in the Link

Note. The SAO is legally responsible for attendance, providing consent for attendance plans.

the time these adolescents participated in Link, however, fewer were enrolled in a higher level of education (30%) relative to a moderate or low level of education (70%). Most adolescents (n = 23; 77%) had repeated at least 1 year of primary or secondary schooling and 18 (60%) had changed school at least once prior to participation in the Link.[9] Upon referral to the Link, 24 adolescents (80%) were enrolled in mainstream secondary schools (3 participated in the special needs unit of their school), 3 (10%) were enrolled in special education schools, and 3 (10%) had started a form of vocational education.

Absence from school was typically chronic. Twenty-six adolescents[10] (90%) were completely absent from school for between 5 and 87 weeks (M = 27; SD = 19) prior to participation in the Link. There was no significant difference in school absenteeism between those with a primary diagnosis of ASD and those with other primary diagnoses, t (23) = 0.15, p = .88. Three adolescents were partial attenders prior to participation in the Link. Two of these attended school less than 50% of the time and their school timetables had been adjusted (i.e., amount of time spent at school; activities engaged in). The other adolescent had attended an inpatient clinic school (50% attendance), but was no longer permitted to remain at that school following the termination of inpatient treatment. Case files suggested that at least 10 Link participants (33%) had attendance problems during primary school.

Intelligence data (WISC-III; Wechsler, 1991) were available for 24 of the 30 adolescents (80%). Mean verbal IQ was 96.6 (SD = 17.0) and mean performance IQ was 101.2 (SD = 17.7). Total IQ (calculated for 22 adolescents) ranged from 61 to 124, with a mean total IQ of 96.8 (SD = 16.9). Reading difficulties, diagnosed as dyslexia, were reported in the files of three (10%) adolescents. Other learning disorders were not evident in the case files.

DSM-IV (APA, 1994) diagnoses were accessible for 29 of the 30 adolescents based on the reports of external services.[11] The most common primary diagnosis was ASD

[9] School changes did not include the transition from primary to secondary school.

[10] Data on absenteeism were available for 29 adolescents.

[11] Diagnoses were established prior to participation in Link, between 4 months and 2.5 years earlier. If different disorders were diagnosed over time, the disorder diagnosed closest in time to participation in the Link was used in the descriptive statistics presented here.

(n = 16; 55%). During participation in the Link an additional 2 adolescents were diagnosed with primary ASD, amounting to 18 in total (62%). Other primary diagnoses included generalized anxiety disorder (n = 3; 10%), social anxiety disorder (SAD; n = 2; 7%), dysthymic disorder (DD; n = 2; 7%), and in individual cases the primary diagnosis was anxiety disorder not otherwise specified, depressive disorder not otherwise specified (DD-NOS), adjustment disorder, or attention-deficit/hyperactivity disorder. Eleven of the adolescents (37%) met criteria for at least one comorbid disorder, including depressive disorders (major depressive disorder, DD, DD-NOS; n = 5), anxiety disorders (separation anxiety disorder, posttraumatic stress disorder; n = 3), disruptive behavior disorders (oppositional-defiant disorder, disruptive behavior disorder not otherwise specified; n = 2), eating disorder (eating disorder not otherwise specified; n = 1), and unspecified somatoform disorder (n = 1). Prior to participation in the Link, 13 of the 30 adolescents (43%) had suicidal thoughts, 4 (13%) had engaged in self-mutilation, and 1 adolescent (3%) had attempted suicide. At least 10 adolescents (33%) had experienced bullying at primary and/or secondary school. No bullying was observed by Link staff or reported by adolescents during their time in the program.

Participation at the Link lasted 50 weeks on average (SD = 37.6; range = 8 to 153 weeks). There was no difference between the group of adolescents with primary ASD and those with other primary diagnoses with respect to length of participation, $t(26) = -0.18$, $p = .87$. The collaborative nature of the Link program meant that various external services were involved in supporting the adolescents during participation in the Link. These included outpatient specialist mental health care (n = 19; 63%), inpatient psychiatric services (n = 4; 13%), outpatient primary mental health care (n = 3; 10%), outpatient psychiatric day program (n = 2; 7%), and a long stay youth care facility (n = 2; 7%). There was no indication in the files that any of these services implemented a manualized treatment for SR. After exiting the Link, no adolescents reengaged with the school they were enrolled in when they started in the Link. Most adolescents[12] (n = 23; 79%) reengaged with a school for special education, 4 (14%) started vocational training, 1 (4%) started adult education, and 1 (4%) went to a health care facility to participate in daytime activities.

Case Vignette

The following case vignette illustrates the Link process, from intake at the Link to reintegration to the subsequent school (7 months in total since starting the program, including the 1.5 months of school break during Summer). The three key interventions that characterize the Link are exemplified. The vignette is based on the case of Lily (a pseudonym), a 16-year-old adolescent of Dutch origin who participated in the program 8 years after it started. Lily and her mother provided permission for de-identified case information to be used.

Background Information

Lily grew up in an intact family comprised of her biological mother, biological father, and a younger brother. Her parents described her as an insecure child who nevertheless attended primary school without much difficulty. She repeated the last year of primary school because school staff suggested that she was emotionally unready for secondary school, although her cognitive abilities were assumed to be above average. When she started secondary school, Lily attended a mainstream school that provided a combined curriculum of higher general education and pre-university education. From the second year of her secondary schooling she participated in the lower of these two tracks (i.e., higher general education).

Lily's attendance problem emerged in the first year of secondary school. Absence increased from 1 to 2 days per month in the first year, to 4 or 5 days per month in the third year. Illness was the reason usually given for her absence. By the end of her third year she was staying at home most of the time. At this time, the school counselor invited Lily to participate in a special class within the mainstream school. In this class, individual support was provided to a small group of students for some parts of the school day. Lily could go to this class at scheduled times (e.g., at the beginning of a school day to help her get started). She could also go there at times that she felt she needed extra support or time-out (e.g., when she felt too anxious to attend the regular lessons). She occasionally made use of this class during the last months of her third year at secondary school.

Lily was engaged with mental health services from the second year of secondary school. The reasons provided were major depressive disorder, nonsuicidal self-injury, anxiety, and eating problems. Initially, Lily received outpatient primary health care, followed by outpatient specialist mental health care involving psychosocial therapy, a short trial of antidepressant medication, and systemic therapy. Her emotional problems increased and suicidal thoughts arose. At the start of her fourth year of secondary school she was admitted to a short stay inpatient psychiatric unit. There she attended a clinic-based classroom for half of each school day. After discharge she attended an outpatient psychiatric day program four afternoons per week. This took place at a different psychiatric facility where there was no clinic-based classroom. When not required at this facility, Lily

[12] Data were available for 29 adolescents.

failed to attend her mainstream school. At the time of referral to the Link she was diagnosed with major depressive disorder and SAD; nonsuicidal self-injury and eating problems had diminished. Lily's social anxiety was related to concerns about her physical appearance. On school mornings she spent much time standing in front of the mirror and there were occasions when her absence from school stemmed from her dissatisfaction with her appearance. There were no reports of ASD.

Referral

The counselor at Lily's mainstream school invited Lily and her parents to make a plan for re-engaging with school. The Link's educational psychologist was invited to the meeting because the school counselor considered the Link a potentially helpful option. During the meeting the school counselor and educational psychologist suggested that Lily participate in the Link, concurrent with her participation in the outpatient psychiatric day program. Lily refused the offer, preferring to be "normal" by going to "a normal school." All agreed on a plan for reengagement with her mainstream school rather than the Link. She would attend the special class at her mainstream school for 1 hour per day and gradually increase her participation in regular school activities. After several weeks it became clear that Lily was unable to follow this plan. She had attended the special class on some days and also participated in some regular school activities, but overall there was little change in her attendance. When she was in attendance, she felt too anxious to concentrate on her school work. The plan was evaluated with Lily, Lily's mother, the school counselor, the therapist from the day program, and the educational psychologist from the Link. Lily said that her goal would be to start full-time at her mainstream school in the next school year. The educational psychologist from the Link explained to Lily that the Link would be able to help her achieve this goal. Lily acknowledged that participation in the Link could have advantages (e.g., being with teachers and students who could understand her) and she thought she needed to try the Link to see if it could help. She agreed to attend an intake interview held at the Link.

Intake

During the intake, Lily was given an opportunity to look around the Link and ask questions. She was then given some time to think about whether she would attend the Link. Six days later the educational psychologist received an e-mail from Lily's mother which stated that Lily would like to participate at the Link while continuing with the day program at the psychiatric facility. Hereafter an appointment was made for Lily, her mother, and the support person from the special class at her mainstream school to meet the Link mentor. All agreed that Lily would attend the Link for half an hour per day for 4 days per week, while also attending the special class at her mainstream school 1 morning per week, concurrent with the day program at the psychiatric facility. Lily would be brought to the Link by her parents. Goals while attending the Link would be as follows: going to school daily (i.e., to the Link and to the special class at her mainstream school), staying engaged with the process of doing school-work, participating in social interactions, and preparing for reengagement with regular classes at the mainstream school in the new school year.

Intervention

Adapted Educational Setting

At the start of her time in the Link classroom, Lily worked quietly at her own desk using the school books provided by her mainstream school. The Link teachers provided academic support as required (e.g., when Lily had difficulty concentrating on her school-work). Lily rarely initiated contact with the Link teachers or other Link students but responded well when a teacher initiated contact with her. The Link teachers also provided support when they observed social difficulties for Lily (e.g., addressing isolation by inviting her to play a game with other Link students). After approximately 1 month Lily became more socially active, asking the teachers questions about her school-work and conversing with peers during break times.

CBT Orientation

Lily's meetings with her Link mentor were initiated at first by the mentor and later by herself. On average, the meetings occurred once a week. During these meetings CBT principles were evident in the mentor's approach. Lily was helped to challenge her unhelpful thoughts about school and about school peers, to problem-solve difficult situations (e.g., what to do when former classmates contacted her via social media and she felt distressed), to evaluate progress towards her goals, and to make plans regarding exposure to social situations. When Lily started attending the mainstream school full-time, the mentor remained available to provide support as needed. For example, the mentor made an appointment with Lily to help her formulate helpful thoughts when she experienced a setback at the start of the new school year.

Collaborative Approach

The first multidisciplinary evaluation was held 2 months after Lily started at the Link. It was attended by Lily, her mother, the therapist from the day program, the regional student attendance officer, the support person from the special class at the mainstream school, the Link mentor, and the Link's educational psychologist.

It was clear that Lily had made considerable progress: she was attending the Link for 2.5 hours a day, she spent less time worrying about her appearance before going out, she was more active (e.g., engaging in sports after school), her mood had improved, and she felt more confident and believed that things could improve for her. She said she had learned to "just do it, instead of overthinking it." However, she had not accomplished her goal of attending the mainstream school for some part of the day once per week. Lily agreed that this was an important goal and said it would be easier for her to achieve this in the new school year (3 months away) when she could be in the same class with some peers she liked. Lily was invited to list the names of these peers and was informed that her preferred class placement would be arranged by staff at the mainstream school. The therapist from the day program at the psychiatric facility indicated that treatment there would conclude within a few weeks based on the standard length of the program and the progress Lily had made.

The second multidisciplinary evaluation was held 2 months later, 1 month before the end of the school year. As planned, Lily was still attending the Link 2.5 hours per day and she was now cycling to the Link instead of being brought by her parents. She had succeeded in attending her mainstream school on four occasions, but on two other occasions she stayed at home. When she first attended the mainstream school she participated in the special class, and on subsequent occasions she participated in regular lessons. After the conclusion of Lily's involvement in the outpatient psychiatric day program, she participated in a couple of follow-up meetings with her therapist. She was then referred to the outpatient mental health care facility where she had previously participated, for ongoing care.

During this second multidisciplinary evaluation the educational psychologist invited Lily to think about the next school year and how the Link could help her. Lily wanted to attend the mainstream school full-time from the start of the new school year to participate in the formation of friendship groups. She said the Link had helped her feel comfortable with school again, and that she no longer needed to be involved at the Link. Because she was uncertain about what it would be like to attend her mainstream school full-time, she decided to try and attend the mainstream school for the last 1.5 weeks of the current school year and to resort to attending the Link if she had difficulty attending the mainstream school on a particular day.

The final multidisciplinary evaluation was held 1 month after the previous meeting, 5 months since commencement at the Link. Shortly after the previous evaluation Lily had attended an entire school day at the mainstream school, but thereafter she stayed at home. At first she did not respond to telephone messages from the support person at the mainstream school or emails from her mentor at the Link. However, in the week before the evaluation she appeared at the Link and explained to her mentor that she had felt lonely at the mainstream school because she did not belong to a friendship group. Despite this experience, Lily still wanted to attend her mainstream school full-time (i.e., without a gradual increase in attendance) at the start of the new school year. Everyone present at the multidisciplinary evaluation agreed to this plan. Lily was invited to visit her Link mentor once a week for extra support while reengaging with her mainstream school.

Full Reintegration Into Mainstream Education

After the summer holiday period, Lily started attending her mainstream school. During the first week, however, her mother called the Link mentor with the message that Lily was not doing well. The Link mentor arranged an appointment with Lily and a multidisciplinary meeting was arranged at the mainstream school. The multidisciplinary meeting was attended by Lily, her mother, the therapist from the outpatient specialist mental health care facility, the support person from the special class at the mainstream school, the Link mentor, and the Link's educational psychologist. The first weeks of the new school year had been very difficult for Lily, contributing to anxious and depressive symptoms, concurrent with her full-time attendance. Lily was advised that it is not unusual to experience setbacks and encouraged to make use of the available help. Lily agreed to seek help if she experienced difficulties (e.g., from her Link mentor, the support person at the mainstream school, or her therapist, depending on the issue). The management of Lily's school attendance was transferred from the Link to the support person at her mainstream school.

Within 2 months after her rocky start at the mainstream school, Lily had achieved a high level of school attendance (i.e., average of 85% across the first 2 months), she was engaged with the academic curriculum, and she was achieving good grades. She had made some new friends from her class and was socializing with these friends outside of school. There was no formal assessment of Lily's social-emotional functioning. However, the Link mentor and the support person at the mainstream school reported that Lily was more confident in her interactions with them.

Almost 2 years after returning to her mainstream school, Lily obtained her diploma in higher general education. During these 2 years Lily had experienced occasional setbacks (e.g., feeling uncomfortable in the classroom, experiencing sad mood and low energy). Whenever this occurred, the support person at the mainstream school provided emotional support and

helped Lily develop plans to address the difficulties (e.g., asking teachers to temporarily refrain from asking Lily questions in front of the whole class, allowing Lily to start school a little later on some days, identifying and using helpful thoughts). The setbacks never led to prolonged absence.

Instrumental Factors

Next, we propose ways in which the three key interventions of the Link were instrumental to Lily's reengagement with schooling and thus to her integration back into mainstream education. The extent to which the Link's key interventions actually contribute to SR adolescents' reengagement with schooling warrants empirical investigation.

Adapted Educational Setting

The likely benefits for Lily of the educational setting inherent to the Link are considered with respect to the five domains of school climate (Zullig et al., 2010). *Order, safety, and discipline* are integral to the Link. Because the Link is situated in a quiet, supervised corner of an educational facility, with very few students, it probably made it much easier for Lily to feel comfortable getting back into the rhythm of school attendance. Moreover, getting out of bed each day to attend this low-threshold setting may have provided a form of activation that helped to counter her depressive affect. With respect to *academic outcomes*, Lily was helped to stay engaged with school-work from the mainstream school. This is likely to have lowered the hurdle for her reengagement with the mainstream school after the initial period at the Link. Lily's *social relationships* with Link peers and teachers was a focus of the intervention, since Lily's social anxiety was a likely factor in the development and maintenance of her SR. Link teachers supported her in increasing positive social contact with peers during the school day. The fact that other Link students were encouraged to be accepting, and to speak about their own difficulties, may have lowered the hurdle for Lily to initiate social contact with them. Lily herself said that her Link mentor and the support person at school were friendly and understanding. She believed that this contributed to her attendance at the Link and at the mainstream school thereafter. With respect to *school facilities*, there was sufficient space to provide Lily with her own desk away from others. During her initial time at the Link, she could comfortably engage in schoolwork on her own. Lily explained that this made it easier for her to go to the Link, even on mornings when she was "not in the mood" for school. For Lily, a sense of *school connectedness* at the Link was likely facilitated via acceptance of Link teachers and students, social reinforcement for attendance and achievements, and participation in decision-making. By Lily's own account, her reintegration to the mainstream school was influenced by the support person there. The support person helped Lily feel understood, supported, and valued, and she helped Lily work through setbacks. This likely prevented the re-occurrence of SR.

CBT Orientation

Lily was very motivated to return to her mainstream school and obtain her high school diploma. Link staff reinforced her motivation and drew upon it to engage Lily in activities that prepared her for reintegration to mainstream school. For example, Lily willingly participated in exposure to the successively difficult social situations that were arranged by Link staff. She received practice in replacing unhelpful thoughts with more helpful thoughts, problem-solving difficult situations, and adjusting her expectations for social contact with others.

Collaborative Approach

Five multidisciplinary evaluations were held between Lily's referral to the Link and her full reintegration back into mainstream education. An important aspect of the meetings was the development of clear plans for each stage of the process. This ensured consistency across all involved professionals and provided Lily with clear goals for each stage.

Discussion

School-related factors are associated with the development and maintenance of SR. AEPs provide a setting in which these factors can be closely managed and monitored, making it easier for SR youth to reengage with education before transitioning to a more typical form of education. The Link is an AEP characterized by three key interventions, including an adapted educational setting, a CBT orientation, and collaboration. The adapted educational setting targets various aspects of school climate to support SR adolescents during their reengagement with education.

Participants in the Link have often experienced severe absenteeism, chronic SR, and psychopathology. Our review of 30 case files revealed that most adolescents were completely absent from school prior to commencement at the Link. Many had been absent from school for the previous 6 months, and one-third had attendance difficulties at primary school. Regarding psychopathology, one-third had a primary diagnosis of anxiety or depressive disorder, more than one-half were diagnosed with ASD, and 40% reported suicidal thoughts. In addition, one third of adolescents reported being bullied before commencement at the Link. In these ways, the Link provides a service for a distressed group of SR adolescents.

Bullying warrants special consideration. Thirty-three percent of Link participants had experienced bullying prior to Link. This corresponds with bullying rates in

other samples of SR youth (Egger et al., 2003; Havik et al., 2014). Among Dutch secondary school students (i.e., not SR adolescents per se), 11% had been bullied at least once in the preceding 3 months (Gezondheidsmonitor Jeugd, 2015). The higher rate observed among Link adolescents is suggestive of the role of bullying in the development of SR. Moreover, the fact that fewer Dutch children and adolescents display SR (0.6%; Sauter, 2004) than are bullied suggests that other factors combine with the experience of being bullied to contribute to the development of SR. The report of Place et al. (2000) suggests that bullied youth with less well-developed problem-solving skills are at greater risk for developing SR.

By extension, bullying interventions at the individual level and school level are needed to prevent SR relapse among adolescents transitioning from the Link to a subsequent school. At the individual level, rigorous training in problem-solving and assertiveness skills may be needed, beyond the ad hoc work on these skills that is currently conducted by Link staff. At the school level, antibullying strategies and one-on-one support need to be implemented in such a way that SR adolescents returning to school will feel protected and supported (Day, 1996). If educational settings—alternative *and* typical—attend to the domains of school climate suggested by Zullig et al. (2010; e.g., safety, contact with school peers), it is likely to be easier for SR adolescents transitioning from alternative settings to typical settings to not only survive there, but to also thrive. Specific attention could be devoted to fostering positive peer contacts (e.g., placing adolescents in classes with established friends), monitoring closely (e.g., weekly conversations with a support person), and providing alternatives to unstructured social situations (e.g., permitting adolescents to spend lunchtime in a supervised location).

ASD was diagnosed in 6 of the 10 adolescents who had been bullied before commencement at the Link. Youth with ASD who are bullied may be at particular risk for SR. Little (2001, cited in van Roekel, Scholte, & Didden, 2010) reported that adolescents in mainstream education who had Asperger's syndrome were bullied four times more often than adolescents without Asperger's syndrome. On the other hand, adolescents in schools for students with ASD experienced no more bullying than typically developing adolescents within mainstream education (Begeer, Fink, Van der Meijden, Goossens, & Olthof, 2015; van Roekel et al., 2010). According to van Roekel et al., victimization does not disappear completely when ASD youth attend special education schools, but its prevalence seems to decrease. With respect to the Link, no adolescents mentioned being bullied during their time there, and there was no bullying observed by Link staff. This suggests that the Link fulfilled an important role in reducing bullying, also for the adolescents with ASD. Because the Link provides a secure environment (e.g., small class size, close monitoring by Link teachers, exclusion of adolescents with behavior problems), the potential for bullying is reduced. If it does occur, it is likely to quickly come to the attention of Link staff.

Implications for Implementation

Implementation of an AEP like the Link presents specific challenges. The Link is a labor-intensive and thus expensive AEP. The Link expertise team (specialized teachers, educational psychologists, and a school-based social worker) meets weekly to manage the process of the adolescents' reengagement with schooling and every 6 weeks a multidisciplinary evaluation is held for each adolescent. Link requires a dedicated teaching staff expert in supporting SR adolescents with social-emotional, academic, and behavioral needs. These teachers, wholly assigned to the Link program, are funded via education funding.

At the Link, reintroduction to the educational curriculum of the original school is graded, which may slow the adolescent's academic progress. However, it very likely increases the adolescents' willingness and ability to reengage with the schooling process. Often, flexible and creative solutions need to be found (e.g., completing only some of the subjects for that school year). To accomplish this, Link staff has contact with staff from the original school to formulate educational goals and determine the most relevant curriculum. Thereafter, ongoing collaboration between Link staff and staff of the original school is required (e.g., ensuring tests are delivered to the Link in a timely fashion, accessing books and assignments used at the original school). Close collaboration between the Link and the subsequent school is also required to design and implement plans for increased attendance at that school.

Another challenge for implementation is to determine the ideal timeframe for the adolescent's transition from the supportive environment of the Link to a more typical educational setting. Our review of AEPs for SR indicated that all but one (Nuttall & Woods, 2013) specifically employed the AEP as an intermediate step prior to reengagement with another form of education. However, very little information was provided about the process of reengagement. It is only in the report of Grandison (2011) that there was such a reference, whereby reengagement with the mainstream school was gradual. Grandison also reflected upon the challenge in identifying the ideal timing for transition: "While these two aspects of the role of the short stay school [creating a safe and supportive environment; challenging adolescents to reengage with mainstream schooling] may not be mutually exclusive, they do create a certain tension for all involved" (p. 2). At the Link, the ideal timeframe for each adolescent's reengagement with a more typical

educational setting is a focus of the weekly meetings of the Link expertise team.

Experience gained through implementation of the Link indicates that the social-emotional and educational needs of adolescents with ASD have been adequately met via the highly structured and supportive environment of the Link. This impression is supported by our finding that Link adolescents with a primary diagnosis of ASD did not differ from those with other primary diagnoses with respect to the length of participation at the Link. Preece and Howley's (2018) description of an AEP specifically for SR adolescents with ASD suggests that most of the characteristics of their AEP were similar to characteristics of the Link, as well as the four other AEPs described in this article. There would be value in systematically evaluating the relative merits of an AEP dedicated to SR youth with ASD, against AEPs such as the Link which include SR youth with and without ASD.

Link teachers have observed that it takes considerable time for participating adolescents to freely and comfortably engage with each other. This may slow the process of them transitioning to a subsequent school. If the Link were to incorporate a group-based CBT dedicated to social skills and competence, some adolescents may be able to transition to the subsequent school more quickly. Indeed, group intervention to build social skills and reduce social anxiety is argued to be a valuable adjunct to individual treatment for SR (Heyne, Sauter, Van Widenfelt, Vermeiren, & Westenberg, 2011). Moreover, a school-based cognitive-behavioral intervention for socially anxious adolescents without SR was found to reduce social anxiety (Masia-Warner, Fisher, Shrout, Rathor, & Klein, 2007; Masia-Warner et al., 2005). The researchers pointed out that school is a natural context for the treatment of adolescent SAD, mainly because the setting creates many possibilities for in vivo exposure. The Link is especially conducive to offering group-based intervention because the hurdle has already been lowered with respect to helping participating SR adolescents attend this educational setting.

Concurrent treatment offered by external agencies is not always welcomed by adolescents participating in the Link, sometimes resulting in no-shows at the treatment facility. When possible, the Link expertise team arranges mental health care via a treatment facility with an established alliance with the Link. A therapist from the allied facility is present at the Link at various times during the school week. Observations made by Link staff suggest that the therapist's presence at the Link leads to adolescents being more receptive to individual therapy. It also makes it possible for the Link mentor to have weekly face-to-face discussions with the therapist about the adolescent's progress and about adaptations to the intervention plan as difficulties and opportunities arise.

Strengths and Limitations

A strength of the current paper lies in its focus on adolescent SR. By focusing on this group, as opposed to SR youth in general, specific expertise and interventions relevant to adolescent SR can be honed and evaluated. Moreover, this paper draws attention to SR adolescents with ASD. In other reports on AEPs for SR, either there was no mention of whether ASD youth were included, or youth with ASD were excluded. The current paper also differs from prior reports on AEPs for SR by including more detail about the process for reengaging the adolescent with a school setting subsequent to participation in the Link.

A number of limitations warrant consideration. First, the response rate for consent to review files was low. Even though there were no differences between responders and nonresponders with respect to age and gender, the nonresponders may represent the most severe cases, reducing the generalizability of the data reported here. Second, some files were incomplete, and the reported diagnoses were not verified by an independent researcher. This compromises the reliability of the diagnostic information reported here. Third, no standardized measures of the adolescents' functioning were available, and attendance data were not routinely gathered from school records, prohibiting empirical evaluation of outcomes.

Conclusion

The effectiveness of the Link program awaits robust evaluation via a randomized controlled trial or a single-arm trial incorporating standardized assessments at pre- and postintervention, and at follow-ups. Nonetheless, this paper suggests to mental health and education professionals that interventions that address school-based factors may play—and may need to play—an important role when working with adolescents with severe and chronic SR. When these youth have not been helped via interventions implemented in typical educational settings, referral to an AEP such as the Link should be considered.

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